STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING ______ B. WING ______	C 05/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 5/2/17 through 5/4/17. Complaints were investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 169 certified bed facility was 155 at the time of the survey. The survey sample consisted of 22 current resident reviews (Residents #1 through #21 and #27) and 5 closed record reviews (Residents #22 through #26).	F 000		
F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to	F 157		5/26/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 05/26/2017

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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F 157	Continued From page 1 commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to notify the physician of a weight change, per the physician order, for one of 27 residents in the survey sample, Resident #14. The facility staff failed to notify the physician when the resident's weight gain was greater than two pounds from one day to the next or five pound weight gain in a week for Resident #14.	F 157	F157 1. The physician was informed of resident #14□s weight change. 2. All resident□s with physician orders to report weight changes have the potential to be affected by this deficient practice. Residents with orders for weight change notification have been reviewed for MD notification if needed 3. The DON or designee will educate licensed nurses on following MD orders	

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The findings include:

Resident #14 was admitted to the facility on 10/24/16 with a readmission on 11/21/16. Her diagnoses included but were not limited to: congestive heart failure (CHF), acute and chronic respiratory failure, fracture of the lower leg, high blood pressure, sleep apnea (periods of not breathing while someone sleeps (1)), anemia, chronic obstructive pulmonary disease (COPD), and atrial fibrillation (rapid and random contractions of the atria of the heart causing irregular beats of the ventricles decreasing the heart output (2)).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/14/17, coded the resident as scoring a 14 on the BIMS (brief interview for mental status) score, indicating she was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance for most of her activities of daily living. She was coded as only requiring supervision after set up assistance was provided for eating.

The physician order dated, 11/21/16, documented, "Obtain weight daily; one time a day for monitoring. If there is a weight gain of 2 lbs. (pounds) in one day or 5 lbs. in one week, notify MD (medical doctor)."

The MAR (medication administration record) for February 2017 documented, "Obtain weight daily; one time a day for monitoring. If there is a weight gain of 2 lbs. in one day or 5 lbs. in one week, notify MD." The following weight gains were documented:
2/5/17 - 249.8; 2/6/17 - 251.9, a gain of two

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and notification of change of condition.
4. The Unit Managers will audit all residents with orders to report weight changes to the physician five times weekly for four weeks, then randomly weekly for eight weeks. Results of audits will be carried to QAPI monthly for 3 months for review and revisions as necessary.
5. Date of compliance: June 16, 2017.

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pounds.
2/18/17 - 252.2; 2/19/17 - 254.2, a gain of two pounds.

The March 2017 MAR documented, "Obtain weight daily; one time a day for monitoring. If there is a weight gain of 2 lbs. in one day or 5 lbs. in one week, notify MD." The following weight gains were documented:
3/8/17 - 256; 3/9/17 - 258.6, a gain of 2.6 pounds.
3/16/17 - 257.8; 3/17/17 - 260.2, a gain of 2.4 pounds.
3/17/17 - 260.2; 3/18/17 - 263, a gain of 2.8 pounds.
3/26/17 - 252; 3/27/17 - 259.4, a gain of 7.4 pounds.

The April 2017 MAR documented, "Obtain weight daily; one time a day for monitoring. If there is a weight gain of 2 lbs. in one day or 5 lbs. in one week, notify MD." The following weight gains were documented:
4/3/17 - 252.8; 4/4/17 - 256.4, a gain of 3.6 pounds.
4/7/17 - 256; 4/8/17 - 258, a gain of two pounds.

The above order was discontinued on 4/20/17.

Review of the nurse's notes from 2/1/17 through 4/20/17 did not evidence any documentation of the physician being notified of the weight gain.

The comprehensive care plan dated, 10/25/16 and revised on 3/21/17, documented in part, "Focus: Risk for fluid output exceeding intake characterized by fluid volume deficit; dry skin and mucous membranes, poor skin turgor and integrity related to: diuretics, CHF." The "Interventions" documented in part, "Notify MD &

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RD (registered dietician) of weight change per facility routines."

An interview was conducted with LPN (licensed practical nurse) #4 on 5/3/17 at 3:10 p.m. The above daily weight order was reviewed with her. When asked what is expected of the nurse with the above order, LPN #4 stated, "We have to weigh the person every day and call the doctor according to the order." When asked where that is documented, LPN #4 stated, "It's documented in the progress notes and or 24 hour book." When asked if the 24 hour book was part of the clinical record, LPN #4 stated, "It should be in both but definitely the progress note."

On 5/3/17 at 3:17 p.m., an interview was conducted with LPN #10, the unit manager. LPN #10 was asked to review the above order for daily weights. LPN #10 was then asked to explain what the nurse's responsibility is, LPN #10 stated, "They have to weigh the resident daily and notify the doctor if the weight is more than two pounds in a day or five pounds in a week." When asked where this notification is documented, LPN #10 stated, "It should be in a nurse progress note to say at least the doctor was notified."

The facility policy, "Change in Resident Condition" documented in part, "The Charge Nurse will recognize and appropriately intervene in the event of a change in resident condition. The Physician/Family/Responsible Party will be notified as soon as the nurse had identified the change in condition and the resident is stable."

In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and

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F 157	Continued From page 5 notification. Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health 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. Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, ASM #3, corporate nurse, and RN (registered nurse) #3, the transitional care coordinator, were made aware of the above findings on 5/3/17 at 5:35 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 45. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.	F 157		
F 166 SS=D	RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES CFR(s): 483.10(j)(2)-(4) (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the	F 166		5/26/17

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F 166	Continued From page 6 resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;	F 166		

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(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and

(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.

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This REQUIREMENT is not met as evidenced by:

Based on staff interview and facility document review, it was determined that the facility staff failed to maintain grievance logs for six months since the prior survey.

The facility staff could not locate the grievance logs from April 2016 until November 2016.

The findings include:

Upon entrance on 5/2/17 at 12:30 p.m., the grievance policy and logs were requested.

On 5/3/17 at 4:25 p.m. other staff member (OSM) #12, the director of social services, presented the grievance logs from 11/8/16 through present. When asked for the previous logs going back to the last survey, OSM #12 stated, "I just started here on 1/2/17 and the other social worker came a week later, 1/9/17."

An interview was conducted with administrative staff member (ASM) #1, the administrator and ASM #2, the director of nursing, on 5/4/17 at 9:28 a.m. When asked about the process for filing a grievance, ASM #2 stated, "Anyone can file a grievance and give it to any staff member. The grievance is forwarded to the social services department and they will give it to the proper department head that relates to the grievance and take action on it. Action is taken until the resolution section is filled in." When asked who keeps the logs of the grievances, ASM #2 stated, "Social Services." This surveyor informed ASM #1, that the director of social services could not locate any grievances prior to 11/8/16; ASM #1 and ASM #2 stated that they would look

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1. Grievance/concern log current as of January 2017. .
2. All residents have the potential to be affected by this deficient practice.
3. Facility staff educated on grievance/concern process by DON/designee. DON/designee to educate Social workers on maintaining grievance/concern log. .
4. The grievance log will be audited by the Administrator or designee weekly for 12 weeks for accuracy and completeness. Results of audits will be taken to QAPI committee monthly for 3 months for review and revisions as necessary.
5. Date of compliance: June 16, 2017

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F 166	Continued From page 9 elsewhere for those. On 5/4/17 at approximately 2:50 p.m. ASM #1 informed this surveyor, they could not locate any other grievance logs. The facility policy, "Resident Grievances & Concerns" documented in part, "The facility strives to meet the needs of the residents, their representatives and staff. However, there may be times that a concern or grievance may be voiced without discrimination or reprisal by the resident or family. The facility will assist the residents, their representatives and other interested parties in filing grievances or concerns. The facility will investigate all grievances and concerns. Procedure: A. Any resident or their representatives may file a concern regarding his/her treatment, medical care, behavior of other residents, staff members, theft of property, etc. utilizing the Resident/Family Concern Form. 1. The facility staff can provide assistance in locating the form, and documenting on the form. B. The completed Resident/Family Concern Form will be forwarded to the facility Administrator to investigate the concern within 72. 1. The facility Administrator may delegate the responsibility to investigate to the appropriate department director. C. The investigation and report will include: 1. The date and time the incident occurred; 2. The circumstances surrounding the incident; 3. Where the incident occurred; 4. Statements from the resident; 5. The names of any witnesses and their statements; 6. Recommended corrective action. D. The outcome of the investigation with resolution will be documented on the Resident/Family Concern Form within 5 days and discussed with individual filing the grievance/concern to ensure satisfaction	F 166		

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F 166	Continued From page 10 with resolution...G. Written grievances are forwarded to the Social Services Department for documenting on the Grievance/Complaint Logs. 1. The following information, as applicable, will be recorded on the log; a. The date of the grievance/concern was received; b. The mane and room number of the resident; c. The name and relationship of the person filing the grievance/concern; d. The date the alleged incident occurred; e. The name of the person(s) investigating the incident; f. The date the Resident or their representative was informed of the outcome; g. The disposition of the grievance/concern." ASM #1 and ASM #2 were made aware of the above concern on 5/4/17 at 2:52 p.m.	F 166		
F 167 SS=C	RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE CFR(s): 483.10(g)(10)(i)(11) (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	F 167		5/26/17

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years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and

(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, staff interview and facility document review, it was determined that the facility staff failed to post a notice of the availability of the last three preceding year's survey results and their corresponding plan of corrections.

A notice was not posted to the residents and responsible parties that the results of the previous three years of survey results, with the plan of corrections, were available for review.

The findings include:

On 5/2/17 at 12:30 p.m. and 2:41 p.m., the survey results for the last three years were observed in a binder labeled "State Inspection Results" located on the bottom shelf of a drop leaf credenza in the lobby. No notice regarding the survey results was observed in the lobby.

On 5/2/17 at 2:45 P.M., ASM (administrative staff member) #1 (the administrator) was asked who was responsible for posting the survey results. ASM #1 stated the business office manager was.

On 5/2/17 at 2:48 p.m., an interview was

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1. Posted signs were changed to state that three years of survey results are available for review.
2. All residents who desire to review survey results have the potential to be affected by this deficient practice.
3. Administrator was in-serviced by Regional Director of Clinical Services on signage indicating 3 years of surveys available for review.
4. Business Office Manager or designee will audit signage weekly for 12 weeks to assure signage is in place and visible to visitors/residents. Results of audits will be carried to QAPI committee monthly for 3 months for review and revisions as necessary.
5. Date of compliance: June 16, 2017.

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conducted with OSM (other staff member) #4 (the business office manager). OSM #4 was asked if she was responsible for posting the survey results. OSM #4 stated she makes copies of the survey results and places them in the binder when the administrator gives them to her. OSM #4 was asked how residents and families are made aware the survey results are available. OSM #4 stated the survey results are located "up front" on the credenza. OSM #4 was asked if there were any notices posted that documented the survey results are available for review. OSM #4 stated, "Not that I know of." When asked if there were any notices posted on the nursing units, OSM #4 stated, "No."

On 5/2/17 at 3:00 p.m., OSM #4 stated there was a sign regarding the survey results posted on bulletin boards on both ends of the main hall in the facility. At this time, this surveyor confirmed the signs were posted on the bulletin boards. The signs documented: "Results of the most recent inspection by the Virginia Department of Health, Office of Licensure and Certification can be reviewed any time. It is located on the credenza in the lobby." The sign failed to document information regarding the survey results for the previous three years and the corresponding plans of corrections for these surveys.

On 5/3/17 at 5:42 p.m., ASM #1, ASM #2 (the director of nursing), ASM #3 (the regional director of clinical services) and RN (registered nurse) #3 (the transitional care coordinator) were made aware of the above findings. ASM #1 was asked what should be documented on the posted notice regarding the survey results. ASM #1 stated the notice was posted at each nurse's station and by

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the social services office. ASM #1 further stated the survey results were discussed at the resident council meetings. When asked what the posting should document, ASM #1 stated, "Results of the last three years are available on the credenza in the white book in the lobby."

The facility document titled, "RESIDENT RIGHTS" documented, "Is the policy at this Facility that all Residents shall have the following rights and privileges...To be notified of the findings in any Centers for Medicare & Medicaid Services surveys and investigations concerning the facility..."

On 5/4/17 at 8:30 a.m., ASM #3 stated the facility did not have a policy regarding the survey results.

No further information was presented prior to exit.

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DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES
CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3)

483.12
(b) The facility must develop and implement written policies and procedures that:

(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,

(2) Establish policies and procedures to investigate any such allegations, and

(3) Include training as required at paragraph §483.95,

483.95

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(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-

(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.

(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property

(c)(3) Dementia management and resident abuse prevention.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document review it was determined, that the facility staff failed to implement the facility abuse policy for screening, for one of five employee records reviewed per policy.

The facility staff failed to obtain license verification in a timely manner for CNA (certified nursing assistant) #7.

The findings include:

Review of CNA #7's employee record documented that the employee was hired on 3/7/17 and that the license was verified as being active on 3/29/17.

An interview was conducted on 5/4/17 at 11:35 p.m. with OSM (other staff member) #13, human resources and payroll personnel. When asked if there had been a license verification done for

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F226
1. The license verification for CNA # 7 was in the employee□s file.
2. All residents have the potential to be affected by this deficient practice.
3. The Administrator or designee will educate human resource department and department managers on verification of certification/licensure prior to hire.
4. Human Resources/designee will audit potential new employee□s paper work weekly for completeness and accuracy. Audits will be taken to QAPI committee monthly times 3 months for review and revisions as necessary.
5. Date of compliance: June 16, 2017

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CNA #7 prior to hire, OSM #13 stated, "If it's not in the file we don't have it. We always keep the original in the file and put a red line through it." When asked why staff licenses are verified prior to hire, OSM #13 stated, "To make sure they actually have a valid license. A request was made for the number of shifts CNA #7 worked with the residents before the license was verified. On 5/4/17 at 1:00 p.m. CNA #7's schedule was received. CNA #7 worked with residents for 6 days prior to having the license verified.

An interview was conducted on 5/4/17 at 2:07 p.m. with ASM (administrative staff member) #2, the director of nursing. When asked why employees were screened prior to hiring, ASM #2 stated, "We check to protect them (residents) from a criminal." When asked why references were obtained, ASM #2 stated, "References ideally are going to find out what kind of person you are hiring." ASM #2 was made aware of the findings at that time.

Review of the facility's policy titled, "Virginia Resident Abuse Policy" documented, "POLICY: This Facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone. PROCEDURE: 1. Screening-facility will not employ or otherwise engage individuals who have been found guilty of abuse, neglect, or mistreatment of residents by a court of law; had a finding of abuse, neglect, mistreatment, exploitation, involuntary seclusion and/or misappropriation of property reported into a state nurse aide registry, or had a disciplinary action taken against a professional license by a state licensure body as a result of a finding of abuse, neglect, or mistreatment of residents or a finding

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F 226	Continued From page 16 or a finding of misappropriation of property. 1.) It is the policy of the Facility to undertake background checks of all employees and to retain on file applicable records of current employees regarding such checks. a. The Facility will do the following prior to hiring a new employee:.. ii. Check with the applicable nurse assistant registry, and any other nurse assistant registries that the Facility has reason to believe contain information on an individual, prior, to using the individual as a nurse assistant." No further information was obtained prior to exit.	F 226		
F 241 SS=D	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to provide wound care in a dignified manner for one of 27 residents in the survey sample, Resident #7. The facility staff documented the date of the dressing while the dressing was on the resident's heels and buttock for Resident #7. The findings include: Resident #7 was admitted to the facility on 1/7/15 with diagnoses that included but were not limited	F 241	F241 1. LPN #10 was in-serviced and counseled by the DON on providing wound care in a dignified manner. 2. All residents receiving wound treatments have the potential to be affected by this deficient practice. 3. The DON or designee will in-service licensed nurses on providing wound care in a dignified manner. 4. Unit Manager/designee will observe 25% of wound treatments weekly for four weeks and randomly for eight weeks to assure compliance. Results of audits will	5/26/17

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F 241	Continued From page 17 to: diabetes, high blood pressure, depression, chronic pain, gastroesophageal reflux disease, anemia (too low blood count (1)), pressure ulcer of the sacral region (inflammation or sore over a bony prominence resulting from prolonged pressure to the area (2)), dysphagia, and dementia. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 2/3/17, coded the resident as a zero on the BIMS (brief interview for mental status) score, indicating that she was severely impaired to make cognitive daily decisions. Resident #7 was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living. In Section M - Skin Conditions, the resident was coded as having an unstageable pressure ulcer*. Also known as a pressure injury.* *Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. (3) **Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in	F 241	be carried to QAPI committee monthly for 3 months for review and revisions as necessary. 5. Date of compliance: June 16, 2017.	

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combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. (4)

Observation was made of LPN (licensed practical nurse) #10, the unit manager and wound care nurse; on 5/3/17 at 10:50 a.m. LPN #10 proceeded to perform Resident #7's wound care treatment to her bilateral heels and sacrum. After LPN #10 completed each of the dressings, she placed the dressings on the resident. She then proceeded to write on both heel dressings and the sacral dressing, with a permanent marker, her initials and the date of 5/3/17.

An interview was conducted with LPN #10 on 5/3/17 at 1:54 p.m. When asked if a nurse is expected to write on a dressing while it is on the resident, like the sacrum or heels, LPN #10 stated, "I should have dated the dressing before putting it on the resident. I was afraid to break my clean field to get the sharpie (permanent marker) out of my pocket." When asked how she would feel if someone was writing on her sacral area or heels, LPN #10 did not respond.

On 5/4/17 at 10:25 a.m., an interview was conducted with RN (registered nurse) #8, a unit manager. RN #8 was asked when staff would date a dressing during a dressing change. RN #8 stated, "I date them prior to putting it on the resident." When asked if staff should write on a dressing and date it after it has already been placed on the resident, RN #8 stated, "No." When asked why staff don't date a dressing while it is on a resident, RN #8 stated, "It can cause pain from the pressure of the pen or marker and it's just wrong." When asked if that affects

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someone's dignity, RN #8 stated, "Yes, it would."

The facility policy, "Resident Rights" documented in part, "IT is the policy of (name of corporation) that resident will be cared for in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. (Name of corporation) is committed to assuring that the resident's rights articulated under federal law are protected.

Guidance is given to nurses for the preservation of dignity in "Fundamentals of Nursing, 7th Edition, Potter Perry, p. 476." Included in the guidance is, "Nurses promote a client's self-esteem and dignity by respecting him or her as a whole person with feelings, accomplishments, and passions independent of the illness experience."

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, ASM #3, the corporate nurse and RN #3, the transitional care coordinator, were made aware of the above findings on 5/3/17 at 5:35 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 33.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 155.
(3) This information was obtained from the following website:
http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/

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F 241	Continued From page 20 (4) This information was obtained from the following website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/	F 241		
F 248 SS=D	ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES CFR(s): 483.24(c)(1) (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide an ongoing activities program designed to meet residents' needs and interests for two of 27 residents in the survey sample, Residents #4 and #7. 1. The facility staff failed to involve Resident #4 in activities individualized to meet the resident's interests. 2. The facility staff failed to evidence Resident #7 was provide with an activity program. The findings include:	F 248	F248 1. Residents #4 and #7 were assessed for activity preferences and care plans were reviewed for accuracy. 2. All residents have the potential to be affected by this deficient practice. 3. The MDS Coordinator or designee will in-service the Activity Director and the Activities staff on completing and documenting activity assessments, documenting resident participation, and updating care plans. 4. The MDS Coordinator or designee will audit 10% of care plans and activity assessments weekly for four weeks, and then randomly for eight weeks to assure	5/26/17

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1. The facility staff failed to involve Resident #4 in activities individualized to meet the resident's interests.

Resident #4 was admitted to the facility on 1/21/15. Resident #4's diagnoses included but were not limited to: heart failure, major depressive disorder and overactive bladder. Resident #4's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/21/17, coded the resident's cognition as severely impaired. Section G coded Resident #4 as requiring extensive assistance of one staff with bed mobility and locomotion. Resident #4's annual MDS with an ARD of 12/19/16 coded the resident as being cognitively intact. Section G coded Resident #4 as requiring limited assistance of one staff with bed mobility and supervision with set up help with locomotion. The resident interview for activity preferences was not completed. The staff assessment for activity preferences documented Resident #4 preferred activities including but not limited to: reading, listening to music, being around animals, keeping up with the news and spending time outdoors.

Review of Resident #4's clinical record failed to reveal any documentation from the activities department (including evaluations, notes or evidence of participation). Resident #4's comprehensive care plan initiated on 4/28/16 failed to document information regarding activities.

On 5/2/17 at 5:15 p.m., Resident #4 was observed lying in bed and watching television. On 5/3/17 at 11:25 a.m., Resident #4 was

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that information regarding activities is recorded. The Director of Social Work will conduct audits of participation log five times weekly for four weeks, then randomly weekly for eight weeks to assure that they are complete. Results of audits will be carried to the QAPI committee monthly for 3 months for review and revisions as necessary.

5. Date of compliance: June 16, 2017.

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observed lying in bed. The resident stated she preferred to stay in bed.

On 5/3/17 at 2:27 p.m., RN (registered nurse) #2 (the MDS coordinator) confirmed there were no activity notes in Resident #4's clinical record.

On 5/3/17 at 2:29 p.m., an interview was conducted with OSM (other staff member) #2 (the activities director). OSM #2 was asked to provide participation documentation to evidence Resident #4 was offered activities. OSM #2 confirmed she could not provide any documentation. OSM #2 stated Resident #4 preferred to stay in her room. OSM #2 was asked if she had completed any evaluations of Resident #4's activity preferences other than the staff assessment that was completed on the 12/19/16 MDS. OSM #2 stated the resident was admitted to the facility prior to her (OSM #2's) employment. OSM #2 stated she was completing quarterly progress notes but they were not currently showing up on the computer. OSM #2 stated since her employment she had not offered Resident #4 activities. OSM #2 was made aware that Resident #4's 12/19/16 MDS documented the resident preferred reading, music, animals and news and was asked if she offered Resident #4 these or any other activities. OSM #2 stated, "No but I can start." OSM #2 stated she conducts one on one visits with some residents and she could begin to conduct those visits with Resident #4. OSM #2 stated the activities director previously employed should have had documentation to evidence the resident's activity participation but she (OSM #2) could not provide the evidence.

On 5/3/17 at 2:40 p.m. Resident #4 was observed sitting up in bed and watching television. The

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resident was asked if there were any particular activities that she would like to be provided in her room. Resident #4 stated, "Maybe." When asked what activities she would like, the resident stated, "I don't know. I can't think right now."

On 5/3/17 at 5:42 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional director of clinical services) and RN (registered nurse) #3 (the transitional care coordinator) were made aware of the above findings.

The facility policy titled, "Activity Documentation Protocol" documented "Purpose: In order to promote the physical, mental and psychosocial well-being of residents, an Activity Assessment is conducted and on-going documentation is maintained for each resident.
Procedure:
- Within 3 days of a resident's admission to the facility, an Activity Assessment utilizing Med Pass form (MP 5450), will be conducted to help develop an activities plan that reflects the choices and interests of the resident.
- The resident's Activity Assessment is to be conducted by Activity Department personnel, in conjunction with other staff who will assess related factors such as functional level, cognition, and medical conditions that may affect activities participation. The resident's lifelong interests, spirituality, life roles, goals, strengths, needs and activity pursuit patterns and preferences will be included in the assessment...
-Each resident's Activities Care Plan shall relate to his/her Comprehensive Assessment and should reflect his/her individual needs...
-The Activity Assessment and Activities Care Plan will identify if a resident is capable of pursuing

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activities without intervention from the facility...
-Activity progress note needs to be written at minimal every 3 months, including MDS documentation when section F is completed..."

No further information was presented prior to exit.

2. The facility staff failed to evidence Resident #7 was provide with an activity program.

Resident #7 was admitted to the facility on 1/7/15 with diagnoses that included but were not limited to: diabetes, high blood pressure, depression, chronic pain, gastroesophageal reflux disease, anemia (too low blood count (1)), pressure ulcer of the sacral region (inflammation or sore over a bony prominence resulting from prolonged pressure to the area (2)), dysphagia, and dementia.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 2/3/17, coded the resident with a zero on the BIMS (brief interview for mental status) score, indicating that she was severely impaired to make cognitive daily decisions. Resident #7 was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living.

The comprehensive MDS assessment, a significant change assessment, with an assessment reference date of 7/20/16, coded the resident as scoring a "6" on the BIMS, indicating she was severely impaired to make cognitive daily decisions. In Section F - Preferences for Customary Routine and Activities the resident was coded as while in the facility, the resident felt that the following things were somewhat

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important to her; having books and newspapers to read, listening to music, be around animals, keep up with the news, do things with groups of people, do her favorite activity, go outside to get fresh air when the weather is good, and participate in religious services or practices.

The comprehensive care plan, dated, 4/26/16 with a revised on date of 2/21/17, documented in part, "Focus: Resident enjoys the following solitary activities; watching TV in the living room area and talking to other residents." The "Interventions" documented, "Engage resident in group activities. Offer activity program directed toward specific interests/needs of resident. Provide and encourage visits for socialization prn (as needed). Resident will receive monthly calendar."

Resident #7's room was observed on 5/2/17 at 5:04 p.m. The resident was not in the room. The resident was then observed on the side of the hallway in her wheelchair. A staff member greeted her. Other residents were gathering at the dining tables for dinner.

On 5/3/17 at 7:42 a.m. the resident's room was observed. The room was dark with the curtains pulled. Resident #7 was in bed.

On 5/3/17 at 10:50 a.m. the resident was observed in bed. The curtains were pulled as morning care had just been given. The television was not on. There was no music playing in the room.

On 5/3/17 at 1:52 p.m. the resident was observed in the hallway in her wheelchair, trying to self-propel. Some residents were in the living

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room area watching the television.

On 5/3/17 at 3:30 p.m. the resident was observed in the hallway in her wheelchair not engaged in any activity.

An interview was conducted with other staff member (OSM) #2, the director of activities. When asked where notes regarding Resident #7's activities were documented, OSM #2 stated, "I can't find any of my quarterly notes. We keep a daily log of activities when the residents attend but not an individual log for each person." When asked if she had any idea of what activities Resident #7 attends, OSM #2 stated, "Occasionally she will come to music activities, she does not attend on a daily basis." When asked what the activity department does for Resident #7, OSM #2 stated, "I'll have to get back with you."

On 5/3/17 at 5:02 p.m. OSM #2 presented records of attendance at activities for Resident #7, but the records were all for 2016. When asked where Resident #7's attendance or refusal to attend activities would be documented, OSM #2 stated, "I am told by the other activity staff that she declines activities." When asked if this should be documented, OSM #2 stated, "Yes. We have no log for her." When asked if she could provide evidence of any activities Resident #7 had attended activities for the last three months, OSM #2 stated, "Nom Ma'am, I can't tell you if she has come to anything in the last three months."

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, ASM #3, the corporate nurse and RN #3, the transitional care coordinator, were made aware of

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F 248	Continued From page 27 the above findings on 5/3/17 at 5:35 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 33. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 155.	F 248		
F 278 SS=E	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (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 penalty of not more than $1,000 for each	F 278		5/26/17

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F 278	Continued From page 28 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 staff interview and clinical record review, it was determined that the facility failed to maintain an accurate MDS (minimum data set) assessment for four of 27 residents in the survey sample, Residents # 12, # 4, # 10 and # 16. 1. The facility staff failed to complete the cognition section on Resident # 12's quarterly MDS (Minimum Data Set) assessment with an ARD (assessment reference date) of 01/24/17. 2. The facility staff failed to attempt the resident interview for daily and activity preferences on Resident #4's annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/19/16. 3. The facility staff failed to accurately record that Resident # 10 had two falls in Section J on her significant change MDS (minimum data set) assessment with an ARD of 4/21/17. 4. The facility staff failed to complete the resident interview portion of Section F "Preferences for Customary Routine and Activities" on Resident #16's 4/19/17 admission/5-day MDS assessment. The findings include:	F 278	F278 1. The MDS of residents #12, #4, #10 and #16 were reviewed and changes made to ensure accuracy. 2. All residents have the potential to be affected by this deficient practice. 3. The MDS department and IDCP team were in-serviced by Regional MDS Nurse on an accurate and complete MDS. 4. The MDS Coordinator or designee will audit MDS completion weekly for four weeks, then randomly weekly for eight weeks to assure completion and accuracy. The results of the audits will be taken to the QAPI committee monthly for 3 months for review and revision as needed.. 5. Date of compliance: June 16, 2017.	

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1. The facility staff failed to complete the cognition section on Resident # 12's quarterly MDS (Minimum Data Set) assessment with the ARD (assessment reference date) of 01/24/17.

Resident # 12 was admitted to the facility on 04/22/16 with diagnoses that included but not limited to: dementia (1), heart disease (2), depressive disorder, anxiety (3), and Parkinson's disease (4).

The most recent comprehensive MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 04/29/16 coded the resident as scoring a three on the brief interview for mental status (BIMS) of a score of 0 - 15, three being severely impaired of cognition. Resident # 12 was coded as requiring limited assistance of one staff member for activities of daily living.

The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/24/17 failed to evidence the completion of Section C "Cognitive Patterns." Further review of section C revealed C0100 through C1000 was blank.

On 05/03/17 at 4:15 p.m. an interview was conducted with LPN (licensed practical nurse) # 9, MDS nurse. LPN # 9 was asked to review Sections C0100 through C1000 "Cognitive Patterns" of Resident # 12's quarterly MDS assessment with an ARD of 01/24/17. When asked why Sections C0100 through C1000 "Cognitive Patterns" was not completed. LPN # 9 stated, "I was responsible for that. It should have been completed." When asked what guidance

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they follow for completing the MDS LPN # 9 stated, "We use the RAI (resident assessment instrument) manual."

2. The facility staff failed to attempt the resident interview for daily and activity preferences on Resident #4's annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/19/16.

Resident #4 was admitted to the facility on 1/21/15. Resident #4's diagnoses included but were not limited to: heart failure, major depressive disorder and overactive bladder. Resident #4's most recent MDS, a quarterly assessment with an ARD of 3/21/17, coded the resident's cognition as severely impaired, scoring a six out of a possible 15 on the BIMS (brief interview for mental status) assessment. Resident #4's annual MDS with an ARD of 12/19/16 coded the resident as being cognitively intact, scoring a 15 out of a possible 15 on the BIMS assessment. Section B coded Resident #4 as being understood and as understanding others. Section F300 documented, "Should Interview for Daily and Activity Preferences be Conducted? - Attempt to interview all residents able to communicate. If resident is unable to complete, attempt to complete interview with family member or significant other. 0- No (resident is rarely/never understood and family/significant other not available..." The staff assessment of daily and activity preferences was completed.

On 5/3/17 at 1:40 p.m., an interview was conducted with RN (registered nurse) #2 (the MDS coordinator). RN #2 was asked how to

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F 278	Continued From page 31 determine whether a resident interview versus a staff interview should be conducted for an MDS assessment. RN #2 stated she would look at the resident's BIMS on the MDS assessment and if a resident couldn't answer the interview questions then she would complete the staff assessment. RN #2 was asked what number the resident would have to score on the BIMS in order for her to attempt the interview. RN #2 stated that was a tricky question but if the resident scored a five on the BIMS then she may consider the staff interview and it depended on if the resident could answer the questions or how the resident answered the question. RN #2 was asked if staff should have attempted the interview for daily and activity preferences with Resident #4 regarding the MDS with an ARD of 12/19/16. RN #2 stated, "I would say yes." On 5/3/17 at 2:11 p.m., an interview was conducted with OSM (other staff member) #2 (the activities director and person responsible for completing section F on MDS assessments). OSM #2 stated she completes the resident interview for daily and activity preferences if she feels she can obtain accurate information from the resident. OSM #2 stated she completes the staff assessment for daily and activity preferences if a resident's dementia is to a point where she can't understand the resident or if a resident is in the hospital. OSM #2 stated she worked at an assisted living facility prior to her employment at this facility and she did not have previous experience with completing MDS assessments. OSM #2 stated she probably did not attempt Resident #4's interview for daily and activity preferences while completing the MDS assessment with an ARD of 12/19/16. OSM #2 stated Resident #4 wasn't the easiest person to	F 278		

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talk to and wanted to go home. OSM #2 stated she is now more experienced in determining whether to complete the resident interview versus the staff assessment and she probably should have completed Resident #4's daily and activity preference interview with the resident. OSM #2 stated she references the MDS coordinator if she has questions while completing MDS assessments.

On 5/3/17 at 2:24 p.m. RN #2 stated she references the CMS (Centers for Medicare & Medicaid Services) RAI (Resident Assessment Instrument) manual when completing MDS assessments.

On 5/3/17 at 5:42 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional director of clinical services) and RN (registered nurse) #3 (the transitional care coordinator) were made aware of the above findings.

The CMS RAI manual documented the following: "SECTION F: PREFERENCES FOR CUSTOMARY ROUTINE AND ACTIVITIES
Intent: The intent of items in this section is to obtain information regarding the resident's preferences for his or her daily routine and activities. This is best accomplished when the information is obtained directly from the resident or through family or significant other, or staff interviews if the resident cannot report preferences. The information obtained during this interview is just a portion of the assessment. Nursing homes should use this as a guide to create an individualized plan based on the resident's preferences, and is not meant to be all-inclusive.

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F 278	Continued From page 33 F0300: Should Interview for Daily and Activity Preferences Be Conducted? Item Rationale Health-related Quality of Life Most residents capable of communicating can answer questions about what they like. Obtaining information about preferences directly from the resident, sometimes called 'hearing the resident's voice,' is the most reliable and accurate way of identifying preferences. If a resident cannot communicate, then family or significant other who knows the resident well may be able to provide useful information about preferences. Planning for Care Quality of life can be greatly enhanced when care respects the resident's choice regarding anything that is important to the resident. Interviews allow the resident's voice to be reflected in the care plan. Information about preferences that comes directly from the resident provides specific information for individualized daily care and activity planning. Steps for Assessment 101. Determine whether or not resident is rarely/never understood and if family/significant other is available. If resident is rarely/never understood and family is not available, skip to item F0800, Staff Assessment of Daily and Activity Preferences. 102. Conduct the interview during the observation period. 103. Review Language item (A1100) to determine whether or not the resident needs or wants an interpreter. If the resident needs or wants an interpreter, complete the interview with an interpreter. 4. The resident interview should be conducted if the resident can respond:	F 278		

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verbally, by pointing to their answers on the cue card, OR by writing out their answers..."

No further information was presented prior to exit.

The RAI (Resident Assessment Instrument) manual documented, "SECTION C: COGNITIVE PATTERNS. Intent: The items in this section are intended to determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions."

On 05/04/17 at approximately 1:50 p.m. ASM (administrative staff member) # 1 the administrator, and ASM # 2, director of nursing, were made aware of the findings.

No further information was provided prior to exit.

References:

(1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

(2) There are many different forms of heart disease. The most common cause of heart disease is narrowing or blockage of the coronary arteries, the blood vessels that supply blood to the heart itself. This is called coronary artery disease and happens slowly over time. It's the major reason people have heart attacks. Other kinds of heart problems may happen to the valves in the heart, or the heart may not pump well and cause heart failure. Some people are born with heart disease. This information was obtained

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from the website:
https://medlineplus.gov/heartdiseases.html.

(3) Fear. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.

(4) A type of movement disorder. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

3. The facility staff failed to accurately record that Resident # 10 had two falls in Section J on her significant change MDS (minimum data set) assessment with an ARD (assessment reference date) of 4/21/17.

Resident # 10 was admitted to the facility on 1/14/16 and again on 4/14/17 with diagnoses that included, but were not limited to, hypertension, dementia, anxiety, depression, atrial fibrillation, coronary artery disease, seizures, and hypothyroidism [a low functioning thyroid (1)].

Resident # 10's most recent MDS is a significant change assessment with an ARD of 4/21/17. Resident # 10 was coded as usually understanding and as usually able to understand others. Resident # 10 was coded as scoring zero out of a possible 15 on the BIMS (Brief Interview for Mental Status) indicating that Resident #10 was severely cognitively impaired. Section J1800: (Any Falls since Admission/Entry or Reentry or Prior Assessment...) coded Resident #10 as having 0 (zero) falls since the last MDS assessment.

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A review of Resident #10's clinical record revealed that Resident #10 had two documented falls dated 1/23/17 and 4/10/17 since her last MDS assessment with an ARD of 1/14/17.

During an interview on 5/3/17 at 1:35 p.m. with RN (registered nurse) # 2, the MDS coordinator, Resident # 10's significant change assessment was reviewed. RN # 2 stated that the error was "an item coding error". When asked what reference she (RN # 2) uses to complete the MDS assessments. RN # 2 stated, "The RAI (resident assessment instrument) manual."

During the end of day interview on 5/3/17 at 5:30 p.m. with ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nurses, ASM # 3, regional director of clinical services, and RN (registered nurse) # 3, the transitional care coordinator, this concern was revealed.

The RAI manual revealed, in part, the following documentation regarding the coding of falls:

J1800: Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA [Omnibus Budget Reconciliation Act] or Scheduled PPS [Prospective Payment Systems]), whichever is more recent (cont.)

Planning for Care:

" Identification of residents who are at high risk of falling is a top priority for care planning. A previous fall is the most important predictor of risk for future falls.
" Falls may be an indicator of functional decline and development of other serious conditions such

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as delirium, adverse drug reactions, dehydration, and infections.

" External risk factors include medication side effects, use of appliances and restraints, and environmental conditions.

" A fall should stimulate evaluation of the resident's need for rehabilitation, ambulation aids, modification of the physical environment, or additional monitoring (e.g., toileting, to avoid incontinence).

Steps for Assessment:

1. If this is the first assessment (A0310E = 1), review the medical record for the time period from the admission date to the ARD.

2. If this is not the first assessment (A0310E = 0), the review period is from the day after the ARD of the last MDS assessment to the ARD of the current assessment.

3. Review all available sources for any fall since the last assessment, no matter whether it occurred while out in the community, in an acute hospital, or in the nursing home. Include medical records generated in any health care setting since last assessment.

4. Review nursing home incident reports, fall logs and the medical record (physician, nursing, therapy, and nursing assistant notes).

5. Ask the resident and family about falls during the look-back period. Resident and family reports of falls should be captured here whether or not these incidents are documented in the medical record.

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Coding Instructions:

"   Code 0, no: if the resident has not had any fall since the last assessment. Skip to Swallowing Disorder item (K0100).
"   Code 1, yes: if the resident has fallen since the last assessment. Continue to Number of Falls since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS) item (J1900), whichever is more recent.

Examples:

1. An incident report describes an event in which Mr. S. was walking down the hall and appeared to slip on a wet spot on the floor. He lost his balance and bumped into the wall, but was able to grab onto the hand rail and steady himself.

Coding: J1800 would be coded 1, yes.
Rationale: An intercepted fall is considered a fall.

(1) This information was obtained from the website:https://www.nlm.nih.gov/medlineplus/ency/article/000353.htm
4. The facility staff failed to complete the resident interview portion of Section F "Preferences for Customary Routine and Activities" on Resident #16's 4/19/17 admission/5-day MDS assessment.

Resident #16 was admitted to the facility on 4/12/17 with the diagnoses of but not limited to sepsis, cellulitis, end stage renal disease, diabetes, high blood pressure, spinal stenosis. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 4/19/17. The resident was coded as being cognitively intact in

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ability to make daily life decisions, scoring a 13 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring extensive assistance for transfers, dressing, hygiene and bathing; supervision for eating.

A review of Resident #16's above identified MDS assessment revealed the resident was coded in Section B "Hearing, Speech, and Vision" as able to make herself understood and able to understand others.

Further review of the MDS assessment, revealed the resident interview for Section F "Preferences for Customary Routine and Activities" was not completed. The staff interview section was completed instead. In Section F0300 "Should Interview for Daily and Activity Preferences be Conducted?" The resident was coded as "0" for "No (resident is rarely/never understood and family/significant other not available). The resident should have been marked as "1" for "Yes - Continue to F0400, Interview for Daily Preferences."

On 5/4/17 at 10:58 a.m., an interview was conducted with OSM #2 (Other Staff Member) the activities director. When asked if she is familiar with (Resident #16), she stated she wasn't sure. When asked if she attempted to interview the resident for Section F of the MDS, she stated that she attempted to interview the resident but that the resident was asleep. She did not document this and made no further attempts to complete the resident interview. When asked if she has a guide to use when complete the MDS assessment, if she isn't sure about how to do it, she stated she didn't have one, and that she

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F 278	Continued From page 40 usually asked the MDS nurses. On 5/4/17 at 11:05 a.m., in an interview with RN #2 (Registered Nurse) the MDS nurse, she stated that they have 7 to 8 days to get the MDS assessments done and that the interviews should be attempted multiple times. She stated the facility uses the RAI Manual (Resident Assessment Instrument) for completing the MDS and that all departments which complete sections of the MDS are aware of this and have access to the manual. According to the CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) MDS 3.0 Manual, Section F of the RAI Users Manual documents the following on page F-1 through F-3: "Obtaining information about preferences directly from the resident....is the most reliable and accurate way of identifying preferences....Quality of life can be greatly enhanced when care respects the resident's choice regarding anything that is important to the resident. Interviews allow the resident's voice to be reflected in the care plan.....A lack of attention to lifestyle preferences can contribute to depressed mood and increased behavior symptoms." On 5/4/17 at 1:52 p.m., the Administrator (Administrative Staff Member [ASM] #1) and the Director of Nursing (ASM #2) were made aware of the findings. No further information was provided by the end of the survey.	F 278		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2)	F 280		5/26/17

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F 280	Continued From page 41 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident’s strengths and needs. (iii) Incorporate the resident’s personal and cultural preferences in developing goals of care.	F 280		

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483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:

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Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to review and revise the comprehensive care plan for two of 27 residents in the survey sample, Residents #14 and #8.

1. The facility staff failed to review and revise the comprehensive care plan with a change in condition related to a fractured ankle for Resident #14.

2. For Resident #8, facility staff failed to revise the comprehensive care plan after an order for bilateral fall mats was discontinued on 4/27/17.

The findings include:

1. Resident #14 was admitted to the facility on 10/24/16 with a readmission on 11/21/16. Her diagnoses included but were not limited to: congestive heart failure (CHF), acute and chronic respiratory failure, fracture of the lower leg, high blood pressure, sleep apnea (periods of not breathing while someone sleeps (1)), anemia, chronic obstructive pulmonary disease (COPD), and atrial fibrillation (rapid and random contractions of the atria of the heart causing irregular beats of the ventricles decreasing the heart output (2)).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/14/17, coded the resident as scoring a 14 on the BIMS (brief interview for mental status) score, indicating she was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance for most of her activities of daily living.

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1. The Care Plans of Resident #14 and #8 were reviewed and updated to reflect resident□s current needs at time of survey.
2. All residents have the potential to be affected by this deficient practice.
3. The Care Plan team and licensed nurses were educated by the MDS Coordinator on reviewing and revising the comprehensive care plan.
4. The DON or designee will audit care plans 5 times a week for four weeks, then randomly weekly for eight weeks to assure that care plans are updated with changes in resident condition. Results of audits will be taken to the QAPI committee monthly for 3 months for review and revisions as needed..
5. Date of compliance: June 16, 2017.

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She was coded as requiring only supervision after set up assistance was provided for eating.

The resident was observed in the dining room on 5/2/17 in her wheelchair. She had black closed toed shoes on her feet. No surgical boot.

The resident was observed in her room on 5/3/17 at 3:44 p.m. She had black closed toed shoes on her feet. No surgical boot.

The comprehensive care plan dated, 10/25/16, with a revised on date of 4/12/17, documented in part, "Focus: Fracture: right ankle fracture. Healed per ortho (orthopedist) on 4/11/17. WBAT (weight bearing as tolerated)." The "Interventions" documented in part, "25% WT (weight) bearing flat foot. Cam boot (surgical boot) to be worn at all times except for showers." The care plan dated, 10/24/16 and revised on 3/20/17, documented in part, "Focus: Altered skin integrity; fracture to right ankle, incontinence." The "Interventions" documented in part, "1/24 (date) Post op (operation) shoe for all transfers and standing activities. Post-op shoe to be worn during all transfer and standing activities Q (every) shift." The care plan dated, 10/24/16 and revised on 3/7/17, documented in part, "Focus: Self-Care Deficit d/t (due to) COPD, Lack of coordination." The "Interventions" documented in part, "Cast to right leg."

An interview was conducted with RN (registered nurse) #8, the unit manager, on 5/4/17 at 10:25 a.m. When asked who is responsible for updating the comprehensive care plans, RN #8 stated, "The MDS team, many times, anyone can update the care plan. The unit managers will update them after a fall but any staff member can update

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a care plan." When asked if a resident has had a cast and a restricted weight bearing status documented on the care plan, but the orthopedist changed the weight bearing status to as tolerated and the cast was removed, should the care plan be updated to reflect these changes, RN #8 stated, "Yes they should be marked as resolved on the care plan."

The facility policy, "Care plan" documented in part, "Policy: An interdisciplinary plan of care will be established for every resident and updated in accordance with state and federal regulatory requirements and on an as needed basis...Goals must be measurable and objective...The MDS Coordinator is to review the 24 -hour Report daily for significant changes or changes in resident's ADL (activity of daily living) status. The Care Planning Coordinator will add minor changes in resident's status to the existing Care Plans on daily basis."

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (3).

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, ASM #3, the corporate nurse and RN #3 the

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transitional care coordinator, were made aware of the above findings on 5/3/17 at 5:35 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 45.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.
(3) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77.

2. The facility staff failed to revise Resident #8's care plan after an order for bilateral fall mats was discontinued on 4/27/17.

Resident #8 was admitted to the facility on 10/18/16 with diagnoses that included but were not limited to stroke, type two diabetes mellitus, major depressive disorder, anxiety disorder, paralytic gait and muscle spasms. Resident #8's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/17/17. Resident #8 was coded as being cognitively impaired in the ability to make daily decisions scoring 06 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #8 was coded as requiring extensive assistance from one staff member with transfers, ambulation, dressing, hygiene, and bathing; and independent with eating.

On 5/4/17 at 11:00 a.m., an observation was made of Resident #8. She was lying in bed with

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no fall mats on the floor.

On 5/4/17 at 11:30 a.m., an observation was made of Resident #8. She was lying in bed with no fall mats on the floor.

On 5/4/17 at 12:40 p.m., an observation was made of Resident #8. She was lying in bed with no fall mats on the floor.

Review of Resident #8's fall care plan dated 10/18/16, with a revised on date of 4/24/17 documented the following intervention: "Resident will have bilateral floor mat while in bed." This intervention was initiated on 3/14/17.

Review of the most recent Resident Care Guide (a document for CNAs (certified nursing assistants) to use as a reference) for Resident #8 documented the following: "Safety...Resident will have bilateral floor mats while in bed."

Review of Resident #8's clinical record revealed a physician's order dated 4/27/17 that documented the following: "Bilateral floor mats at bedtime for fall...Discontinue Date/Reason: 4/27/17 2:04 p.m. Dr. (doctor) order."

On 5/4/17 at approximately 11:45 a.m., an interview was conducted with CNA # 6, a CNA who regularly works with Resident #8. When asked how CNAs would determine the needs of each resident in terms of safety interventions, CNA #6 stated, "We can look at the care guides on the unit." When asked if Resident #8 needed fall mats to the ground while she was in bed, CNA #6 stated, "I haven't been seeing them. I think they were d/c'd (discontinued); even though the care guide says she needs them. She gets up

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unassisted and she never rings the call bell." CNA #6 stated that she felt fall mats would do more harm than good. When asked who was responsible for updating the care guides, CNA #6 stated that nursing updated the care guides. When asked how a new CNA would know if Resident #8 needed fall mats on the floor, CNA #6 stated, "I would go ask the nurse."

On 5/4/17 at 12:00 p.m., an interview was conducted with LPN (licensed practical nurse) #14, Resident #8's nurse. When asked if Resident #8 was supposed to have fall mats as a safety intervention, LPN #14 stated, "We would need an order for fall mats and fall mats are not on the MAR (Medication Administration Record) or TAR (Treatment Administration Record)." LPN #14 stated that because fall mats were not on Resident #8's MAR or TAR then there was no order for fall mats. When asked if the care plan would be updated if a Resident received new orders to discontinue fall mats, LPN #14 stated, "Yes". When asked who was responsible for updating the care plan, LPN #14 stated that the nurses or unit manager was responsible for updating the care plan.

On 5/4/17 at 12:41 p.m., an interview was conducted with RN (registered nurse) #8, the unit manager. When asked who was responsible for updating care plans, RN #8 stated, "Several people can add interventions to the care plan. I usually do it myself." RN #8 also stated that she was responsible for updating the care guides. When asked if Resident #8 was supposed to have fall mats down while she was in bed, RN #8 stated, "No, because she can stand. She had an order that was d/c'd. (discontinued) They were more of a danger." When RN #8 was shown

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F 280	Continued From page 49 Resident #8's fall care plan, RN #8 stated, "I forgot to take it off the fall care plan. I took it off the ADL care plan. I just missed it." On 5/4/17 at 1:52 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the corporate nurse were made aware of the above concerns. No further information was presented prior to exit. ASM #2 stated the facility uses Lippincott as a reference for providing nursing care. According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..."	F 280		
F 281 SS=E	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 281		5/26/17

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by:
Based on observation, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to follow professional standards of practice for four of 27 residents in the survey sample, Resident #8, #15, #3, and #14.

1. The facility staff failed to clarify the parameters of PRN (as needed) pain medication for Resident #8.

2. The facility staff failed to follow professional standards of practice for medication preparation/administration to Resident #15. RN (registered nurse) #5 failed to administer Resident #15's medication directly after preparing the medication.

3. The facility staff failed to clarify the parameters for administration of PRN (as needed) pain medication for Resident # 3.

4. The facility staff failed to clarify Resident #14's physician order for Tylenol which the physician prescribed for fever to determine if the medication could also be administered for pain.

The findings include:

1. Resident #8 was admitted to the facility on 10/18/16 with diagnoses that included but were not limited to stroke, type two diabetes mellitus, major depressive disorder, anxiety disorder, paralytic gait and muscle spasms. Resident #8's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/17/17. Resident #8 was coded as being cognitively impaired in the ability

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F 281
1. Resident□s # 3 and #8 parameters for prn pain medication were clarified by MD. RN #5 was counseled on preparing and administering of medications. Resident #14□s Tylenol order was clarified and is now current.
2. All residents have the potential to be affected by these deficient practices.
3. The DON or designee will in-service all licensed nurses on Administering medications to include providing clarification for the administration of PRN medications, clarification on orders for use of Tylenol, and on administering medications directly after preparation.
4. The DON/designee will audit physician□s orders 5 times a week for 4 weeks then weekly for 8 weeks. The DON/designee will audit 4 medication passes weekly for 4 weeks than randomly for 8 weeks. Results of audits will be taken to the QAPI committee monthly for 3 months for review and revision as needed.
5. Date of compliance: June 16, 2017.

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to make daily decisions scoring 06 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #8 was coded requiring as extensive assistance from one staff member with transfers, ambulation, dressing, hygiene, and bathing; and independent with eating.

Review of Resident #8's POS (Physician Order Sheet) dated 4/1/17 through 4/30/17 revealed the following prn (as needed) orders:
"   "Norco Tablet [1] 5-325 mg (milligrams) Give 1 tablet by mouth every four hours as needed for pain. (This order was initiated on 11/2/16).

"   Tylenol Tablet [2] 325 mg (acetaminophen) Give 2 tablet by mouth every 4 hours as needed for pain. (This order was initiated on 11/9/16."

Pain parameters could not be found on the physician orders documenting instructions to staff when each pain should be administered.

Review of Resident #8's April 2017 MAR (Medication Administration Record) revealed that Resident #8 received Norco and Tylenol on the following dates and times:
"   Norco: 4/18/17 at 7:16 p.m., 4/24/17 at 2:24 a.m., and 1:46 p.m.
"   Tylenol: 4/26/17 at 7:26 p.m., and 4/27/17 at 11:27 a.m.

On 5/4/17 at 9:09 a.m. an interview was conducted with LPN (licensed practical nurse) #14, Resident #8's nurse. When asked how she determines which pain medication to administer when Resident #8 is experiencing pain, LPN #14 stated that she will first assess the resident's pain to determine her pain level. LPN #14 stated that the facility uses a pain scale from 1-10; 10 being

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the worst possible pain. LPN #14 stated that she considers 1-3 mild pain, 5-6 moderate pain and anything over 6 as severe pain. LPN #14 stated that she will administer Tylenol for pain at a level of 1-5. If the Tylenol is ineffective, LPN #14 stated that she would then administer the Norco. LPN #14 stated that if the Resident rates their pain at a 6 or higher, she would just administer the Norco. When asked if other nurses do the same exact process for administering pain medications without parameters, LPN #14 stated that she assumed other nurses would do the same process but was not sure what numbers they considered to be mild, moderate or severe pain or how they would decide which pain medication to give. When asked if the orders for the Norco and Tylenol should have pain parameters, LPN #14 stated, "Yes. The orders should be clarified."

On 5/4/17 at 9:10 a.m., an interview was conducted with RN (Registered Nurse) #8, the Unit Manager. When asked how she determines which pain medication to administer when Resident #8 is experiencing pain, RN #8 stated, "If her pain is a 4 or less on a scale from 1-10, I would administer the Tylenol and that is also after other interventions have been attempted." RN #8 stated that she considers pain at a 2-4 to be low, 4-7 to be moderate pain, and 7 and greater to be severe. RN #8 stated that she would administer the Norco if her pain was at a 7 or greater. RN #8 stated that she wasn't sure if all nurses knew when to give which medication and what pain level they considered to be low, moderate or severe. RN #8 stated, "The orders should be clarified so nursing knows what and when to use each medication."

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The facility Policy titled, "4.1 Physician/Prescriber Authorization and Communication of Orders to Pharmacy" documents in part, the following:
"...3. Orders that may not be accepted by the pharmacy from the electronic medical record system include the following:
3.3.1 Orders with missing diagnoses if required by law and regulation.
3.3.2 Orders with missing stop dates (i.e. antibiotics);
3.3.3 Orders with missing or incomplete information
...6. Pharmacy may contact Facility staff via fax or telephone order before dispensing a medication when the pharmacist believes that there is a need to clarify the medication order because the order is unclear, incomplete or vague, contraindicated, or has a drug-drug interaction.
6.1 Facility staff should regularly check the fax machine(s) for any pharmacy communication.
6.2 Pharmacy will hold medication orders until Physician/Prescriber is able to clarify the order.
6.3 Facility staff should contact the Physician/Prescriber when staff is notified by pharmacy of an order requiring clarification.
6.4 Facility should explain the issue to the Physician/Prescriber document the clarification and document any new orders received."
6.5 Facility staff should then communicate the result and any new orders or directions to the Pharmacy."

On 5/4/17 at 1:52 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the corporate nurse were made aware of the above concerns. No further information was presented prior to exit.

[1] Norco is a narcotic pain reliever used to treat

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pain. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010590/?report=details

[2] Tylenol (Acetaminophen) is used to treat minor aches and pains and also reduces fever. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008785/?report=details.

2. Resident #15 was admitted to the facility on 3/29/17. Resident #15's diagnoses included but were not limited to: diabetes, chronic kidney disease and muscle weakness. Resident #15's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 4/26/17, coded the resident's cognition as moderately impaired. Resident #15's comprehensive care plan initiated on 3/29/17 failed to document information regarding the timing of medication preparation and administration.

On 5/2/17 at 5:05 p.m. this surveyor approached RN (registered nurse) #5 who was standing at the medication cart in the hall and asked to observe RN #5's medication pass. RN #5 stated there was only one person left to give medication to. RN #5 told this surveyor Resident #15's name and room number. RN #5 removed a medication cup that contained two pills from a drawer in the medication cart. RN #5 stated, "I'm going to show you because I already pulled them even though I probably should not have." RN #5 compared the two pills in the medication cup to two pharmacy labeled medication packs in the medication cart. RN #5 administered the two pills to Resident #15.

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On 5/2/17 at 5:10 p.m. an interview was conducted with RN #5. RN #5 was asked why she had already prepared Resident #15's medication and why she didn't prepare Resident #15's medication directly before administering the medication. RN #5 stated, "I was trying to be fast." RN #5 was asked when medication should be prepared and stated, "Right as I'm about to give it to the patient." RN #5 stated she had prepared Resident #15's medication while she was standing down the hall, approximately five minutes before this surveyor approached her.

On 5/3/17 at 5:42 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional director of clinical services) and RN (registered nurse) #3 (the transitional care coordinator) were made aware of the above findings. ASM #2 was asked what standard of practice the facility followed and stated the facility referenced Lippincott.

Lippincott, Williams & Wilkins. 5th edition, Philadelphia, PA. Page 568, "Procedure 29-1; Administering Oral Medications"
"Procedure:
1. Wash hands
2. Arrange MAR next to medication supply ....
3. Prepare medications for only one client at a time
4. Remove ordered medications from supply ....
5. Calculate correct drug dosage ....
6. Prepare selected medications ....
7. Take medication directly to client's room. Do not leave medication unattended."

On 5/4/17 at 8:46 a.m., ASM #2 stated the facility followed the below policy:

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The facility/pharmacy policy titled, "General Dose Preparation and Medication Administration" documented, "3. Dose preparation: Facility should take all measures required by Facility policy and Applicable Law, including, but not limited to the following...3.2 Facility staff should only prepare medications for one resident at a time..."

No further information was presented prior to exit.

3. Resident # 3 was readmitted to the facility on 03/11/17 with diagnoses that included but were not limited to: neuromuscular dysfunction of the cancer (1), gastroesophageal reflux disease (2), diabetes mellitus (3), anxiety (4), depression, hypertension (5), atrial fibrillation (6), glaucoma (7), and neuropathy (8).

Resident # 3's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 03/16/17, coded Resident # 3 as scoring a nine on the brief interview for mental status (BIMS) of a score of 0 - 15, nine being moderately impaired of cognition for making daily decisions. Resident # 3 was coded as requiring extensive assistance of one staff member for activities of daily living.

A review of the POS (Physician's Order Sheet) For Resident # 3 dated 04/03/2017 through 05/03/2017 documented, "Hydrocodone-Acetaminophen Tablet (9) 7.5-325 MG (milligram) Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Order Date: 03/11/2017." "Tylenol (10) Tablet 325 MG. Give 2 (two) tablets by mouth every 12 hours as needed for pain. Order Date: 03/11/2017." "Hydrocodone-Ibuprofen Tablet (9) 7.5-200 MG.

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Give 1 (one) tablet by mouth every 4 hours as needed for pain. Order Date: 03/12/2017."

The eMAR (electronic medication administration record) for Resident # 3 dated "March 2017 documented the above orders. The eMAR dated March 2017 revealed the following:
- Hydrocodone-Acetaminophen 7.5-325 MG was administered on 03/12/17 at 12:35 a.m. and 8:56 p.m., 03/13/17 at 10:33 p.m., 03/15/17 at 12:23 a.m. and 11:12 a.m., 03/16/17 at 12:15 p.m., 03/17/17 at 5:39 a.m. and 12:31 p.m., 03/18/17 12:02 p.m., 03/19/17 at 10:34 a.m., 03/20/17 at 2:52 a.m. and 9:28 a.m., 03/21/17 at 11:17 a.m., 03/22/17 at 8:58 p.m., and on 03/24/17 at 1:03 a.m.

- Hydrocodone-Ibuprofen 7.5-200 MG was administered on 03/12/17 at 1:22 p.m., 03/14/17 at 2:41 a.m. and 1:28 p.m., 03/29/17 at 10:19 a.m., and on 03/31/17 at 12:30 p.m.

- Tylenol 325 MG was administered on 03/12/17 at 1:46 a.m. and on 03/16/17 at 11:27 a.m.

The eMAR (electronic medication administration record) for Resident # 3 dated April 2017 documented the above physician orders. The eMAR dated April 2017 revealed the following:
- Hydrocodone-Acetaminophen 7.5-325 MG was administered on 04/01/17 at 10:35 p.m., 04/03/17 at 4:33 a.m., 04 04/17 at 9:44 a.m., 04/05/17 at 9:31 a.m. and 04/05/17 at 8:35 p.m., 04/07/17 at 9:25 a.m., 04/10/17 at 9:37 a.m., 04/11/17 at 1:42 a.m. and 9:00 a.m., 04/14/17 at 5:01 a.m., 04/16/17 at 12:47 p.m., 04/17/17 at 1:32 a.m., 04 19/17 at 3:20 a.m., 04/24/17 at 1:46 a.m. and 2:52 p.m., 04/26/17 at 4:15 a.m. 04/28/17 at 1:16 a.m., 04/29/17 at 1:08 a.m. and on 04/30/17 at

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4:42 a.m.

- Tylenol 325 MG was administered on 04/29/17 at 4:01 p.m.

The eMAR (electronic medication administration record) for Resident # 3 dated May 2017 documented, "Hydrocodone-Acetaminophen Tablet (9) 7.5-325 MG (milligram) Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Order Date: 03/11/2017." The eMAR dated April 2017 revealed, Hydrocodone-Acetaminophen 7.5-325 MG was administered on 05/01/17 at 1:49 a.m.

The "Progress Notes" for Resident # 3 dated 03/11/2017 through 05/01/2017 were reviewed and failed to evidence Resident # 3's PRN pain medications were clarified.

The care plan for Resident # 3 dated 07/12/16 failed to evidence parameters for the administration of Resident # 3's PRN pain medication of Hydrocodone-Acetaminophen, Hydrocodone-Acetaminophen and Tylenol.

On 05/03/17 at 1:20 p.m. an interview was conducted with LPN (licensed practical nurse) # 5. When asked to describe the procedure of administering PRN (as needed) pain medication, LPN # 5 stated, "I would ask where the pain is, what type of pain, determine the level of pain on a scale one to ten, based on the level of pain would administer what is prescribed, I would reassess the resident after 30 minutes to see if the medication was effective. When asked how it is was determined what PRN pain medication should be administered LPN # 5 stated, "If there are several pain meds (medications) there needs

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to be a parameter on the physician's order. If there are no parameters I would get clarification from the physician before giving the medication." When asked to describe parameters, LPN # 5 stated, "You would give one pain medication for mild pain another pain medication for moderate pain. It would depend on the resident's pain level." After reviewing the eMARs dated March, April and May 2017 and the physician's orders for Resident # 3's PRN pain medications LPN # 5 was asked if there was documentation of parameters. LPN # 5 stated, "There are no parameters."

On 05/03/17 at 1:40 p.m. an interview was conducted with RN (registered nurse) # 6, unit manager. When asked to describe the procedure of administering PRN pain medication, RN # 6 stated, "Do a pain assessment, location, intensity, observe nonverbal cues, use pain scale one to ten, ten being most severe. Check the order to see what was ordered, check to see when they last got pain medication and administer according to the physician's order, you then follow-up approximately 30 to 60 minutes after giving the medication to determine if it (the medication) was effective using the pain scale." When asked how it is determined what PRN pain medication should be administered, RN # 6 stated, "I would ask them [resident] what pain medication they would prefer."

On 05/03/17 at 2:00 p.m. an interview was conducted with RN (registered nurse) # 7, unit manager. When asked to describe the procedure of administering PRN pain medication, RN # 7 stated, "Rate the resident's pain on a scale of one to ten, ask where the pain is and to describe it. The pain medication should be administered

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according to the pain level." When asked how it is determined what PRN pain medication should be administered, RN # 7 stated, "There should be parameters on the physician's order. If there are no parameters I would get clarification from the physician before giving the medication." After reviewing the eMARs dated March, April and May 2017 and the physician's orders for Resident # 3's PRN pain medications, RN # 7 was asked if there was documentation of parameters. RN # 7 stated, "There are no parameters."

On 05/04/17 at approximately 1:50 p.m. ASM (administrative staff member) # 1 the administrator, and ASM # 2, director of nursing, were made aware of the findings.

No further information was provided prior to exit.

References:

1. The uncontrolled growth of abnormal cells in the body. Cancerous cells are also called malignant cells. This information was obtained from the website: https://medlineplus.gov/ency/article/001289.htm.

2. Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

3. A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

4. Fear. This information was obtained from the

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website:
https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.

5. High blood pressure. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

6. A problem with the speed or rhythm of the heartbeat. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

7. A group of diseases that can damage the eye's optic nerve. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/glaucoma.html.

8. Nerve damage. This information was obtained from the website:
https://www.google.com/#q=neuropathy+nih.

9. Hydrocodone is available in combination with other ingredients, and different combination products are prescribed for different uses. Some hydrocodone combination products are used to relieve moderate-to-severe pain. Other hydrocodone combination products are used to relieve cough. Hydrocodone is in a class of medications called opiate (narcotic) analgesics and in a class of medications called antitussives. Hydrocodone relieves pain by changing the way the brain and nervous system respond to pain. This information was obtained from the website:
https://medlineplus.gov/druginfo/meds/a601006.html.

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10. (Acetaminophen) Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a681004.html.

4. The facility staff failed to clarify Resident #14's physician order for Tylenol which the physician prescribed for fever to determine if the medication could also be administered for pain.

Resident #14 was admitted to the facility on 10/24/16 with a readmission on 11/21/16. Her diagnoses included but were not limited to: congestive heart failure (CHF), acute and chronic respiratory failure, fracture of the lower leg, high blood pressure, sleep apnea (periods of not breathing while someone sleeps (1)), anemia, chronic obstructive pulmonary disease (COPD), and atrial fibrillation (rapid and random contractions of the atria of the heart causing irregular beats of the ventricles decreasing the heart output (2)).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/14/17, coded the resident as scoring a 14 on the BIMS (brief

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interview for mental status) score, indicating she was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance for most of her activities of daily living. She was coded as requiring only supervision after set up assistance was provided for eating.

The physician order dated, 1/1/17, documented, "Tylenol Tablet 325 MG (milligrams); Give 2 tablet by mouth every 8 hours as needed for Fever."

The February 2017 MAR (medication administration record) documented, "Tylenol Tablet 325 MG; Give 2 tablet by mouth every 6 hours as needed for Fever." The MAR documented the resident received Tylenol on 2/21/17 at 9:04 a.m. and a pain level of "6" was documented. Review of the nurse's notes did not reveal documentation of a fever for Resident #14. Review of the vital signs section of the clinical record did not reveal any evidence the resident had a fever.

The April 2017 MAR documented, "Tylenol Tablet 325 MG; Give 2 tablet by mouth every 6 hours as needed for Fever." The MAR documented the resident received Tylenol on 4/28/17 at 12:10 p.m. for a pain level of "6." Review of the nurse's notes did not reveal documentation of a fever for Resident #14. Review of the vital signs section of the clinical record did not reveal any evidence the resident had a fever.

The May 2017 MAR documented, "Tylenol Tablet 325 MG; Give 2 tablet by mouth every 6 hours as needed for Fever." The MAR documented the resident received Tylenol on 5/1/17 at 12:55 p.m. for a documented pain level of "4." The review of the nurse's notes did not reveal documentation of

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a fever for Resident #14. Review of the vital signs section of the clinical record did not reveal any evidence the resident had a fever.

The comprehensive care plan dated, 10/24/16, did not address fevers.

An interview was conducted with LPN (licensed practical nurse) #4, on 5/3/17 at 3:10 p.m. The order for the Tylenol above was reviewed with LPN #4. When asked if the nurse could give the Tylenol for pain, based on the above order, LPN #4 stated, "No, they would have to get a whole new order."

An interview was conducted with LPN #10, the unit manager, on 5/3/17 at 3:17 p.m. The order for Tylenol above was reviewed with LPN #10. When asked if the nurse could give the Tylenol for pain, based on the above order, LPN #10 stated, "According to this order, it should only be given for fever." When asked what the nurse should do, LPN #10 stated, "They need to clarify the order and or get a new order for Tylenol for pain for the resident."

The facility policy, "Physician/Prescriber Authorization and Communication of Orders to Pharmacy" documented in part, "8.1 Facility's licensed nurses should contact the resident' Physician/Prescriber when there is a change in condition that may require a new medication or a renewal of an existing order."

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, ASM #3, corporate nurse, and RN (registered nurse) #3, the transitional care coordinator, were made aware of the above findings on 5/3/17 at

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F 281	Continued From page 65 5:35 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 45. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.	F 281		
F 282 SS=E	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (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. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, facility document review and clinical record review, it was determined that the facility staff failed to follow the written plan of care for four of 27 residents in the survey sample, Residents #14, #7, #3, and #8. 1. a. The facility staff failed to provide restorative nursing services per the written plan of care for Resident #14 b. The facility staff failed to notify the physician for a change in weight, per the written plan of care, for Resident #14.	F 282	F282 1. Resident #14s change in weight was reported to the physician. Resident #14 is currently receiving skilled therapy. If appropriate, Resident #14 will resume restorative care after skilled therapy ends. The physician was notified of staff failure to obtain blood pressure for resident #7. Resident #8 discharged from the facility 5/9/17. The physician was informed of staffs failure to document Resident #3s blood pressure weekly. 2. All residents have the potential to be affected by these deficient practices.	5/30/17

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2. The facility staff failed to obtain a blood pressure according to the written plan of care for Resident #7.

3. The facility staff failed to follow Resident # 3's comprehensive care plan for pain.

4. The facility staff failed to attempt non-pharmacological interventions prior to the administration of PRN pain medications per Resident #8's written plan of care.

The findings include:

1. a. Resident #14 was admitted to the facility on 10/24/16 with a readmission on 11/21/16. Her diagnoses included but were not limited to: congestive heart failure (CHF), acute and chronic respiratory failure, fracture of the lower leg, high blood pressure, sleep apnea (periods of not breathing while someone sleeps) (1), anemia, chronic obstructive pulmonary disease (COPD), and atrial fibrillation (rapid and random contractions of the atria of the heart causing irregular beats of the ventricles decreasing the heart output) (2).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/14/17, coded the resident as scoring a 14 on the BIMS (brief interview for mental status) score, indicating she was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance for most of her activities of daily living. She was coded as requiring only supervision after set up assistance was provided for eating.

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3. Director of Nursing or designee will in-service licensed nurses on non-pharmacological interventions, assessing to determine which pain medication should be administered when there are choices of pain medications; documenting weights and blood pressures as ordered by physicians, and reporting to the physician when values are outside of stated parameters. The MDS coordinator or designee will in-service CNAs on providing restorative care.
4. The Unit Managers or designees will audit the documentation of non-pharmacological interventions before the administration of pain medication; Unit Managers will audit blood pressure and weight documentation as ordered by physician, and the reporting of variances as ordered. The Unit Managers or designees will audit the documentation of restorative care to indicated residents. Audits will be conducted five times weekly for four weeks, then randomly weekly for eight weeks. Audits will be reviewed by the QAPI committee for three months.
5. Date of completion: June 16, 2017.

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The comprehensive care plan dated, 4/4/17, documented in part, "Focus: Requires assistance for ambulation related to: Requires assistive device, unsteady balance." The "Interventions" documented in part, "Ambulation per restorative plan. Resident will practice 15 minutes a day for 6/7 days a week."

An interview was conducted with Resident #14 on 5/3/17 at 3:44 p.m. Resident #14 stated that today (5/3/17) was the first day in weeks that she had been walked with the restorative aide. Resident #14 stated, "They can't walk me every day, which is what the restorative aide told me. She gets pulled off restorative to work on the floor as a CNA (certified nursing assistant)."

An interview was conducted with RN (registered nurse) #2, the MDS nurse, on 5/3/17 at 4:40 p.m. When asked who oversees the restorative nursing program, RN #2 stated, "I do." When asked if a physician order was required for restorative nursing, RN #2 stated, "Not that I'm aware of." RN #2 was asked to provide any documentation evidencing Resident #14 was in a restorative program.

On 5/3/17 at 5:14 p.m. RN #2 presented the "Restorative Ambulation Program Daily Record" for April 2017 for Resident #14. The "Problem/Need" documented, "Resident is able to ambulate with RW (rolling walker) and min assist (minimum assistance) 50 feet." The "Interventions" documented in part, "15 min (minutes); 6-7 days/week, device needed - walker, ambulate 50 feet.

The "Restorative Ambulation Program" dated for

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April 2017 documented the resident received restorative ambulation program on the following days:
The week of April 2 - 8, 2017, the resident received restorative nursing on five days.
The week of April 9 - 15, 2017, the resident received restorative nursing on four days.
The week of April 16 - 22, 2017, the resident did not receive any restorative nursing.
The week of April 23 - 29, 2017, the resident received restorative nursing on six days.

An interview was conducted with RN #2 on 5/3/17 at 5:14 p.m. When asked why the resident is not receiving the restorative nursing program per her plan of care, RN #2 stated, "We've had times when the restorative aid is pulled to the floor." When asked if someone else should cover, RN #2 stated, "Yes." When asked if a resident has a program for restorative care, should it be followed, RN #2 stated, "Yes."

An interview was conducted with RN #8, a unit manager, on 5/4/17 at 10:25 a.m. When asked the purpose of the care plan, RN #8 stated, "It's the guidance we are given and a plan of action to be taken to care for a resident." When asked if the care plan should be followed, RN #8 stated, "Yes, Ma'am."

The facility policy, "Care Plan" documented in part, "All direct care staff must always know, understand and follow their Resident's Care Plan. If unable to implement any part of the plan, notify your Charge Nurse or MDS Coordinator, so that this can be documented or the Care Plan changed if necessary."

According to Fundamentals of Nursing Lippincott

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Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care.

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, ASM #3, the corporate nurse and RN #3 the transitional care coordinator, were made aware of the above findings on 5/3/17 at 5:35 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 45.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.

b. The facility staff failed to notify the physician for a change in weight, per the plan of care, for Resident #14.

The comprehensive care plan dated, 10/25/16, with a revised on date of 3/21/17, documented in part, "Focus: Risk for fluid output exceeding intake characterized by fluid volume deficit; dry skin and mucous membranes, poor skin turgor and integrity related to: diuretics, CHF." The "Interventions" documented in part, "Notify MD (medical doctor) & (and) RD (registered dietician) of weight change per facility routines."

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The physician order dated, 11/21/16, documented, "Obtain weight daily; one time a day for monitoring. If there is a weight gain of 2 lbs. (pounds) in one day or 5 lbs. in one week, notify MD (medical doctor)."

The MAR (medication administration record) for February 2017 documented, "Obtain weight daily; one time a day for monitoring. If there is a weight gain of 2 lbs. in one day or 5 lbs. in one week, notify MD." The following weight gains were documented:
2/5/17 - 249.8; 2/6/17 - 251.9, a gain of 2 pounds.
2/18/17 - 252.2; 2/19/17 - 254.2, a gain of 2 pounds.

The March 2017 MAR documented, "Obtain eight daily; one time a day for monitoring. If there is a weight gain of 2 lbs. in one day or 5 lbs. in one week, notify MD." The following weight gains were documented:
3/8/17 - 256; 3/9/17 - 258.6, a gain of 2.6 pounds.
3/16/17 - 257.8; 3/17/17 - 260.2, a gain of 2.4 pounds.
3/17/17 - 260.2; 3/18/17 - 263, a gain of 2.8 pounds.
3/26/17 - 252; 3/27/17 - 259.4, a gain of 7.4 pounds.

The April 2017 MAR documented, "Obtain eight daily; one time a day for monitoring. If there is a weight gain of 2 lbs. in one day or 5 lbs. in one week, notify MD." The following weight gains were documented:
4/3/17 - 252.8; 4/4/17 - 256.4, a gain of 3.6 pounds.
4/7/17 - 256; 4/8/17 - 258, a gain of 2 pounds.

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The above order was discontinued on 4/20/17.

Review of the nurse's notes from 2/1/17 through 4/20/17 did not evidence any documentation of the physician being notified of the weight gain.

An interview was conducted with LPN (licensed practical nurse) #4 on 5/3/17 at 3:10 p.m. The above daily weight order was reviewed with her. When asked what is expected of the nurse with the above order, LPN #4 stated, "We have to weigh the person every day and call the doctor according to the order." When asked where that would be documented, LPN #4 stated, "It's documented in the progress notes and or 24 hour book." When asked if the 24 hour book was part of the clinical record, LPN #4 stated, "It' should be in both but definitely the progress note."

On 5/3/17 at 3:17 p.m., an interview was conducted with LPN #10, the unit manager. LPN #10 was asked to review the above order for daily weights. LPN #10 was then asked to explain what the nurse's responsibility is, LPN #10 stated, "They have to weigh the resident daily and notify the doctor if the weight is more than two pounds in a day or five pounds in a week." When asked where this notification is documented, LPN #10 stated, "It should be in a nurse progress note to say at least the doctor was notified."

An interview was conducted with RN #8, a unit manager, on 5/4/17 at 10:25 a.m. When asked the purpose of the care plan, RN #8 stated, "It's the guidance we are given and a plan of action to be taken to care for a resident." When asked if the care plan should be followed, RN #8 stated, "Yes, Ma'am." When asked if the physician orders are part of the plan of care, RN #8 stated,

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"Absolutely."

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, ASM #3, the corporate nurse and RN #3 the transitional care coordinator, were made aware of the above findings on 5/3/17 at 5:35 p.m.

No further information was provided prior to exit.

2. The facility staff failed to obtain a blood pressure according to the written plan of care for Resident #7.

Resident #7 was admitted to the facility on 1/7/15 with diagnoses that included but were not limited to: diabetes, high blood pressure, depression, chronic pain, gastroesophageal reflux disease, anemia (too low blood count (1)), pressure ulcer of the sacral region (inflammation or sore over a bony prominence resulting from prolonged pressure to the area (2)), dysphagia, and dementia.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 2/3/17, coded the resident as scoring a zero on the BIMS (brief interview for mental status) score, indicating that she was severely impaired to make cognitive daily decisions. Resident #7 was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living.

The comprehensive care plan dated, 4/11/16, with a revised on date of 2/27/17, documented in part, "Focus: Altered cardiac profusion relate to

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diagnosis of HTN, PVD (peripheral vascular disease) (any abnormal condition affecting blood vessels outside the heart) (3) and Atherosclerosis of aorta (common disorder of the arteries in which plaques consisting mostly of cholesterol and lipids form on the inner arterial/aortic wall leading to decreased blood flow) (4)." The "Interventions" documented in part, "Assess vital signs."

The physician order dated, 4/28/16, documented, "Weekly B/P (blood pressure) check one time a day every Thu (Thursday) for HTN (hypertension - high blood pressure)."

The MAR (medication administration record) for April 2017 documented, "Weekly B/P check one time a day every Thu for HTN." The MAR documented a check mark and the nurse's initials on 4/5/17, 4/12/17, 4/20/17 and 4/27/17. There was no documentation of the blood pressures on the MAR.

The review of the nurse's notes for 4/5/17 documented a blood pressure taken on 4/4/17 at 11:17 a.m. The nurse's note dated, 4/12/17 at 12:40 p.m. did not document a blood pressure. There were no nurse's notes dated 4/20/17 or 4/27/17.

Review of the "Vital signs" tab in the electronic medical record, documented no blood pressure on 4/5/17 or 4/12/17. On 4/20/17 the blood pressure was documented as, "0/0 mmHg (millimeters of mercury)." There was a blood pressure of 133/69 mmHg documented on 4/27/17 at 9:15 a.m."

An interview was conducted with LPN (licensed practical nurse) #5, on 5/3/17 at 3:15 p.m. When

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asked what staff should do if the physician has written an order for a blood pressure to be taken every Thursday, LPN #5 stated, "The nurse should check the blood pressure every Thursday." When asked where the blood pressure reading would be documented, LPN #5 stated, "It's in the electronic record in a progress note or in the vital signs tab in the computer."

An interview was conducted with LPN #10, the unit manager, on 5/3/17 at 3:18 p.m. When asked what staff should do if the physician has written an order for a blood pressure to be taken every Thursday, LPN #10 stated, the blood pressure should be on the MAR. Technically, it should not be allowed to be charted on unless the blood pressure value is inserted." The MAR and vital signs tab was reviewed with LPN #10. LPN #10 stated, "It's not there. The order was not put into the system correctly."

An interview was conducted with RN #8, a unit manager, on 5/4/17 at 10:25 a.m. When asked the purpose of the care plan, RN #8 stated, "It's the guidance we are given and a plan of action to be taken to care for a resident." When asked if the care plan should be followed, RN #8 stated, "Yes, Ma'am." When asked if the physician orders are part of the written plan of care, RN #8 stated, "Absolutely."

Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern on 5/4/17 at 2:52 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the

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F 282	Continued From page 75 Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 33. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 155. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 447. (4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 53. 3. The facility staff failed to follow Resident #3's comprehensive care plan for implementing non pharcological interventions for pain. Resident # 3 was readmitted to the facility on 03/11/17 with diagnoses that included but were not limited to: neuromuscular dysfunction of the cancer (1), gastroesophageal reflux disease (2), diabetes mellitus (3), anxiety (4), depression, hypertension (5), atrial fibrillation (6), glaucoma (7), and neuropathy (8). Resident # 3's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 03/16/17, coded Resident # 3 as scoring a nine on the brief interview for mental status (BIMS) of a score of 0 - 15, nine being moderately impaired of cognition for making daily decisions. Resident # 3 was coded as requiring extensive assistance of one staff member for activities of daily living. The POS (Physician's Order Sheet) For Resident	F 282		

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3 dated 04/03/2017 through 05/03/2017 documented, "Hydrocodone-Acetaminophen Tablet (9) 7.5-325 MG (milligram) Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Order Date: 03/11/2017." "Tylenol (10) Tablet 325 MG. Give 2 (two) tablets by mouth every 12 hours as needed for pain. Order Date: 03/11/2017." "Hydrocodone-Ibuprofen Tablet (9) 7.5-200 MG. Give 1 (one) tablet by mouth every 4 hours as needed for pain. Order Date: 03/12/2017."

The eMAR (electronic medication administration record) for Resident # 3 dated "March 2017 documented, "Hydrocodone-Acetaminophen Tablet (9) 7.5-325 MG (milligram) Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Order Date: 03/11/2017." "Tylenol (10) Tablet 325 MG. Give 2 (two) tablets by mouth every 12 hours as needed for pain. Order Date: 03/11/2017." "Hydrocodone-Ibuprofen Tablet (9) 7.5-200 MG. Give 1 (one) tablet by mouth every 4 hours as needed for pain. Order Date: 03/12/2017."

The eMAR dated March 2017 revealed: Hydrocodone-Acetaminophen 7.5-325 MG was administered on 03/12/17 at 12:35 a.m. and 8:56 p.m., 03/13/17 at 10:33 p.m., 03/15/17 at 12:23 a.m. and 11:12 a.m., 03/16/17 at 12:15 p.m., 03/17/17 at 5:39 a.m. and 12:31 p.m., 03/18/17 12:02 p.m., 03/19/17 at 10:34 a.m., 03/20/17 at 2:52 a.m. and 9:28 a.m., 03/21/17 at 11:17 a.m., 03/22/17 at 8:58 p.m., and on 03/24/17 at 1:03 a.m.

Hydrocodone-Ibuprofen 7.5-200 MG was administered on 03/12/17 at 1:22 p.m., 03/14/17 at 2:41 a.m. and 1:28 p.m., 03/29/17 at 10:19

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a.m., and on 03/31/17 at 12:30 p.m.

Tylenol 325 MG was administered on 03/12/17 at 1:46 a.m. and on 03/16/17 at 11:27 a.m.

The eMAR (electronic medication administration record) for Resident # 3 dated April 2017 documented, "Hydrocodone-Acetaminophen Tablet (9) 7.5-325 MG (milligram) Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Order Date: 03/11/2017." "Tylenol (10) Tablet 325 MG. Give 2 (two) tablets by mouth every 12 hours as needed for pain. Order Date: 03/11/2017."

The eMAR dated April 2017 revealed, "Hydrocodone-Acetaminophen 7.5-325 MG was administered on 04/01/17 at 10:35 p.m., 04/03/17 at 4:33 a.m., 04 04/17 at 9:44 a.m., 04/05/17 at 9:31 a.m. and 04/05/17 at 8:35 p.m., 04/07/17 at 9:25 a.m., 04/10/17 at 9:37 a.m., 04/11/17 at 1:42 a.m. and 9:00 a.m., 04/14/17 at 5:01 a.m., 04/16/17 at 12:47 p.m., 04/17/17 at 1:32 a.m., 04 19/17 at 3:20 a.m., 04/24/17 at 1:46 a.m. and 2:52 p.m., 04/26/17 at 4:15 a.m. 04/28/17 at 1:16 a.m., 04/29/17 at 1:08 a.m. and on 04/30/17 at 4:42 a.m. Tylenol 325 MG was administered on 04/29/17 at 4:01 p.m.

The eMAR (electronic medication administration record) for Resident # 3 dated May 2017 documented, "Hydrocodone-Acetaminophen Tablet (9) 7.5-325 MG (milligram) Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Order Date: 03/11/2017."

The eMAR dated April 2017 revealed, "Hydrocodone-Acetaminophen 7.5-325 MG was administered on 05/01/17 at 1:49 a.m."

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The "Progress Notes" for Resident # 3 dated 03/11/2017 through 05/01/2017 were reviewed and failed to evidence documentation of non-pharmacological interventions prior to the administration of Hydrocodone-Ibuprofen, Hydrocodone-Acetaminophen and Tylenol.

The care plan for Resident # 3 dated 07/12/16 documented, "Focus: Pain related to Arthritis, Neuropathy, Glaucoma. Date Initiated: 03/24/2016. Revision on 01/19/2017." Under "Interventions" it documented, "Staff to offer non-pharmacological interventions as tolerated. Date Initiated: 04/11/2016."

On 05/03/17 at 1:20 p.m. an interview was conducted with LPN (licensed practical nurse) # 5. When asked to describe the procedure of administering PRN (as needed) pain medication LPN # 5 stated, "I would ask where the pain is, what type of pain, determine the level of pain on a scale one to ten, based on the level of pain, I would administer what is prescribed, I would reassess the resident after 30 minutes to see if the medication was effective. When asked to describe the purpose of the care plan, LPN # 5 stated, "It tells you how to take care of the resident." After reviewing the care plan for Resident # 3's pain, LPN # 5 was asked if the care plan was followed for non-pharmacological interventions. LPN # 5 stated, "No."

On 05/03/17 at 1:40 p.m. an interview was conducted with RN (registered nurse) # 6, unit manager. When asked to describe the procedure of administering PRN pain medication RN # 6 stated, "Do a pain assessment, location, intensity, observe nonverbal cues, use pain scale one to

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ten, ten being most severe. Check the order to see what was ordered, check to see when they last got pain medication and administer according to the physician's order, follow-up approximately 30 to 60 minutes after giving the medication to determine if it was effective using the pain scale." When asked to describe the purpose of the care plan, RN # 6 stated, "It tells you what interventions are in place. It tells what the resident's needs are and what we are going to do to take care of them while they are here." After reviewing the care plan for Resident # 3's pain, RN # 6 was asked if the care plan was followed for non-pharmacological interventions. RN # 6 stated, "No, it wasn't followed for pain."

On 05/03/17 at 2:00 p.m. an interview was conducted with RN (registered nurse) # 7, unit manager. When asked to describe the procedure of administering PRN pain medication RN # 7 stated, "Rate the resident's pain on a scale of one to ten, ask where the pain is and to describe it. The pain medication should be administered according to the pain level." When asked to describe the purpose of the care plan, RN # 7 stated, "It shows what we're doing, a description of all the care for the resident. If it's on the care plan it needs to be followed." After reviewing the care plan for Resident # 3's pain, RN # 7 was asked if the care plan was followed for non-pharmacological interventions. RN # 7 stated, "No, it wasn't followed."

On 05/04/17 at approximately 1:50 p.m. ASM (administrative staff member) # 1 the administrator, and ASM # 2, director of nursing, were made aware of the findings.

No further information was provided prior to exit.

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References:

1. The uncontrolled growth of abnormal cells in the body. Cancerous cells are also called malignant cells. This information was obtained from the website: https://medlineplus.gov/ency/article/001289.htm.

2. Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

3. A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

4. Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.

5. High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

6. A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

7. A group of diseases that can damage the eye's optic nerve. This information was obtained from the website:

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https://www.nlm.nih.gov/medlineplus/glaucoma.html.

8. Nerve damage. This information was obtained from the website: https://www.google.com/#q=neuropathy+nih.

9. Hydrocodone is available in combination with other ingredients, and different combination products are prescribed for different uses. Some hydrocodone combination products are used to relieve moderate-to-severe pain. Other hydrocodone combination products are used to relieve cough. Hydrocodone is in a class of medications called opiate (narcotic) analgesics and in a class of medications called antitussives. Hydrocodone relieves pain by changing the way the brain and nervous system respond to pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601006.html.

10. (Acetaminophen) Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a681004.html.

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4. The facility staff failed to attempt non-pharmacological interventions prior to the administration of PRN pain medications per Resident #8's plan of care.

Resident #8 was admitted to the facility on 10/18/16 with diagnoses that included but were not limited to stroke, type two diabetes mellitus, major depressive disorder, anxiety disorder, paralytic gait and muscle spasms. Resident #8's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/17/17. Resident #8 was coded as being cognitively impaired in the ability to make daily decisions scoring 06 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #8 was coded requiring as extensive assistance from one staff member with transfers, ambulation, dressing, hygiene, and bathing; and independent with eating.

Review of Resident #8's POS (Physician Order Sheet) dated 4/1/17 through 4/30/17 revealed the following prn (as needed) orders:
"Norco Tablet [1] 5-325 mg (milligrams) Give 1 tablet by mouth every four hours as needed for pain.
Tylenol Tablet [2] 325 mg (acetaminophen) Give 2 tablet by mouth every 4 hours as needed for pain."

Review of Resident #8's April 2017 MAR (Medication Administration Record) revealed that Resident #8 received Norco and Tylenol on the following dates and times:
Norco: 4/18/17 at 7:16 p.m., 4/24/17 at 2:24 a.m., and 1:46 p.m.

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Tylenol: 4/26/17 at 7:26 p.m., and 4/27/17 at 11:27 a.m.

There was no evidence in the clinical record that non-pharmacological interventions were attempted prior to the administration of the Norco and Tylenol to Resident #8 on the dates above.

Review of Resident #8's Pain care plan dated 10/18/16 and updated 3/10/17 documented the following: "Pain d/t (due to) limited mobility, falls, polyneuropathy, and muscle spasm...Goal: Will maintain comfort to highest degrees possible. Interventions: ...Staff to attempt non-pharmacological interventions as tolerated."

On 5/4/17 at 8:29 a.m., an interview was conducted with LPN (licensed practical nurse) #14, a nurse who administered prn pain medication on 4/27/17 to Resident #8. When asked the process staff follows prior to administering a prn pain medication, LPN #14 stated that she would first calm the resident down to see if they really needed the medication and then she would ask the resident to rate their pain. LPN #14 stated that for residents who cannot speak she would look at non-verbal cues for pain such as facial expressions. LPN #14 stated that she will always attempt non-pharmacological interventions prior to administering pain medication. When asked where non-pharmacological interventions attempted would be documented in the clinical record, LPN #14 stated, "It should be on the MAR." When asked if she administered Tylenol to Resident #8 on 4/27/17, LPN #14 looked at the initials on the MAR and stated, "Yes." When asked where non-pharmacological interventions were documented, LPN #14 stated, "She requested it. I

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think she said her shoulder was hurting. I think I might have just given her the Tylenol. I didn't want to try to a warm compress to it (shoulder) because then I would have needed a physician's order."

On 5/4/17 at 9:30 a.m., an interview was conducted with LPN #6, a nurse who administered Norco on 4/18/17. When asked about the process staff follows prior to administering a prn pain medication, LPN #6 stated that she would assess the pain and if it was under a 4 on a scale from 1-10 she would administer Tylenol or apply ice, reposition, or attempt to redirect the resident. When asked if she always attempts non-pharmacological interventions prior to administering pain medications, LPN #6 stated, "Yes." When asked where non-pharmacological interventions attempted prior to administering pain medications would be documented in the clinical record, LPN #6 stated, "In the progress notes." When asked if she was familiar with Resident #8, LPN #6 stated, "Yes." When asked if she attempts non-pharmacological interventions prior to administering prn pain medications to Resident #8, LPN #6 stated, "She has a lot if issues like chronic back pain and serious psych (psychiatric) issues as well. I just give her the medication. She has to have the real thing. Her pain is always a six or more." LPN #6 stated that she will administer Tylenol to Resident #8 if her pain is a 4 or less and Norco if her pain is a 6 or more.

On 5/4/17 at 10:21 a.m., further interview was conducted with LPN #14. When asked the purpose of the care plan, LPN #14 stated, "So you know how to care for the patient, especially for new nurses." When asked what the

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intervention, "Attempt non-pharmacological interventions," meant on Resident #8's care plan, LPN #14 stated, "It means to attempt other things such as a back rub or lying the patient down before giving the medication." When asked if the care plan was followed the day she administered Tylenol on 4/27/17, LPN #14 stated, "That day the care plan was not followed."

On 5/4/17 at 10:35 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON. When asked the purpose of the care plan, ASM #2 stated, "The purpose of the care plan is that anyone working with the resident can see the needs of that resident." When asked what the intervention to "Attempt non-pharmacological interventions" on Resident #8's care plan meant, ASM #2 stated, "It means to try to repositioning or distraction. It doesn't say before giving pain medications." When asked if the care plan was followed on the days nursing stated they did not attempt non-pharmacological interventions prior to administering pain medication, ASM #2 stated, "If that is what they said, then the care plan would not be followed." ASM #2 stated that the facility used Lippincott as a professional standard.

Facility policy titled, "Pain Management and Pain Protocol," documents in part, the following: "It is the policy of this facility to ensure any resident that is admitted to the facility is assessed for pain, and/or the potential for pain in order for the resident to obtain or maintain his/her practicable level of physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care."

On 5/4/17 at 1:52 p.m. , ASM (administrative staff

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F 282	Continued From page 86 member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the corporate nurse was made aware of the above concerns. [1] Norco is a narcotic pain reliever used to treat pain. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010590/?report=details [2] Tylenol (Acetaminophen) is used to treat minor aches and pains and also reduces fever. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008785/?report=details.	F 282		
F 309 SS=E	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 309		5/30/17

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F 309	Continued From page 87 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to provide care and services to maintain the highest level of physical well-being for four of 27 residents in the survey sample, Resident #8, #3, #7 and #14. 1. The facility staff failed to attempt/implement non-pharmacological interventions prior to the administration of PRN pain medications to Resident #8. 2. The facility staff failed to implement non-pharmacological interventions prior to the administration of PRN (as needed) pain medication for Resident # 3. 3. The facility staff failed to obtain physician ordered blood pressures for Resident #7.	F 309	F309 1. Resident #14s physician was notified of the weight change. Resident #14s Tylenol order was clarified. RN #5 was in-serviced and counseled for not administering medications to resident # 5 directly after preparation. The physician was notified of the facilitys failure to obtain and record ordered blood pressures for resident #7. Staff will be in-serviced on providing non-pharmacological interventions before administering pain medications to resident #3. Resident #8 discharged from the facility 5/9/17. 2. All residents have the potential to be affected by these deficient practices. 3. The DON or designee will in-service licensed nurses on clarification of physicians orders, medication	

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4. a. The facility staff failed to follow the physician order to notify the physician of a weight change based on daily weights for Resident #14.

b. The facility staff failed to follow the physician orders for the administration of Tylenol to Resident #14.

The findings include:

1. The facility staff failed to attempt/implement non-pharmacological interventions prior to the administration of PRN pain medications to Resident #8.

Resident #8 was admitted to the facility on 10/18/16 with diagnoses that included but were not limited to stroke, type two diabetes mellitus, major depressive disorder, anxiety disorder, paralytic gait and muscle spasms. Resident #8's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/17/17. Resident #8 was coded as being cognitively impaired in the ability to make daily decisions scoring 06 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #8 was coded as requiring extensive assistance from one staff member with transfers, ambulation, dressing, hygiene, and bathing; and independent with eating.

Review of Resident #8's POS (Physician Order Sheet) dated 4/1/17 through 4/30/17 revealed the following prn (as needed) orders:
"Norco Tablet [1] 5-325 mg (milligrams) Give 1 tablet by mouth every four hours as needed for pain.
Tylenol Tablet [2] 325 mg (acetaminophen) Give 2

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administration, following physician□s orders, and non-pharmacological interventions for pain.
4. The DON or designee will audit physician orders daily for four weeks, then randomly weekly for eight weeks. The Unit Manager will audit residents with orders for reporting weight changes and recording blood pressure, and for documentation of non-pharmacological interventions for prn pain medications daily for four weeks and randomly weekly for eight weeks. The Unit Manager or designee will observe four med passes for four weeks, then randomly weekly for eight weeks to assure that medications are given directly after preparation. Audits will be reviewed by the QAPI committee for three months.
5. Date of compliance: June 16, 2017.

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tablet by mouth every 4 hours as needed for pain."

Review of Resident #8's April 2017 MAR (Medication Administration Record) revealed that Resident #8 received Norco and Tylenol on the following dates and times:
Norco: 4/18/17 at 7:16 p.m., 4/24/17 at 2:24 a.m., and 1:46 p.m.
Tylenol: 4/26/17 at 7:26 p.m., and 4/27/17 at 11:27 a.m.

There was no evidence in the clinical record that non-pharmacological interventions were attempted prior to the administration of Norco and Tylenol to Resident #8.

Review of Resident #8's Pain care plan dated 10/18/16 and updated 3/10/17 documented the following: "Pain d/t (due to) limited mobility, falls, polyneuropathy, and muscle spasm...Goal: Will maintain comfort to highest degrees possible. Interventions: ...Staff to attempt non-pharmacological interventions as tolerated."

On 5/4/17 at 8:29 a.m., an interview was conducted with LPN (licensed practical nurse) #14, a nurse who administered prn pain medication on 4/27/17 to Resident #8. When asked about the process staff follows prior to administering a prn pain medication, LPN #14 stated that she would first calm the resident down to see if they really needed the medication and then she would ask the resident to rate their pain. LPN #14 stated that for residents who cannot speak she would look at non-verbal cues for pain such as facial expressions. LPN #14 stated that she will always attempt non-pharmacological interventions prior to administering pain

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F 309	Continued From page 90 medication. When asked where non-pharmacological interventions attempted would be documented in the clinical record, LPN #14 stated, "It should be on the MAR." When asked if she administered Tylenol to Resident #8 on 4/27/17, LPN #14 looked at the initials on the MAR and stated, "Yes." When asked where non-pharmacological interventions were documented, LPN #14 stated, "She requested it. I think she said her shoulder was hurting. I think I might have just given her the Tylenol. I didn't want to try to a warm compress to it (shoulder) because then I would have needed a physician's order." On 5/4/17 at 9:10 a.m., an interview was conducted with RN (Registered Nurse) #8, the unit manager. When asked about the process staff follows prior to administering PRN pain medication, RN #8 stated, "As a nurse I would try Tylenol, repositioning, and a warm compress first before giving pain medication." When asked if non-pharmacological interventions should also be attempted prior to administering PRN Tylenol, RN #8 stated, "Yes." On 5/4/17 at 9:30 a.m., an interview was conducted with LPN #6, a nurse who administered Norco on 4/18/17. When asked the process prior to administering a prn pain medication, LPN #6 stated that she would assess the pain and if it was under a 4 on a scale from 1-10 she would administer Tylenol or apply ice, reposition, or attempt to redirect the resident. When asked if she always attempts non-pharmacological interventions prior to administering pain medications, LPN #6 stated, "Yes." When asked where non-pharmacological interventions attempted prior to administering	F 309		

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pain medications would be documented in the clinical record, LPN #6 stated, "In the progress notes." When asked if she was familiar with Resident #8, LPN #6 stated, "Yes." When asked if she attempts non-pharmacological interventions prior to administering prn pain medications to Resident #8, LPN #6 stated, "She has a lot of issues like chronic back pain and serious psych (psychiatric) issues as well. I just give her the medication. She has to have the real thing. Her pain is always a six or more." LPN #6 stated that she will administer Tylenol to Resident #8 if her pain is a 4 or less and Norco if her pain is a 6 or more.

The facility policy titled, "Pain Management and Pain Protocol," documents in part, the following: "It is the policy of this facility to ensure any resident that is admitted to the facility is assessed for pain, and/or the potential for pain in order for the resident to obtain or maintain his/her practicable level of physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Procedure: 1. The interdisciplinary team will establish a care plan to identify the goals of the pain program and the care plan will be reviewed and updated as needed. 2. The nurse will evaluate the non-verbal resident and/or the resident with dementia for non-specific signs and systems that could reflect pain. 3. Non-pharmacological intervention will be attempted prior to the administration of PRN pain medications. When it is determined the resident's pain will need pharmacological interventions:
a. Documentation of administration of medications will be located on the Medication Administration Record.
b. The Response of medication(s) will be

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identified on the pain flow record for effectiveness of the medication."

On 5/4/17 at 1:52 p.m. , ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the corporate nurse was made aware of the above concerns. No further information was presented prior to exit.

[1] Norco is a narcotic pain reliever used to treat pain. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010590/?report=details

[2] Tylenol (Acetaminophen) is used to treat minor aches and pains and also reduces fever. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008785/?report=details.

2. The facility staff failed to implement non-pharmacological interventions prior to the administration of PRN (as needed) pain medication for Resident # 3.

Resident # 3 was readmitted to the facility on 03/11/17 with diagnoses that included but were not limited to: neuromuscular dysfunction of the cancer (1), gastroesophageal reflux disease (2), diabetes mellitus (3), anxiety (4), depression, hypertension (5), atrial fibrillation (6), glaucoma (7), and neuropathy (8).

Resident # 3's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 03/16/17,

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coded Resident # 3 as scoring a nine on the brief interview for mental status (BIMS) of a score of 0 - 15, nine being moderately impaired of cognition for making daily decisions. Resident # 3 was coded as requiring extensive assistance of one staff member for activities of daily living.

The POS (Physician's Order Sheet) For Resident # 3 dated 04/03/2017 through 05/03/2017 documented, "Hydrocodone-Acetaminophen Tablet (9) 7.5-325 MG (milligram) Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Order Date: 03/11/2017." "Tylenol (10) Tablet 325 MG. Give 2 (two) tablets by mouth every 12 hours as needed for pain. Order Date: 03/11/2017." "Hydrocodone-Ibuprofen Tablet (9) 7.5-200 MG. Give 1 (one) tablet by mouth every 4 hours as needed for pain. Order Date: 03/12/2017."

The eMAR (electronic medication administration record) for Resident # 3 dated "March 2017 documented,
"Hydrocodone-Acetaminophen Tablet (9) 7.5-325 MG (milligram) Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Order Date: 03/11/2017." "Tylenol (10) Tablet 325 MG. Give 2 (two) tablets by mouth every 12 hours as needed for pain. Order Date: 03/11/2017." "Hydrocodone-Ibuprofen Tablet (9) 7.5-200 MG. Give 1 (one) tablet by mouth every 4 hours as needed for pain. Order Date: 03/12/2017."

The eMAR dated March 2017 revealed: Hydrocodone-Acetaminophen 7.5-325 MG was administered on 03/12/17 at 12:35 a.m. and 8:56 p.m., 03/13/17 at 10:33 p.m., 03/15/17 at 12:23 a.m. and 11:12 a.m., 03/16/17 at 12:15 p.m., 03/17/17 at 5:39 a.m. and 12:31 p.m., 03/18/17

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12:02 p.m., 03/19/17 at 10:34 a.m., 03/20/17 at 2:52 a.m. and 9:28 a.m., 03/21/17 at 11:17 a.m., 03/22/17 at 8:58 p.m., and on 03/24/17 at 1:03 a.m.
Hydrocodone-Ibuprofen 7.5-200 MG was administered on 03/12/17 at 1:22 p.m., 03/14/17 at 2:41 a.m. and 1:28 p.m., 03/29/17 at 10:19 a.m., and on 03/31/17 at 12:30 p.m.
Tylenol 325 MG was administered on 03/12/17 at 1:46 a.m. and on 03/16/17 at 11:27 a.m.

The eMAR (electronic medication administration record) for Resident # 3 dated April 2017 documented,
"Hydrocodone-Acetaminophen Tablet (9) 7.5-325 MG (milligram) Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Order Date: 03/11/2017." "Tylenol (10) Tablet 325 MG. Give 2 (two) tablets by mouth every 12 hours as needed for pain. Order Date: 03/11/2017."

The eMAR dated April 2017 revealed,
Hydrocodone-Acetaminophen 7.5-325 MG was administered on 04/01/17 at 10:35 p.m., 04/03/17 at 4:33 a.m., 04 04/17 at 9:44 a.m., 04/05/17 at 9:31 a.m. and 04/05/17 at 8:35 p.m., 04/07/17 at 9:25 a.m., 04/10/17 at 9:37 a.m., 04/11/17 at 1:42 a.m. and 9:00 a.m., 04/14/17 at 5:01 a.m., 04/16/17 at 12:47 p.m., 04/17/17 at 1:32 a.m., 04 19/17 at 3:20 a.m., 04/24/17 at 1:46 a.m. and 2:52 p.m., 04/26/17 at 4:15 a.m. 04/28/17 at 1:16 a.m., 04/29/17 at 1:08 a.m. and on 04/30/17 at 4:42 a.m.
Tylenol 325 MG was administered on 04/29/17 at 4:01 p.m.

The eMAR (electronic medication administration record) for Resident # 3 dated May 2017 documented,

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"Hydrocodone-Acetaminophen Tablet (9) 7.5-325 MG (milligram) Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain. Order Date: 03/11/2017."

The eMAR dated April 2017 revealed, Hydrocodone-Acetaminophen 7.5-325 MG was administered on 05/01/17 at 1:49 a.m.

The care plan for Resident # 3 dated 07/12/16 documented, "Focus: Pain related to Arthritis, Neuropathy, Glaucoma. Date Initiated: 03/24/2016. Revision on 01/19/2017." Under "Interventions" it documented, "Staff to offer non-pharmacological interventions as tolerated. Date Initiated: 04/11/2016."

The "Progress Notes" for Resident # 3 dated 03/11/2017 through 05/01/2017 were reviewed and failed to evidence documentation of non-pharmacological interventions prior to the administration of Hydrocodone-Ibuprofen, Hydrocodone-Acetaminophen and Tylenol.

On 05/03/17 at 1:20 p.m. an interview was conducted with LPN (licensed practical nurse) # 5. When asked to describe the procedure of administering PRN (as needed) pain medication, LPN # 5 stated, "I would ask where the pain is, what type of pain, determine the level of pain on a scale one to ten, based on the level of pain would administer what is prescribed, I would reassess the resident after 30 minutes to see if the medication was effective. When asked how often the non-pharmacological interventions should be attempted, LPN # 5 stated, "I would use non-pharmacological interventions if their pain level was like a level one and they can tolerate the pain that level."

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On 05/03/17 at 1:40 p.m. an interview was conducted with RN (registered nurse) # 6, unit manager. When asked to describe the procedure of administering PRN pain medication, RN # 6 stated, "Do a pain assessment, location, intensity, observe nonverbal cues, use pain scale one to ten, ten being most severe. Check the order to see what was ordered, check to see when they last got pain medication and administer according to the physician's order, follow-up approximately 30 to 60 minutes after giving the medication to determine if it was effective using the pain scale." When asked how often the non-pharmacological interventions should be attempted, RN # 6 stated, "I would try non-pharmacological interventions depending on the resident. I would ask them if there is something I could do before the medication to relieve their pain." When asked where they would document the use of non-pharmacological interventions, RN # 6 stated, "It's documented on the MAR and in the nurse's notes."

On 05/03/17 at 2:00 p.m. an interview was conducted with RN (registered nurse) # 7, unit manager. When asked to describe the procedure of administering PRN pain medication, RN # 7 stated, "Rate the resident's pain on a scale of one to ten, ask where the pain is and to describe it. The pain medication should be administered according to the pain level." When asked about the use of non-pharmacological interventions, RN # 7 stated, "Non-pharmacological interventions should be tried every time before giving PRN pain medication and documented in the nurse's notes what was tried or if the resident refused the interventions." After reviewing the MARs dated March, April and May 2017 and the progress

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notes dated 03/11/2017 through 05/01/2017 for Resident # 3, RN # 1 was asked if there was documentation of non-pharmacological interventions attempted prior to the administration of PRN pain medication. RN # 1 stated, "No, it wasn't done."

On 05/04/17 at approximately 1:50 p.m. ASM (administrative staff member) # 1 the administrator, and ASM # 2, director of nursing, were made aware of the findings.

No further information was provided prior to exit.

References:

1. The uncontrolled growth of abnormal cells in the body. Cancerous cells are also called malignant cells. This information was obtained from the website: https://medlineplus.gov/ency/article/001289.htm.

2. Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

3. A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

4. Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.

5. High blood pressure. This information was

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obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

6. A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

7. A group of diseases that can damage the eye's optic nerve. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/glaucoma.html.

8. Nerve damage. This information was obtained from the website: https://www.google.com/#q=neuropathy+nih.

9. Hydrocodone is available in combination with other ingredients, and different combination products are prescribed for different uses. Some hydrocodone combination products are used to relieve moderate-to-severe pain. Other hydrocodone combination products are used to relieve cough. Hydrocodone is in a class of medications called opiate (narcotic) analgesics and in a class of medications called antitussives. Hydrocodone relieves pain by changing the way the brain and nervous system respond to pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601006.html.

10. (Acetaminophen) Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to

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vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a681004.html.

3. The facility staff failed to obtain physician ordered blood pressures for Resident #7.

Resident #7 was admitted to the facility on 1/7/15 with diagnoses that included but were not limited to: diabetes, high blood pressure, depression, chronic pain, gastroesophageal reflux disease, anemia (too low blood count (1)), pressure ulcer of the sacral region (inflammation or sore over a bony prominence resulting from prolonged pressure to the area (2)), dysphagia, and dementia.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 2/3/17, coded the resident as scoring a zero on the BIMS (brief interview for mental status) score, indicating that she was severely impaired to make cognitive daily decisions. Resident #7 was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living.

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The physician order dated, 4/28/16, documented, "Weekly B/P (blood pressure) check one time a day every Thu (Thursday) for HTN (hypertension - high blood pressure)."

The MAR (medication administration record) for April 2017 documented, "Weekly B/P check one time a day every Thu for HTN." The MAR documented a check mark and the nurse's initials on 4/5/17, 4/12/17, 4/20/17 and 4/27/17. There was no documentation of the blood pressures on the MAR.

A review of the nurse's notes for 4/5/17 documented a blood pressure taken on 4/4/17 at 11:17 a.m. The nurse's note dated, 4/12/17 at 12:40 p.m. did not document a blood pressure. There were no nurse's notes dated 4/20/17 or 4/27/17.

A review of the "Vital signs" tab in the electronic medical record, documented no blood pressure on 4/5/17 or 4/12/17. On 4/20/17 the blood pressure "0/0 mmHg (millimeters of mercury)" was documented. There was a blood pressure documented on 4/27/17 at 9:15 a.m. of 133/69 mmHg."

The comprehensive care plan dated, 4/11/16 and revised on 2/27/17, documented in part, "Focus: Altered cardiac profusion relate to diagnosis of HTN, PVD (peripheral vascular disease) (any abnormal condition affecting blood vessels outside the heart) (3) and Atherosclerosis of aorta (common disorder of the arteries in which plaques consisting mostly of cholesterol and lipids form on the inner arterial/aortic wall leading to decreased blood flow (4))." The "Interventions" documented in part, "Assess vital signs."

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An interview was conducted with LPN (licensed practical nurse) #5, on 5/3/17 at 3:15 p.m. When asked what staff should do if the physician has written an order for a blood pressure to be taken every Thursday, LPN #5 stated, "The nurse should check the blood pressure every Thursday." When asked where blood pressure readings were documented, LPN #5 stated, "It's in the electronic record in a progress note or in the vital signs tab in the computer."

An interview was conducted with LPN #10, the unit manager, on 5/3/17 at 3:18 p.m. When asked what staff should do if the physician has written an order for a blood pressure to be taken every Thursday, LPN #10 stated, the blood pressure should be on the MAR. Technically, it should not be allowed to be charted on unless the blood pressure value is inserted." The MAR and vital signs tab was reviewed with LPN #10. LPN #10 stated, "It's not there. The order was not put into the system correctly."

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, ASM #3, corporate nurse, and RN (registered nurse) #2, the transitional care coordinator, were made aware of the above findings on 5/3/17 at 5:35 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 33.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 155.

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(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 447.
(4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 53.

4. a. The facility staff failed to follow the physician order to notify the physician of a weight change based on daily weights for Resident #14.

Resident #14 was admitted to the facility on 10/24/16 with a readmission on 11/21/16. Her diagnoses included but were not limited to: congestive heart failure (CHF), acute and chronic respiratory failure, fracture of the lower leg, high blood pressure, sleep apnea (periods of not breathing while someone sleeps (1)), anemia, chronic obstructive pulmonary disease (COPD), and atrial fibrillation (rapid and random contractions of the atria of the heart causing irregular beats of the ventricles decreasing the heart output (2)).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/14/17, coded the resident as scoring a 14 on the BIMS (brief interview for mental status) score, indicating she was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance for most of her activities of daily living. She was coded as only requiring supervision after set up assistance was provided for eating.

The physician order dated, 11/21/16, documented, "Obtain weight daily; one time a day for monitoring. If there is a weight gain of 2 lbs.

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(pounds) in one day or 5 lbs. in one week, notify MD (medical doctor)."

The MAR (medication administration record) for February 2017 documented, "Obtain weight daily; one time a day for monitoring. If there is a weight gain of 2 lbs. in one day or 5 lbs. in one week, notify MD." The following weight gains were documented:
2/5/17 - 249.8; 2/6/17 - 251.9, a gain of 2 pounds.
2/18/17 - 252.2; 2/19/17 - 254.2, a gain of 2 pounds.

The March 2017, MAR documented, "Obtain weight daily; one time a day for monitoring. If there is a weight gain of 2 lbs. in one day or 5 lbs. in one week, notify MD." The following weight gains were documented:
3/8/17 - 256; 3/9/17 - 258.6, a gain of 2.6 pounds.
3/16/17 - 257.8; 3/17/17 - 260.2, a gain of 2.4 pounds.
3/17/17 - 260.2; 3/18/17 - 263, a gain of 2.8 pounds.
3/26/17 - 252; 3/27/17 - 259.4, a gain of 7.4 pounds.

The April 2017, MAR documented, "Obtain weight daily; one time a day for monitoring. If there is a weight gain of 2 lbs. in one day or 5 lbs. in one week, notify MD." The following weight gains were documented:
4/3/17 - 252.8; 4/4/17 - 256.4, a gain of 3.6 pounds.
4/7/17 - 256; 4/8/17 - 258, a gain of 2 pounds.

The above order was discontinued on 4/20/17.

Review of the nurse's notes from 2/1/17 through 4/20/17 did not evidence any documentation of

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the physician being notified of the above weight gains.

The comprehensive care plan dated, 10/25/16 and revised on 3/21/17, documented in part, "Focus: Risk for fluid output exceeding intake characterized by fluid volume deficit; dry skin and mucous membranes, poor skin turgor and integrity related to: diuretics, CHF." The "Interventions" documented in part, "Notify MD & RD (registered dietician) of weight change per facility routines."

An interview was conducted with LPN (licensed practical nurse) #4 on 5/3/17 at 3:10 p.m. The above daily weight order was reviewed with her. When asked what is expected of the nurse with the above order, LPN #4 stated, "We have to weigh the person every day and call the doctor according to the order." When asked where that is documented, LPN #4 stated, "It's documented in the progress notes and or 24 hour book." When asked if the 24 hour book was part of the clinical record, LPN #4 stated, "It' should be in both but definitely the progress note."

An interview was conducted with LPN #10, the unit manager, on 5/3/17 at 3:17 p.m. When asked to review the above order for daily weights, and what staff should do, LPN #10 stated, "They have to weigh the resident daily and notify the doctor if the weight is more than two pounds in a day or five pounds in a week." When asked where this notification is documented, LPN #10 stated, "It should be in a nurse progress note to say at least the doctor was notified."

The facility policy, "Change in Resident Condition" documented in part, "The Charge Nurse will

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recognize and appropriately intervene in the event of a change in resident condition. The Physician/Family/Responsible Party will be notified as soon as the nurse had identified the change in condition and the resident is stable."

In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, ASM #3, corporate nurse, and RN (registered nurse) #3, the transitional care coordinator, were made aware of the above findings on 5/3/17 at 5:35 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 45.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.

b. The facility staff failed to follow the physician orders for the administration of Tylenol to Resident #14.

The physician order dated, 1/1/17, documented, "Tylenol Tablet 325 MG (milligrams); Give 2 tablet by mouth every 8 hours as needed for Fever."

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The February 2017 MAR (medication administration record) documented, "Tylenol Tablet 325 MG; Give 2 tablet by mouth every 6 hours as needed for Fever." The MAR documented the resident received Tylenol on 2/21/17 at 9:04 a.m. and a pain level of "6" was documented. Review of the nurse's notes did not reveal documentation of a fever for Resident #14. Review of the vital signs section of the clinical record did not reveal any evidence the resident had a fever.

The April 2017 MAR documented, "Tylenol Tablet 325 MG; Give 2 tablet by mouth every 6 hours as needed for Fever." The MAR documented the resident received Tylenol on 4/28/17 at 12:10 p.m. for a pain level of "6." Review of the nurse's notes did not reveal documentation of a fever for Resident #14. Review of the vital signs section of the clinical record did not reveal any evidence the resident had a fever.

The May 2017 MAR documented, "Tylenol Tablet 325 MG; Give 2 tablet by mouth every 6 hours as needed for Fever." The MAR documented the resident received Tylenol on 5/1/17 at 12:55 p.m. for a documented pain level of "4." Review of the nurse's notes did not reveal documentation of a fever for Resident #14. Review of the vital signs section of the clinical record did not reveal any evidence the resident had a fever.

The comprehensive care plan dated, 10/24/16, did not address fevers.

An interview was conducted with LPN (licensed practical nurse) #4, on 5/3/17 at 3:10 p.m. The order for the Tylenol above was reviewed with

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F 309	Continued From page 107 LPN #4. When asked if the nurse could give the Tylenol for pain, based on the above order, LPN #4 stated, "No, they would have to get a whole new order." An interview was conducted with LPN #10, the unit manager, on 5/3/17 at 3:17 p.m. The order for Tylenol above was reviewed with LPN #10. When asked if the nurse could give the Tylenol for pain, based on the above order, LPN #10 stated, "According to this order, it should only be given for fever." When asked what the staff should do, LPN #10 stated, "They need to clarify the order and or get a new order for Tylenol for pain for the resident." The facility policy, "Physician/Prescriber Authorization and Communication of Orders to Pharmacy" documented in part, "1. Facility should not administer medications or biologicals except upon the order of a Physician/Prescriber lawfully authorized to prescribe for and treat human illnesses." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, ASM #3, corporate nurse, and RN (registered nurse) #3, the transitional care coordinator, were made aware of the above findings on 5/3/17 at 5:35 p.m. No further information was provided prior to exit.	F 309		
F 311 SS=D	TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS CFR(s): 483.24(a)(1) (a)(1) A resident is given the appropriate treatment and services to maintain or improve his	F 311		5/26/17

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F 311	Continued From page 108 or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section. This REQUIREMENT is not met as evidenced by: Based on resident interview, resident interview, facility document review and clinical record review, it was determined that the facility staff failed to provide restorative services per the plan of care for one of 27 residents in the survey sample, Resident #14. The facility staff failed to provide restorative ambulation services to Resident #14 per the plan of care. The findings include: Resident #14 was admitted to the facility on 10/24/16 with a readmission on 11/21/16. Her diagnoses included but were not limited to: congestive heart failure (CHF), acute and chronic respiratory failure, fracture of the lower leg, high blood pressure, sleep apnea (periods of not breathing while someone sleeps (1)), anemia, chronic obstructive pulmonary disease (COPD), and atrial fibrillation (rapid and random contractions of the atria of the heart causing irregular beats of the ventricles decreasing the heart output (2)). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/14/17, coded the resident as scoring a 14 on the BIMS (brief interview for mental status) score, indicating she was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance for most of her activities of daily living.	F 311	F311 1. MD was notified of resident # 14 not receiving restorative services. Therapy evaluation was performed; currently receiving therapy services. 2. All residents receiving restorative nursing care have the potential to be affected by this deficient practice. 3. The MDS Coordinator and Director of Rehabilitation or designees, will in-service clinical staff on providing and documenting restorative services. 4. The MDS Coordinator or designee will audit restorative care documentation 5 times a week for four weeks then randomly for eight weeks. Results of audits will be taken to QAPI committee monthly for 3 months for review and revision as needed. 5. Date of Compliance: June 16, 2017.	

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She was coded as requiring only supervision after set up assistance was provided for eating.

An interview was conducted with Resident #14 on 5/3/17 at 3:44 p.m. Resident #14 stated that today (5/3/17) was the first day in weeks that she had been walked with the restorative aide. Resident #14 stated, "They can't walk me every day, which what the restorative aide told me. She gets pulled off restorative to work on the floor as a CNA (certified nursing assistant)."

An interview was conducted with RN (registered nurse) #2, the MDS nurse, on 5/3/17 at 4:40 p.m. When asked who oversees the restorative nursing program, RN #2 stated, "I do." When asked if a physician order was required for restorative nursing, RN #2 stated, "Not that I'm aware of." RN #2 was asked to provide any documentation that evidenced Resident #14 was in a restorative program.

On 5/3/17 at 5:14 p.m. RN #2 presented the "Restorative Ambulation Program Daily Record" for April 2017 for Resident #14. The "Problem/Need" documented, "Resident is able to ambulate with RW (rolling walker) and min assist (minimum assistance) 50 feet." The "Interventions" documented in part, "15 min (minutes); 6-7 days/week, device needed - walker, ambulate 50 feet.

The "Restorative Ambulation Program" dated for April 2017 documented the resident received restorative ambulation program on the following days:
The week of April 2 - 8, 2017, the resident received restorative nursing on five days.
The week of April 9 - 15, 2017, the resident

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received restorative nursing on four days.
The week of April 16 - 22, 2017, the resident did not receive any restorative nursing.
The week of April 23 - 29, 2017, the resident received restorative nursing on six days.

The comprehensive care plan dated, 4/4/17, documented in part, "Focus: Requires assistance for ambulation related to: Requires assistive device, unsteady balance." The "Interventions" documented in part, "Ambulation per restorative plan. Resident will practice 15 minutes a day for 6/7 days a week."

An interview was conducted with RN #2 on 5/3/17 at 5:14 p.m. When asked why the resident is not receiving the restorative nursing program per her plan of care, RN #2 stated, "We've had times when the restorative aid is pulled to the floor." When asked if someone else should cover, RN #2 stated, "Yes." When asked if a resident has a program for restorative care, should it be followed, RN #2 stated, "Yes."

The facility policy, "Introduction to the Restorative Nursing Program" documented in part, " Purpose: The purpose of the restorative nursing programs is to allow our facilities to be the providers of choice by delivering quality restorative care that meets the needs of each resident. Our facilities will focus on achieving and maintaining optimal physical, mental and psychosocial functioning for our residents. The goal for each resident is to improve or maintain current functioning for our residents. The goal for each resident is to improve or maintain current functional level, and to ensure that the resident does not exhibit any decline that is medically avoidable. Procedure: The restorative nursing programs are carried out

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F 311	Continued From page 111 under the direction of the nursing department, and are provided by licensed nurses and trained restorative aides. These programs employ measurable goals, and each resident is evaluated quarterly (or more often, if need be). Restorative programs are provided in groups of four residents or less. Nursing management will provide supervision of the restorative programs and is therefore responsible for program implementation, program utilization, documentation, review of progress, consultation with therapists, and program evaluation. The nursing staff will be trained in restorative are through staff development in-service programs. Goals: Supportive and restorative measures are used to increase our residents' level of physical independence. In the face of limitations, the goal is to maintain the resident's present level of independence and prevent any further loss, where prevention is a realizable goal. Some degenerative disease processes dictate that disability is progressive, regardless of attempts at intervention." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, ASM #3, corporate nurse, and RN (registered nurse) #3, the transitional care coordinator, were made aware of the above findings on 5/3/17 at 5:35 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 45. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.	F 311		

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F 314 SS=D	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide would care in a manner to promote healing and prevent infection of a pressure sore, for one of 27 residents in the survey sample, Resident #7. LPN (licensed practical nurse) #10 was not observed cleaning her scissors prior to cutting a dressing that was placed into Resident #7's sacral pressure wound. The findings include: Resident #7 was admitted to the facility on 1/7/15	F 314	F314 1. LPN #10 was educated and counseled by the DON on providing wound care in a manner to promote healing and prevent infection. Resident # 7 sustained no ill effects due to this deficient practice. 2. All residents receiving wound care have the potential to be affected by this deficient practice. 3. The DON or designee will in-service licensed nurses on providing wound care in a manner which promotes healing and prevents infection. 4. The Unit Managers or designees will observe wound care on 25% of residents with wounds weekly for four weeks, then	5/30/17

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with diagnoses that included but were not limited to: diabetes, high blood pressure, depression, chronic pain, gastroesophageal reflux disease, anemia (too low blood count (1)), pressure ulcer of the sacral region (inflammation or sore over a bony prominence resulting from prolonged pressure to the area (2)), dysphagia, and dementia.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 2/3/17, coded the resident as scoring a zero on the BIMS (brief interview for mental status) score, indicating that she was severely impaired to make cognitive daily decisions. Resident #7 was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living. In Section M - Skin Conditions, the resident was coded as having an unstageable pressure ulcer*. Also known as a pressure injury.**

*Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. (3)

**Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense

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randomly for eight weeks. Results of audits will be reviewed by the QAPI committee for three months.
5. Date of compliance: June16, 2017.

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and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. (4)

The physician orders dated, 3/1/17, documented, "Sacrum one time a day for wound care; cleanse sacrum with wound cleanser pat dry and apply hydrofera blue* soaked with sterile water and cover with dry dressing daily."

*Hydrofera Blue -- A foam dressing bound with gentian violet and methylene blue (GV/MB) antibacterial agents (Hydrofera Blue; Hollister Wound Care, Libertyville, IL) has been shown to be effective against a wide spectrum of microorganisms found in wounds, including methicillin-resistant staphylococcus aureus (MRSA), vancomycin-resistant enterococcus VRE and Candida. (5)

On 5/3/17 at 10:50 a.m. LPN (licensed practical nurse) #10 was observed administering wound care to Resident #7's sacral wound. LPN #10 gathered her supplies from the treatment cart positioned at the doorway to Resident #7's room. She pulled scissors out of the top draw of the treatment cart, and proceeded to cut a small, approximately 1/2 inch by 1/2 inch of the hydrofera blue. She placed this in a plastic medication cup. She proceeded to put sterile water in the cup with the dressing. She did not clean her scissors prior to cutting the dressing. LPN #10 placed all of her wound care supplies on Resident #7's over bed table. LPN #10 then removed the old dressing on Resident #7's sacrum; she then removed her gloves and washed her hands. LPN #10 proceeded to clean

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the wound with the wound cleanser. She then took the small piece of hydrofera blue and placed it directly into the wound cavity, and then she applied the dry dressing.

An interview was conducted with LPN #10 on 5/3/17 at 1:54 p.m. LPN #10 was informed of the above observation of cutting the hydrofera blue, and was asked when she cleaned her scissors. LPN #10 stated, "The last usage. I always use the bleach wipes after each use." When asked if scissors should be cleaned prior to cutting a dressing, LPN #10 stated, "I am the only one using that cart (treatment) and I know I clean them when I put them away." When asked if she should clean the scissors before cutting a dressing that is placed inside a resident's wound, LPN #10 stated, "I guess so."

The facility policy, "Skin and Wound Care Guideline" documented in part, "Clean technique involves strategies used in patient care to reduce the overall number of microorganisms or to prevent or reduce the risk of transmission of microorganisms from one person to another or from one place to another. Clean technique involves meticulous hand-washing, maintaining a clean environment by preparing a clean field, using clean gloves, sterile instruments and prevention of direct contamination of materials and supplies. No 'sterile to sterile' rules apply. This technique may also be termed 'non-sterile."

An interview was conducted with ASM #2, the director of nursing; on 5/3/17 at 5:58 p.m. ASM #2 was asked who has access to the treatment carts, ASM #2 stated, "All nurses."

Administrative staff member (ASM) #1, the

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F 314	Continued From page 116 administrator, ASM #2, the director of nursing, ASM #3, the corporate nurse and RN #3, the transitional care coordinator, were made aware of the above findings on 5/3/17 at 5:35 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 33. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 155. (3) This information was obtained from the following website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ (4) This information was obtained from the following website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ (5) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4717508/	F 314		
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		5/26/17

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F 323	Continued From page 117 (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review it was determined that the facility staff failed to store chemicals in a safe manner in one of four soiled utility rooms, (soiled utility room beside the Summer unit) and one of three janitor closets (janitor closet across the hall from the rehabilitation department). The following was observed in the unlocked soiled utility room beside the summer unit: -One 32 ounce container of TB-Cide Quat disinfectant solution -One 67.6 ounce container of BioRenewables glass cleaner The following was observed in the unlocked janitor closet across the hall from the rehab department: - One three liter container of neutral disinfectant cleaner -One three liter container of Ecolution glass	F 323	F323 1. The chemicals were immediately removed from the indicated soiled utility room and housekeeping closet. The housekeeping closet was locked immediately. 2. All residents who can access housekeeping closets and/or soiled utility rooms have the potential to be affected by this deficient practice. 3. The housekeeping and maintenance staff and clinical staff were educated on proper storage of chemicals by administrator or designee. 4. The Maintenance Director/designee will audit housekeeping closets to assure that they are locked 5 times a week for 8 weeks. The Unit Managers/designee will audit soiled utility rooms for the presence of chemicals five times weekly for 8 weeks. Results of audits will be taken to	

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F 323	Continued From page 118 cleaner -One three liter container of disinfectant bowl cleaner -One three liter container of Ecolution odor remover - One two liter container of BioRenewables glass cleaner The findings include: On 5/2/17 at 2:16 p.m., observation of the soiled utility room beside the summer unit was conducted. The door to the room was unlocked and the following chemicals were observed in the room: -One 32 ounce container of TB-Cide Quat disinfectant solution -One 67.6 ounce container of BioRenewables glass cleaner On 5/2/17 at 2:19 p.m. observation of the janitor closet across the hall from the rehab department was conducted. The door to the room was unlocked and the following chemicals were observed in the room: - One three liter container of neutral disinfectant cleaner -One three liter container of Ecolution glass cleaner -One three liter container of disinfectant bowl cleaner -One three liter container of Ecolution odor remover - One two liter container of BioRenewables glass cleaner During the above observations, two residents were observed propelling themselves in wheelchairs in the hall adjacent to the soiled utility	F 323	QAPI committee monthly for 3 months for review and revisions as needed. . 5. Date of compliance: June 16, 2017.	

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room and the janitor closet. No residents were observed in the rooms or attempting to enter the rooms.

On 5/2/17 at 2:25 p.m., an interview was conducted with OSM (other staff member) #3 (the director of environmental services). OSM #3 stated all chemicals were supposed to be stored in locked rooms. OSM #3 was shown the chemicals in the unlocked soiled utility room. OSM #3 stated, "That shouldn't be there" and discarded the chemicals. OSM #3 was shown the chemicals in the unlocked janitor closet. OSM #3 stated the janitor closet door should be locked. At this time, OSM #3 was asked to provide a policy regarding the safe storage of chemicals. On 5/2/17 at 3:20 p.m., OSM #3 stated she couldn't find the requested policy.

On 5/3/17 at 5:42 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional director of clinical services) and RN (registered nurse) #3 (the transitional care coordinator) were made aware of the above findings.

The safety data sheet for TB-Cide Quat disinfectant solution documented, "Hazard Statements: Causes serious eye irritation..."
The safety data sheet for BioRenewables glass cleaner documented, "Hazard Statements: Causes serious eye irritation..."
The safety data sheet for the neutral disinfectant cleaner documented, "Hazard Statements: Causes severe skin burns and eye damage. Harmful if inhaled. Harmful if swallowed..."
The safety data sheet for the Ecolution glass cleaner documented, "Hazard statements: Causes mild skin irritation. Causes eye irritation.

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F 323	Continued From page 120 May be harmful if swallowed..." The safety data sheet for disinfectant bowl cleaner documented, "Hazard statements: Causes severe skin burns and eye damage. Harmful if inhaled. Harmful if swallowed..." The safety data sheet for the Ecolution odor remover documented, "Hazard statements: Causes mild skin irritation. Causes eye irritation..." No further information was presented prior to exit.	F 323		
F 328 SS=D	TREATMENT/CARE FOR SPECIAL NEEDS CFR(s): 483.25(b)(2)(f)(g)(5)(h)(i)(j) (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services	F 328		5/26/17

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F 328	Continued From page 121 to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, it was determined that the facility staff failed to provide proper treatment and services for respiratory care for two of 27 residents in the survey sample, Resident #14 and #13. 1. The facility staff failed to store a nebulizer	F 328	F328 1. The CPAP mask was cleaned and bagged, and the oxygen nasal cannula tubing for resident #14 was changed and bagged. The oxygen tubing resident #13 was changed and bagged. 2. All residents receiving oxygen have the potential to be affected by this	

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mask, CPAP mask and oxygen nasal cannula in a sanitary manner for Resident #14.

2. The facility staff failed to ensure Resident #13's oxygen nasal cannula and tubing was properly bagged in a sanitary manner.

The findings include:

1. Resident #14 was admitted to the facility on 10/24/16 with a readmission on 11/21/16. Her diagnoses included but were not limited to: congestive heart failure (CHF), acute and chronic respiratory failure, fracture of the lower leg, high blood pressure, sleep apnea (periods of not breathing while someone sleeps (1)), anemia, chronic obstructive pulmonary disease (COPD), and atrial fibrillation (rapid and random contractions of the atria of the heart causing irregular beats of the ventricles decreasing the heart output (2)).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/14/17, coded the resident as scoring a 14 on the BIMS (brief interview for mental status) score, indicating she was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance for most of her activities of daily living. She was coded requiring only supervision after set up assistance was provided for eating. In Section O - Special Treatments, Procedures, and Programs, the resident was coded as having received oxygen while a resident at the facility.

Resident #14's room was observed during the initial tour of the facility on 5/2/17 at 12:40 p.m. The nebulizer mask was sitting on the bedside

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deficient practice.
3. The DON or designee will educate clinical staff on the proper maintenance of CPAP masks and oxygen tubing.
4. The Unit Managers or designees will audit 25% of residents receiving oxygen therapy and CPAP usage weekly for four weeks and then randomly for eight weeks. Results of audits will be taken to the QAPI committee monthly for 3 months for review and revisions as needed.
5. Date of compliance: June 16, 2017.

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table. It was not in a protective bag or covering, exposed to air. The oxygen concentrator, machine, was on the opposite side of the bed. The nasal cannula (tubing to administer oxygen through the nose) was lying on the floor. The oxygen tubing was dated 5/1/17.

Resident #14's room was observed on 5/2/17 at 5:07 p.m. All respiratory equipment was covered in a plastic bag. The oxygen tubing was dated 5/1/17.

Resident #14's room was observed on 5/3/17 at 8:20 a.m. The resident was using the nebulizer mask for a treatment. The oxygen tubing was placed in the resident's nose. The CPAP* mask was resting on the bedside table, not in a bag. The oxygen tubing was dated 5/1/17.

*C-PAP, Continuous Positive Airway Pressure, is a machine used to assist people who are diagnosed with sleep apnea. A C-Pap machine increased air pressure in the throat so that the airway does not collapse when you breathe in. (3)

On 5/3/17 at 3:44 p.m., an interview was conducted with Resident #14. When asked if there were any concerns, Resident #14 stated, "My daughter gets so upset when she comes in and finds the oxygen tubing on the floor. She usually picks it up and cleans it with an alcohol swab." When asked how frequently she has to do this, Resident #14 stated, "Almost every day."

The physician orders documented the following:
"11/21/16 - Oxygen @ (at) 2 1/2 LPM (liters per minute) via nasal cannula every shift for respiratory needs.
11/21/16 - Change oxygen cannula every week

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and PRN (as needed).
11/22/16 - CPAP Q HS (every bedtime) every evening shift for Respiratory needs.
5/1/17 - Change nebulizer tubing and bag q (every) week, in the morning every Mon (Monday) for change for 2 weeks.

The comprehensive care plan dated, 10/25/16 and revised on 3/7/17, documented in part, "Altered Cardiac/Resp (respiratory) Functioning; CPAP at hs (bedtime), CHF, Pacemaker, COPD." The "Interventions" documented in part, "Change nebulizer tubing and bag q week. O2 (oxygen) therapy as ordered." The care plan dated, 11/1/16, documented in part, "Resident requires oxygen R/T (related to) CHF, COPD, disease process." The "Interventions" documented in part, "Administer oxygen as ordered. Aerosol/nebulizer treatments as orders, change oxygen tubing, cannula q week."

On 5/3/17 at 3:54 p.m., an interview was conducted with RN (registered nurse) #7, the unit manager. When asked how respiratory equipment, nebulizer mask, oxygen tubing and CPAP masks, should be stored, RN #7 stated, "It should all be stored in a plastic bag when not in use." When asked what happens to oxygen tubing if it is found on the floor, RN #7 stated, "You need to go get new tubing."

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, ASM #3, the corporate nurse and RN #3, the transitional care coordinator, were made aware of the above findings on 5/3/17 at 5:35 p.m.

On 5/4/17 at approximately 9:00 a.m. a copy of the policy on the storage of respiratory equipment

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was requested from ASM #2.

On 5/4/17 at 12:05 p.m. ASM #2 stated the facility did not have a policy on storing respiratory equipment. The facility practice is to bag equipment when not in use.

In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 648. "Box 34-2 Sites for and Causes of Health Care-Associated Infections under Respiratory Tract -- Contaminated respiratory therapy equipment."

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 45.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.
(3) This information was obtained from the following website: www.webmd.com/sleep-disorders/sleep-apnea.

2. The facility staff failed to ensure Resident #13's oxygen nasal cannula and tubing was properly bagged in a sanitary manner.

Resident #13 was admitted to the facility on 3/16/17 with the diagnoses of but not limited to paranoid schizophrenia, dementia, heart failure, chronic obstructive pulmonary disease, coronary artery disease, and high blood pressure. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 3/23/17. The

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resident was coded as being moderately impaired in ability to make daily life decisions, scoring a 9 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident required extensive assistance for transfers, dressing, and hygiene; limited assistance for bathing; supervision for eating; and was coded as incontinent of bowel and bladder.

On 5/2/17 at 12:40 p.m., an observation of the room for Resident #13 was conducted. The oxygen tubing from the concentrator was hanging over the over-bed table and the cannula end was dangling in the air, and was not bagged.

On 5/2/17 at 5:17 p.m., another observation was made. There was no change from the previous observation.

On 5/4/17 at 7:50 a.m., an observation was made of Resident #13. He was in the bed asleep. The wheelchair was next to the bed. The oxygen tubing from the tank that hangs on the wheelchair was coiled up in the seat of the wheelchair, wrapped around his shoes which were in the seat of the wheelchair. The cannula end was not bagged.

On 5/4/17 at 7:55 a.m., in an interview with LPN #4 (Licensed Practical Nurse) the resident's nurse for the day, she stated it should have been bagged and not wrapped around his shoes.

On 5/4/17 at 1:52 p.m., the Administrator (Administrative Staff Member [ASM] #1) and the Director of Nursing (ASM #2) were made aware of the findings. No further information was provided by the end of the survey.

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F 334 SS=E	INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS CFR(s): 483.80(d)(1)(2) (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must	F 334		5/26/17

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develop policies and procedures to ensure that-

(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;

(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and

(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and

(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, facility document review and clinical record review, the facility staff failed to provide education prior to the administration of the influenza vaccine for five of 27 residents in the survey sample, Residents # 10, # 4, # 3, # 7, and # 6.

1. The facility staff could not provide evidence

F 334

F334
1. The facility cannot demonstrate that education on immunizations was provided to residents #3, #4, #6, #7 and #10.
2. All residents have the potential to be affected by this deficient practice.
3. The Director of Nursing educated Nursing Managers and Supervisors, and

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that Resident # 10 had received education prior to the administration of the flu vaccine.

2. The facility staff failed to provide Resident #4 and or the resident's representative education regarding the benefits and potential side effects of the influenza immunization during the 2016/2017 flu season.

3. The facility staff failed to provide education prior to the administration of the influenza vaccine for Resident # 3.

4. The facility staff failed to have evidence of the education and consent for an influenza vaccine for Resident #7.

5. The facility staff failed to evidence that education was provided prior to Resident # 6's refusal of the flu vaccine. In addition, the Resident # 6's consent to refuse the vaccine was not maintained on the clinical record.

The findings include:

1. Resident # 10 was admitted to the facility on 1/14/16 and again on 4/14/17 with diagnoses that included, but were not limited to, hypertension, dementia, anxiety, depression, atrial fibrillation, coronary artery disease, seizures, and hypothyroidism [a low functioning thyroid (1)].

Resident # 10's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 4/21/17. Resident # 10 was coded as usually understanding and as usually able to understand others. Resident # 10 was coded as scoring zero out of a possible 15 on the BIMS (Brief Interview

Provider's Plan of Correction (F 334):

the Admissions staff on obtaining consents for immunizations and providing education on influenza prior to the administration of the vaccine.

4. The DON or designee will audit new admissions 5 times a week for 8 weeks to assure that education and consents have been given and obtained per facility policy. Results of audits will be taken to the QAPI committee monthly for 3 months for review and revision as needed.

5. Date of compliance: June 16, 2017.

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for Mental Status) indicating that Resident #10 was severely cognitively impaired.

Review of Resident # 10's clinical record documented that she had received the flu vaccine on 10/8/16. No documentation of the consent or the education could be found.

During the end of day interview on 5/3/17 at 5:30 p.m. with ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nurses, ASM # 3, regional director of clinical services, and RN (registered nurse) # 3, the transitional care coordinator, this concern was revealed.

During an interview on 5/4/17 at approximately 8:00 a.m. with ASM # 2, ASM # 2 stated that no consent/education could be found.

The facility policy "Influenza Vaccine - Resident" was reviewed. Under "POLICY: All residents will be offered an influenza vaccine beginning in October of each year, unless medically contraindicated or the resident has already been vaccinated. The facility will provide educational information regarding the significant risks and benefits of the vaccine to the resident and/or residents' responsible party annually." Under "PROCEDURE: A. Consent for the influenza vaccine will be obtained by the Admissions director (or designee) upon the resident's admission to the facility. In the event of weekend or after hour's admission the admitting nurse will obtain consent. B. The completed consent (Form 5.5) will be placed on the resident's chart with a copy of the consent forwarded to the DON to ensure follow up. C. The Social Service director (or designee) will provide the resident and/or

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residents' responsible party with information and education regarding the benefits and potential side effects of the influenza vaccine, every year, in the beginning of September...D. The Social Service Director (or designee) will document the provision of education in the resident's medical record..."

Review of the blank consent (Form 5.5), "INFORMED CONSENT FOR INFLUENZA VACCINE" documented that the following: "Why you should get vaccinated?" "When should you get vaccinated?" and "Potential Adverse Effect/Negative Outcomes of Receiving the Vaccine."

No further information was provided prior to exit.

If possible, all residents should receive trivalent inactivated influenza vaccine (TIV) annually before influenza season. In the majority of seasons, TIV will become available to long-term care facilities beginning in September, and influenza vaccination should commence as soon as vaccine is available. Informed consent is required to implement a standing order for vaccination, but this does not necessarily mean a signed consent must be present.

In the event that a new patient or resident is admitted after the influenza vaccination program has concluded in the facility, the benefits of vaccination should be discussed, educational materials should be provided, and an opportunity for vaccination should be offered to the new resident as soon as possible after admission to the facility. Since October 2005, the Centers for Medicare and Medicaid Services (CMS) has

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required nursing homes participating in Medicare and Medicaid programs to offer all residents influenza and pneumococcal vaccines and to document the results. According to requirements, each resident is to be vaccinated unless contraindicated medically, the resident or legal representative refuses vaccination, or the vaccine is not available because of storage. This information is to be reported as part of the CMS Minimum Data Set, which tracks nursing home health parameters.

Information obtained from <http://www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm>

(1) This information was obtained from the website:https://www.nlm.nih.gov/medlineplus/ency/article/000353.htm

2. The facility staff failed to provide Resident #4 and or the resident's representative education regarding the benefits and potential side effects of the influenza immunization during the 2016/2017 flu season.

Resident #4 was admitted to the facility on 1/21/15. Resident #4's diagnoses included but were not limited to: heart failure, major depressive disorder and overactive bladder. Resident #4's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/21/17, coded the resident's cognition as severely impaired. Section O documented Resident #4 received the influenza vaccine in the facility on 10/13/16. Resident #4's comprehensive care plan initiated on 4/28/16 failed to document information

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regarding the influenza vaccine.

Review of Resident #4's clinical record failed to reveal evidence that Resident #4 and or the resident's representative were provided education regarding the benefits and potential side effects of the influenza vaccine.

On 5/3/17 at 5:42 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional director of clinical services) and RN (registered nurse) #3 (the transitional care coordinator) were made aware of the above findings.

On 5/4/17 at 8:00 a.m. an interview was conducted with RN (registered nurse) #1 (the assistant director of nursing and former staff development coordinator). RN #1 stated she was responsible for mailing a letter to families that included a consent form and the Centers for Disease Control education regarding the influenza vaccine. RN #1 stated the letters were dated 9/2/16 and mailed on 9/3/16. RN #1 stated the consent form was supposed to be returned to the facility as soon as possible and the letter stated the form could be returned to the receptionist or charge nurse/medication nurse on each unit. RN #1 stated she did not place a copy of the education in residents' clinical records. RN #1 was asked to provide evidence that residents/representatives were provided education regarding the influenza vaccine during the 2016/2017 influenza season. RN #1 provided a copy of the letter and attachments sent to residents' families. RN #1 stated she could not provide evidence that residents/representatives were provided influenza vaccine education other than a statement documented on the letter that

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F 334	Continued From page 134 the education was attached. RN #1 stated she could not validate residents/representatives read the letter nor could she validate representatives received the letter because the letters were not sent via certified mail. The letter provided by RN #1 was dated 9/2/16 documented, "Dear Families, In preparing for the upcoming influenza season we want to update you on our process. We will be offering the flu vaccine to all current residents, as well as all new admissions, beginning October 1, 2016. Your consent is needed in order to administer this vaccine. You are being provided with an influenza vaccine information statement from the Centers for Disease Control (CDC) that will give you information pertaining to the benefits and risk of the influenza vaccine. Please fill out the attached consent/declination form and return it to the facility as soon as possible. You may return the form to the Receptionist at the main entrance or the charge nurse/medication nurse on the unit..." Attached to the letter was the CDC influenza vaccine information statement and a blank copy of a vaccine consent form that documented, "Flu Vaccine- I understand it is the policy of this facility to offer the flu vaccine annually and I (a blank line for the responsible party to write his/her name) give permission for (a blank line for the resident's name to be written) receive this vaccine pending the attending physician's approval..." Another section documented a blank line and, "DO NOT GIVE my permission for (a blank line) to receive this vaccine..." No further information was presented prior to exit.	F 334		

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3. The facility staff failed to provide education prior to the administration of the influenza vaccine for Resident # 3.

Resident # 3 was readmitted to the facility on 03/11/17 with diagnoses that included but were not limited to: neuromuscular dysfunction of the cancer (1), gastroesophageal reflux disease (2), diabetes mellitus (3), anxiety (4), depression, hypertension (5), atrial fibrillation (6), glaucoma (7), and neuropathy (8).

Resident # 3's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 03/16/17, coded Resident # 3 as scoring a nine on the brief interview for mental status (BIMS) of a score of 0 - 15, nine being moderately impaired of cognition for making daily decisions. Resident # 3 was coded as requiring extensive assistance of one staff member for activities of daily living.

Review of Resident # 3's clinical record failed to evidence Resident # 3 or their responsible party was provided education about the influenza vaccine. Further review of the clinical did reveal a signed consent dated 9/12/16. Further review of Resident # 3's clinical record revealed the influenza vaccine was administered to Resident # 3 on 10/10/2016.

On 05/04/17 at 8:00 a.m. an interview was conducted with RN (registered nurse) # 1, assistant director of nursing and previous director of staff development. RN # 1 stated, "I was responsible for compiling the influenza consent and the CDC (Center for Disease Control) influenza education with a letter and mailing it to

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the resident's families. The letter was dated 9/2/17 and mailed 9/3/17. The consent was to be returned to the facility, the education was not part of the resident's clinical record." When asked to provide evidence that the CDC (Center for Disease Control) influenza education was provided to Resident # 3 or their responsible party RN # 1 stated that she couldn't provide the evidence.

On 05/04/17 at approximately 1:50 p.m. ASM (administrative staff member) # 1 the administrator, and ASM # 2, director of nursing, were made aware of the findings.

No further information was provided prior to exit.

References:

1. The uncontrolled growth of abnormal cells in the body. Cancerous cells are also called malignant cells. This information was obtained from the website: https://medlineplus.gov/ency/article/001289.htm.

2. Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

3. A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

4. Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html

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#summary.

5. High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

6. A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

7. A group of diseases that can damage the eye's optic nerve. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/glaucoma.html.

8. Nerve damage. This information was obtained from the website: https://www.google.com/#q=neuropathy+nih.
4. The facility staff failed to have evidence of the education and consent for an influenza vaccine for Resident #7.

Resident #7 was admitted to the facility on 1/7/15 with diagnoses that included but were not limited to: diabetes, high blood pressure, depression, chronic pain, gastroesophageal reflux disease, anemia (too low blood count (1)), pressure ulcer of the sacral region (inflammation or sore over a bony prominence resulting from prolonged pressure to the area (2)), dysphagia, and dementia.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 2/3/17, coded the

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resident as scoring a zero on the BIMS (brief interview for mental status) score, indicating that she was severely impaired to make cognitive daily decisions. Resident #7 was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living.

Review of the clinical record failed to evidence documentation of the influenza consent and education provided to the resident or responsible party prior to receiving the influenza vaccine on 10/19/16.

A request was made for the copies of the education and consent for the influenza vaccine for Resident #7 on 5/3/17 at 1:25 p.m. and 5/3/17 at 5:35 p.m.

At the end of the day meeting on 5/3/17 at 5:35 p.m. the concern for no education and consent for the influenza vaccine was made to administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, ASM #3, the corporate nurse and RN #3, the transitional care coordinator,

On 5/4/17 at 7:58 a.m. RN (registered nurse) #1, the assistant director of nursing and formerly the staff development nurse, presented copies of consents and educations. Resident #7's papers were not in her package. RN #1 was asked to explain her role with the influenza program. RN #1 stated, "I was responsible for compiling the mailing to the family and residents. The mailing consisted of a letter to the family, the consent form and the CDC (center for disease control) education sheet." These letters were dated 9/2/16 and were mailed on 9/3/16." When asked if she

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knew what happened to the consents, RN #1 stated, "No. The consent form was to be returned to the facility as soon as possible." RN #1 went on to say, "The consents were to be returned to the receptionist, charge nurse, or medication nurse on the unit." At this time it was verified with RN #1 that there was no documentation of education part in the clinical record, RN #1 stated, "Correct, I can't evidence that the RP (responsible party) or resident received the education. The only thing returned is the consent." When asked if the letter is returned with the consent, RN #1 stated, "No." When asked in the legal clinical record, is there anything documenting that the education was done, RN#1 stated, "No."

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 33.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 155.

5. The facility staff failed to evidence that education was provided prior to Resident # 6's refusal of the flu vaccine. In addition, the Resident # 6's consent to refuse the vaccine was not maintained on the clinical record.

Resident #6 was admitted to the facility on 5/6/16 and readmitted on 12/30/16 with the diagnoses of but not limited to: multiple sclerosis, quadriplegia, dysphagia, osteomyelitis, pressure ulcers and neurogenic bladder. The most recent MDS (Minimum Data Set) was a quarterly assessment

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with an ARD (Assessment Reference Date) of 4/13/17. The resident was coded as moderately impaired in ability to make daily life decisions, scoring a 10 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring total care for transfers, dressing, and hygiene; extensive assistance for eating and bathing; and as incontinent of bowel and as having an indwelling catheter for bladder.

A review of the above identified MDS documented that the resident had refused her flu vaccine. A review of the clinical record failed to reveal any evidence of the resident's flu status, education, consent or refusal.

On 5/3/17 at 5:31 p.m., at the end of day meeting, the Administrator (Administrative Staff Member [ASM] #1) and the Director of Nursing (ASM #2) were made aware of the findings.

On 5/4/17 at 7:30 a.m., upon arriving to the facility, a consent form was provided indicating the resident refused the vaccine on 10/20/16. No education was documented on this form.

On 5/4/17 at 7:45 a.m., in an interview with RN #3 (Registered Nurse) the Transitional Care Nurse, she stated that there was no evidence of education.

On 5/4/17 at 7:59 a.m., in an interview with the ADON (Assistant Director of Nursing, RN #1) she stated that the consents were not maintained on the clinical record, and that the letter and education sheet that was sent to the responsible party was not maintained on the clinical record.

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F 334	Continued From page 141 On 5/4/17 at 1:52 p.m., the Administrator, ASM #1 and Director of Nursing, ASM #2 were made aware of the findings. No further information was provided by the end of the survey.	F 334		
F 372 SS=C	DISPOSE GARBAGE & REFUSE PROPERLY CFR(s): 483.60(i)(4) (i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, it was determined that the facility staff failed to maintain the dumpsters in a sanitary manner. Used gloves, and debris was observed around the facility's trash dumpster area during observations on 05/02/17. The findings include: During an observation on 05/02/17 at approximately 1:00 p.m. with OSM (other staff member) #5, assistant dietary manager and OSM #24, director of maintenance, the facility's dumpsters were observed. The dumpsters were located in the back driveway of the facility; these dumpsters were side by side enclosed within a wooden fence and accessed through a wooden gate. During this observation two pairs of used plastic gloves, used plastic wrap, used medicine cup and other pieces of debris was on the ground behind the trash dumpster. During an interview on 05/02/17 at approximately 1:05 p.m. an interview was conducted with OSM #5 and OSM #24. OSM #5 and OSM #24 stated that the responsibility to maintain the dumpster area clean was a combination of the two	F 372	F372 1. The dumpster area was cleaned immediately. 2. All residents have the potential to be affected by this deficient practice. 3. The Environmental Services Director educated housekeeping, maintenance and dietary staff on the requirements for proper maintenance of the dumpster area. 4. The Environmental Services Director or designee will audit the dumpster area for cleanliness twice daily five times a week for four weeks and randomly for eight weeks to assure compliance. Results of audits will be reviewed by the QAPI committee for three months. 5. Date of compliance: June 16, 2017.	5/26/17

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F 372	Continued From page 142 departments. They further stated that the ground around the dumpsters should be clean and all doors should be closed. OSM #5 and OSM #5 immediately instructed staff to begin cleaning the dumpster area. On 05/04/17 at approximately 1:50 p.m. ASM (administrative staff member) # 1 the administrator, and ASM # 2, director of nursing, were made aware of the findings. No further information was provided prior to exit.	F 372		
F 428 SS=E	DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON CFR(s): 483.45(c)(1)(3)-(5) c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any	F 428		5/26/17

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F 428	Continued From page 143 drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to ensure monthly medication regimen reviews were completed; maintained within the facility readily available for review and or on the clinical record for nine of 27 residents in the survey sample, Resident #2, #8, #9, #1, #4, #11, #7, #14, and #6. 1. The facility staff failed to ensure the monthly medication regimen reviews were maintained	F 428	F428 1. Resident monthly Medication Reviews were filed in the resident clinical records. 2. All residents receiving medications have the potential to be affected by this deficient practice. 3. The Director of Nursing will in-service nursing management and the medical records clerk on the process of filing monthly medication reviews. 4. The Director of Nursing or designee	

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F 428	Continued From page 144 within the facility and readily available for review and or maintained the in the clinical record for Resident # 2. 2. The facility staff failed to ensure the monthly medication regimen reviews were maintained within the facility and readily available for review and or maintained the in the clinical record for Resident # 8. 3. The facility staff failed to ensure the monthly medication regimen reviews were maintained within the facility and readily available for review and or maintained the in the clinical record for Resident # 9. 4. The facility staff failed to provide evidence that Resident #1's monthly pharmacy medication recommendation reviews were completed for June 2016 through October 2016 and failed to have readily available for review and or maintain monthly pharmacy medication recommendation reviews in the resident's clinical record for the months of November 2016 and January 2017 through April 2017. 5. The facility staff failed to provide evidence that Resident #4's August 2016 monthly pharmacy medication recommendation review was completed and failed to have readily available for review and or maintain monthly pharmacy medication recommendation reviews in the resident's clinical record for the months of November 2016 and January 2017 through April 2017. 6. The facility staff failed to have readily available for review and or maintain Resident #11's January 2017 through April 2017 monthly	F 428	will audit medical records three times weekly for four weeks, then weekly for eight weeks to assure that pharmacy medication regimen reviews are scanned to the medical record. Results of audits will be taken to the QAPI committee monthly for 3 months for review and revision as needed. 5. Date of compliance: June 16, 2017.	

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pharmacy medication recommendation reviews in the resident's clinical record.

7. The facility staff failed to evidence that the medication regimen review for Resident #7 was conducted in September 2016, and failed to ensure the monthly medication regimen reviews for January through April 2017 were maintained within the facility and readily available for review and or maintained the in the clinical record.

8. The facility staff failed to maintain Resident #14's medication regimen reviews for January through April 2017 within the facility, readily available for review and or ensure medication regimen reviews were maintained in the clinical record.

9. The facility staff failed to ensure Resident #6's monthly pharmacy medication regimen reviews for January through April of 2017, were maintained within the facility, readily available for review and or on the clinical record. In addition, the September 2016 monthly medication regimen review was not completed.

The findings include:

1. The facility staff failed to ensure the monthly medication regimen reviews were maintained within the facility and readily available for review and or maintained the in the clinical record for Resident # 2.

Resident #2 was admitted to the facility on 10/15/16 with diagnoses that included but were not limited to spinal stenosis, lymphedema, cellulitis of the left and right lower limb, atrial

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fibrillation, type two diabetes mellitus, and high blood pressure. Resident #2's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/19/17. Resident #2 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status exam).

Review of the clinical record revealed that Resident 2's monthly medication regimen reviews for January, February, and March 2017 could not be found.

On 5/3/17 at 1:55 p.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). When asked about the process staff follows for processing pharmacy reviews, ASM #2 stated that pharmacy will email reviews to her (the DON) and she will divide the reviews by unit and place them in a physician's book. ASM #2 stated she will then have the reviews sent to her for a signature. ASM #2 stated that she will then take the recommendations and walk them down to medical records to be filed in the clinical record. ASM #2 presented this writer with Resident #2's January, February, and March pharmacy reviews. ASM #2 stated that she had pharmacy resend the reviews because she could not find them in the facility. ASM #2 stated that all recommendations made for January and March 2017 had been followed. When asked if the pharmacy reviews should have been in the clinical record, ASM #2 stated, "Yes."

Review of Resident #2's pharmacy recommendation dated 1/23/17 revealed the following recommendation was made: "(Name of

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Resident) currently receives Xarelto [1] 15 mg (milligrams) every morning. Recommendation: Recommend administering Xarelto once daily with the evening meal."

Review of Resident #2's active POS (physician order sheet) revealed that Xarelto was changed to "at bedtime" per pharmacy recommendation on 1/23/17.

Review of Resident #2's pharmacy recommendation dated 3/16/17 revealed the following recommendation was made: "(Name of Resident #2) has a PRN (as needed) order for diphenhydramine (Benadryl) [2] 50 mg qhs (every night), a high risk medication due to increased risk for prolonged sedation and increased risk for falls and anticholinergic [3] properties. Recommendations: Please consider discontinuing PRN diphenhydramine. If therapy desired, please consider initiating melatonin [4], or prn trazadone [5]."

Review of Resident #2's telephone physician orders revealed that Benadryl was discontinued on 3/17/17.

On 5/3/17 at 1:55 p.m., ASM #2, the DON was made aware of the above concerns.

The facility policy titled, "Medication Regimen Review," documents in part the following: "Procedure: 1. The consultant Pharmacist will conduct MRRs if required under a Pharmacy Consultant Agreement. 2. Facility should ensure that the Consultant Pharmacist has access to:
2.1 The resident and/or the resident's Responsible Party;
2.2 The resident's records, in accordance with

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F 428	Continued From page 149 with a copy of the MRRS and should alert the Medical Director where MRRs require follow-up. 9. Facility should maintain copies of MRRs on file in Facility, either as part of the resident's permanent medical record or in a special file, in accordance with Applicable Law. [1] Xarelto is used to treat and prevent blood clots, which lowers the risk of stroke, deep vein thrombosis and pulmonary embolism. This information was obtained from the National Institutes of health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012021/?report=details. [2] Benadryl is an antihistamine that is used for symptoms of allergic rhinitis and the common cold. This information was obtained from the National Institutes of Health. https://livertox.nih.gov/Diphenhydramine.htm. [3] Anticholinergic side effects may include dry mouth, constipation, urinary retention, bowel obstruction, dilated pupils, blurred vision, increased heart rate and impairment of cognitive function that is caused by a wide variety of medications. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC487008/. [4] Melatonin is a natural hormone that plays a role in sleep. Melatonin dietary supplements are used for those with sleep disorders or have trouble falling asleep. This information was obtained from The National Institutes of Health. https://nccih.nih.gov/health/melatonin.	F 428		

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[5] Trazadone is an antidepressant used to treat depression that can cause sleepiness. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012504/?report=details.

2. The facility staff failed to ensure the monthly medication regimen reviews were maintained within the facility and readily available for review and or maintained the in the clinical record for Resident # 8.

Resident #8 was admitted to the facility on 10/18/16 with diagnoses that included but were not limited to: stroke, type two diabetes mellitus, major depressive disorder, anxiety disorder, paralytic gait and muscle spasms. Resident #8's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/17/17. Resident #8 was coded as being cognitively impaired in the ability to make daily decisions scoring 06 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #8 was coded as extensive assistance from one staff member with transfers, ambulation, dressing, hygiene, and bathing; and independent with eating.

Review of the clinical record revealed that Resident #8's monthly medication regimen reviews for January, February, March and April of 2017 could not be found.

On 5/4/17 at 8:47 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). When asked about the process for processing monthly pharmacy reviews, ASM #2 stated, "Reviews are emailed to me, and I print them. I

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F 428	Continued From page 151 will sort through them by unit and put them in the physician book for review." ASM #2 stated that the reviews will then get sent back to her for her signature and she will give the pharmacy reviews to medical records to file in the clinical record. ASM #2 provided this writer with Resident #8's January, February, March and April 2017 monthly pharmacy reviews. When asked where each review came from, ASM #2 stated that she would have to check. Review of Resident #8's January, February, and April 2017 monthly medication regimen reviews revealed no recommendations during these months. Review of Resident's 8's monthly medication regimen review for March 2017 revealed a recommendation that documented the following: "Comment: After reviewing (Name of Resident #8) chart, there appears to be no diagnosis and/or documentation in the resident record which supports continued use of the following medication(s): "Topamax [1] Dx (diagnoses) seizures or mood? Recommendation: Please re-evaluate continued use, or provide documentation in this page or in the resident record which supports the clinical rationale for routine use of this/these medications moving forward." Review of Resident #8's most recent POS (physician order sheet) dated 4/01/17 through 4/30/17 revealed the following order: "Topamax Tablet 25 mg (milligrams) Give 2 tablet by mouth at bedtime for Anticonvulsant." This order was initiated on 12/31/16. On 5/4/17 at 8:55 a.m., further interview was	F 428		

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conducted with ASM #2, the director of nursing. ASM #2 stated that Resident #8's January, February, and March 2017 pharmacy reviews were scanned to her from pharmacy that day. ASM #2 stated that she could not find these reviews and had pharmacy resend them to her. ASM #2 stated that Resident #9's April 2017 pharmacy review was in a folder in the medical records office. ASM #2 stated that medical records had not yet filed this pharmacy review. When asked if the facility had followed the March 2017 recommendation for Topamax, ASM #2 stated, "I can check on that to see if a new diagnosis was added."

On 5/4/17 at 10:30 a.m., ASM #2 stated that Resident #8 was receiving Topamax for mood and a new diagnosis was not added to the POS (physician order sheet) per pharmacy recommendation. ASM #2 stated, "The order was not revised around that time."

On 5/4/17 at 10:30 a.m., ASM #2 was made aware of the above concerns. No further information was presented prior to exit.

[1] Topamax is used to treat seizures in adults and children and also used as an add-on medication for the treatment of bi-polar disorder. This information was obtained from the National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2671954/.

3. The facility staff failed to ensure the monthly medication regimen reviews were maintained within the facility and readily available for review and or maintained the in the clinical record for

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Resident # 9.

Resident #9 was admitted to the facility on 4/20/15 and readmitted on 10/6/16 with diagnoses that included but were not limited to Fracture of unspecified part of neck of right femur, difficulty in walking, history of falling, dementia, major depressive disorder, anxiety disorder and bipolar disorder. Resident #9's most recent MDS (minimum data set) was a quarterly MDS with an ARD (assessment reference date) of 4/12/17. Resident #9 was coded as being severely cognitively impaired in the ability to make daily decisions.

Review of the clinical record revealed that Resident #9's monthly medication regimen reviews for January, February, March and April of 2017 could not be found.

On 5/4/17 at 8:47 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). When asked about the process for processing monthly pharmacy reviews, ASM #2 stated, "Reviews are emailed to me, and I print them. I will sort through them by unit and put them in the physician book for review." ASM #2 stated that the reviews will then get sent back to her for her signature and she will give the pharmacy reviews to medical records to file in the clinical record. ASM #2 provided this writer with Resident #9's January, February, March and April 2017 monthly pharmacy reviews. When asked where each review came from, ASM #2 stated that she would have to check.

Review of Resident #9's January, February, March and April 2017 monthly medication

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regimen reviews revealed no recommendations during these months.

On 5/4/17 at 8:55 a.m., ASM #2 stated that Resident #9's January, February, and March 2017 pharmacy reviews were scanned to her from pharmacy that day. ASM #2 stated that she could not find these reviews and had pharmacy resend them to her. ASM #2 stated that Resident #9's April 2017 pharmacy review was in a folder in the medical records office. ASM #2 stated that medical records had not yet filed this pharmacy review.

On 5/3/17 at 8:55 a.m., ASM #2 was made aware of the above findings. No further information was presented prior to exit.

4. The facility staff failed to provide evidence that Resident #1's monthly pharmacy medication recommendation reviews were completed for June 2016 through October 2016 and failed to have readily available for review and or maintain monthly pharmacy medication recommendation reviews in the resident's clinical record for the months of November 2016 and January 2017 through April 2017.

Resident #1 was admitted to the facility on 10/17/16. Resident #1's diagnoses included but were not limited to: Alzheimer's disease (1), overactive bladder and lymphedema (2). Resident #1's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/24/17, coded the resident as being cognitively intact.

Review of Resident #1's clinical record revealed a monthly pharmacy medication recommendation

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review dated 12/16/16. No other monthly medication recommendation reviews were observed in the clinical record. On 5/3/17 at 2:35 p.m., OSM (other staff member) #23 (the medical records employee) presented monthly pharmacy medication recommendation reviews dated 1/23/17, 2/24/17, 3/16/17 and 4/10/17.

On 5/3/17 at 2:00 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated many of the monthly pharmacy medication recommendation reviews were not in the clinical record. ASM #2 stated some of the reviews were in the medical records office and some reviews were sent from the pharmacy. ASM #2 confirmed the reviews should be in the clinical record. ASM #2 stated a day or two after the pharmacist completes the reviews, the pharmacist emails the reviews to her (ASM #2). ASM #2 stated she divides the reviews between units and between reviews with recommendations and reviews with no recommendations. ASM #2 stated reviews with no recommendations are directly walked to the medical records department. ASM #2 stated reviews with recommendations are addressed then she signs off on the reviews and takes them to the medical records department. ASM #2 stated the reviews are supposed to be scanned into the medical record within a week after they are taken to the medical records department.

On 5/3/17 at 5:42 p.m., ASM #1 (the administrator), ASM #2, ASM #3 (the regional director of clinical services) and RN (registered nurse) #3 (the transitional care coordinator) were made aware of the above findings.

On 5/4/17 at 7:45 a.m. upon entrance into the

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facility, a monthly medication recommendation review dated 11/7/16 was presented in a folder lying on the table in the conference room and addressed to this surveyor.

On 5/4/17 at 8:20 a.m., ASM #2 was made aware this surveyor still needed to see Resident #1's reviews for June 2016, July 2016, August 2016, September 2016 and October 2016. ASM #2 stated her understanding was that if facility staff didn't find the reviews then the facility didn't have them and she was unable to get information from the previous pharmacy that provided services until a new pharmacy began services in November 2016.

No further information was presented prior to exit.

(1) "Alzheimer's disease (AD) is the most common form of dementia among older people. Dementia is a brain disorder that seriously affects a person's ability to carry out daily activities..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=alzheimers+disease&_ga=2.192845283.853609700.1494263454-139120270.1477942321

(2) "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..." This information was obtained from the website:
https://medlineplus.gov/lymphedema.html

5. The facility staff failed to provide evidence that

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Resident #4's August 2016 monthly pharmacy medication recommendation review was completed and failed to have readily available for review and or maintain monthly pharmacy medication recommendation reviews in the resident's clinical record for the months of November 2016 and January 2017 through April 2017.

Resident #4 was admitted to the facility on 1/21/15. Resident #4's diagnoses included but were not limited to: heart failure, major depressive disorder and overactive bladder. Resident #4's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/21/17, coded the resident's cognition as severely impaired.

Review of Resident #4's clinical record revealed monthly pharmacy medication recommendation reviews dated 6/15/16, 7/14/16, 9/11/16 and 10/12/16. No other monthly pharmacy medication recommendation reviews were observed in the clinical record.

On 5/3/17 at 2:00 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 presented Resident #4's monthly pharmacy medication recommendation reviews for the months of November 2016 through April 2017. ASM #2 stated many of the monthly pharmacy medication recommendation reviews were not in the clinical record. ASM #2 stated some of the reviews were in the medical records office and some reviews were sent from the pharmacy. ASM #2 confirmed the reviews should be in the clinical record. ASM #2 stated a day or two after the pharmacist completes the reviews, the

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pharmacist emails the reviews to her (ASM #2). ASM #2 stated she divides the reviews between units and between reviews with recommendations and reviews with no recommendations. ASM #2 stated reviews with no recommendations are directly walked to the medical records department. ASM #2 stated reviews with recommendations are addressed then she signs off on the reviews and takes them to the medical records department. ASM #2 stated the reviews are supposed to be scanned into the medical record within a week after they are taken to the medical records department.

On 5/3/17 at 5:42 p.m., ASM #1 (the administrator), ASM #2, ASM #3 (the regional director of clinical services) and RN (registered nurse) #3 (the transitional care coordinator) were made aware of the above findings.

On 5/4/17 at 8:20 a.m., ASM #2 was made aware this surveyor still needed to see Resident # 4's August 2016 review. ASM #2 stated her understanding was that if facility staff didn't find the reviews then the facility didn't have them and she was unable to get information from the previous pharmacy that provided services until a new pharmacy began services in November 2016.

No further information was provided prior to exit.

6. The facility staff failed to have readily available for review and or maintain Resident #11's January 2017 through April 2017 monthly pharmacy medication recommendation reviews in the resident's clinical record.

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F 428	Continued From page 159 Resident #11 was admitted to the facility on 7/10/15. Resident #11's diagnoses included but were not limited to: chronic kidney disease, diabetes and major depressive disorder. Resident #11's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/13/17, coded the resident's cognition as severely impaired. Resident #11's comprehensive care plan initiated on 3/14/16 failed to document information regarding monthly pharmacy medication recommendation reviews. Review of Resident #11's clinical record failed to review monthly pharmacy medication recommendation reviews for the months of January 2017 through April 2017. On 5/3/17 at 2:35 p.m., OSM (other staff member) #23 (the medical records employee) provided reviews for the months of January 2017, February 2017 and April 2017. On 5/3/17 at 2:00 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated many of the monthly pharmacy medication recommendation reviews were not in the clinical record. ASM #2 stated some of the reviews were in the medical records office and some reviews were sent from the pharmacy. ASM #2 confirmed the reviews should be in the clinical record. ASM #2 stated a day or two after the pharmacist completes the reviews, the pharmacist emails the reviews to her (ASM #2). ASM #2 stated she divides the reviews between units and between reviews with recommendations and reviews with no recommendations. ASM #2 stated reviews with no recommendations are directly walked to	F 428		

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the medical records department. ASM #2 stated reviews with recommendations are addressed then she signs off on the reviews and takes them to the medical records department. ASM #2 stated the reviews are supposed to be scanned into the medical record within a week after they are taken to the medical records department.

On 5/3/17 at 5:42 p.m., ASM #1 (the administrator), ASM #2, ASM #3 (the regional director of clinical services) and RN (registered nurse) #3 (the transitional care coordinator) were made aware of the above findings. Resident #11's March 2017 review was requested. On 5/4/17 at 7:45 a.m., upon this surveyor's entrance into the facility, the requested March 2017 review was present in a file addressed to this surveyor and sitting on the table in the conference room.

No further information was presented prior to exit.

7. The facility staff failed to evidence that the medication regimen review for Resident #7 was conducted in September 2016, and failed to ensure the monthly medication regimen reviews for January through April 2017 were maintained within the facility and readily available for review and or maintained the in the clinical record.

Resident #7 was admitted to the facility on 1/7/15 with diagnoses that included but were not limited to: diabetes, high blood pressure, depression, chronic pain, gastroesophageal reflux disease, anemia (too low blood count (1)), pressure ulcer of the sacral region (inflammation or sore over a bony prominence resulting from prolonged pressure to the area (2)), dysphagia, and dementia.

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The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 2/3/17, coded the resident as a zero on the BIMS (brief interview for mental status) score, indicating that she was severely impaired to make cognitive daily decisions.

Review of the clinical record did not reveal any documentation of the monthly medication regimen (MRR) reviews being completed in September 2016, January 2017, March and April 2017.

A request was made for the MRRs for the above time frame on 5/2/17 at 6:09 p.m.

The MRRs for January through April 2017 were presented on 5/3/17 at 2:35 p.m. Administrative staff member (ASM) #2, the director of nursing, stated that if the ones she's just handed to the survey team are blank, that indicated that they (the facility) had to get them from the pharmacy. Resident #7's September 2016, MRR was not provided. There was no evidence that a MRR was conducted in September for Resident #7.

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 5/4/17 at 8:50 a.m. When asked where Resident #7's MRRs were obtained from, ASM #2 stated, "They were not in the clinical record. We got them reprinted from the pharmacy." When asked about the process for processing the MRRs in the facility, ASM #2 stated, "They are emailed to me. I print them out, sort them by unit. They are given to the unit managers to put in the doctor's books for review. Once reviewed, they are given back to me for signature. After I have

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received them back, I give them to medical records to scan into the electronic medical record." When asked why they were not in the clinical record, ASM #2 stated, "I don't know."

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, ASM #3, the corporate nurse and RN #3, the transitional care coordinator, were made aware of the above findings on 5/3/17 at 5:35 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 33.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 155.

8. The facility staff failed to maintain Resident #14's medication regimen reviews for January through April 2017 within the facility, readily available for review and or ensure medication regimen reviews were maintained in the clinical record.

Resident #14 was admitted to the facility on 10/24/16 with a readmission on 11/21/16. Her diagnoses included but were not limited to: congestive heart failure (CHF), acute and chronic respiratory failure, fracture of the lower leg, high blood pressure, sleep apnea (periods of not breathing while someone sleeps (1)), anemia, chronic obstructive pulmonary disease (COPD), and atrial fibrillation (rapid and random contractions of the atria of the heart causing irregular beats of the ventricles decreasing the

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heart output (2)).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/14/17, coded the resident as scoring a 14 on the BIMS (brief interview for mental status) score, indicating she was cognitively intact to make daily decisions.

Review of the clinical record on 5/3/17, did not reveal any documentation that the monthly medication regimen (MRR) reviews were completed in January through April 2017.

A request was made for the MRRs for the above time frame on 5/2/17 at 6:09 p.m.

Copies of the MRRs for January through April 2017 were presented to this surveyor on 5/4/17 at 7:30 a.m.

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 5/4/17 at 8:50 a.m. When asked where Resident #14's MRRs were obtained from, ASM #2 stated, "They were not in the clinical record. We got them reprinted from the pharmacy." When asked about the process for processing the MRRs in the facility, ASM #2 stated, "They are emailed to me. I print them out, sort them by unit. They are given to the unit managers to put in the doctor's books for review. Once reviewed, they are given back to me for signature. After I have received them back, I give them to medical records to scan into the electronic medical record." When asked why they were not in the clinical record, ASM #2 stated, "I don't know."

The facility policy, "Medication Regimen Review"

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F 428		F 428		

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documented in part, "Facility should maintain copies of MRRs on file in Facility, either as part of the resident's permanent medical record or in a special file, in accordance with Applicable Law."

ASM #1 and ASM #2 were made aware of the above concern on 5/4/17 at 2:52 p.m.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 45.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.

9. The facility staff failed to ensure Resident #6's monthly pharmacy medication regimen reviews for January through April of 2017, were maintained within the facility, readily available for review and or on the clinical record. In addition, the September 2016 monthly medication regimen review was not completed.

Resident #6 was admitted to the facility on 5/6/16 and readmitted on 12/30/16 with the diagnoses of but not limited to: multiple sclerosis, quadriplegia, dysphagia, osteomyelitis, pressure ulcers and neurogenic bladder. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 4/13/17. The resident was coded as moderately impaired in ability to make daily life decisions, scoring a 10 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam.

A review of Resident #6's clinical record failed to reveal monthly pharmacy reviews for January

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F 428	Continued From page 165 through April 2017 and September 2016. On 5/3/17 at 10:15, the monthly pharmacy reviews were requested from the DON (Director of Nursing - ASM [Administrative Staff Member] #2) On 5/3/17 at 2:00 p.m., the monthly pharmacy reviews for January through April 2017 were provided. The DON stated that they were not on the clinical record, and that the pharmacy sent them over. When asked about the September 2016 review, she stated there wasn't one. On 5/4/17 at 1:52 p.m., the Administrator (Administrative Staff Member [ASM] #1) and the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey.	F 428		
F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(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	F 431		5/26/17

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F 431	Continued From page 166 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 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, staff interview and facility document review, it was determined that the	F 431	F431 1. The expired medications were	

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facility staff failed to appropriately label and store medications in two of four medication rooms, (autumn and winter medications rooms).

1. The facility staff failed to label an open bottle of lorazepam oral concentrate (1), located in the refrigerator in the autumn medication room.

2. The facility staff failed to discard an open vial of acetylcysteine (2) solution, located in the refrigerator in the winter medication room.

The findings include:

1. On 5/2/17 at 1:50 p.m. observation of the autumn medication room was conducted with RN (registered nurse) #4. An open bottle of lorazepam oral concentrate was observed in the refrigerator. The open date was not documented on the bottle or the manufacturers' box containing the bottle. The instructions on the manufacturers' box documented, "Discard opened bottle after 90 days." The pharmacy label on the manufacturers' box documented the medication was sent to the facility on 12/24/16. RN #4 confirmed the lorazepam bottle was open. RN #4 stated, "It's been discontinued." RN #4 was asked when the open bottle of lorazepam expired. RN #4 stated, "I would say 30 days. I don't know if it's in the fridge is it 45 days?" RN #4 looked at the manufacturers' box and stated, "90 days." RN #4 was asked if the medication was supposed to be labeled with an open date and stated, "Yes."

On 5/3/17 at 5:42 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional director of clinical services) and RN (registered nurse) #3 (the transitional care coordinator) were made

Provider's Plan of Correction (F 431):

disposed of immediately.
2. All residents receiving medications have the potential to be affected by this deficient practice.
3. The DON or designee will educate licensed nurses on the disposal of expired medications.
4. The Unit Managers/designee will conduct audits of medications weekly for four weeks and then randomly for eight weeks to assure that expired medications are disposed of properly. Results of audits will be taken to the QAPI committee monthly for 3 months for review and revision as needed.
5. Date of compliance: June 16, 2017.

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aware of the above findings.

The facility/pharmacy policy titled, "5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles" documented, "4. Facility should ensure that medications and biologicals: 4.1 Have an Expiration Date on the label; 4.2 Have not been retained longer than recommended by manufacturer or supplier guidelines...5. Once any medication or biological is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened..."

No further information was provided prior to exit.

2. On 5/2/17 at 2:00 p.m., observation of the winter medication room was conducted with LPN (licensed practical nurse) #2. A vial of acetylcysteine solution was observed in the refrigerator. A sticker on the vial documented, "Discard 4 days after opening. Date opened" The open date was hand written and documented "4/11/17." LPN #2 stated the resident prescribed the medication was discharged from the facility the previous week. When asked when the medication should be discarded, LPN #2 stated, "Four days after opening." When asked if the medication should be in the refrigerator, LPN #2 stated, "No."

On 5/3/17 at 5:42 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional director of clinical services) and RN (registered nurse) #3 (the transitional care coordinator) were made

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aware of the above findings.

The manufacturers' product insert documented, "Storage of Opened Vials: This product does not contain an antimicrobial agent, and care must be taken to minimize contamination of the sterile solution. If only a portion of the solution in a vial is used, store the remainder in a refrigerator and use for inhalation only within 96 hours..." This information was obtained from the website: http://labeling.pfizer.com/ShowLabeling.aspx?id=4101

No further information was presented prior to exit.

(1) lorazepam oral concentrate is used to treat anxiety. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=BF265C2E-AB2F-42E5-96CF-3998EB5A644D

(2) acetylcysteine is used to treat patients with abnormal mucous secretions. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=5558a5f5-e821-473b-7d8a-5d33d09f0586

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F 441 SS=F	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 441		5/26/17

(a) Infection prevention and control program.

The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

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F 441	Continued From page 170 (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 441		

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disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review it was determined, that the facility staff failed to maintain an effective infection control program as evidenced by incomplete and missing infection control logs.

The facility staff failed to consistently document the infectious organisms on the infection control logs. There were no organisms documented on the log for the months of July, and August 2016, January and February 2017. Also the facility failed to evidence infection control tracking logs for May and June 2016.

The findings include:

F 441

F441
1. A complete and accurate infection log for the facility will be maintained.
2. All residents have the potential to be affected by this deficient practice.
3. The DON or designee educated Unit Managers and Supervisors on the maintenance of complete and accurate infection logs. Monthly logs will be kept on the units and reviewed weekly by the Unit Managers to assure that all required information is documented. The completed logs will be turned in to the Director of Nursing at the end of each month and maintained in a log book in the DON office.
4. The DON or designee will conduct audits of the facility infection control log weekly for four weeks, then randomly

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Review of the facility's infection control logs documented titled columns that included: Resident name; culture (obtained) and organism (found in the culture). The infection control logs from July 2016 to April 2017 were reviewed. May 2016 and June 2016 infection control logs were not included.

The July 2016 infection control log documented that on 7/14/16 and 7/7/16 two residents had urine cultures taken. No organisms were documented on the log.

The August 2016 infection control log documented that on 8/8/16, 8/11/16 (2 residents) 8/19/16 8/26/16 and 8/31/16 that six residents had urine cultures. No organisms were documented on the log.

The January 2017 infection control log documented that on 1/26/17 a stool specimen on one resident and urine specimen as sent on another resident. No organisms were documented on the log.

The February 2017 infection control log documented that on 2/17/17 and 2/21/17 two residents had urine cultures taken. No organisms were documented on the log.

An interview was conducted on 5/4/17 at 12:38 p.m. with RN (registered nurse) #1, the assistant director of nursing. RN #1 was asked for a copy of the May 2016 and June 2016 infection control logs. RN #1 stated, "We couldn't find May and June (infection control logs for 2016)." When asked if the organism obtained from a culture was to be documented on the infection control log, RN #1 stated, "Yes. I will educate them on

weekly for eight weeks. Results of audits will be taken to the QAPI committee monthly for 3 months for review and revision as needed.

5. Date of compliance: June 16, 2017

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F 441	Continued From page 173 that." When asked why they documented the organisms on the logs, RN #1 stated, "It's part of our surveillance. We take our grid and put it (the infected residents) on a map of each unit." When asked why this was done, RN #1 stated, "We look for trends." RN #1 stated that they would then look if it was necessary to educate staff on handwashing or perineal care." An interview was conducted on 5/4/17 at 12:38 p.m. with ASM (administrative staff member) #2, the director of nursing. When asked why organisms from cultures were tracked, ASM #2 stated, "First of all we want to treat the residents appropriately. We want to identify trends; and patterns that might want to identify and change practice." Review of the facility's policy titled, "Infection Control Committee" documented, "D) The ICC (infection control committee) agenda will include: 2. Review of surveillance reports of infections and infectious disease will be presented to the committee by the Infection Control Coordinator. A. Monthly Infection Control Log (Form 5) for individual nursing unit is used to and trend infections by site and organism." No further information was provided prior to exit.	F 441		
F 513 SS=D	X-RAY/DIAGNOSTIC REPORT IN RECORD-SIGN/DATED CFR(s): 483.50(b)(2)(iv) (b) Radiology and other diagnostic services. (2) The facility must- (iv) File in the resident's clinical record signed and	F 513		5/26/17

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F 513	Continued From page 174 dated reports of radiologic and other diagnostic services. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to file radiology results in the clinical record for one of 27 residents in the survey sample, Resident #10. The facility staff failed to file the results of a chest x-ray that was ordered on 4/20/17 in Resident #10's record. The findings include: Resident # 10 was admitted to the facility on 1/14/16 and again on 4/14/17 with diagnoses that included, but were not limited to, hypertension, dementia, anxiety, depression, atrial fibrillation, coronary artery disease, seizures, and hypothyroidism [a low functioning thyroid (1)]. Resident # 10's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 4/21/17. Resident # 10 was coded as usually understanding and as usually able to understand others. Resident # 10 was coded as scoring zero out of a possible 15 on the BIMS (Brief Interview for Mental Status) cognitively severely impaired. Review of the clinical record documented a physician order for a chest x-ray dated 4/20/17. Further review of the clinical record revealed no chest x-ray report. During an interview on 5/3/17 at approximately 11:40 a.m. with ASM (administrative staff	F 513	F513 1. The results of the X-ray completed on resident #10 on 4/20/17 were filed in the resident□s medical record. 2. All residents having X-rays have the potential to be affected by this deficient practice. 3. The DON or designee will in-service licensed nurses on the responsibility of filing radiology reports in the medical record. 4. The Unit Managers/designee will audit radiology reports 5 times a week for 8 weeks to ensure part of clinical record. Results of audits will be taken to the QAPI committee monthly for 3 months for review and revision as needed. 5. Date of compliance: June 16, 2016.	

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member) # 2, the director of nurses, a request was made for the location of the chest x-ray report.

On 5/3/17 at approximately 2:00 p.m. ASM # 2 provided the chest x-ray report and stated the report had not been scanned into the electronic record.

During the end of day interview on 5/3/17 at 5:30 p.m. with ASM # 1, the administrator, ASM # 2, ASM # 3, regional director of clinical services, and RN (registered nurse) # 3, the transitional care coordinator, this concern was reviewed.

Review of the facility policy "Accurate Record Policy" documented: "POLICY: Health information Records shall be retained by the Facility in accordance with current applicable laws. However, in the event health information records are lost, destroyed by actual disaster, or incomplete the Facility will attempt to reproduce the information to maintain the record." Under "PROCEDURE: ...C) The NHA (nursing home administrator) and the Medical Records Director or designee will reconstruct the health information by, but not limited to: 1. Reprinting or uploading documents from any undamaged databases (i.e. laboratory, and radiology, etc.): ..."

No further information was provided prior to exit.

(1) This information was obtained from the website:https://www.nlm.nih.gov/medlineplus/ency/article/000353.htm