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	495413	A. BUILDING ______ B. WING ______	C 07/12/2018

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AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted on 7/12/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. 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 have a complete emergency preparedness plan. The facility staff failed to demonstrate the method the facility had developed for sharing the emergency plan with residents/clients and their families or representatives. The findings include: On 7/12/18 at 8:00 a.m., a review of the facility's emergency preparedness plan was conducted. Review of the facility's emergency preparedness plan failed to demonstrate the method the facility	E 035	E035: LTC and ICF/IID Sharing Plan with Patients 1. Letters will be given to residents and/or their representatives sharing with them our Emergency Preparedness Plan and where copies of the plan can be located in the facility. 2. All residents have the potential to be affected by this deficient practice. 3. Regional Director of Clinical Services educated the Administrator, Assistant Administrator and Director of Nursing educated on requirement of sharing the	8/13/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 08/02/2018

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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E 035	Continued From page 1 had developed for sharing the emergency plan with residents or clients and their families or representatives. On 7/12/18 at approximately 9:50 a.m., ASM (administrative staff member) #1, the administrator presented a newsletter that is kept at every nursing station that documented the following: "Autumn Cares number one goal is the safety of your loved ones. We are working with the Central Virginia Healthcare Coalition to make sure that we do all that we can to make that happen. Together our Emergency Preparation Program will be the best that it can be no matter the natural disaster." ASM #1 stated that this statement was on all monthly newsletters. The newsletter did not give any information on how residents and family members can access the emergency preparedness plan. ASM #1 stated that red binders (emergency preparedness) binders were located at each nursing station and in the lobby. On 7/12/18 at 10:00 a.m., the nursing units and the front lobby were observed. Red binders could not found at the nursing stations. There was no signage directing residents or family members to the emergency preparedness binder. The emergency preparedness binder in the front lobby was behind the receptionist desk. The binder was red and documented the following: "Fire Plan/Disaster Plan." There was no signage directing residents and family members to the emergency preparedness binder. ASM #1 was made aware of the above concerns at this time. No further information was presented prior to exit.	E 035	emergency preparedness plan with residents and their families or representatives. 4. Administrator or designee to conduct quality monitoring through review of new admit/readmit agreement packets for emergency preparedness plan notification letter signed by resident or their family or representative: weekly x 12 weeks. Findings to be reported to QAPI committee for 3 months and updated as indicated. Quality monitoring schedule based on findings. 5. Date of compliance: August 13, 2018	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 7/10/18 through 7/12/18. A complaint was investigated during the survey.	F 000		

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F 000	Continued From page 2 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 131 at the time of the survey. The survey sample consisted of 35 current resident reviews (Residents #58, #94, #53, #59, #28, #100, #82, #87, #71, #328, #332, #475, #31, #376, #91, #9, #7, #15, #56, #36, #46, #67, #27, #70, #2, #101, #108, #55, #23, #102, #425, #329, #86, #112, and #34) and two closed record reviews (Residents #125 and #127).	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(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 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)	F 580		8/13/18

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F 580	Continued From page 3 (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). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). 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 RR (resident representative) of a change in a physician's order for one of 37 residents in the survey sample, Resident #58. On 5/14/18 a physician's order for Resident #58's erythromycin (1) eye ointment was changed. The directions changed from administering the ointment to the left eye at bedtime to	F 580	F580: Notify of Changes 1. Resident #58 no longer resides in this facility. 2. All residents who require responsible party (RP) notification have the potential to be affected by this deficient practice. Quality review of all current resident□s charts with new physician orders was	

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F 580	Continued From page 4 administering the ointment to both eyes two times a day. The facility staff failed to notify the RR regarding the change in this order. The findings include: Resident #58 was admitted to the facility on 5/9/18. Resident #58's diagnoses included but were not limited to muscle weakness, urinary retention and glaucoma. Resident #58's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 6/6/18, coded the resident as being cognitively intact. Review of a list of concerns dated 7/2/18 and provided to facility staff from Resident #58's RR revealed the following documentation: CONSISTENT & ACCURATE COMMUNICATIONS CONCERNS: Change in Medical Prescription & Why (Prescribed medication was erroneously applied to Right Eye 2-3 days, before Family was aware of erroneous order change without knowledge or discussion...)" Review of Resident #58's clinical record revealed a physician's note dated 5/14/18 that documented, "Conjunctivitis (2) left eye- new, ongoing. It appears to be viral. Monitor. The patient is on eye drops. She has a droopy eye on the right. The patient is on erythromycin. We will order for bilateral (both) eyes for seven days..." Review of physician's orders revealed an order dated 5/14/18 that changed administration of erythromycin from the left eye at bedtime to both eyes two times a day. Further review of Resident #58's clinical record (including May 2018 progress notes) revealed	F 580	completed by DON or designee to ensure RP notification per policy and procedure. 3. Licensed nurses were educated to policy titled Notification of Change in Resident□'s Condition by DON or designee on the requirement to notify RP of changes in condition or physician orders. 4. DON or designee will conduct quality monitoring to ensure RP notification with change in resident condition or change with physician order without omissions: weekly x 12 weeks. Findings to be reported to QAPI committee for 3 months and updated as indicated. Quality monitoring schedule based on findings. 5. Date of Compliance: August 13, 2018	

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F 580	Continued From page 5	F 580		

Resident #58 was administered erythromycin as prescribed by the physician but failed to reveal the resident's RR was notified regarding the erythromycin order change on 5/14/18.

Review of Resident #58's care plan dated 5/10/18 failed to document specific information regarding RR notification.

On 7/11/18 at 4:40 p.m., an interview was conducted with LPN (licensed practical nurse) #4 (the nurse responsible for noting the change in the erythromycin physician's order on 5/14/18). LPN #4 stated she did not remember any specific details regarding the change in Resident #58's erythromycin on 5/14/18. LPN #4 was asked what should be done when there is a change in a physician's order. LPN #4 stated, "We are supposed to put it into the system exactly as prescribed, send (the order) to the pharmacy and notify the family." When asked if she documents family notification, LPN #4 stated she absolutely does in the progress notes. When asked if she notified Resident #58's RR when the physician wrote an order to change the administration of erythromycin from the left eye to both eyes, LPN #4 stated, "I can't say I did or didn't. I'm not perfect but I'm supposed to. I'm sure I did. I always try. If I documented it then I did it." LPN #4 was made aware she did not document notification.

On 7/11/18 at 6:55 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the assistant administrator), ASM #3 (the director of nursing), ASM #4 (the regional director of clinical services) and ASM #5 (the director of clinical education) were made aware of the above concern.

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F 580	Continued From page 6 The facility policy titled, "Notification of Change in Resident's Condition" documented, "The POA (power of attorney)/responsible party/family member/guardian of residents is to be notified of a change in the resident's condition within 24 hours unless it is an emergency. DEFINITION: A change in condition is: 1. Anything requiring physician intervention..." No further information was presented prior to exit. (1) Erythromycin is used to treat infections. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682381.html (2) "Conjunctivitis is the medical name for pink eye. It involves inflammation of the outer layer of the eye and inside of the eyelid. It can cause swelling, itching, burning, discharge, and redness." 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=conjunctivitis&_ga=2.179190695.221670695.1531740484-139120270.1477942321	F 580		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs	F 622		8/13/18

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cannot be met in the facility;
(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this

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F 622	Continued From page 8 section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by:	F 622		

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Continued From page 9

Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to evidence that all required documentation was provided to the receiving facility for five of 37 residents in the survey sample; Residents #82, #70, #71, #53, and #46.

1. The facility staff failed to evidence that any documentation regarding Resident #82 was provided to the hospital upon transfer to the hospital on 6/3/18.

2. The facility staff failed to evidence that any documentation regarding Resident #70 was provided to the hospital upon a hospital transfer on 5/29/18.

3. The facility staff failed to evidence that any documentation regarding Resident #71 provided to the hospital upon a hospital transfer on 4/14/18.

4. The facility staff failed to evidence that any documentation regarding Resident #53 was provided to the hospital upon transfer to the hospital on 5/13/18.

5. The facility staff failed to evidence that any documentation regarding Resident #46 was provided to the hospital upon transfer to the hospital on 4/25/18.

The findings include:

1. The facility staff failed to evidence that any documentation regarding Resident #82 was provided to the hospital upon transfer to the hospital on 6/3/18.

F 622

F622: Transfer and Discharge Requirements

1. Evidence of documentation could not be corrected in medical records for resident #82, resident #70, resident #71, resident #53, and resident 46.

2. Residents who transfer to ED have the potential to be affected by this deficient practice.

3. Licensed nurses educated to policy titled Discharge Planning by DON or designee on paperwork needed when a resident is sent to ED.

4. DON or designee to conduct quality monitoring to ensure paperwork is sent to ED with patient without omissions: weekly x 12 weeks.

Findings to be reported to QAPI committee for 3 months and updated as indicated. Quality monitoring schedule based on findings

5. Date of Compliance: August 13, 2018

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Resident #82 was admitted to the facility on 3/12/18 with the diagnoses of but not limited to high blood pressure, lumbar disc degeneration, heart failure, dysphagia, thyrotoxicosis, anxiety, schizophrenia, atrial flutter, obstructive uropathy, pneumonia, metabolic encephalopathy, and femur fracture. The most recent MDS (Minimum Data Set) was significant change assessment with an ARD (Assessment Reference Date) of 6/23/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions.

A review of the clinical record revealed that Resident #82 was sent to the hospital on 6/3/18. A physician's note dated 6/2/18 at 2:00 p.m., which documented, "Acute psychosis/schizophrenia/acute schizophrenia exacerbation...The patient's overall prognosis is very poor. She is somewhat slow to respond. She continues to have verbal outbursts. She is clinically hallucinating...there was some discussion about possible transfer and admission to a psychiatric facility. the (sic.) patient's overall schizophrenia, psychosis and delusions are getting worse...."

A nurse's note dated 6/3/18 at 10:02 a.m., documented, "Resident sent to (hospital) for AMS (altered mental status). (Name of responsible party) - RP (responsible party) notified."

Further review failed to reveal any documented evidence of the information sent to the hospital on 6/3/18, regarding Resident #82.

On 7/11/18 at 1:53 p.m., in an interview with LPN #6 (Licensed Practical Nurse), she stated that

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there is a checklist and the items on the checklist are put into the attached envelope and sent to the hospital.

A review of the checklist revealed a carbon copy form with the carbon copy being attached to the front of the envelope and the original perforated copy to tear off for the facility to maintain. The checklist included the following information to be provided: Resident Transfer Form, Face Sheet, Current Medication List or Current MAR (Medication Administration Record). SBAR (situation background, assessments, recommendation) and/or other Change in Condition Progress Note, Advance Directives, Advance Care Orders, Bed Hold (hand written onto the checklist), Most Recent History and Physical, Recent Hospital Discharge Summary, Recent MD/NP/PA (medical doctor, nurse practitioner, physician's assistant) and Specialist Orders, Flow Sheets. Relevant Lab Results, Relevant X-Rays and other Diagnostic Test Results, Nursing Home Capabilities Checklist.

On 7/11/18 at 1:55 p.m., LPN (licensed practical nurse) #6 was notified of the lack of evidence in the clinical record that any of this information was provided to the hospital upon Resident #82's transfer on 6/3/18. LPN #6 stated that the facility copy of the checklist is scanned into the electronic medical record. LPN #6 stated she would research it. In addition, it was noted that the list did not include providing the hospital with the comprehensive care plan goals.

On 7/11/18 at 2:54 p.m., LPN #6 stated there was no evidence that the facility retained the checklist or what documents were sent to the hospital with Resident #82 on 6/3/18. The nurse's notes also

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did not evidence what, if any, documentation was sent to the hospital.

A review of the facility policy "Discharge Planning Policy" documented, "....Documentation Requirements for Involuntary / Unplanned Discharge...When (facility) transfers or discharges a resident for any circumstance, the discharge/transfer must meet the regulatory requirements for transfer/discharge. The facility will take steps to ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.....a. Documentation in the resident's medical record must include: The basis for the transfer or discharge per the regulation (483.15(c)). If the basis is because it is necessary for the resident's welfare and the resident's needs cannot be met in the facility, then the following must be documented: i) the specific resident need(s) that cannot be met, ii) facility attempts to meet the resident needs, iii) the service(s) available at the receiving facility to meet the need(s).....6. Information to the Receiving Provider. Information provided to the receiving provider must include a minimum of the following: a. Contact information of the practitioner responsible for the care of the resident. b. Resident representative information including contact information. c. Advance Directive information. d. All special instructions or precautions for ongoing care, as appropriate. e. Comprehensive care plan goals. f. All other necessary information, including a copy of the residents discharge summary, as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care."

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On 7/11/18 at 6:46 p.m., at the end of day meeting, the Administrator (ASM #1 - Administrative Staff Member) and the Director of Nursing (ASM #3) were made aware of the findings. No further information was provided by the end of the survey.

2. The facility staff failed to evidence that any documentation regarding Resident #70 was provided to the hospital upon a hospital transfer on 5/29/18.

Resident #70 was admitted to the facility on 5/12/15 with the diagnoses of but not limited to Parkinson's disease, dementia, high blood pressure, irritable bowel syndrome, bladder obstruction, benign prostatic hyperplasia, dysphagia, right knee contracture, kyphosis, and diabetes. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 6/11/18. The resident was coded as cognitively intact in ability to make daily life decisions.

A review of the clinical record revealed that Resident #70 was sent to the hospital on 5/29/18. A physician's note dated 5/29/18 at 6:42 p.m., documented, "Pt (patient) was seen 3x (three times) today due to wbc's (white blood count {1}) of 26,000. IM (intramuscular) then IV (intravenous) rocephin (antibiotic {2}) was started however Pt (patient) continued to worsen clinically and staff was given orders to send to er (emergency room) for sepsis (cause is likely multifactorial due to uti (urinary tract infection) and questionable pna (pneumonia) on chest X-ray...."

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Further review failed to reveal any documented evidence of the information sent to the hospital on 5/29/18, regarding Resident #70.

On 7/11/18 at 1:53 p.m., in an interview with LPN #6 (Licensed Practical Nurse), she stated that there is a checklist and the items on the checklist are put into the attached envelope and sent to the hospital.

A review of the checklist revealed a carbon copy form with the carbon copy being attached to the front of the envelope and the original perforated copy to tear off for the facility to maintain. The checklist included the following information to be provided: Resident Transfer Form, Face Sheet, Current Medication List or Current MAR (Medication Administration Record). SBAR (situation background, assessments, recommendation) and/or other Change in Condition Progress Note, Advance Directives, Advance Care Orders, Bed Hold (hand written onto the checklist), Most Recent History and Physical, Recent Hospital Discharge Summary, Recent MD/NP/PA (medical doctor, nurse practitioner, physician's assistant) and Specialist Orders, Flow Sheets. Relevant Lab Results, Relevant X-Rays and other Diagnostic Test Results, Nursing Home Capabilities Checklist.

On 7/11/18 at 1:55 p.m., LPN #6 was notified of the lack of evidence in the clinical record that any of this information was provided. LPN #6 stated that the facility copy of the checklist is scanned into the electronic medical record. LPN #6 stated she would research it. In addition, it was noted that the list did not include providing the hospital with the comprehensive care plan goals.

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On 7/11/18 at 2:54 p.m., LPN #6 stated there was no evidence that the facility retained the checklist, and no evidence of what documents were sent to the hospital on 5/29/18, for Resident #70. The nurse's notes also did not evidence what, if any, documentation was sent to the hospital.

On 7/11/18 at 6:46 p.m., at the end of day meeting, the Administrator (ASM #1 - Administrative Staff Member) and the Director of Nursing (ASM #3) were made aware of the findings. No further information was provided by the end of the survey.

{1} White Blood Cell (WBC) - White blood cells, also called leukocytes, are cells that exist in the blood, the lymphatic system, and tissues and are an important part of the body's defense system. They help protect against infections and also have a role in inflammation, allergic responses, and protecting against cancer. The white blood cell (WBC) count totals the number of white blood cells in a person's sample of blood. It is one test among several that is included in a complete blood count (CBC), which is often used in the general evaluation of a person's health.
Information obtained from
https://labtestsonline.org/tests/white-blood-cell-co
unt-wbc

{2} Rocephin - used to treat certain infections caused by bacteria such as....infections of the lungs, ears, skin, urinary tract, blood, bones, joints, and abdomen....is in a class of medications called cephalosporin antibiotics. It works by killing bacteria.
Information obtained from
https://medlineplus.gov/druginfo/meds/a685032.h

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3. The facility staff failed to evidence that any documentation regarding Resident #71 provided to the hospital upon a hospital transfer on 4/14/18.

Resident #71 was admitted on 5/6/16 with the diagnoses of but not limited to stroke, sepsis, atrial fibrillation, metabolic encephalopathy, dysarthria, dysphagia, seizures, high blood pressure, insomnia, and glaucoma. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 6/11/18. The resident was coded as cognitively intact in ability to make daily life decisions.

A review of the clinical record revealed that Resident #71 was sent to the hospital on 4/14/18. A review of the nurse's notes revealed the following:

- A nurse's note dated 4/14/18 at 3:50 p.m., documented, "Resident had a bowel movement during the afternoon on 7-3 shift. Resident has been c/o (complained of) rectal pain when sitting on sacrum and to the touch when rectal area examined. Also had c/o constipation. Resident pain level was an 8 on pain scale. When resident had a bowel movement a small pool of blood 6 centimeters around, observed within residents' [sic] brief in the bowel movement. When observing resident's rectal area appears to have blood seeping out of rectum. Blood was bright red in color. Resident daughter has been contacted. Called 911 for transport to ED

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(emergency department) at (hospital). On call physician called but no answer left message with on call physician."

- A nurse's note dated 4/14/18 at 5:21 p.m., documented, "(hospital) was called at 1720 (5:20 p.m.) to check on resident condition. Per ER (emergency room) nurse resident to be admitted. bleeding."

- A nurse's note dated 4/14/18 at 5:34 p.m., documented, "On call nurse for facility notified of resident being admitted to ER."

Further review failed to reveal any documented evidence of the information sent to the hospital on 4/14/18, regarding Resident #71.

On 7/11/18 at 1:53 p.m., in an interview with LPN #6 (Licensed Practical Nurse), she stated that there is a checklist and the items on the checklist are put into the attached envelope and sent to the hospital.

A review of the checklist revealed a carbon copy form with the carbon copy being attached to the front of the envelope and the original perforated copy to tear off for the facility to maintain. The checklist included the following information to be provided: Resident Transfer Form, Face Sheet, Current Medication List or Current MAR (Medication Administration Record). SBAR (situation background, assessments, recommendation) and/or other Change in Condition Progress Note, Advance Directives, Advance Care Orders, Bed Hold (hand written onto the checklist), Most Recent History and Physical, Recent Hospital Discharge Summary, Recent MD/NP/PA (medical doctor, nurse

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practitioner, physician's assistant) and Specialist Orders, Flow Sheets. Relevant Lab Results, Relevant X-Rays and other Diagnostic Test Results, Nursing Home Capabilities Checklist.

On 7/11/18 at 1:55 p.m., LPN #6 was notified of the lack of evidence in the clinical record that any of this information was provided. LPN #6 stated that the facility copy of the checklist is scanned into the electronic medical record. LPN #6 stated she would research it. In addition, it was noted that the list did not include providing the hospital with the comprehensive care plan goals.

On 7/11/18 at 2:54 p.m., LPN #6 stated there was no evidence that the facility retained the checklist and no evidence of what documents were sent to the hospital regarding Resident #71 on 4/14/18. The nurse's notes also did not evidence what, if any, documentation was sent to the hospital.

On 7/11/18 at 6:46 p.m., at the end of day meeting, the Administrator (ASM #1 - Administrative Staff Member) and the Director of Nursing (ASM #3) were made aware of the findings. No further information was provided by the end of the survey.

4. The facility staff failed to evidence that any documentation regarding Resident #53 was provided to the hospital upon transfer to the hospital on 5/13/18.

Resident #53 was admitted to the facility on 7/3/17 with recent readmission on 5/17/18, with diagnoses that included but were not limited to: dementia, high blood pressure, glaucoma, enlarged prostate, and hallucinations.

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The most recent MDS (minimum data set) assessment, a significant change in status assessment, with an assessment reference date of 5/28/18, coded the resident as scoring a "5" on the BIMS (brief interview for mental status) score, indicating he has severe cognitive impairment of daily decision making.

The physician's order dated 5/13/18, documented in part, "May send to er (emergency room) for eval [evaluation] and treat [treatment]."

The nurse's note dated 5/13/18 at 9:00 a.m. documented in part, "Resident unresponsive upon entering room to administer meds (medications) at 0825 [8:25 a.m.] ...Writer tried to awake[sic] resident by calling his name and doing a sternal rub with no response ...Writer grabbed crash cart and went back into residents room ...Writer called 911 to send resident out to ER as resident is a full code."

Review of the clinical record failed to evidence what resident information, including clinical information, was included in the Resident's transfer documentation on 5/13/18.

An interview was conducted on 7/11/18 at 2:15 p.m. with LPN (licensed practical nurse) #1. LPN #1 was asked to describe the process staff follows when transferring a resident to the hospital. LPN #1 stated they first obtain a physician's order and notify the Responsible Representative. They then prepare the facility transfer envelope with a checklist on it documenting paperwork sent including the Resident's face sheet, medication list, transfer assessment form, and copies of relevant laboratory reports. When asked if the resident's

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comprehensive care plan or care plan goals are sent, LPN #1 stated, "No". When asked if the facility maintained copies of the documentation sent with Resident #53 upon transfer, LPN #1 stated "No".

An interview was conducted on 7/11/18 at 2:20 p.m. with the assistant administrator, ASM (administrative staff member) #2. When asked if the comprehensive care plan goals are sent with residents upon transfer to a hospital, ASM #2 stated, "I think some units may be doing it, but this unit is not". When asked if she could provide evidence of the information sent with the residents upon transfer, ASM #2 stated, "We use the transfer envelope and fill out the checklist on the front". When asked if she could provide evidence of the information sent with Resident #53 for his facility initiated transfer on 5/13/18, ASM #2 stated she could not.

ASM #1, the administrator, ASM #2, assistant administrator, ASM #3, the director of nursing, ASM #4, regional director of clinical services, and ASM #5, director of clinical education, were made aware of the above findings on 7/11/18 at 6:35 p.m.

No further information was provided prior to exit.

5. The facility staff failed to evidence that any documentation regarding Resident #46 was provided to the hospital upon transfer to the hospital on 4/25/18.

Resident #46 was admitted to the facility on 6/30/17, with a most recent readmission on 4/25/18, with diagnoses that included but were

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not limited to: difficulty swallowing, dementia, seizures, and heart failure.

The most recent MDS (minimum data set) assessment, a quarterly review assessment, with an assessment reference date of 5/18/18, coded the resident as having short and long term memory problems, as well as severely impaired cognitive skills for daily decision making.

The physician progress noted dated 4/25/18 at 5:00 p.m., documented in part, "Patient has lethargy and fever ...recommended for the patient to be transferred to the ER (emergency room) due to his high risk full code status."

The physician order dated 4/25/18, documented in part, "May send to ER for eval [evaluation] and treat [treatment] r/t [related to] abnormal x-ray."

The nurse's note dated 4/26/18 at 3:23 p.m., documented the following, "Late entry for 4/25/18: Resident admitted to [Hospital's name] r/t [related to] pneumonia as of approximately 21:00 [9:00 p.m.]."

Review of the clinical record failed to evidence what resident information, including clinical information, was included in the Resident #46's transfer documentation.

An interview was conducted on 7/11/18 at 2:15 p.m. with LPN (licensed practical nurse) #1. LPN #1 was asked to describe the process staff follows when transferring a resident to the hospital. LPN #1 stated they first obtain a physician's order and notify the Responsible Representative. They then prepare the facility transfer envelope with a checklist on it

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F 622	Continued From page 22 documenting paperwork to send including the Resident's face sheet, medication list, transfer assessment form, and copies of relevant laboratory reports. When asked if the resident's comprehensive care plan or care plan goals are sent to the hospital, LPN #1 stated, "No". When asked if the facility maintained copies of the documentation sent with Resident #46 upon transfer, LPN #1 stated "No". An interview was conducted on 7/11/18 at 2:20 p.m. with the assistant administrator ASM (administrative staff member) #2. When asked if comprehensive care plan goals are sent with residents upon transfer to a hospital, ASM #2 stated, "I think some units may be doing it, but this unit is not". When asked if she could provide evidence of the information sent with residents upon transfer, ASM #2 stated, "We use the transfer envelope and fill out the checklist on the front". When asked if she could provide evidence of the information sent with Resident #46 for his facility initiated transfer on 4/25/18, ASM #2 stated she could not. ASM #1, the administrator, ASM #2, assistant administrator, ASM#3, the director of nursing, ASM #4, regional director of clinical services, and ASM #5, director of clinical education, were made aware of the above findings on 7/11/18 at 6:35 p.m. No further information was provided prior to exit.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a	F 623		8/13/18

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resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

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§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon

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F 623	Continued From page 25 as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed provide written notification of facility initiated hospital transfers to the responsible party, and the ombudsman, for five of 37 residents in the survey sample; Residents #82, #70, #71, #53, and #46. 1. The facility staff failed to evidence that written notification of hospitalization was provided to the responsible party upon Resident #82's transfer to the hospital on 6/3/18. 2. The facility staff failed to evidence that written notification of hospitalization was provided to the responsible party upon Resident #70's transfer to the hospital on 5/29/18. 3. The facility staff failed to evidence that written notification of hospitalization was provided to the responsible party upon Resident #71's transfer to the hospital on 4/14/18. 4. The facility staff failed to provide written notice	F 623	F623: Notice requirements before Transfer/Discharge 1. Identified paperwork needed to notify responsible party and ombudsman when a resident is sent to hospital for evaluation. Identified OSM#10 educated transfer/discharge requirements. Resident #82 is deceased. Evidence of documentation could not be corrected in medical records for resident #70, resident #71, resident #53 and resident #46. 2. Residents who transfer to the hospital have the potential to be affected by this deficient practice. 3. Licensed nurses and social workers were educated to “Discharge/Transfer letter” by ED/DON or designee regarding notifying responsible party and ombudsman when a resident is sent to hospital. 4. Audits of residents sent to hospital will	

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to Resident/Responsible Representative of a facility initiated transfer to hospital for Resident #53 on 5/13/18.

5. The facility staff failed to provide written notice to Resident/Responsible Representative of a facility initiated transfer to hospital for Resident #46 on 4/25/18.

The findings include:

1. The facility staff failed to evidence that written notification of hospitalization was provided to the responsible party upon Resident #82's transfer to the hospital on 6/3/18.

Resident #82 was admitted to the facility on 3/12/18 with the diagnoses of but not limited to high blood pressure, lumbar disc degeneration, heart failure, dysphagia, thyrotoxicosis, anxiety, schizophrenia, atrial flutter, obstructive uropathy, pneumonia, metabolic encephalopathy, and femur fracture. The most recent MDS (Minimum Data Set) was significant change assessment with an ARD (Assessment Reference Date) of 6/23/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions.

A review of the clinical record revealed that Resident #82 was sent to the hospital on 6/3/18. A review of the nurse's notes revealed the following:

- A physician's note dated 6/2/18 at 2:00 p.m., which documented, "Acute psychosis/schizophrenia/acute schizophrenia exacerbation...The patient's overall prognosis is very poor. She is somewhat slow to respond.

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be conducted weekly for twelve weeks by ED/DON or designee to determine compliance with RP and Ombudsman notification when a patient is sent to the hospital per policy and without omissions.

Findings to be reported to QAPI committee for 3 months and updated as indicated. Quality monitoring schedule based on findings

5. Date of Compliance: August 13, 2018

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She continues to have verbal outbursts. She is clinically hallucinating...there was some discussion about possible transfer and admission to a psychiatric facility. the (sic.) patient's overall schizophrenia, psychosis and delusions are getting worse...."

- A nurse's note dated 6/3/18 at 10:02 a.m., documented, "Resident sent to (hospital) for AMS (altered mental status). (Name of responsible party) - RP (responsible party) notified."

Further review failed to reveal any evidence the responsible party was provided with written notification of the facility initiated hospital transfer on 6/3/18.

On 7/11/18 at 1:53 p.m., in an interview with LPN #6 (Licensed Practical Nurse), she stated that nursing does not provide written notification to the family, or notify the ombudsman.

On 7/11/18 at 2:35 p.m., in an interview with OSM #10 (Other Staff Member, the social worker), she stated that she has not been providing written notifications to the responsible party because she did not know that it was required.

A review of the facility policy "Discharge/Transfer Letter Policy" documented, "The facility will complete discharge letters appropriately and according to all federal, state, and local regulations....B) The following situations will result in immediate discharge/transfer from the facility as practicable and in immediate discharge/transfer letter will be issued:...4. An immediate transfer/discharge is required due to the resident's urgent medical needs....D) Discharge notices must have the following

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F 623	Continued From page 28 components: 1. The reason for discharge/transfer, to include appropriate verbiage...2. The effective date of transfer/discharge; 3. The location to which the resident is transferred/discharge, this must be a specific address which has accepted the resident and is an appropriate location; 4. A statement that the resident has the right to appeal the action to the state; 5. The name, address and telephone number of the Local and State long term care ombudsman; 6. The mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; 7. The mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. E. Social Service or designee will assure the original discharge/transfer letter is given to resident or guardian/sponsor, if applicable. 1. Copies will be sent to the Department of Health, Ombudsman Office and filed in the business file and/or scanned into (electronic record system) with administrator/designee signature, with the certified receipt if applicable. 2. For emergency transfers, one list can be sent to the Ombudsman at the end of the month. F. Social service or designee will document in the chart all discharge/transfer reasons, any notices given to the resident or the guardian/sponsor, and discharge planning...." On 7/11/18 at 6:46 p.m., at the end of day meeting, the Administrator (ASM #1 - Administrative Staff Member) and the Director of Nursing (ASM #3) were made aware of the	F 623		

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findings. No further information was provided by the end of the survey.

2. The facility staff failed to evidence that written notification of hospitalization was provided to the responsible party upon Resident #70's transfer to the hospital on 5/29/18.

Resident #70 was admitted to the facility on 5/12/15 with the diagnoses of but not limited to Parkinson's disease, dementia, high blood pressure, irritable bowel syndrome, bladder obstruction, benign prostatic hyperplasia, dysphagia, right knee contracture, kyphosis, and diabetes. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 6/11/18. The resident was coded as cognitively intact in ability to make daily life decisions.

A review of the clinical record revealed that Resident #70 was sent to the hospital on 5/29/18. A physician's note dated 5/29/18 at 6:42 p.m., documented, "Pt (patient) was seen 3x (three times) today due to wbc's (white blood count {1}) of 26,000. IM (intramuscular) then IV (intravenous) rocephin (antibiotic {2}) was started however Pt (patient) continued to worsen clinically and staff was given orders to send to er (emergency room) for sepsis (cause is likely multifactorial due to uti (urinary tract infection) and questionable pna (pneumonia) on chest X-ray...."

Further review failed to reveal any evidence the responsible party was provided with written notification of the facility initiated hospital transfer

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on 5/29/18, and that the ombudsman was notified.

On 7/11/18 at 1:53 p.m., in an interview with LPN #6 (Licensed Practical Nurse, she stated that nursing does not provide written notification to the family, or notify the ombudsman.

On 7/11/18 at 2:35 p.m., in an interview with OSM #10 (Other Staff Member, the social worker), she stated that she has not been providing written notifications to the responsible party because she did not know that it was required. She stated she has been notifying the ombudsman since around April. She was not able to locate any evidence that the ombudsman was notified of the transfer.

On 7/11/18 at 6:46 p.m., at the end of day meeting, the Administrator (ASM #1 - Administrative Staff Member) and the Director of Nursing (ASM #3) were made aware of the findings. No further information was provided by the end of the survey.

{1} White Blood Cell (WBC) - White blood cells, also called leukocytes, are cells that exist in the blood, the lymphatic system, and tissues and are an important part of the body's defense system. They help protect against infections and also have a role in inflammation, allergic responses, and protecting against cancer. The white blood cell (WBC) count totals the number of white blood cells in a person's sample of blood. It is one test among several that is included in a complete blood count (CBC), which is often used in the general evaluation of a person's health. Information obtained from https://labtestsonline.org/tests/white-blood-cell-co

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unt-wbc

{2} Rocephin - used to treat certain infections caused by bacteria such as....infections of the lungs, ears, skin, urinary tract, blood, bones, joints, and abdomen....is in a class of medications called cephalosporin antibiotics. It works by killing bacteria.
Information obtained from https://medlineplus.gov/druginfo/meds/a685032.html

3. The facility staff failed to evidence that written notification of hospitalization was provided to the responsible party upon Resident #71's transfer to the hospital on 4/14/18.

Resident #71 was admitted on 5/6/16 with the diagnoses of but not limited to stroke, sepsis, atrial fibrillation, metabolic encephalopathy, dysarthria, dysphagia, seizures, high blood pressure, insomnia, and glaucoma. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 6/11/18. The resident was coded as being cognitively intact in ability to make daily life decisions.

A review of the clinical record revealed that Resident #71 went to the hospital on 4/14/18. A review of the nurse's notes revealed the following:

- A nurse's note dated 4/14/18 at 3:50 p.m., documented, "Resident had a bowel movement during the afternoon on 7-3 shift. Resident has been c/o (complained of) rectal pain when sitting on sacrum and to the touch when rectal area

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examined. Also had c/o constipation. Resident pain level was an 8 on pain scale. When resident had a bowel movement a small pool of blood 6 centimeters around, observed within residents' [sic] brief in the bowel movement. When observing resident's rectal area appears to have blood seeping out of rectum. Blood was bright red in color. Resident daughter has been contacted. Called 911 for transport to ED (emergency department) at (hospital). On call physician called but no answer left message with on call physician."

- A nurse's note dated 4/14/18 at 5:21 p.m., documented, "(hospital) was called at 1720 (5:20 p.m.) to check on resident condition. Per ER (emergency room) nurse resident to be admitted. bleeding."

- A nurse's note dated 4/14/18 at 5:34 p.m., documented, "On call nurse for facility notified of resident being admitted to ER."

Further review failed to reveal any evidence the responsible party was provided with written notification of the facility initiated hospital transfer on 4/14/18, or the that ombudsman was notified.

On 7/11/18 at 1:53 p.m., in an interview with LPN #6 (Licensed Practical Nurse), she stated that nursing does not provide written notification to the family, or notify the ombudsman.

On 7/11/18 at 2:35 p.m., in an interview with OSM #10 (Other Staff Member, the social worker), she stated that she has not been providing written notifications to the responsible party because she did not know that it was required. She stated she has been notifying the ombudsman since around

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April. She was not able to locate any evidence that the ombudsman was notified of the transfer.

On 7/11/18 at 6:46 p.m., at the end of day meeting, the Administrator (ASM #1 - Administrative Staff Member) and the Director of Nursing (ASM #3) were made aware of the findings. No further information was provided by the end of the survey.

4. The facility staff failed to provide written notice to Resident/Responsible Representative of a facility initiated transfer to hospital for Resident #53 on 5/13/18.

Resident #53 was admitted to the facility on 7/3/17 with recent readmission on 5/17/18, with diagnoses that included but were not limited to: dementia, high blood pressure, glaucoma, enlarged prostate, and hallucinations.

The most recent MDS (minimum data set) assessment, a significant change in status assessment, with an assessment reference date of 5/28/18, coded the resident as scoring a "5" on the BIMS (brief interview for mental status) score, indicating he has severe cognitive impairment of daily decision making.

The physician's order dated 5/13/18, documented in part, "May send to er (emergency room) for eval [evaluation] and treat [treatment]."

The nurse's note dated 5/13/18 at 9:00 a.m. documented in part, "Resident unresponsive upon entering room to administer meds (medication) at 0825 [8:25 a.m.] ...Writer tried to awake[sic] resident by calling his name and doing a sternal rub with no response ...Writer grabbed

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crash cart and went back into residents room ...Writer called 911 to send resident out to ER as resident is a full code."

An interview was conducted on 7/11/18 at 2:15 p.m. with LPN (licensed practical nurse) #1. LPN #1 was asked to describe the process staff follows when transferring a resident to the hospital. LPN #1 stated they first obtain a physician's order and notify the Responsible Representative by telephone. When asked if information regarding the transfer is provided in writing to Resident/Responsible Representative, LPN #1 stated "Not by nursing."

An interview was conducted with OSM, (other staff member), #10, social services, on 7/11/18 at approximately 2:45 p.m. OSM #10 was asked who was responsible for notifying the representative/responsible representative of a resident's transfer to the hospital. OSM #10 replied that it was her responsibility to notify the ombudsman. When asked if she notified the family in writing regarding facility initiated transfers to the hospital, OSM #10 stated "No."

ASM (administrative staff member) #1, the administrator, ASM #2, assistant administrator, ASM #3, the director of nursing, ASM #4, regional director of clinical services, and ASM #5, director of clinical education, was made aware of the above findings on 7/11/18 at 6:35 p.m.

No further information was obtained prior to exit.

5. The facility staff failed to provide written notice to Resident/Responsible Representative of facility

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initiated transfers to hospital for Resident #46 on 4/25/18.

Resident #46 was admitted to the facility on 6/30/17, with a most recent readmission on 4/25/18, with diagnoses that included but were not limited to: difficulty swallowing, dementia, seizures, and heart failure.

The most recent MDS (minimum data set) assessment, a quarterly review assessment, with an assessment reference date of 5/18/18, coded the resident as having short and long term memory problems, as well as severely impaired cognitive skills for daily decision making.

The physician progress noted dated 4/25/18 at 5:00 p.m., documented in part, "Patient has lethargy and fever ...recommended for the patient to be transferred to the ER (emergency room) due to his high risk full code status."

The physician order dated 4/25/18, documented in part, "May send to ER for eval [evaluation] and treat [treatment] r/t [related to] abnormal x-ray."

The nurse's note dated 4/26/18 at 3:23 p.m. documented the following, "Late entry for 4/25/18: Resident admitted to [Hospital's name] r/t [related to] pneumonia as of approximately 21:00 [9:00 p.m.]."

An interview was conducted on 7/11/18 at 2:15 p.m. with LPN (licensed practical nurse) #1. LPN #1 was asked to describe the process staff follows when transferring a resident to the hospital. LPN #1 stated they first obtain a physician's order and notify the Responsible Representative by telephone. When asked if

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F 623	Continued From page 36 information regarding the transfer is provided in writing to Resident/Responsible Representative, LPN #1 stated "Not by nursing." An interview was conducted with OSM, (other staff member), #10, social services, on 7/11/18 at approximately 2:45 p.m. OSM #10 was asked who was responsible for notifying the representative/responsible representative of a resident's transfer to the hospital. OSM #10 replied that it was her responsibility to notify the ombudsman. When asked if she notified the family in writing regarding transfers to the hospital, OSM #10 stated "No." ASM (administrative staff member) #1, the administrator, ASM #2, assistant administrator, ASM #3, the director of nursing, ASM #4, regional director of clinical services, and ASM #5, director of clinical education, was made aware of the above findings on 7/11/18 at 6:35 p.m. No further information was obtained prior to exit.	F 623		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined	F 624	F624: Preparation for Safe/Orderly Transfer/Discharge	8/13/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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that the facility staff failed to evidence that the resident was prepared and oriented for a hospital transfer for two of 37 residents in the survey sample; Residents #70 and #71.

1. The facility staff failed to evidence that Resident #70 was prepared and oriented for a transfer to the hospital on 5/29/18.

2. The facility staff failed to evidence that Resident #71 was prepared and oriented for a transfer to the hospital on 4/14/18.

The findings include:

1. The facility staff failed to evidence that Resident #70 was prepared and oriented for a transfer to the hospital on 5/29/18.

Resident #70 was admitted to the facility on 5/12/15 with the diagnoses of but not limited to Parkinson's disease, dementia, high blood pressure, irritable bowel syndrome, bladder obstruction, benign prostatic hyperplasia, dysphagia, right knee contracture, kyphosis, and diabetes. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 6/11/18. The resident was coded as being cognitively intact in ability to make daily life decisions.

A review of the clinical record revealed that Resident #70 was sent to the hospital on 5/29/18. A review of the nurse's notes revealed the following:

- A nurse's note dated 5/28/18 at 11:12 a.m., documented, "Resident is alert with

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1. Identified scripting needed for nurses to include within transfer/discharge note when residents are sent to hospital. Evidence of documentation that resident #70 and resident #71 were prepared and oriented for transfer to the hospital could not be corrected in the medical record.

2. Residents who transfer to the hospital have the potential to be affected by this deficient practice.

3. Licensed nurses were educated by DON or designee regarding documentation needed as evidence to show residents are prepared and oriented for hospital transfer.

4. Audits of medical records of residents sent to hospital will be conducted weekly for twelve weeks by DON or designee to determine compliance with documentation when a patient is sent to the hospital per policy and without omissions.
Findings to be reported to QAPI committee for 3 months and updated as indicated. Quality monitoring schedule based on findings

5. Date of Compliance: August 13, 2018

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confusion...supra pubic cath (catheter) needs....fluids continue to be encouraged, flush to supra pubic cath given per orders - patent with yellow urine noted draining."

- A physician's note dated 5/28/18 at 12:50 p.m., documented, "AMS (Altered Mental Status), lethargy, and foul smelling urine....Staff report the patient had some increased confusion and lethargy and have noticed some foul smelling urine coming from her [sic] suprapubic catheter {7}. Of note the patient has a history of recurrent UTI (urinary tract infection) secondary to chronic indwelling Foley....Recently, he had his suprapubic catheter changed secondary to having difficulty flushing it....we will test for UTI, however, we will hold off on starting antibiotics as he shows no signs and symptoms of urosepsis and he has had multiple drug resistance in the past. We will also get a CBC {1} (complete blood count) and BMP {2} (basic metabolic panel) in the a.m...."

- A nurse's note dated 5/28/18 at 1:34 p.m., documented, "after lunch time resident was noted to have dark colored strong smelling urine and flush on supra pubic cath was sluggish - a change from early morning flush and urine characteristics - NP (nurse practitioner) ordered U/A {3} (urinalysis) C&S {4} (culture and sensitivity) with cbc with diff (differential), bmp for the morning. fluids will continue to be encouraged. resident and rp (responsible party) notified."

- A nurse's note dated 5/29/18 at 11:07 a.m., documented, "Resident is alert with confusion - Noted to be needing slightly more staff assistance for adl (activities of daily living) care...supra pubic

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cath (catheter) needs......Resident given 960cc (equivalent of millimeters) of cranberry juice this morning and he consumed 100% that was in addition to his normal fluids with meals and at bedside. supra pubic cath flush was easier then [sic] yesterday after noon and urine was lighter in color - still cloudy with a strong odor. Labs and u/s collected and sent this morning awaiting results. Resident denies any pain or discomfort."

- A nurse's note dated 5/29/18 at 2:48 p.m., documented, "Lab results back and show elevated WBC {5} (white blood count). NP made aware and new order for rocephin {6}, CBC with diff on Friday and chest x ray received RP made aware."

- A physician's note dated 5/29/18 at 6:42 p.m., documented, "Pt (patient) was seen 3x (three times) today due to wbc's of 26,000. IM then IV rocephin was started however Pt continued to worsen clinically and staff was given orders to send to er (emergency room) for sepsis (cause is likely multifactorial due to uti and questionable pna (pneumonia) on chest X-ray)...."

Further review failed to reveal any evidence of the resident being prepared and oriented for the hospital transfer.

On 7/11/18 at 1:53 p.m., in an interview with LPN #6 (Licensed Practical Nurse), she stated that the resident should be notified of what is going on with them and that they are going to the hospital. LPN #6 stated this information should be documented. LPN #6 verified that this information was not documented.

A review of the facility policy "Discharge Planning

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Policy" did not address preparing and orienting the resident to their acute care transfer to a hospital setting.

On 7/11/18 at 6:46 p.m., at the end of day meeting, the Administrator (ASM #1 - Administrative Staff Member) and the Director of Nursing (ASM #3) were made aware of the findings. No further information was provided by the end of the survey.

{1} CBC with differential - A CBC (complete blood count) tests measure the number and types of cells in your blood. This helps doctors check on your overall health. The tests can also help to diagnose diseases and conditions such as anemia, infections, clotting problems, blood cancers, and immune system disorders.
A blood differential test measures the amount of each type of white blood cell (WBC) that you have in your body. White blood cells (leukocytes) are part of your immune system, a network of cells, tissues, and organs that work together to protect you from infection. There are five different types of white blood cells.
Information obtained from
https://medlineplus.gov/bloodcounttests.html
Information obtained from
https://medlineplus.gov/labtests/blooddifferential.html

{2} Basic Metabolic Panel (BMP) - A metabolic panel is a group of tests that measures different chemicals in the blood. These tests are usually done on the fluid (plasma) part of blood. The tests provide information about your body's chemical balance and metabolism. They can give doctors information about your muscles (including the heart), bones, and organs, such as the

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kidneys and liver. There are two types: basic metabolic panel (BMP) and comprehensive metabolic panel (CMP). The BMP checks your blood sugar, calcium, and electrolytes. The BMP also has tests such as creatinine to check your kidney function..."
Information obtained from
https://medlineplus.gov/metabolicpanel.html

{3} Urinalysis (UA) - A urinalysis is a test of your urine. It is often done to check for a urinary tract infections, kidney problems, or diabetes. You may also have one during a checkup, if you are admitted to the hospital, before you have surgery, or if you are pregnant. It can also monitor some medical conditions and treatments.
Information obtained from
https://medlineplus.gov/urinalysis.html

{4} Culture and Sensitivity (C&S) - A urine culture is a lab test to check for bacteria or other germs in a urine sample. It can be used to check for a urinary tract infection.
Information obtained from
https://medlineplus.gov/ency/article/003751.htm

{5} White Blood Cell (WBC) - White blood cells, also called leukocytes, are cells that exist in the blood, the lymphatic system, and tissues and are an important part of the body's defense system. They help protect against infections and also have a role in inflammation, allergic responses, and protecting against cancer. The white blood cell (WBC) count totals the number of white blood cells in a person's sample of blood. It is one test among several that is included in a complete blood count (CBC), which is often used in the general evaluation of a person's health.
Information obtained from

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https://labtestsonline.org/tests/white-blood-cell-count-wbc

{6} Rocephin - used to treat certain infections caused by bacteria such as....infections of the lungs, ears, skin, urinary tract, blood, bones, joints, and abdomen....is in a class of medications called cephalosporin antibiotics. It works by killing bacteria.
Information obtained from
https://medlineplus.gov/druginfo/meds/a685032.html

{7} A suprapubic catheter (tube) drains urine from your bladder. It is inserted into your bladder through a small hole in your belly. You may need a catheter because you have urinary incontinence (leakage), urinary retention (not being able to urinate), surgery that made a catheter necessary, or another health problem. This information was obtained from the website:
https://wwwqa.nlm.nih.gov/medlineplus/275/ency/patientinstructions/000145.htm

2. The facility staff failed to evidence that Resident #71 was prepared and oriented for a transfer to the hospital on 4/14/18.

Resident #71 was admitted on 5/6/16 with the diagnoses of but not limited to stroke, sepsis, atrial fibrillation, metabolic encephalopathy, dysarthria, dysphagia, seizures, high blood pressure, insomnia, and glaucoma. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 6/11/18. The resident was coded as being cognitively intact in ability to make daily life decisions.

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A review of the clinical record revealed that Resident #71 went to the hospital on 4/14/18. A review of the nurse's notes revealed the following:

- A nurse's note dated 4/13/18 at 4:45 a.m., documented, "Resident has not slept this entire shift on call bell. Resident has been saying that his bottom hurts and he needs more desitin. Resident has been changed cleaned and desitin applied more than once. There is nothing that can be seen on his buttocks that could be causing him discomfort. Resident receives scheduled pain medication x's 2 (two times) on this shift that has been effective....Will continue to follow...."

- A nurse's note dated 4/13/18 at 8:16 a.m., documented, "Resident has a history of hemorrhoids. Discomfort felt overnight may have been r/t (related to) constipation and hemorrhoids - spoke with NP (nurse practitioner) wanted to Restart Senna plus {1} - only instead of 2 tablets as previous 1 tablet twice a day and a prn (as needed) order for Miralax {2} has been added - also preparation H {3} has been added prn for discomfort - during morning dressing change there was some hard stool noted at the rectum prior to tending to his wound this area was cleanse and more stool came out - resident given prn suppository and is feeling some relief. RP/wife (responsible party) has been updated to the changes."

- A nurse's note dated 4/13/18 at 4:46 p.m., documented, "clarification: PRN hemorrhoid suppository given this am for discomfort."

- A physician's progress note dated 4/13/18 at

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F 624	Continued From page 44 8:15 p.m., documented, ".....Staff report patient is complaining of some constipation, does have a chronic history; however, was having some diarrhea few weeks back and all of his bowel aids were stopped. They were requesting to restart some of his medications on a regular basis. His last bowel movement was today; however, he was having some difficulty passing it, and is having some hemorrhoid pain...." - A nurse's note dated 4/14/18 at 3:43 a.m., documented, "...Resident was c/o (complaining of) hemorrhoids now he has treatment in place for that he is just c/o (complained of) that this groin hurts. Will continue to answer call light and try to assist resident as much as possible." - A nurse's note dated 4/14/18 at 3:50 p.m., documented, "Resident had a bowel movement during the afternoon on 7-3 shift. Resident has been c/o rectal pain when sitting on sacrum and to the touch when rectal area examined. Also had c/o constipation. Resident pain level was an 8 on pain scale. When resident had a bowel movement a small pool of blood 6 centimeters around, observed within residents' [sic] brief in the bowel movement. When observing resident's rectal area appears to have blood seeping out of rectum. Blood was bright red in color. Resident daughter has been contacted. Called 911 for transport to ED (emergency department) at (hospital). On call physician called but no answer left message with on call physician." - A nurse's note dated 4/14/18 at 5:21 p.m., documented, "(hospital) was called at 1720 (5:20 p.m.) to check on resident condition. Per ER (emergency room) nurse resident to be admitted. bleeding."	F 624		

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- A nurse's note dated 4/14/18 at 5:34 p.m., documented, "On call nurse for facility notified of resident being admitted to ER."

Further review failed to reveal any evidence of the resident being prepared and oriented for the hospital transfer.

On 7/11/18 at 1:53 p.m., in an interview with LPN #6 (Licensed Practical Nurse), she stated that the resident should be notified of what is going on with them and that they are going to the hospital. LPN #6 stated this information should be documented. LPN #6 verified that this information was not documented.

On 7/11/18 at 6:46 p.m., at the end of day meeting, the Administrator (ASM #1 - Administrative Staff Member) and the Director of Nursing (ASM #3) were made aware of the findings. No further information was provided by the end of the survey.

{1} Senna - is used to treat constipation
Information obtained from
https://medlineplus.gov/druginfo/meds/a601112.html

{2} Miralax - is used to treat constipation.
Information obtained from
https://medlineplus.gov/druginfo/meds/a603032.html

{3} Preparation H - is used along with other medications to treat proctitis (swelling in the rectum) and ulcerative colitis (a condition which causes swelling and sores in the lining of the large intestine and rectum). It is also used to

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F 624	Continued From page 46 relieve itching and swelling from hemorrhoids and other rectal problems. Information obtained from https://medlineplus.gov/druginfo/meds/a617001.html	F 624		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 625		8/13/18

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Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to evidence that written bed hold notification was provided to the responsible party upon a facility initiated transfer to the hospital for three of 37 residents in the survey sample; Residents #70, #71, and #46.

1. The facility staff failed to evidence that a written bed hold notification was provided to Resident #70's responsible party upon transfer of the resident to the hospital on 5/29/18.

2. The facility staff failed to evidence that a written bed hold notification was provided to Resident #71's responsible party upon transfer of the resident to the hospital on 4/14/18.

3. The facility staff failed to provide written notification regarding bed holds to Resident/Responsible Representative upon transfers to hospital for Resident #46 on 4/25/18.

The findings include:

1. The facility staff failed to evidence that a written bed hold notification was provided to Resident #70's responsible party upon transfer of the resident to the hospital on 5/29/18.

Resident #70 was admitted to the facility on 5/12/15 with the diagnoses of but not limited to Parkinson's disease, dementia, high blood pressure, irritable bowel syndrome, bladder obstruction, benign prostatic hyperplasia, dysphagia, right knee contracture, kyphosis, and diabetes. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 6/11/18.

F 625

F625: Notice of Bed Hold Policy Before/Upon Transfer

1. Residents #70, #71 and #46 have returned from the hospital.

2. Residents who transfer to the hospital have the potential to be affected by this deficient practice.

3. Licensed nurses and Social Workers will be educated to policy titled Discharge/transfer Letter Policy by ED/DON or designee regarding providing written bed hold notification to responsible party upon facility initiated transfer.

4. Audits of medical records of residents sent to hospital will be conducted weekly for twelve weeks by ED/DON or designee to determine compliance with bed-hold notification when a patient is sent to the hospital per policy and without omissions.

Findings to be reported to QAPI committee for 3 months and updated as indicated. Quality monitoring schedule based on findings.

5. Date of Compliance: August 13, 2018

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F 625	Continued From page 48 The resident was coded as being cognitively intact in ability to make daily life decisions. A review of the clinical record revealed that Resident #70 was sent to the hospital on 5/29/18. A physician's note dated 5/29/18 at 6:42 p.m., documented, "Pt (patient) was seen 3x (three times) today due to wbc's (white blood count {1}) of 26,000. IM (intramuscular) then IV (intravenous) rocephin (antibiotic {2}) was started however Pt (patient) continued to worsen clinically and staff was given orders to send to er (emergency room) for sepsis (cause is likely multifactorial due to uti (urinary tract infection) and questionable pna (pneumonia) on chest X-ray...." Further review failed to reveal any evidence of the responsible party being provided with a written bed hold notice. On 7/11/18 at 1:53 p.m., in an interview with LPN #6 (Licensed Practical Nurse), she stated that there is a checklist and the items on the checklist are put into the attached envelope and sent to the hospital. A review of the checklist revealed a carbon copy form with the carbon copy being attached to the front of the envelope and the original perforated copy to tear off for the facility to maintain. The checklist included the following information to be provided: Resident Transfer Form, Face Sheet, Current Medication List or Current MAR (Medication Administration Record). SBAR (situation background, assessments, recommendation) and/or other Change in Condition Progress Note, Advance Directives, Advance Care Orders, Bed Hold (hand written	F 625		

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F 625	Continued From page 49 onto the checklist), Most Recent History and Physical, Recent Hospital Discharge Summary, Recent MD/NP/PA (medical doctor, nurse practitioner, physician's assistant) and Specialist Orders, Flow Sheets. Relevant Lab Results, Relevant X-Rays and other Diagnostic Test Results, Nursing Home Capabilities Checklist. On 7/11/18 at 1:55 p.m., LPN #6 was notified of the lack of evidence in the clinical record that any of this information was provided, including the bed hold. LPN #6 stated that the facility copy of the checklist is scanned into the electronic medical record. LPN #6 stated she would research it. On 7/11/18 at 2:54 p.m., LPN #6 stated there was no evidence that the facility retained the checklist and no evidence of what documents were sent to the hospital with Resident #70 on 5/29/18. The nurse's notes also did not evidence that a bed hold was provided. On 7/11/18 at 2:35 p.m., in an interview with OSM #10 (Other Staff Member, the social worker), she stated that she has a role in providing the written bed hold, and has been doing so since April 2018. She had a binder, which contained bed holds that were sent via certified mail to residents responsible parties. There was no evidence of a bed hold being mailed to the responsible party for Resident #70. On 7/12/18 at 8:33 a.m., in an interview with OSM #11 (the Associate Admissions Director) she stated that a written bed hold is provided at admission and that it is reviewed with the resident or family at that time. OSM #11 stated they are informed that they will be contacted if they go to	F 625		

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the hospital to see if they want to pay to hold the bed. OSM #11 stated that the written copy is included in the packet of information that is sent with the resident upon transfer to the hospital, and that nursing is responsible for putting together the transfer packets.

A review of the facility policy "Discharge/Transfer Letter Policy" documented, "...G) The resident or responsible party will receive a bed hold notice along with the discharge/transfer letter, when applicable. Bed Hold notices can be found within (electronic medical record system)....2. Once form is chosen, form will be printed and filled in where prompted, 3. Information needs to be filled in on how many bed holds are left and/or bed hold rate, if applicable, 4. A copy of the completed bed hold notice will be scanned into (electronic medical record system) and filed in business file with certified receipt attached if applicable, with the copy of the discharge/transfer letter..."

A review of the facility policy, "Bed Hold Notice" documented, "This notice is to be provided to the resident and his/her representative at the time of transfer. In the case of an emergency, the paperwork should be provided within 24 hours....The Facility's rate for holding a bed is $_______ per day. Payments made for the purposes of holding a bed are non-refundable, regardless of whether you actually return to the Facility....Your decision to not pay to have a bed held during your overnight absence will be treated as a voluntary discharge from the Facility. you must remove (or make arrangements to have removed) all your personal belongings from the room that you were occupying. If you wish to be readmitted to the Facility, then you must reapply for admission. If you are eligible for and require

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Medicare skilled nursing facility services or Medicaid nursing facility services, you will be entitled to readmission to he facility (i) if your previous room is available, or (ii) upon the first availability of a bed in a semi-private room or ward....If you are entitled to readmission and the Facility does not readmit you to the first available bed in a semi-private room: You have the right to appeal the Facility's decision to the Department of Medical Assistance Services Appeal Division....You may also file a complaint with the Office of Licensure and Certification...For help in filing an appeal or complaint, contact the Office of the State Long Term Care Ombudsman...."

On 7/11/18 at 6:46 p.m., at the end of day meeting, the Administrator (ASM #1 - Administrative Staff Member) and the Director of Nursing (ASM #3) were made aware of the findings. No further information was provided by the end of the survey.

{1} White Blood Cell (WBC) - White blood cells, also called leukocytes, are cells that exist in the blood, the lymphatic system, and tissues and are an important part of the body's defense system. They help protect against infections and also have a role in inflammation, allergic responses, and protecting against cancer. The white blood cell (WBC) count totals the number of white blood cells in a person's sample of blood. It is one test among several that is included in a complete blood count (CBC), which is often used in the general evaluation of a person's health. Information obtained from https://labtestsonline.org/tests/white-blood-cell-count-wbc

{2} Rocephin - used to treat certain infections

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caused by bacteria such as....infections of the lungs, ears, skin, urinary tract, blood, bones, joints, and abdomen....is in a class of medications called cephalosporin antibiotics. It works by killing bacteria.
Information obtained from https://medlineplus.gov/druginfo/meds/a685032.html

2. The facility staff failed to evidence that a written bed hold notification was provided to Resident #71's responsible party upon transfer of the resident to the hospital on 4/14/18.

Resident #71 was admitted on 5/6/16 with the diagnoses of but not limited to stroke, sepsis, atrial fibrillation, metabolic encephalopathy, dysarthria, dysphagia, seizures, high blood pressure, insomnia, and glaucoma. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 6/11/18. The resident was coded as being cognitively intact in ability to make daily life decisions.

A review of the clinical record revealed that Resident #71 was sent to the hospital on 4/14/18. A review of the nurse's notes revealed the following:

- A nurse's note dated 4/14/18 at 3:50 p.m., documented, "Resident had a bowel movement during the afternoon on 7-3 shift. Resident has been c/o (complained of) rectal pain when sitting on sacrum and to the touch when rectal area examined. Also had c/o (complained of) constipation. Resident pain level was an 8 on pain scale. When resident had a bowel

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movement a small pool of blood 6 centimeters around, observed within residents' [sic] brief in the bowel movement. When observing resident's rectal area appears to have blood seeping out of rectum. Blood was bright red in color. Resident daughter has been contacted. Called 911 for transport to ED (emergency department) at (hospital). On call physician called but no answer left message with on call physician."

- A nurse's note dated 4/14/18 at 5:21 p.m., documented, "(hospital) was called at 1720 (5:20 p.m.) to check on resident condition. Per ER (emergency room) nurse resident to be admitted. bleeding."

- A nurse's note dated 4/14/18 at 5:34 p.m., documented, "On call nurse for facility notified of resident being admitted to ER."

Further review failed to reveal any evidence of the responsible party being provided with a written bed hold.

On 7/11/18 at 1:53 p.m., in an interview with LPN #6 (Licensed Practical Nurse), she stated that there is a checklist and the items on the checklist are put into the attached envelope and sent to the hospital.

A review of the checklist revealed a carbon copy form with the carbon copy being attached to the front of the envelope and the original perforated copy to tear off for the facility to maintain. The checklist included the following information to be provided: Resident Transfer Form, Face Sheet, Current Medication List or Current MAR (Medication Administration Record). SBAR (situation background, assessments,

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recommendation) and/or other Change in Condition Progress Note, Advance Directives, Advance Care Orders, Bed Hold (hand written onto the checklist), Most Recent History and Physical, Recent Hospital Discharge Summary, Recent MD/NP/PA (medical doctor, nurse practitioner, physician's assistant) and Specialist Orders, Flow Sheets. Relevant Lab Results, Relevant X-Rays and other Diagnostic Test Results, Nursing Home Capabilities Checklist.

On 7/11/18 at 1:55 p.m., LPN #6 was notified of the lack of evidence in the clinical record that any of this information was provided, including the bed hold. LPN #6 stated that the facility copy of the checklist is scanned into the electronic medical record. LPN #6 stated she would research it.

On 7/11/18 at 2:54 p.m., LPN #6 stated there was no evidence that the facility retained the checklist and no evidence of what documents were sent to the hospital with Resident #71 on 4/14/18. The nurse's notes also did not evidence that a bed hold was provided.

On 7/11/18 at 2:35 p.m., in an interview with OSM #10 (Other Staff Member, the social worker), she stated that she has a role in providing the written bed hold, and has been doing so since April 2018. She had a binder, which contained bed holds that were sent via certified mail to residents responsible parties. There was no evidence of a bed hold being mailed to the responsible party for Resident #71.

On 7/12/18 at 8:33 a.m., in an interview with OSM #11 (the Associate Admissions Director) she stated that a written bed hold is provided at

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admission and that it is reviewed with the resident or family at that time. OSM #11 stated they are informed that they will be contacted if they go to the hospital to see if they want to pay to hold the bed. OSM #11 stated that the written copy is included in the packet of information that is sent with the resident upon transfer to the hospital, and that nursing is responsible for putting together the transfer packets.

On 7/11/18 at 6:46 p.m., at the end of day meeting, the Administrator (ASM #1 - Administrative Staff Member) and the Director of Nursing (ASM #3) were made aware of the findings. No further information was provided by the end of the survey.

3. The facility staff failed to provide written notification regarding bed holds to Resident/Responsible Representative upon transfer to the hospital for Resident #46 on 04/25/18.

Resident #46 was admitted to the facility on 6/30/17, with a most recent readmission on 4/25/18, with diagnoses that included but were not limited to: difficulty swallowing, dementia, seizures, and heart failure.

The most recent MDS (minimum data set) assessment, a quarterly review assessment, with an assessment reference date of 5/18/18, coded the resident as having short and long term memory problems, as well as severely impaired cognitive skills for daily decision making.

The physician progress noted dated 4/25/18 at 5:00 p.m., documented in part, "Patient has

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lethargy and fever ...recommended for the patient to be transferred to the ER (emergency room) due to his high risk full code status."

The physician order dated 4/25/18, documented in part, "May send to ER for eval [evaluation] and treat [treatment] r/t [related to] abnormal x-ray."

The nurse's note dated 4/26/18 at 3:23 p.m. documented the following, "Late entry for 4/25/18: Resident admitted to [Hospital's name] r/t [related to] pneumonia as of approximately 21:00 [9:00 p.m.]."

An interview was conducted with OSM, (other staff member), #10, social services, on 7/11/18 at approximately 2:45 p.m. OSM #10 was asked how the Resident/Responsible Representative was notified about bed holds when a resident is transferred to the hospital. OSM #10 stated that she sends information regarding the bed hold policy to the Responsible Representative via certified mail. She stated she began this process April 2018. Prior to this process, OSM #10 stated that a phone call was made to responsible representatives about bed holds but it was an inconsistent practice and there was no documentation indicating that the calls were made. When asked if she could provide evidence that the bed hold information was provided in writing to Resident #46's Responsible Representative, OSM #10 stated "No that must have been before I started this new process."

ASM (administrative staff member) #1, the administrator, ASM #2, assistant administrator, ASM#3, the director of nursing, ASM #4, regional director of clinical services, and ASM #5, director

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F 625	Continued From page 57 of clinical education, were made aware of the above findings on 7/11/18 at 6:35 p.m. No further information was provided prior to exit.	F 625		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		8/13/18

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F 656	Continued From page 58 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to implement the comprehensive care plan for four of 37 residents in the survey sample, Residents #100, #329, #55 and #376. 1. The facility staff failed to implement Resident #100's comprehensive care plan for showers. 2. The facility staff failed to implement Resident #329's comprehensive care plan for insulin administration. 3. The facility staff failed to implement the comprehensive care plan and to follow the physician's orders to place fall mats on both sides of the bed for Resident #55. 4.a. The facility staff failed to implement the comprehensive care plan and physician's order to obtain daily weights for Resident #376. 4. b. The facility staff failed to implement the comprehensive care plan and physician's orders to administer insulin and pantoprazole (1) for Resident #376.	F 656	F656: Develop/Implement Comprehensive Care Plan 1. Resident #100 no longer resides in the facility. Resident #329 was evaluated by emergency department and returned to facility. Facility Reported Incident (FRI) submitted 6/28/18. No further events requiring a FRI have occurred. Resident #55 bilateral floor mats placed bedside bed immediately. Resident did not have any signs or symptoms or suffer adverse effects. Resident #376 physician and RP were notified of missing weights. Resident #376 medication received and given. Resident did not have any signs or symptoms or suffer adverse effects. 2. All residents have the potential to be affected by this deficient practice. Quality review of current resident□s care plans completed by DON or designee to	

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The findings include:

1. The facility staff failed to implement Resident #100's comprehensive care plan for showers.

Resident #100 was admitted to the facility on 6/12/18. Resident #100's diagnoses included but were not limited to pneumonia, dementia and major depressive disorder. Resident #100's most recent MDS (minimum data set), a 14 day Medicare assessment with an ARD (assessment reference date) of 6/26/18, coded the resident's cognition as severely impaired. Section G coded Resident #100 as being totally dependent on one staff with bathing.

On 7/10/18 at 11:00 a.m., a complaint regarding Resident #100 was filed with the Office of Licensure and Certification. The complainant stated the resident did not receive a shower the first week of her stay at the facility.

Resident #100's care plan dated 6/13/18 documented, "Needs assistance with adl's (activities of daily living) r/t (related to) weakness...Showers Wed/Sat 7-3 shift..."

Review of June 2018 ADL (activities of daily living) documentation revealed Resident #100 was scheduled for showers every Wednesday and Saturday on the 7:00 a.m. to 3:00 p.m. shift. Further review of the ADL documentation revealed Resident #100 did not receive any bath or shower by facility staff from 6/12/18 (date of admission) until 6/19/18 when a bed bath was documented as being given.

On 7/11/18 at 3:49 p.m., an interview was

F 656

ensure showers are given per physician order. Follow up based on findings.

Quality review through walking rounds of all current resident□s completed by DON or designee to ensure floor mats in place per physician order. Follow up based on findings.

Quality review of current resident□s care plans completed by DON or designee to ensure weights are obtained per physician order. Follow up based on findings.

Quality review of current resident□s care plans completed by DON or designee to ensure insulins and other medications are administered, per physician order. Follow up based on findings.

3. Licensed nurses were educated to policy titled Care Plan by MDS, DON or designee to ensure care plan is followed regarding providing resident showers.

Licensed nurses educated to policy titled Care Plan by MDS, DON or designee to ensure care plan is followed regarding insulin administration.

Licensed nurses educated to policy titled Care Plan by MDS, DON or designee to ensure care plan is followed regarding fall mat placement.

Licensed nurses educated to policy titled Care Plan by MDS, DON or designee to ensure care plan is followed regarding medication administration.

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F 656	Continued From page 60 conducted with CNA (certified nursing assistant) #1 (the CNA who cared for Resident #100 during the 7:00 a.m. to 3:00 p.m. shift on Wednesday 6/13/18 and Saturday 6/16/18). CNA #1 stated residents are given showers twice a week but she provides a total sponge bath every day. CNA #1 was asked how she is made aware when each resident's shower is due. CNA #1 stated a window pops up in the computer system on the days a resident's shower is due. CNA #1 was shown Resident #100's June 2018 ADL documentation. CNA #1 stated the resident was scheduled for day shift showers in the computer system but scheduled for 3:00 p.m. to 11:00 p.m. showers on the unit shower schedule. CNA #1 was asked if the 3:00 p.m. to 11:00 p.m. shift could have documented they gave Resident #100 a shower in the computer although the computer system scheduled the showers for the 7:00 a.m. to 3:00 p.m. shift. CNA #1 stated she did not know if they could have documented the showers in the computer but the CNAs usually also fill out shower sheets to evidence residents are given showers. Review of the unit shower schedule revealed Resident #100 was scheduled for showers during the 7:00 a.m. to 3:00 p.m. shift every Wednesday and Saturday from 6/12/18 until 6/15/18 when the resident moved to a different room. Beginning on 6/15/18, Resident #100 was scheduled for showers on the 3:00 p.m. to 11:00 p.m. shift every Tuesday and Friday. Review of all of Resident #100's shower/tub bath/bed bath sheets failed to reveal any documentation of bathing/showers until 6/20/18. On 7/11/18 at 4:06 p.m., an interview was conducted with LPN (licensed practical nurse) #2.	F 656	Licensed nurses educated to policy titled Care Plan by MDS, DON or designee to ensure care plan is followed regarding obtaining weights per physician order. 4. MDS, DON or designee to conduct quality monitoring weekly for 12 weeks to ensure care plan is followed regarding compliance with showers. MDS, DON or designee to conduct quality monitoring weekly for twelve weeks to ensure care plan is followed regarding compliance with insulin administration. MDS, DON or designee to conduct quality monitoring to ensure care plans are followed regarding placement of floor mats weekly for twelve weeks. MDS, DON or designee to conduct quality monitoring weekly for twelve weeks to ensure care plan is followed regarding compliance with medication administration. Findings to be reported to QAPI committee for 3 months and updated as indicated. Quality monitoring schedule based on findings 5. Date of Compliance: August 13, 2018	

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LPN #2 was asked to explain the purpose of a comprehensive care plan. LPN #2 stated, "For everybody to know how to care for the patient." LPN #2 was asked how the facility staff ensures residents' care plans are implemented. LPN #2 stated, "We keep going back to review."

On 7/12/18 at 8:25 a.m., an interview was conducted with CNA #3. CNA #3 stated residents are given two showers a week and the schedule in the computer system should match the unit shower schedule. When asked what should be done if the schedule in the computer system is different from the unit schedule, CNA #3 stated she tells the unit manager so she can make the appropriate correction. When asked how CNAs evidence showers are given to residents, CNA #3 stated she documents the shower in the computer system, on the shower sheet, and she informs the nurse so the nurse can complete a skin assessment. CNA #3 stated if she gives a shower other than the time scheduled in the computer system, she still fills out a shower sheet to evidence the shower was given.

On 7/12/18 at 10:21 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the assistant administrator) and ASM #3 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Bathing and Showering" documented, "Assistance with showering and bathing will be provided twice a week and PRN (as needed)..."

No further information was presented prior to exit.

COMPLAINT DEFICIENCY

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2. The facility staff failed to implement Resident #329's comprehensive care plan for insulin administration.

Resident #329 was admitted to the facility on 6/27/18. Resident #329's diagnoses included but were not limited to diabetes, heart failure and chronic kidney disease. Resident #329's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 7/4/18, coded the resident as being cognitively intact. Section N documented Resident #329 received insulin injections seven out of the last seven days.

Resident #29's care plan created on 6/27/18 documented, "Resident is at risk for unstable blood glucose (sugar) related to diabetes...Administer oral hypoglycemic and/or insulin as directed by the physician."

Review of Resident #329's clinical record revealed a physician's order dated 6/27/18 that documented, "Humalog (1) Solution 100 UNIT/ML (milliliter) (Insulin Lispro) Inject 5 unit subcutaneously before meals and at bedtime for DM (diabetes mellitus) for 2 Weeks. Give for BS (blood sugar) greater than 350." Review of Resident #329's June 2018 MAR (medication administration record) revealed five units of Humalog was given on 6/27/18 at 4:30 p.m. although the resident's blood sugar was 137, and on 6/27/18 at 9:00 p.m. although the resident's blood sugar was 202.

A nurse's note dated 6/28/18 at 4:52 a.m. documented, "Writer called to assist. Resident observed lethargic with much perspiration

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present. Blood sugar taken. Results 26 mg/dl (milligrams per deciliter). Given as able to receive sweeten milkshake. Not able to accept well via mouth. Glucagon (2) jel (sic) given via supervisor, as writer called on call. Blood sugar now, 38 mg/dl. (Name of physician), on call, update given and order received to give Glucagon 1mg injection and send to (name of hospital). 911 called. Glucagon injection given via supervisor. Blood sugar reading, 35 mg/dl. Resident is now alert and able to tell staff that his sugar is low. 911 is now on site with resident."

Review of hospital documentation dated 6/28/18 revealed Resident #329 was administered an intravenous sugar solution at the hospital and transferred back to the facility that same day.

On 7/11/18 at 4:06 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked to explain the purpose of a comprehensive care plan. LPN #2 stated, "For everybody to know how to care for the patient." LPN #2 was asked how the facility staff ensures residents' care plans are implemented. LPN #2 stated, "We keep going back to review." At this time, LPN #2 confirmed she administered insulin to Resident #329 when she should not have on two occasions on 6/27/18. LPN #2 stated the entire insulin order did not appear in the computer system when she read the order and administered the medication. LPN #2 stated she did not click on the button to read the entire order and did not see the sentence that documented to give the insulin for a blood sugar greater than 350.

On 7/11/18 at 6:55 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2

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(the assistant administrator), ASM #3 (the director of nursing), ASM #4 (the regional director of clinical services) and ASM #5 (the director of clinical education) were made aware of the above concern.

The facility pharmacy policy titled, "Care Plan" documented, "D) All staff must be familiar with each resident's Care Plan and all approaches must be implemented."

No further information was presented prior to exit.

(1) Humalog insulin is used to treat diabetes. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697021.html

(2) Glucagon is used to raise low blood sugar. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682480.html

3. The facility staff failed to implement the comprehensive care plan and to follow the physician's orders to place fall mats on both sides of the bed for Resident #55.

Resident #55 was admitted to the facility on 4/28/18 with diagnoses that included but were not limited to: cancer, weakness, depression and anxiety.

The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 6/1/18 coded the resident as having scored a 13 out of 15 on the brief interview for mental status indicating the resident was cognitively intact. The resident was

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coded as requiring assistance for all activities of daily living except for eating which the resident could perform after the tray was set-up.

An observation was made on 7/10/18 at 10:07 a.m. of Resident #55. The resident was lying in a low bed and two friends were sitting in chairs in the room. There were no fall mats in place.

An observation was made on 7/10/18 at 1:35 p.m. of Resident #55. The resident was lying in the low bed. There were no visitors in the room. There were no fall mats in place.

An observation was made on 7/11/18 at 2:37 p.m. of Resident #55. The resident was lying in the low bed. There no visitors in the room. There were no fall mats in place.

An observation was made on 7/11/18 at 1:51 a.m. of Resident #55. The resident was in the low bed. There was a visitor sitting on the right side of the bed. There were no fall mats in place.

An observation was made on 7/11/18 at 2:15 p.m. of Resident #55. The resident was in the low bed. There were fall mats on the floor. A visitor was in the room. When asked if the fall mats were usually in place, the visitor stated, "No, this is the first day. The hospice nurse put them down."

Review of the comprehensive care plan initiated on 4/28/18 and revised on 7/3/18 documented, "Focus At risk for falls r/t (related to) deceased mobility. ACTUAL Fall 6/4/18; Fall 6/23/18; Fall 6/29/18. Interventions floor mats on both sides of bed when resident laying down Date initiated 6/6/18."

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Review of the July 2018 physician's orders documented, "Fall mats on either side of bed when patient is laying down. Start date. 6/6/18."

Review of the July 2018 treatment administration record did not evidence documentation regarding the fall mats.

An interview was conducted on 7/11/18 at 2:20 p.m. with LPN (licensed practical nurse) #4, the resident's nurse. When asked why residents had care plans, LPN #4 stated, "To know what to do as far as for safety, pain, fall prevention and update it after every fall. Their nutrition. It's a way to communicate things to the CNAs (certified nursing assistants) and other staff members." When asked if staff were expected to follow the care plan, LPN #4 stated, "Yeah, you should always follow it unless it's causing harm to the resident." When asked if Resident #55 had fall mats, LPN #4 stated, "Yes, I take them up when she has visitors so they can sit close to her and then I put them down after they leave." When made aware of the above observations when the resident was alone without the fall mats in place, LPN #4 did not have a response.

An interview was conducted on 7/11/18 at 2:25 p.m. with CNA #1, the resident's aide. When asked how staff found out what care needs their residents required, CNA #1 stated, "Usually early in the morning we get report and they tell us if there is a special need." When asked who gave this information, CNA #1 stated, "The charge nurse and the off-going charge nurse." When asked what process staff followed if a resident was to have fall mats, CNA #1 stated, "The only time I take them up is if she is out of the bed or out of the room." When asked if staff took up the

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fall mats when the resident had visitors, CNA #1 stated, "I actually put them down and explain the importance of why we have them."

An interview was conducted on 7/11/18 at 2:55 p.m. with LPN #15. When asked how CNAs were made aware of their assignments, LPN #15 stated, "We print out care guides at the beginning of the shift for the CNAs," Resident #55's care guide was requested at this time and was received. Review of the care guide documented, "Floor mats on either side of bed when patient is laying down. Order Status Active. Revision Date 06.05.2018."

An interview was conducted on 7/11/18 at 4:04 p.m. with LPN #3, the unit manager. When asked why residents had care plans, LPN #3 stated, "So that we all know what is going on with the resident and what they need." When asked who used the care plan, LPN #3 stated, "Everyone. When asked if staff were expected to follow the care plan, LPN #3 stated, "Yes."

On 7/11/18 at 5:45 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the assistant administrator and ASM #3, the director of nursing were made aware of the findings.

An interview was conducted on 7/12/18 at 9:03 a.m. with CNA #6. When asked when she had last cared for Resident #55, CNA #6 stated, "It was some time last week." When asked if the resident had fall mats, CNA #6 stated, "No. They started those this week." When asked how staff were made aware of treatments and care the resident was to have, CNA #6 stated, "I have a resident care guide that I can keep in my pocket because things do change." When asked to

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review the resident's care guide, CNA #6 stated, "Oh wow. I know she definitely did not have any (fall mats) last week." When asked what she would do if the resident was supposed to have fall mats, CNA #6 stated, "I would tell the nurse I need some to put down." When asked if she knew why the fall mats were not put in place, CNA #6 stated, "No I don't know. I didn't see it on there (the care guide) the last time I had her."

Review of the facility's policy titled, "Care Plan" documented, "POLICY: an interdisciplinary plan of care will be established for every resident and updated in accordance with stated and federal regulatory requirements an on an as needed basis. PROCEDURE: Z) All direct care staff must always know, understand and follow their Resident's Care Plan."

No further information was obtained prior to exit.

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..." (1)

(1) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77.

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4. a. The facility staff failed to implement the comprehensive care plan and physician's order to obtain daily weights for Resident #376.

Resident #376 was admitted to the facility on 7/2/18 with diagnoses that included but were not limited to: chronic lung disease, kidney failure, heart disease, congestive heart failure, diabetes, difficulty swallowing and high blood pressure.

A minimum data set (MDS) was not completed at the time of the survey. Review of the nurse's admission assessment dated 7/2/18, documented, "1. Level of Consciousness: Alert X2 with confusion at times. 11. Respiratory F. Oxygen."

Review of the care plan initiated on 7/9/18 documented, "Focus. Resident has increased nutrition/hydration risk related to...heart failure. Interventions. Monitor weight per protocol."

Review of the July 2018 physician's orders documented, "Obtain Weight Daily one time a day for Monitoring Notify MD (medical doctor) if there is a 3 lb (pound) weight gain in one day or 5 lbs in one week. Start Date: 07/03/2018."

Review of the July 2018 medication administration record documented, "Obtain Weight Daily one time a day for Monitoring Notify MD (medical doctor) if there is a 3 lb (pound) weight gain in one day or 5 lbs in one week. Start Date: 07/03/2018." There was evidence documented that the resident's weight had been obtained on 7/7/18.

Review of the nurse's notes for 7/7/18 did not

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evidence documentation of the resident's weight.

Review of the July 2018 weight summary form did not evidence documentation of the resident's 7/7/18 weight.

An interview was conducted on 7/11/18 at 3:05 p.m. with LPN #14, the resident's nurse. When asked why residents had care plans, LPN #14 stated, it was so staff knew how to care for the residents. When asked if staff were to follow the care plan, LPN #14 stated, "Yes." When asked why Resident #376 was getting daily weights, LPN #14 stated, "He is a CHF (congestive heart failure) patient and we have to keep track of the fluid." LPN #14 reviewed the medication administration record. LPN #14, "It's important to get these weights."

An interview was conducted on 7/11/18 at 4:04 p.m. with LPN #3, the unit manager. When asked why residents had care plans, LPN #3 stated, "So that we all know what is going on with the resident and what they need." When asked who used the care plan, LPN #3 stated, "Everyone. When asked if staff were expected to follow the care plan, LPN #3 stated, "Yes."

On 7/11/18 at 5:45 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the assistant administrator and ASM #3, the director of nursing were made aware of the findings.

4. b. The facility staff failed to follow the care plan and physician's orders to administer pantoprazole (1) for Resident #376.

Review of the care plan initiated on 7/3/18

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F 656	Continued From page 71 documented, "Focus At risk for pain r/t gout (2), GERD (3) Interventions meds (medications) as ordered." Review of the July 2018 physician's orders documented, "Pantoprazole sodium Packet 40 MG (milligrams) Give 1 packet by mouth two times a day for Gerd." Review of the July 2018 medication administration record documented, "Pantoprazole Sodium Packet 40 MG (milligrams) Give 1 packet by mouth two times a day for Gerd." On 7/3/18 at 6:30 a.m., the medication was documented as given. On 7/3/18 at 4:30 p.m. and 7/4/18 at 6:30 a.m. a "19" was in the box with the nurse's initials. Review of the chart codes documented, "19=Other/ See nurse's notes." Review of the nurse's notes dated 7/3/18 at 11:23 p.m. documented, "Pantoprazole Sodium Packet 40 MG Give 1 packet by mouth two times a day for Gerd Arriving on second run (pharmacy delivery)." Review of the nurse's notes dated 7/4/18 at 6:06 a.m. documented, "Pantoprazole Sodium Packet 40 MG Give 1 packet by mouth two times a day for Gerd Pharmacy was called and notified that medication needs to be sent." Review of the pharmacy manifest dated 7/3/18 documented, "Last status: DELIVERED Last status on: 7/3/2018 2:09 AM (a.m.). PROTONIX (pantoprazole) UD (unit dose) 40MG SUSPOR PKT (packet) Qty (quantity) 14." (The medication was available to be administered on 7/3/18 at 4:30 p.m. and 7/4/18 at 6:30 a.m.)	F 656		

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An interview was conducted on 7/11/18 at 4:04 p.m. with LPN #3, the unit manager. When asked why residents had care plans, LPN #3 stated, "So that we all know what is going on with the resident and what they need." When asked who used the care plan, LPN #3 stated, "Everyone. When asked if staff were expected to follow the care plan, LPN #3 stated, "Yes."

An interview was conducted on 7/12/18 at 7:43 a.m. with LPN #13; the nurse who documented the medication was not available on 7/4/18 at 6:06 a.m. When asked how Pantoprazole could be administered on 7/3/18 at 6:30 a.m. but not be available for administration on 7/3/18 at 4:30 p.m. and 7/4/18 at 6:30 a.m., LPN #13 stated, "I don't know. I was looking for the packet and I didn't see any." When asked what she did next, LPN #13 stated, "We get a pharmacy delivery at night and I look for all those meds. I called the pharmacy and they said it had already been sent or it would come on the next run."

On 7/12/18 at 10:30 a.m. ASM #3, the director of nurses stated she was going to do some review of the pharmacy manifest to try to determine why the medication was not given when it was available. At 12:30 p.m., ASM #3 returned and handed the manifest to this writer. When asked if she had determined why the medication was not given, ASM #3 stated no. ASM #3 was made aware of the findings at that time.

No further information was provided prior to exit.

1. Pantoprazole -- Pantoprazole is a proton pump inhibitor (PPI) and a potent inhibitor of gastric acidity which is widely used in the therapy of

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 73 gastroesophageal reflux and peptic ulcer disease. Pantoprazole therapy is associated with a low rate of transient and asymptomatic serum aminotransferase elevations and is a rare cause of clinically apparent liver injury. This information was obtained from: https://livertox.nlm.nih.gov/Pantoprazole.htm 2. Gout -- Gout is a common, painful form of arthritis. It causes swollen, red, hot and stiff joints. This information was obtained from: https://medlineplus.gov/gout.html 3. GERD -- Your esophagus is the tube that carries food from your mouth to your stomach. Gastroesophageal reflux disease (GERD) happens when a muscle at the end of your esophagus does not close properly. This information was obtained from: https://medlineplus.gov/gerd.html	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(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 by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to follow professional standards of practice for one of 37 residents in the survey sample, Resident #40. The facility staff failed to follow the medication label instructions during the 7/10/18 medication	F 658	F658: Services Provided Meet Professional Standards 1. Resident #40 expired medication was discarded immediately. Identified LPN # 17 and RN # 4 were educated regarding entering open date and shortened expiration date on medication as well as	8/13/18

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Continued From page 74

pass for Resident #40.

The findings include:

Resident #40 was admitted to the facility on 1/25/18 with diagnoses that included but were not limited to: high blood pressure, depression, dementia and chronic pain.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 5/4/18 coded the resident as having scored a 12 out of 15 on the brief interview for mental status indicating the resident was moderately impaired cognitively. The resident was coded as requiring staff assistance for bathing and dressing.

An observation of the medication administration was conducted on 7/10/18 at 8:47 a.m. with LPN (licensed practical nurse) #16. LPN #16 took a box out of the medication cart. The box's label documented, "Calcitonin (Salmon) 200 unit...MEDICATION EXPIRES 30 DAYS AFTER OPENING." The medication was dated as opened on 6/6/18. (The medication would have expired on 7/6/18.) LPN #16 then took the medication into the room and administered the nasal spray into the resident's right nostril.

An interview was conducted on 7/10/18 at 2:34 p.m. with LPN #16. When asked what things the staff reviewed prior to giving a medication, LPN #16 stated, "That is the right medication, the right dose, it's the right patient." When asked if staff checked the expiration date on medications, LPN

F 658

checking medication labels prior to resident administration.

2. All residents who receive medications have the potential to be effected by this deficient practice.

Quality review of medication carts and medication rooms was completed by DON or designee on 7/10/18 to ensure all medications were in compliance with expiration dates.

Omnicare quality nurse reviewed all medication carts and rooms for compliance on 7/17/18

3. Licensed nurses were educated to policy titled General Dose and Preparation and Medication by DON or designee to ensure entering open date and shortened expiration date on medication as well as checking medication labels prior to resident administration.

4. DON or designee to conduct quality monitoring to ensure medications are labeled with open and expiration dates without omissions weekly x 12 weeks.

Findings to be reported to QAPI committee for 3 months and updated as indicated. Quality monitoring schedule based on findings.

5. Date of Compliance: August 13, 2018

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F 658	Continued From page 75	F 658		

#16 stated, "Yes." When asked to look at Resident #40's Calcitonin nasal spray, LPN #16 stated, "I'm not the regular nurse so that's on me." When asked if the medication should have been given, LPN #16 stated, "No."

An interview was conducted on 7/11/18 at 8:35 a.m. with RN (registered nurse) #4, the unit manager. RN #4 stated, "I called the pharmacy about the Calcitonin because I had seen an expiration date of 35 days on other boxes. They said it would expire in 35 days and it was a mistake." When asked what staff should do if the medication was labeled as expiring in 30 days, RN #4 stated, "Either don't give it or clarify it with the pharmacy." When asked if this was the responsibility of the nurse administering the medication, RN #4 stated, "Yes."

On 7/11/18 at 5:45 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the assistant administrator and ASM #3, the director of nursing were made aware of the findings.

On 7/12/18 at 9:30 a.m. ASM (administrative staff member) #3, the director of nursing was made aware of the findings. When asked what nursing standard the facility used, ASM #3 stated, "Lippincott and our policies."

An interview was conducted on 7/12/18 8:40 at a.m. with LPN #3. When asked what process staff follow when giving a medication, LPN #3 stated, "Right dose the right patient, the right route, double checking the medication with the card," When asked if the nurse was to read any instructions on the medication label, LPN #3 stated, "Yes. When asked what process staff

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F 658	Continued From page 76 follow if a medication label said to discard the medication in 30 days, LPN #3 stated, "You discard it." When asked why, LPN #3 stated, "Because it's expired." Review of the facility's policy titled, General Dose "Preparation and Medication Administration" documented, "Procedure 3. Dose Preparation: Facility should take all measures required by facility policy and applicable law, including, but not limited to the following: 3.11 Facility staff should enter the date opened on the label of medications with shortened expiration dates...3.11.1 Facility staff may record the expiration date based on date opened on the label of medications with shortened expiration dates. 4. Prior to administration of medication, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: 4.1 Facility staff should: 4.1.3 Check the expiration date on the medication..." No further information was obtained prior to exit. Calcitonin-salmon nasal spray is indicated for the treatment of postmenopausal osteoporosis in women greater than 5 years postmenopausal. Fracture reduction efficacy has not been demonstrated. Calcitonin-salmon nasal spray should be reserved for patients for whom alternative treatments are not suitable (e.g., patients for whom other therapies are contraindicated or for patients who are intolerant or unwilling to use other therapies). How do I store Calcitonin-salmon? Store open bottles of Calcitonin-salmon at room temperature between 59°F to 86°F (15°C to 30°C) for 35 days. This information was obtained from:	F 658		

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F 658	Continued From page 77 https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=0614bf53-9644-47d2-b46e-8efbcd63afe6	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to provide bathing assistance for one of 37 residents in the survey sample, Resident #100. Resident #100, who was coded as totally-dependent on one staff with bathing, was not provided a shower or a complete bed bath for seven days from 6/12/18 until 6/19/18. The findings include: Resident #100 was admitted to the facility on 6/12/18. Resident #100's diagnoses included but were not limited to pneumonia, dementia and major depressive disorder. Resident #100's most recent MDS (minimum data set), a 14 day Medicare assessment with an ARD (assessment reference date) of 6/26/18, coded the resident's cognition as severely impaired. Section G coded Resident #100 as being totally dependent on one staff with bathing. On 7/10/18 at 11:00 a.m., a complaint regarding	F 677	677: ADL Care Provided for Dependent Residents 1. Resident #100 no longer resides in facility. 2. All residents have the potential to be affected by this deficient practice. Quality review of current resident□s care plans completed by DON or designee to ensure ADL care is provided per facility policy and procedure. Follow up based on findings. 3. Nursing staffeducated to policy title Bathing/Showering by DON or designee to ensure bath/shower schedule is followed per patient choice and care plan. 4. DON or designee to conduct quality monitoring to ensure care plan is followed regarding compliance with showers: weekly x 12 weeks. Findings to be reported to QAPI	8/13/18

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F 677	Continued From page 78 Resident #100 was filed with the Office of Licensure and Certification. The complainant stated the resident did not receive a shower the first week of her stay at the facility. Resident #100's care plan dated 6/13/18 documented, "Needs assistance with adl's (activities of daily living) r/t (related to) weakness...Showers Wed/Sat 7-3 shift..." Review of June 2018 ADL documentation revealed Resident #100 was scheduled for showers every Wednesday and Saturday on the 7:00 a.m. to 3:00 p.m. shift. Further review of the ADL documentation revealed Resident #100 did not receive any bath or shower by facility staff from 6/12/18 (date of admission) until 6/19/18 when a bed bath was documented as being given. On 7/11/18 at 3:49 p.m., an interview was conducted with CNA (certified nursing assistant) #1 (the CNA who cared for Resident #100 during the 7:00 a.m. to 3:00 p.m. shift on Wednesday 6/13/18 and Saturday 6/16/18). CNA #1 stated residents are given showers twice a week but she provides a total sponge bath every day. CNA #1 was asked how she is made aware when each resident's shower is due. CNA #1 stated a window pops up in the computer system on the days a resident's shower is due. CNA #1 was shown Resident #100's June 2018 ADL documentation. CNA #1 stated the resident was scheduled for day shift showers in the computer system but scheduled for 3:00 p.m. to 11:00 p.m. showers on the unit shower schedule. CNA #1 was asked if the 3:00 p.m. to 11:00 p.m. shift could have documented they gave Resident #100 a shower in the computer although the computer	F 677	committee for 3 months and updated as indicated. Quality monitoring schedule based on findings 5. Date of Compliance: August 13, 2018	

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F 677	Continued From page 79	F 677		

system scheduled the showers for the 7:00 a.m. to 3:00 p.m. shift. CNA #1 stated she did not know if they could have documented the showers in the computer but the CNAs usually also fill out shower sheets to evidence residents are given showers.

Review of the unit shower schedule revealed Resident #100 was scheduled for showers during the 7:00 a.m. to 3:00 p.m. shift every Wednesday and Saturday from 6/12/18 until 6/15/18 when the resident moved to a different room. Beginning on 6/15/18, Resident #100 was scheduled for showers on the 3:00 p.m. to 11:00 p.m. shift every Tuesday and Friday. Review of all of Resident #100's shower/tub bath/bed bath sheets failed to reveal any documentation of bathing/showers until 6/20/18.

On 7/12/18 at 8:25 a.m., an interview was conducted with CNA #3. CNA #3 stated residents are given two showers a week and the schedule in the computer system should match the unit shower schedule. When asked what should be done if the schedule in the computer system is different from the unit schedule, CNA #3 stated she tells the unit manager so she can make the appropriate correction. When asked how CNAs evidence showers are given to residents, CNA #3 stated she documents the shower in the computer system, on the shower sheet, and she informs the nurse so the nurse can complete a skin assessment. CNA #3 stated if she gives a shower other than the time scheduled in the computer system, she still fills out a shower sheet to evidence the shower was given.

On 7/12/18 at 10:21 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2

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F 677	Continued From page 80 (the assistant administrator) and ASM #3 (the director of nursing) were made aware of the above concern. The facility policy titled, "Bathing and Showering" documented, "Assistance with showering and bathing will be provided twice a week and PRN (as needed)..." No further information was presented prior to exit. COMPLAINT DEFICIENCY	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review it was determined facility staff failed to ensure residents received treatment and services in accordance with professional standards of practice and the comprehensive person-centered care plan for two of 37 residents in the survey sample, Resident #367 and Resident #87. 1. a. The facility staff failed to follow the physician's order to obtain daily weights for Resident #376.	F 684	F684: Quality of Care 1. Resident #376 received medication. Resident did not suffer any signs and symptoms or adverse effects. Evidence of a daily weight for resident #376 for 7/7/18 could not be corrected in the medical record. Resident # 387 order to document a weekly status note each shift was discontinued per physician's order. 2. All residents have the potential to be affected by this deficient practice.	8/13/18

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F 684	Continued From page 81	F 684		

1. b. The facility staff failed to follow the physician's order to administer pantoprazole to Resident #376.

2. The facility staff failed to follow the physician's order to document a weekly status note on each shift for Resident #87.

The findings include:

1. a. Resident #376 was admitted to the facility on 7/2/18 with diagnoses that included but were not limited to: chronic lung disease, kidney failure, heart disease, congestive heart failure, diabetes, difficulty swallowing and high blood pressure.

The MDS (minimum data set) assessment was not completed at the time of the survey. Review of the nurse's admission assessment dated 7/2/18 documented, "1. Level of Consciousness: Alert X2 with confusion at times. 11. Respiratory F. Oxygen." The resident was documented as requiring assistance from staff for all activities of daily living expect for eating which the resident could perform after the tray was set-up.

Review of the care plan initiated on 7/9/18 documented, "Focus. Resident has increased nutrition/hydration risk related to...heart failure. Interventions. Monitor weight per protocol."

Review of the July 2018 physician's orders documented, "Obtain Weight Daily one time a day for Monitoring Notify MD (medical doctor) if there is a 3 lb (pound) weight gain in one day or 5 lbs in one week. Start Date: 07/03/2018."

Review of the July 2018 medication

Quality review of current residents with orders for daily weights was completed by DON or designee to ensure daily weights were obtained. Follow up based on findings.
Quality review of current residents medication availability was completed by DON or designee to ensure all medications were onsite and available. Follow up based on findings.
Quality review of current resident's completed by DON or designee to ensure physician orders are followed for residents requiring weekly status notes each shift. Follow up based on findings.
3. Licensed nurses re-educated to policy titled "General Medication Administration" by DON or designee to ensure physician orders are followed regarding medication administration.
Licensed nurses re-educated to "Weights" by DON or designee to ensure physician orders are followed regarding weekly resident status documentation.
4. DON or designee to conduct quality monitoring to ensure physician orders are followed regarding compliance with obtaining daily weights, medication administration and documentation: weekly for twelve weeks.
Findings to be reported to QAPI committee for 3 months and updated as indicated. Quality monitoring schedule based on findings

5. Date of Compliance: August 13, 2018

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F 684	Continued From page 82 administration record documented, "Obtain Weight Daily one time a day for Monitoring Notify MD (medical doctor) if there is a 3 lb (pound) weight gain in one day or 5 lbs in one week. Start Date: 07/03/2018." There was evidence documented that the resident's weight had been obtained on 7/7/18. Review of the nurse's notes for 7/7/18 did not evidence documentation of the resident's weight. Review of the July 2018 weight summary form did not evidence documentation of the resident's 7/7/18 weight. An interview was conducted on 7/11/18 at 3:05 p.m. with LPN #14, the resident's nurse. When asked why Resident #376 was getting daily weights, LPN #14 stated, "He is a CHF (congestive heart failure) patient and we have to keep track of the fluid." LPN #14 reviewed the medication administration record. LPN #14, "I can't believe they didn't get it. It's important to get these weights." When asked if the doctor's order had been followed, LPN #14 stated, "No." On 7/11/18 at 5:45 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the assistant administrator and ASM #3, the director of nursing were made aware of the findings. Review of the facility's policy titled, "Weights" documented, "POLICY: Weights must be obtained routinely in order to monitor parameters of nutrition over time. each individual's width will be determined upon admission/readmission to the facility, weekly for the first four weeks after admission/readmission, and monthly or more often if risk is identified. PROCEDURE: Obtaining	F 684		

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F 684	Continued From page 83 accurate weights is vital for the nutrition assessment of each resident and is used as the basis for Medical Nutrition Therapy Intervention. Nursing is responsible for the determination of each individuals weight. (A) Admission or Readmission: 2. After admission weights are obtained; the individual weekly for 4 weeks,, or more often per physician order." 1. b. The facility staff failed to follow the physician's order to administer pantoprazole to Resident #376. Review of the care plan initiated on 7/3/18 documented, "Focus At risk for pain r/t gout (2), GERD (3) Interventions meds (medications) as ordered." Review of the July 2018 physician's orders documented, "Pantoprazole sodium Packet 40 MG (milligrams) Give 1 packet by mouth two times a day for Gerd." Review of the July 2018 medication administration record documented, "Pantoprazole Sodium Packet 40 MG (milligrams) Give 1 packet by mouth two times a day for Gerd." On 7/3/18 at 6:30 a.m., the medication was documented as being given. On 7/3/18 at 4:30 p.m. and 7/4/18 at 6:30 a.m. a "19" was in the box with the nurse's initials. Review of the chart codes documented, "19=Other/ See nurse's notes." Review of the nurse's notes dated 7/3/18 at 11:23 p.m. documented, "Pantoprazole Sodium Packet 40 MG Give 1 packet by mouth two times a day for Gerd Arriving on second run (pharmacy delivery)."	F 684		

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Review of the nurse's notes dated 7/4/18 at 6:06 a.m. documented, "Pantoprazole Sodium Packet 40 MG Give 1 packet by mouth two times a day for Gerd Pharmacy was called and notified that medication needs to be sent."

Review of the pharmacy manifest dated 7/3/18 documented, "Last status: DELIVERED Last status on: 7/3/2018 2:09 AM (a.m.). PROTONIX (pantoprazole) UD (unit dose) 40MG SUSPOR PKT (packet) Qty (quantity) 14." (The medication was available to be administered on 7/3/18 at 4:30 p.m. and 7/4/18 at 6:30 a.m.)

An interview was conducted on 7/12/18 at 7:43 a.m. with LPN #13; the nurse who documented the medication was not available on 7/4/18 at 6:06 a.m. When asked how the Pantoprazole medication could be administered on 7/3/18 at 6:30 a.m., but not be available for administration on 7/3/18 at 4:30 p.m. and 7/4/18 at 6:30 a.m., LPN #13 stated, "I don't know. I was looking for the packet and I didn't see any." When asked what she did next, LPN #13 stated, "We get a pharmacy delivery at night and I look for all those meds (medications). I called the pharmacy and they said it had already been sent or it would come on the next run." When asked about the process staff follows when there is a pharmacy delivery, LPN #13 stated that the nurses put the medications away in the medication cart.

On 7/12/18 at 10:30 a.m. ASM #3, the director of nurses stated she was going to do some review of the pharmacy manifest to try to determine why the medication was not given when it was available. At 12:30 p.m., ASM #3 returned and handed the manifest to this writer. When asked if she had determined why the medication was not

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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 684		F 684		

Continued From page 85
given, ASM #3 stated no. ASM #3 was made aware of the findings at that time.

No further information was provided prior to exit.

1. Pantoprazole -- Pantoprazole is a proton pump inhibitor (PPI) and a potent inhibitor of gastric acidity which is widely used in the therapy of gastroesophageal reflux and peptic ulcer disease. Pantoprazole therapy is associated with a low rate of transient and asymptomatic serum aminotransferase elevations and is a rare cause of clinically apparent liver injury. This information was obtained from: https://livertox.nlm.nih.gov/Pantoprazole.htm

2. Gout -- Gout is a common, painful form of arthritis. It causes swollen, red, hot and stiff joints. This information was obtained from: https://medlineplus.gov/gout.html

3. GERD -- Your esophagus is the tube that carries food from your mouth to your stomach. Gastroesophageal reflux disease (GERD) happens when a muscle at the end of your esophagus does not close properly. This information was obtained from: https://medlineplus.gov/gerd.html

2. The facility staff failed to follow the physician's order to document a weekly status note on each shift for Resident #87.

Resident #87 was admitted to the facility on 1/21/15 with diagnoses that included but were not limited to: irregular heart beat, heart failure, high blood pressure and depression.

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F 684	Continued From page 86	F 684		

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 6/21/18 coded the resident as having scored 11 out of 15 on the brief interview for mental status indicating the resident was moderately impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the July 2018 physician's order documented, "Weekly Q (every) shift note every shift every Fri (Friday) Document on overall condition, level of assistance required, and any behaviors noted. Start Date -- 8/12/16."

Review of the resident's care plan did not evidence documentation specific to the weekly every shift status notes.

Review of the July 2018 treatment administration record documented, "Weekly Q (every) shift note every shift every Fri (Friday) Document on overall condition, level of assistance required, and any behaviors noted. Start Date -- 8/12/16." Review of the record did not evidence documentation that a weekly note was completed on 7/6/18 on the 3:00 p.m. to 11:00 p.m. shift and on 7/13/18 on all shifts.

Review of the nurse's notes for 7/6/18 and 7/7/18 failed to evidence a 7:00 a.m. to 3:00 p.m. status note. Review of the nurse's notes for 7/13/18 did not evidence documentation of the status notes.

An interview was conducted on 7/11/18 at 3:05 p.m. with LPN #14, the resident's nurse. When asked when staff would not follow a physician's order, LPN #14 stated, never. When asked to review the physician's order for the weekly status

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F 684	Continued From page 87 note and then to review the nurse's notes for 7/6 and 7/13/18, LPN #14 stated, "We're not always documenting." When asked if they should, LPN #14 stated, "Yes." An interview was conducted on 7/11/18 at 4:27 p.m. with RN (registered nurse) #4, the unit manager. When asked when a nurse would not follow a physician's order, RN #4 stated never. When asked to review Resident #87's orders for the weekly status report, RN #1 stated, "The order is in wrong but they still should have documented." On 7/11/18 at 5:45 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the assistant administrator and ASM #3, the director of nursing were made aware of the findings. No further information was obtained prior to exit.	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by:	F 685		8/13/18

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F 685	Continued From page 88 Based on observation, staff interview, facility policy review and clinical record review, it was determined that the facility staff failed to provide care and services for oxygen therapy for one of 37 residents in the survey sample, Resident #376. The facility staff failed to store oxygen tubing in a sanitary manner for Resident #376. The findings include: Resident #376 was admitted to the facility on 7/2/18 with diagnoses that included but were not limited to: chronic lung disease, kidney failure, heart disease, congestive heart failure, diabetes, difficulty swallowing and high blood pressure. The MDS (minimum data set) assessment was not completed at the time of the survey. Review of the nurse's admission assessment dated 7/2/18 documented, "1. Level of Consciousness: Alert X2 with confusion at times. 11. Respiratory F. Oxygen." An observation was made on 7/10/18 at 7:45 a.m. of Resident #376. The resident was in bed with eyes closed. In the bathroom was the resident's wheelchair with the nasal cannula (soft plastic prongs that fit in the nose to deliver oxygen) wrapped around the neck of the tank. There was no storage bag observed. An observation was made on 7/10/18 at 2:43 p.m. of Resident #376. The resident was not in the room. The nasal cannula connected to the oxygen concentrator was lying on the bed uncovered.	F 685	F685: Treatment/Devices to Maintain Hearing/Vision 1. Resident #376 no longer resides in facility. 2. All residents receiving oxygen have the potential to be affected by this deficient practice. 3. Nursing and therapy educated to Infection control process and procedure by DON or designee to ensure proper storage of oxygen tubing. 4. DON or designee to conduct quality monitoring to ensure oxygen tubing is placed in storage bag when not in use: weekly for twelve weeks. Findings to be reported to QAPI committee for 3 months and updated as indicated. Quality monitoring schedule based on findings 5. Date of Compliance: August 13, 2018	

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F 685	Continued From page 89	F 685		

An observation was made on 7/10/18 at 2:50 p.m. of Resident #376. The resident was in the physical therapy room. The resident had the oxygen on at three and a half liters per minute via the nasal cannula connected to an oxygen tank.

An interview was conducted on 7/10/18 at 2:55 p.m. with OSM (other staff member) #6, the physical therapy assistant. When asked if she had brought the resident to the therapy department, OSM #6 stated she had. When asked how the oxygen tubing was stored on the oxygen tank, OSM #6 stated, "It was wrapped around the tank." When asked if the tubing was in a bag, OSM #6 stated, "No."

An interview was conducted on 7/10/18 at 3:05 p.m. with RN (registered nurse) #4, the unit manager. When asked how oxygen tubing was stored when not in use, RN #4 stated, "In a bag, with the name and date on it." When asked why the tubing was stored in a bag, RN #4 stated, "Infection control."

An interview was conducted on 7/10/18 at 3:7 p.m. with LPN #14, the resident's nurse. When asked how oxygen tubing was stored, LPN #14 stated, "It goes in a bag." When asked why, LPN #14 stated, "Why? Its germs and not breathing it all up there."

On 7/11/18 at 5:45 p.m. ASM #1, the administrator, ASM #2, the assistant administrator and ASM #3, the director of nursing were made aware of the findings.

Review of the facility's policy titled, "Infection Control" did not specifically address the proper way to store oxygen tubing when not in use.

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F 685	Continued From page 90 No further information was provided prior to exit. 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."	F 685		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on family interview, staff interview, and clinical record review it was determined, that the facility staff failed to ensure assistance devices to prevent accidents were implemented for one of 37 residents in the survey sample, Resident #55. The facility staff failed to follow the physician's order to place fall mats on each side of the bed for Resident #55. The findings include: Resident #55 was admitted to the facility on 4/28/18 with diagnoses that included but were not limited to: cancer, weakness, depression and anxiety.	F 689	F689: Free From Accidents and Hazards/ Supervision/Devices 1. Resident no longer resides in facility 2. All residents with floor mats have the potential to be affected by this deficient practice. Quality review of current resident□s care guides and plans completed by DON or designee to ensure floor mats are in place per physician order. Follow up based on findings 3. Nursing staff educated by DON or	8/13/18

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F 689

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The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 6/1/18 coded the resident as having scored a 13 out of 15 on the brief interview for mental status indicating the resident was cognitively intact. The resident was coded as requiring assistance for all activities of daily living except for eating which the resident could perform after the tray was set-up.

An observation was made on 7/10/18 at 10:07 a.m. of Resident #55. The resident was lying in a low bed and two friends were sitting in chairs in the room. There were no fall mats in place.

An observation was made on 7/10/18 at 1:35 p.m. of Resident #55. The resident was lying in the low bed. There were no visitors in the room. There were no fall mats in place.

An observation was made on 7/11/18 at 2:37 p.m. of Resident #55. The resident was lying in the low bed. There no visitors in the room. There were no fall mats in place.

An observation was made on 7/11/18 at 1:51 a.m. of Resident #55. The resident was in the low bed. There was a visitor sitting on the right side of the bed. There were no fall mats in place.

An observation was made on 7/11/18 at 2:15 p.m. of Resident #55. The resident was in the low bed. There were fall mats on the floor. A visitor, the resident's daughter in law, was in the room. When asked if the fall mats were usually in place, the visitor stated, "No, this is the first day. The hospice nurse put them down."

F 689

designee to ensure care guide/plan is followed regarding fall mat placement

4. DON or designee to conduct quality monitoring to ensure residents with floor mat orders are positioned by bedside per care plan and physician order: weekly for twelve weeks.

Findings to be reported to QAPI committee for 3 months and updated as indicated. Quality monitoring schedule based on findings

5. Date of Compliance: August 13, 2018

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F 689	Continued From page 92	F 689		

Review of the care plan initiated on 4/28/18 and revised on 7/3/18 documented, "Focus At risk for falls r/t (related to) deceased mobility. ACTUAL Fall 6/4/18; Fall 6/23/18; Fall 6/29/18. Interventions floor mats on both sides of bed when resident laying down Date initiated 6/6/18."

Review of the July 2018 physician's orders documented, "Fall mats on either side of bed when patient is laying down. Start date. 6/6/18."

Review of the July 2018 treatment administration record did not evidence documentation regarding the fall mats.

An interview was conducted on 7/11/18 at 2:20 p.m. with LPN (licensed practical nurse) #4, the resident's nurse. When asked if Resident #55 had fall mats, LPN #4 stated, "Yes, I take them up when she has visitors so they can sit close to her and then I put them down after they leave." When made aware of the above observations when the resident was alone without the fall mats in place, LPN #4 did not have a response.

An interview was conducted on 7/11/18 at 2:25 p.m. with CNA #1, the resident's aide. When asked how staff found out what care needs their residents required, CNA #1 stated, "Usually early in the morning we get report and they tell us if there is a special need." When asked who gave this information, CNA #1 stated, "The charge nurse and the off-going charge nurse." When asked what process staff followed if a resident was to have fall mats, CNA #1 stated, "The only time I take them up is if she is out of the bed or out of the room." When asked if staff took up the fall mats when the resident had visitors, CNA #1 stated, "I actually put them down and explain the

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F 689	Continued From page 93 importance of why we have them." An interview was conducted on 7/11/18 at 2:55 p.m. with LPN #15. When asked how CNAs were made aware of their assignments, LPN #15 stated, "We print out care guides at the beginning of the shift for the CNAs," A request for Resident #55's care guide was requested and received. Review of the care guide documented, "Floor mats on either side of bed when patient is laying down. Order Status Active. Revision Date 06.05.2018." On 7/11/18 at 5:45 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the assistant administrator and ASM #3, the director of nursing were made aware of the findings. An interview was conducted on 7/12/18 at 9:03 a.m. with CNA #6. When asked when she had last cared for Resident #55, CNA #6 stated, "It was some time last week." When asked if the resident had fall mats, CNA #6 stated, "No. They started those this week." When asked how staff were made aware of treatments and care the resident was to have, CNA #6 stated, "I have a resident care guide that I can keep in my pocket because things do change." When asked to review the resident's care guide, CNA #6 stated, "Oh wow. I know she definitely did not have any (fall mats) last week." When asked what she would do if the resident was supposed to have fall mats, CNA #6 stated, "I would tell the nurse I need some to put down." When asked if she knew why the fall mats were not put in place, CNA #6 stated, "No I don't know. I didn't see it on there (the care guide) the last time I had her." No further information was provided prior to exit.	F 689		

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F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 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 ensure a resident was free of unnecessary medication for one of 37 residents in the survey sample, Resident #329. The facility staff failed to follow Resident #329's physician order for insulin and administered insulin when it should not have been administered twice on 6/27/18. The findings include:	F 757	F757: Drug Regimen is Free from Unnecessary Drugs 1. Resident #329 no longer resides in facility. Resident evaluated by emergency department and returned to facility. Facility Reported Incident (FRI) submitted 6/28/18 No further events requiring a FRI have occurred. 2. Quality review of current resident□s care plans completed by DON or designee to ensure insulins and other	8/13/18

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Resident #329 was admitted to the facility on 6/27/18. Resident #329's diagnoses included but were not limited to diabetes, heart failure and chronic kidney disease. Resident #329's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 7/4/18, coded the resident as being cognitively intact. Section N documented Resident #329 received insulin injections seven out of the last seven days.

Review of Resident #329's clinical record revealed a physician's order dated 6/27/18 that documented, "Humalog (1) Solution 100 UNIT/ML (milliliter) (Insulin Lispro) Inject 5 unit subcutaneously before meals and at bedtime for DM (diabetes mellitus) for 2 Weeks. Give for BS (blood sugar) greater than 350." Review of Resident #329's June 2018 MAR (medication administration record) revealed five units of Humalog was given on 6/27/18 at 4:30 p.m. although the resident's blood sugar was 137, and on 6/27/18 at 9:00 p.m. although the resident's blood sugar was 202.

A nurse's note dated 6/28/18 at 4:52 a.m. documented, "Writer called to assist. Resident observed lethargic with much perspiration present. Blood sugar taken. Results 26 mg/dl (milligrams per deciliter). Given as able to receive sweeten milkshake. Not able to accept well via mouth. Glucagon (2) jel (sic) given via supervisor, as writer called on call. Blood sugar now, 38 mg/dl. (Name of physician), on call, update given and order received to give Glucagon 1mg injection and send to (name of hospital). 911 called. Glucagon injection given via supervisor. Blood sugar reading, 35 mg/dl. Resident is now alert and able to tell staff that his

F 757

medications are administered, per physician order. Follow up based on findings.

3. Licensed nurses educated to policy titled General Dose Preparation and Medication by DON or designee to ensure orders and care plan are followed per physician order regarding medication administration including insulin.

4. DON or designee to conduct quality monitoring to ensure care plan is followed regarding compliance with medication to include insulin: weekly for twelve weeks.

Findings to be reported to QAPI committee for 3 months and updated as indicated. Quality monitoring schedule based on findings

5. Date of Compliance: August 13, 2018

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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

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sugar is low. 911 is now on site with resident."

Review of hospital documentation dated 6/28/18 revealed Resident #329 was administered an intravenous sugar solution at the hospital and transferred back to the facility that same day.

Resident #29's care plan created on 6/27/18 documented, "Resident is at risk for unstable blood glucose (sugar) related to diabetes...Administer oral hypoglycemic and/or insulin as directed by the physician."

On 7/11/18 at 4:06 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 confirmed she administered insulin to Resident #329 when she should not have on two occasions on 6/27/18. LPN #2 stated the entire insulin order did not appear in the computer system when she read the order and administered the medication. LPN #2 stated she did not click on the button to read the entire order and did not see the sentence that documented to give the insulin for a blood sugar greater than 350.

On 7/11/18 at 6:55 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the assistant administrator), ASM #3 (the director of nursing), ASM #4 (the regional director of clinical services) and ASM #5 (the director of clinical education) were made aware of the above concern.

The facility pharmacy policy titled, "6.0 General Dose Preparation and Medication Administration" documented, "4.1 Facility staff should: 4.1.1 Verify each time a medication is administered that it is the correct medication, at the correct dose, at

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F 757	Continued From page 97 the correct route, at the correct rate, at the correct time, for the correct resident..." No further information was presented prior to exit. (1) Humalog insulin is used to treat diabetes. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697021.html (2) Glucagon is used to raise low blood sugar. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682480.html	F 757		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. 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 ensure a resident was free of unnecessary medication for one of 37 residents in the survey sample, Resident #329. The facility staff failed to follow Resident #329's physician order for insulin and administered insulin when it should not have been administered twice on 6/27/18. The findings include: Resident #329 was admitted to the facility on 6/27/18. Resident #329's diagnoses included but were not limited to diabetes, heart failure and	F 760	F760: Residents are Free of Significant Med Errors 1. Resident #329 no longer resides in facility. Resident evaluated by emergency department and returned to facility. Facility Reported Incident (FRI) submitted 6/28/18 No further events requiring a FRI have occurred. 2. Quality review of current resident□s care plans completed by DON or designee to ensure insulins and other medications are administered, per physician order. Follow up based on findings.	8/13/18

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F 760	Continued From page 98 chronic kidney disease. Resident #329's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 7/4/18, coded the resident as being cognitively intact. Section N documented Resident #329 received insulin injections seven out of the last seven days. Review of Resident #329's clinical record revealed a physician's order dated 6/27/18 that documented, "Humalog (1) Solution 100 UNIT/ML (milliliter) (Insulin Lispro) Inject 5 unit subcutaneously before meals and at bedtime for DM (diabetes mellitus) for 2 Weeks. Give for BS (blood sugar) greater than 350." Review of Resident #329's June 2018 MAR (medication administration record) revealed five units of Humalog was given on 6/27/18 at 4:30 p.m. although the resident's blood sugar was 137, and on 6/27/18 at 9:00 p.m. although the resident's blood sugar was 202. A nurse's note dated 6/28/18 at 4:52 a.m. documented, "Writer called to assist. Resident observed lethargic with much perspiration present. Blood sugar taken. Results 26 mg/dl (milligrams per deciliter). Given as able to receive sweeten milkshake. Not able to accept well via mouth. Glucagon (2) jel (sic) given via supervisor, as writer called on call. Blood sugar now, 38 mg/dl. (Name of physician), on call, update given and order received to give Glucagon 1mg injection and send to (name of hospital). 911 called. Glucagon injection given via supervisor. Blood sugar reading, 35 mg/dl. Resident is now alert and able to tell staff that his sugar is low. 911 is now on site with resident." Review of hospital documentation dated 6/28/18	F 760	3. Licensed nurses educated to policy titled General Dose Preparation and Medication by DON or designee to ensure orders and care plan is followed per physician order regarding medication administration to include insulins. 4. DON or designee to conduct quality monitoring to ensure care plan is followed regarding compliance with medication administration to include insulin: weekly for twelve weeks. Findings to be reported to QAPI committee for 3 months and updated as indicated. Quality monitoring schedule based on findings. 5. Date of Compliance: August 13, 2018	

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revealed Resident #329 was administered an intravenous sugar solution at the hospital and transferred back to the facility that same day.

Resident #29's care plan created on 6/27/18 documented, "Resident is at risk for unstable blood glucose (sugar) related to diabetes...Administer oral hypoglycemic and/or insulin as directed by the physician."

On 7/11/18 at 4:06 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 confirmed she administered insulin to Resident #329 when she should not have on two occasions on 6/27/18. LPN #2 stated the entire insulin order did not appear in the computer system when she read the order and administered the medication. LPN #2 stated she did not click on the button to read the entire order and did not see the sentence that documented to give the insulin for a blood sugar greater than 350.

On 7/11/18 at 6:55 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the assistant administrator), ASM #3 (the director of nursing), ASM #4 (the regional director of clinical services) and ASM #5 (the director of clinical education) were made aware of the above concern.

The facility pharmacy policy titled, "6.0 General Dose Preparation and Medication Administration" documented, "4.1 Facility staff should: 4.1.1 Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident..."

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F 760	Continued From page 100 No further information was presented prior to exit. (1) Humalog insulin is used to treat diabetes. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697021.html (2) Glucagon is used to raise low blood sugar. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682480.html	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(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. §483.45(h)(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	F 761		8/13/18

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F 761	Continued From page 101 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined the facility staff failed to ensure expired medications were not available for use in two of four medication rooms, (Summer and Autumn unit medication rooms) and three of four medication carts on the Winter and Spring units; and the facility staff failed to date and label multi-dose vials of medications when they were opened in one of four medication rooms (Summer unit medication room), and on two of four medication carts, on the Spring and Summer units; and the facility staff failed to secure one of two medication carts on the Winter unit. 1. The facility staff failed to discard expired medications in two medication rooms, (Summer and Autumn unit medication rooms), and failed to discard expired medications on three of four medication carts, (Winter and Spring Unit medications carts). 2. The facility staff failed to label and date multi-dose vials of medications when they were opened in one medication room, Summer unit, and on two medication carts, Spring and Summer units. 3. The facility staff failed to lock the medication cart prior to leaving the cart unsupervised for one of two carts on the Winter unit. The findings include: 1. The facility staff failed to discard expired medications in two medication rooms, Summer	F 761	F761: Label Storage Drugs and Biologicals 1. Expired meds were discarded immediately. Opened and unlabeled multi-dose medication bottles stored in medication rooms and on carts were discarded. Identified medication cart located on winter unit was locked immediately. 2. All residents receiving medications have the potential to be affected by this deficient practice. Quality review of medication carts and medication rooms were completed by DON or designee on 7/10/18 to ensure medication compliance with expiration dates on open vials and to ensure all carts were locked. Omnicare quality nurse assessed medication room and medication carts for compliance on 7/17/18. 3. Licensed nurses educated to policy titled of Storage and Expiration of Medications, Biologicals, Syringes, and Needles by DON or designee to ensure orders and care plan is followed per physician order regarding medication administration to include insulins	

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F 761	Continued From page 102	F 761		

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and Autumn units, and failed to discard expired medications on three of four medication carts, (Winter and Spring Unit medications carts).

Observation was made of the Summer medication room on 7/10/18 at 8:09 a.m. Two prefilled single dose influenza vaccine (used to prevent infections by the influenza virus (1)) syringes, 0.5 ml (milliliters) were noted in the refrigerator. The prefilled syringes had an expiration date of 04/2018 (April 2018). A bottle of Atropine drops (used to decrease salivation and bronchial secretions (2)) 1% solution was observed with a notation on the bottle documented, "Discard after 3/10/18."

An interview was conducted with LPN (licensed practical nurse) # 12 on 7/10/18 at 8:09 a.m. When asked if the above medications were available for use, LPN # 12 stated yes they were available for use. LPN #12 was asked to review the expiration date of the above medications; LPN # 12 stated the medications should have been discarded.

Observation was made of the Autumn medication room on 7/10/18 at 8:30 a.m. A bottle of Magic Mouthwash (with antihistaminic, anti-inflammatory, and antifungal activities. It inhibits the cytokine-mediated inflammation and yeast colonization of the oral mucosa associated with chemotherapy and radiation therapy. (3)) 80/60/60 had a label that documented, "Dispensed 6/9/18. Expires 6/23/18."

An interview was conducted with RN (Registered Nurse) # 4 on 7/10/18 at approximately 8:35 a.m. When asked if the medication was available for use, RN # 4 stated that it was. She further stated

Provider's Plan of Correction (F 761):

4. DON or designee to conduct quality monitoring through walking rounds to ensure medication rooms and carts are free of expired medications: weekly for twelve weeks.

DON or designee to conduct quality monitoring through walking rounds to ensure medication carts are locked: weekly for twelve weeks.

Findings to be reported to QAPI committee for 3 months and updated as indicated. Quality monitoring schedule based on findings

5. Date of Compliance: August 13, 2018

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that the medication should have been discarded.

Observation was made of the medication cart on the Winter unit, on 7/10/18 at 8:45 a.m. A stock bottle of Cetrizine (used to treat indoor and outdoor allergies (4)) 10 mg (milligram) tablets expired on 03/2018. A bottle of Calcium Antacids (otherwise known as Tums) (used to treat heartburn, sour stomach and acid indigestion (5)) had an expiration date of 05/18.

An interview was conducted with LPN # 5 on 7/10/18 at approximately 8:50 a.m. When asked if the medications were available for use, LPN # 5 stated that they were. LPN # 5 verified that the medications were expired and should have been discarded.

Observation was made of the medication cart on the Spring unit, on 7/10/18 at 9:39 a.m. A vial of Humalog Insulin (fast acting insulin used to treat diabetes (6)) was dated as opened on 6/10/18. The label documented, "Discard after 28 days." 7/10/18 was 30 days after opening. A second vial of Humalog Insulin was dated as dispensed from the pharmacy on 4/23/18. It was dated as opened on 4/25/18. The label documented, "Discard after open for 28 days." The vial was open for 76 days.

An interview was conducted with LPN # 8 on 7/10/18 at 9:45 a.m. When asked about the process followed for the use of multi-dose vials, LPN # 8 stated, "You have to check the expiration date before using the medication." When asked what should be done if she was the first one to open the vial, LPN # 8 stated, "I will date it when I open it."

Observation was made of the medication cart on

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F 761	Continued From page 104 the Summer unit on 7/10/18 at 10:27 a.m. A bottle of Calcium antacid (Tums) 500 mg chewable tablets was opened and had an expiration date on the label of 5/18. A vial of Lantus Insulin (long acting insulin used to treat diabetes (7)) was dated as dispensed on 2/25/18 and labeled as opened on 3/1/18. A label documented, "Discard after open for 28 days." This bottle had been opened for 131 days and was available for use. A bottle of Cetirizine 10 mg tablets had an expiration date of 03/2018. An interview was conducted with LPN # 12 on 7/10/18 at 10:35 a.m. When asked how long Lantus is good for once opened, LPN # 12 stated, "It's not that long, I think a month." When asked what should be done when a multi-dose vial is opened, LPN # 12 stated, "The nurse needs to date it when they open it." All of the above expired medications were reviewed with LPN # 12. An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 7/10/18 at 1:30 p.m. When asked about the process for opening a new multi-dose vial, ASM #2 stated the nurse should date it when she opens it. When asked how long the stock bottles of medication are good for, ASM #2 stated, "They are good until the expiration date printed on the bottle." When asked how often the medication carts and medication rooms are checked for expired medications, ASM #2 stated, "The practice I am trying here is to have them checked on a weekly basis." The facility policy, "Storage and Expiration of Medications, Biologicals, Syringes and Needles, "documented in part, "4. Facility should ensure	F 761		

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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 package 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. 5.1 Facility staff may record the calculated expiration date based on date opened on the medication container.

ASM #1, the administrator, was made aware of the above findings on 7/10/18 at 1:48 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0014206/
(2) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?id=63620.
(3) This information was obtained from the following website: https://www.cancer.gov/publications/dictionaries/cancer-drug/def/diphenhydramine-hydrochloride-dexamethasone-nystatin-magic-mouthwash.
(4) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=0f725624-ce3b-493c-9045-40162d7f4e11.
(5) This information was obtained from the following website:

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https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=ad7c343d-ba04-448a-8996-e45d0b19665f.
(6) This information was obtained from the following website:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=c5f75765-86b8-4926-b8c3-b42133ca7ac8.
(7) This information was obtained from the following website:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d5e07a0c-7e14-4756-9152-9fea485d654a.

2. The facility staff failed to label and date multi-dose vials of medications when they were opened in one medication room, (Summer unit), and on two medication carts, Spring and Summer units.

Observation was made of the Summer medication room on 7/10/18 at 8:09 a.m. A multi-dose vial of Tuberculin Purified Protein was observed opened, with no opened date.

An interview was conducted with LPN (licensed practical nurse) # 12 on 7/10/18 at 8:09 a.m. When asked if a multi-dose vial should be dated when opened, LPN # 12 stated that it should be dated. LPN # 12 then looked at the vial of Tuberculin Purified Protein for an opened date. LPN # 12 stated there was no date.

The package insert for the Tuberculin Purified Protein documented in part, "Vials in use more that 30 days should be discarded due to possible oxidation and degradation which may affect potency."

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F 761	Continued From page 107 The medication cart on the Spring unit was observed on 7/10/18 at 9:39 a.m. A vial of Novolog insulin was documented as opened on 6/1/18. The label documented, "Discard after 28 days after opening." The vial was open for 39 days. A vial of Humalog insulin was dated as opened on 6/10/18. The label documented "Discard after 28 days." The vial had been opened for 30 days. A vial of Lantus Insulin was noted to have been dispensed from the pharmacy on 6/27/18. The vial had been opened. There was no date of when the vial was opened. An interview was conducted on 7/10/18 at 9:39 a.m., with LPN (licensed practical nurse) #8. When asked the process for the use of multi-dose vials, LPN # 8 stated she would check the expiration date prior to using it." When asked what she did if she was the first staff to use the vial, LPN # 8 stated, "I would date it when I opened it." Observation of the medication cart on the Summer unit was conducted on 7/10/18 at 10:27 a.m. Two vials of Lantus Insulin was observed to be in the cart and opened. The one vial was dispensed from the pharmacy on 6/17/18. There was no date when it was opened. The second vial of Lantus was dispensed from the pharmacy on 6/27/18. It was opened and there was no date of when it was opened. An interview was conducted with LPN # 12 on 7/10/18 at 10:27 a.m. When asked why it is important to date a multi-dose vial when it is opened, LPN # 12 stated it was so we know when to throw it out after it's opened.	F 761		

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An interview was conducted with administrative staff member (ASM) #3, the director of nursing, on 7/10/18 at 1:30 p.m. When asked about the process for opening a new multi-dose vial, ASM #2 stated the nurse should date it when she opens it.

The ASM #3 presented a policy, "Medication Storage and Expiration Quick Reference" document that documented in part, "Humalog insulin - opened - room temperature - 28 days. Lantus insulin - opened - room temperature - 28 days, Novolog insulin - opened - room temperature - 28 days.

"When should multi-dose vials be discarded?
In addition, the United States Pharmacopeia (USP) General Chapter 797 [16] recommends the following for multi-dose vials of sterile pharmaceuticals:
If a multi-dose has been opened or accessed (e.g., needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial." (1)

ASM #1, the administrator, was made aware of the above findings on 7/10/18 at 1:48 p.m.

No further information was obtained prior to exit.

(1) This information was obtained from the website:
http://www.cdc.gov/injectionsafety/providers/provider_faqs_multivials.html

3. The facility staff failed to lock the medication cart prior to leaving the cart unsupervised for one of two medication carts on the Winter unit.

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An observation was made on 7/11/18 at 11:51 a.m. of a medication cart on the Winter unit. The cart was placed against the wall opposite the nurse's station. The cart was observed unlocked. There was no nurse in line of sight of the medication cart. There was a resident approximately three feet from the cart with his back to the medication cart. At approximately 11:53 a.m. LPN (licensed practical nurse) #3, the unit manager entered the nursing station, picked up a chair and moved it to the dining room. LPN #3 went over to the cart and locked it.

An interview was conducted on 7/11/18 at 11:55 a.m., with LPN (licensed practical nurse) #5, the nurse who was responsible for the medication cart. When asked about the process staff follows when leaving the cart unsupervised, LPN #5 stated, "We lock it." When asked why, LPN #5 stated, "For safety reasons. So no one can go into the cart." When informed that the cart was left unlocked, LPN #5 stated, "It shouldn't have been unlocked."

An interview was conducted on 7/11/18 at 4:27 p.m. with LPN #14. When asked about the process staff follows when the medication cart is left unattended, LPN #14 stated, "You lock it." When asked why, LPN #14 stated, "You don't want anybody to take anything from it."

On 7/11/18 at 6:45 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the assistant administrator and ASM #3, the director of nursing were made aware of the findings.

Review of the fallibility's policy titled, "General Dose Preparation and Medication Administration"

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F 761	Continued From page 110 documented, "Procedure: 7. Facility should ensure that medication carts are always locked when out of sight or unattended." No further information was provided prior to exit.	F 761		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the	F 803	F803: Menus Meet Resident NDS/Prep in Adv/Followed	8/13/18

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facility staff failed to provide food that met the nutritive value in four of four dining rooms.

The facility staff failed to serve three ounces of bologna as per the facility's requirement to ensure the nutritive value for residents in four of the four dining rooms.

The findings include:

A dining observation was made on the Winter unit on 7/10/18 at 12:15 p.m. A thin piece of dark meat was observed on rolls on many of the resident's plates. An observation was made with another surveyor of the steamer table, fried bologna slices were observed being served to residents. The slices appeared to be very thin. OSM #15, the dietary server was asked about the bologna. OSM #15 stated, "This is a resident choice meal." When asked if all units were serving the bologna, OSM #15 stated, "Yes.

A dining observation was made on the Summer unit on 7/10/18 at 12:25 p.m. with two surveyors. An observation was made of the steamer table, fried bologna slices were observed being served to the residents. The slices appeared to be very thin.

On 7/10/18 at 12:30 p.m., a request for a food scale was made to OSM #12, the dietary manager. OSM (other staff member) #12, the dietary manager brought a food scale to the unit and weighed the bologna slice. The slice weighed 1 3/4 ounces. When asked what the serving size was supposed to be, OSM #12 stated, "Three ounces." OSM #12 stated that the bologna shrinks when cooked. OSM #12 stated, "We weigh the meat before we cook it."

F 803

1. Education provided to OSM #13, OSM #14 on portion control policy to ensure nutritive value.

2. All residents have the potential to be affected by this deficient practice.

3. Dietary staff educated by dietician or designee to policy titled Portion Control to ensure correct portioning in compliance with dietician approved menus, to meet the nutritive needs of each resident.

4. Dietary manager or designee will complete quality review observation audits weekly for 12 weeks at random meal times on each unit.

Findings to be reported to QAPI committee for 3 months and updated as indicated. Quality monitoring schedule based on findings.

5. Date of Compliance: August 13, 2018

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On 7/10/18 at 12:25 p.m., OSM #12 and two surveyors went to the kitchen. OSM #14, the dietitian was present at the time and when asked what weight the bologna slices should be, OSM #14 stated, "Three ounces. It can shrink a little when it cooks because it loses some water but it won't lose protein." When asked how many ounces of bologna the residents were to have, OSM #13, the cook, stated, "Three ounces, the same as in a sandwich." When asked about the process staff follows to weigh portions, OSM #13 stated, "We weigh it before we cook it and after we cook it." OSM #13 was asked if the bologna had been weighed, OSM #13 stated it had. When asked how much the slices weighed, OSM #3 stated, "Three ounces." A slice of uncooked bologna was selected to be weighted. Everyone agreed the slice of bologna was representative of the slices that were cooked and served to the residents. The slice of bologna weighed two ounces.

Review of the facility's menu did not evidence documentation of the weight of a sandwich's meat.

Review of the facility's policy titled, "PORTION CONTROL" documented, "POLICY: In order to ensure nutritional adequacy, Residents will receive the appropriate portions of food as planned on the menu. PROCEDURE: 3. Slice foods (e.g. meats) shall be weighed on a scale at the beginning and midway through slicing."

On 7/11/18 at 5:45 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the assistant administrator and ASM #3, the director of nursing were made aware of the findings.

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F 803	Continued From page 113 No further information was obtained prior to exit.	F 803		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings,	F 842		8/13/18

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law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to ensure an accurate medical record for two of 37 residents in the survey sample, Resident #425, #40 and #376.

1a. The facility staff inaccurately documented that

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F842: Resident Record

1. The medical records of resident #425, #40, #376 cannot be corrected.

2. Residents with medical records have the potential to be affected by this

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a blood pressure medication was administered to Resident #425 outside of ordered parameters on 7/1/18.

1b. The facility staff failed to document daily weights in the clinical record on several occasions in May of 2018 for Resident #425.

2. The facility staff failed to document that the physician had been notified that the insulin was not administered for Resident #376.

The findings include:

1. a. Resident #425 was admitted to the facility on 4/3/18 with diagnoses that included but were not limited to muscle weakness, chronic heart failure, bipolar disorder and age related osteoporosis. Resident #425's most recent MDS (minimum data set) assessment was a thirty day scheduled assessment with an ARD (assessment reference date) of 6/19/18. Resident #425 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. Resident #425 was coded as requiring extensive assistance from one person with transfers, walking, dressing, toileting, personal hygiene, and bathing; and supervision only with meals.

Review of Resident #425's July 2018 POS (physician Order Summary) revealed the following order: "Lisinopril (1) Tablet 2.5 MG (milligrams) Give 1 tablet by mouth one time a day for HTN (hypertension) (high blood pressure) Hold for SBP (systolic blood pressure) (2) < (less than) 100." This order was initiated on 5/25/18 and discontinued on 7/3/18.

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deficient practice.

3. Licensed nurses educated to policy titled General Dose preparation by DON or designee to ensure accurate and timely documentation.

4. Audits of medication administration and vital signs documentation will be conducted weekly x 12 weeks to assure compliance.

Findings to be reported to QAPI committee for 3 months updated as indicated. Quality monitoring schedule based on findings

5. Date of Compliance: August 13, 2018

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Review of Resident #425's July 2018 MAR (medication administration record) documented the following order:
"Lisinopril Tablet 2.5 mg Give 1 tablet mouth one time a day for HTN (high blood pressure) Hold For SBP <100."

Review of Resident #42's July MAR revealed that her blood pressure was 99/56 on 7/1/18. Further review of the MAR documented that her Lisinopril was administered outside of ordered parameters on 7/1/18.

Review of Resident #425's cardiac care plan dated 4/3/18 documented the following intervention: "Administer medications as directed by the physician."

On 7/11/18 at 3:09 p.m., an interview was conducted with LPN (licensed practical nurse) #9, the nurse who documented that he administered the Lisinopril on 7/1/18 to Resident #425. When asked about the process staff follows if an order for a blood pressure medication has parameters attached to the order, LPN #8 stated that he would first check the resident's blood pressure, and if the blood pressure were outside of ordered parameters, he would hold the medication. When asked if blood pressure medication should be held if the parameters state "Hold for SBP less than 100" and the resident's SBP was 99, LPN #8 stated that the medication should be held. When asked what check marks meant on the MAR, LPN #8 stated that check marks meant a medication was administered. When asked if he could remember why he administered Lisinopril to Resident #425 when her SBP was 99 on 7/1/18, LPN #8 stated, "No, I held the medication."

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When asked why it was documented as administered, LPN #8 stated, "I don't know." LPN #8 then stated that he remembered checking the medication off in the electronic system as he was preparing the medication. LPN #8 stated that he put the Lisinopril in a separate medication cup and when he took the resident's blood pressure and saw that her SBP was low, he discarded the Lisinopril. LPN #8 stated he forgot to uncheck the Lisinopril in the electronic system before he documented all medications as administered. When asked if it was ever okay to document that a medication or treatment was provided or administered when it was not, LPN #8 stated that it was not okay.

On 7/11/18 at 6:47 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the assistant administrator, ASM #3, the DON (Director of Nursing), ASM #4, the Regional Director of Clinical Services, and ASM #5, the Director of Clinical Education were all made aware of the above concerns. No further information was presented prior to exit.

Facility policy titled, "General Dose Preparation and Administration" documents in part, the following: "Document necessary medication administration/treatment information (e.g., when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN (as needed) medications, application site) on appropriate forms."

The following is from Lippincott's Nursing Procedures 6th edition: "Documentation is the process of preparing a complete record of a patient's care and is a vital tool for

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

(1) Lisinopril is an ACE inhibitor that is used alone or together with other blood pressure medications to treat high blood pressure. Lisinopril works by blocking a substance in the body that causes the blood vessels to tighten. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010968/?report=details.

(2) Systolic Blood pressure- "Blood pressure is the force of blood pushing against the walls of arteries. When the doctor measures your blood pressure, the results are given in two numbers. The first number, called systolic blood pressure, is the pressure caused by your heart contracting and pushing out blood...Normal blood pressure for adults is defined as a systolic pressure of less than 120..." This information was obtained from The National Institutes of Health. https://www.nia.nih.gov/health/high-blood-pressure.

1b. The facility staff failed to document daily weights in the clinical record on several occasions in May of 2018 for Resident #425.

Review of Resident #425's July 2018 POS (physician Order Summary) revealed the following order: "Obtain daily weight every day shift for Monitoring/CHF (chronic heart failure).

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Notify MD (medical doctor) if there is a weight gain of 3 lbs (pounds) in one day or 5 lbs in one week." This order was initiated on 4/10/18.

Review of her May 2018 MAR (medication administration record) revealed holes or blank spaces for daily weights on the following dates:

5/6/18, 5/9/19, 5/13/18, and 5/26/18.

Review of the vital sign tab on the electronic chart failed to evidence weights for the above dates.

Review of the nursing notes for May 2018 failed to evidence weights for the above dates. Further review of the May nursing notes failed to evidence that Resident #425 had refused her daily weights for above dates.

Review of Resident #425's comprehensive care plan dated 4/3/18 and revised 6/6/18 documented the following: "Resident is at risk for being non-complaint related to refusing to be weighed...Interventions: Educate resident of risks not complying and benefits if they comply, Educate on importance of needed/care and services, Ensure resident is safe and then return to re-attempt what you would like resident to comply with, Inform MD (medical doctor) /physician, if applicable of non-compliance, Involve family if applicable to help find ways to help resident comply."

On 7/11/18 at 4:27 p.m., an interview was conducted with LPN (licensed practical nurse) #8, a nurse who worked on one of the above dates when Resident #425's daily weight was missing. When asked the purpose of taking daily weights, LPN #8 stated that the purpose of daily weights

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F 842	Continued From page 120 was to monitor for any changes in condition such as weight loss and/or fluid buildup for residents with conditions such as congestive heart failure. LPN #8 stated that for residents with CHF, there were usually parameters on the weight order instructing nurses when to notify the medical doctor. When asked who takes the daily weights, LPN #8 stated that the CNAs (certified nursing assistants) take the weights and then the nurse will document this weight on the MAR (medication administration record). When asked if weights were documented in other places of the clinical record, LPN #8 stated that weights could be documented under the vital sign tab in PCC (Point Click Care). When asked about the process staff follows if a resident refuses weights, LPN #8 stated that nurses would notify the physician with every refusal and then monitor the resident. When asked if it is documented anywhere that the resident refused daily weights, LPN #8 stated that a skilled note should be written in the clinical record. When asked what blanks or holes for daily weights meant on the MAR, LPN #8 stated, "Typically the resident refused or was not available." When asked if Resident #425 ever refused weights for her, LPN #8 stated that Resident #425 never refused her daily weights. When asked why there were holes on the MAR for 5/6/18, 5/9/19, 5/13/18, and 5/26/18, LPN #8 stated that she worked with the resident on 5/6 and 5/9/18. LPN #8 stated that she believed the resident was unavailable and out of the facility those days. LPN #8 stated that on 5/6/18, she believed the resident was out with family all day and that on 5/9 the resident had a double cardiology appointment. When asked if this information should be documented in the clinical record, LPN #8 stated that typically she would document.	F 842		

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Evidence could not be provided showing Resident #425 was out with family on 5/6/18 and that she had a cardiology appointment on 5/9/18.

On 7/11/18 at 4:41 p.m., an interview was conducted with LPN #7, the LPN who worked on 5/13/18 and 5/26/18. When asked about the process staff follows for obtaining daily weights, LPN #7 stated that the CNAs obtain the weight and then report the weights to the nurse. LPN #7 stated that the weights are recorded on the MARS or TARS. When asked what blanks or holes meant on the MARS or TARS (treatment administration record) for daily weights, LPN #7 stated that the weights might have not been documented. When asked if she could recall why daily weights were not recorded for Resident #425 on 5/13/18 and 5/26/18, LPN #7 stated that she might not have documented. LPN #7 stated, "I can't remember." When asked if daily weights should be documented in the record, LPN #7 stated that daily weights should be documented. When asked why Resident #425 needed daily weights, LPN #7 stated that she was not sure and that she could not remember Resident #425. When asked how nursing would monitor daily weights and how they would know what Resident #425's weight was on the above dates, if there is nothing recorded in the clinical record, LPN #7 stated that they wouldn't know.

On 7/11/18 at 6:47 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the assistant administrator, ASM #3, the DON (Director of Nursing), ASM #4, the Regional Director of Clinical Services, and ASM #5, the Director of Clinical Education were all made aware of the above concerns. No further

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information was presented prior to exit.

The following is from Lippincott's Nursing Procedures 6th edition: "Documentation is the process of preparing a complete record of a patient's care and is a vital tool for communication among health care team members. Accurate, detailed charting shows extent and quality of the care nurse's provide, the outcomes of that care, and treatment and education that the patient still needs. Thorough, accurate documentation decreases the potential for miscommunication and errors."

2. The facility staff failed to document that the physician had been notified that the insulin was not administered for Resident #376.

Resident #376 was admitted to the facility on 7/2/18 with diagnoses that included but were not limited to: chronic lung disease, kidney failure, heart disease, congestive heart failure, diabetes, difficulty swallowing and high blood pressure.

The minimum data set (MDS) assessment was not completed at the time of the survey. Review of the nurse's admission assessment dated 7/2/18 documented, "1. Level of Consciousness: Alert X2 with confusion at times. 11. Respiratory F. Oxygen."

Review of the July 2018 physician's orders documented, "Insulin NPH (1) Inject 9 unit (sic) subcutaneously two times a day for DM (diabetes)...Start Date 07/03/2018."

Review of the July 2018 medication administration record documented, "Insulin NPH (1) Inject 9 unit (sic) subcutaneously two times a

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day for DM (diabetes)...Start Date 07/03/2018." On 7/3/18 at 7:30 a.m. and 6:30 p.m., there was a "19" and the nurse's initials. Review of the chart codes documented, "19=Other/See Nurse's Notes."

Review of the care plan initiated did not evidence documentation regarding physician notification.

Review of the nurse's notes dated 7/3/18 at 2:17 p.m. documented, "Insulin NPH (Human)...Inject 9 unit subcutaneously two times a day for DM ...Awaiting pharmacy to STAT over." There was no documentation that the physician had been notified that the insulin was not available to be administered.

Review of the nurse's notes dated 7/3/18 at 11:34 p.m. documented, "Insulin NPH (Human)...Inject 9 unit subcutaneously two times a day for DM...Arriving on second run." There was no documentation that the physician had been notified that the insulin was not available to be administered.

An interview was conducted on 7/12/18 at 7:43 a.m. with LPN (licensed practical nurse) #13. When asked how staff obtained medications, LPN #13 stated, "We get a pharmacy delivered at night and I look for al those meds (medications)." When asked what staff did if the medication was not sent, LPN #13 stated, "I do try to find it in the facility and if I do I let my relief know. I don't call the doctor that early, they generally come in early and then it's word of mouth." When asked if that was documented, LPN #13 did not respond.

An interview was conducted on 7/12/18 at 8:05 a.m. with LPN #14 the resident's nurse who

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documented the insulin was not given. When asked what process staff follows if a medication was not available, LPN #14 stated, "I call the pharmacy and I call the doctor to see what he wants us to do." When asked about the insulin for Resident #376's LPN #14 stated, "I know about that. I called the pharmacy." When asked if the physician had been notified, LPN #14 stated, "I always do." When asked if that was documented, LPN #14 stated, "Yes. If I didn't I just forgot to." When asked if it was expected to document that, the physician was notified, LPN #14 stated yes.

On 7/12/18 at 9:30 a.m. ASM (administrative staff member) #3, the director of nursing was made aware of the findings. When asked what nursing standard the facility used, ASM #3 stated, "Lippincott and our policies."

Review ;of the facility's policy titled, "DOCUMENTATION. Documentation is the process of preparing a complete record of a patient's care and is a vital tool for communication among health care team members. Accurate, detailed, charting shows the extent and quality of the care that nurses provide, the outcomes of that care, and treatment and education that the patient still needs. Thorough, accurate documentation decreases the potential for miscommunication and errors."

No further information was provided prior to exit.

1. NPH Insulin -- Insulin is a pancreatic hormone that plays an essential role in regulation of blood glucose as well as lipid and carbohydrate metabolism. Both natural and recombinant forms of insulin are used therapeutically to treat type 1 diabetes. While insulin itself is not hepatotoxic

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F 842	Continued From page 125 and has not been linked to serum enzyme elevations or instances of clinically apparent liver injury, high doses including overdoses of insulin and glucose can result in hepatic glycogenosis and serum aminotransferase elevations. This information was obtained from: https://livertox.nlm.nih.gov/Insulin.htm	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(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: §483.80(a)(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; §483.80(a)(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	F 880		8/13/18

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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 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.

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

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

§483.80(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

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F880: Infection Prevention & Control

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determined the facility staff failed to maintain infection control practices for two of 37 residents in the survey sample, Resident #108, #376 and #102.

1. The facility staff failed to handle medication in a sanitary manner for Resident #108.

2. The facility staff failed to follow contact precautions for C-Diff while interacting with Resident #102 in the resident's room.

The findings include:

1. Resident #108 was admitted to the facility on 6/7/18 and readmitted on 6/27/18 with diagnoses that included but were not limited to: back pain, kidney transplant, arthritis and high blood pressure.

The most recent minimum data set, a five day assessment, with an assessment reference date of 7/4/18 coded the resident as having scored a 15 out of 15 on the brief interview for mental status indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring staff assistance for all activities of daily living except for eating which the resident could perform after the tray was prepared.

Review of the July 2018 physician orders documented, "Tacrolimus (1) Tablet Extended Release 24 Hour 1 MG (milligram) Give 2 tablet (sic) by mouth two times a day for Kidney Transplant."

Review of the July 2018 medication administration record documented, "Tacrolimus

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1. Identified LPN#17 was educated immediately on proper handling of medications in sanitary manner. Resident #108 did not show any signs/ symptoms or adverse effect.

Identified OSM#4 was educated on proper infection control techniques to include contact precautions for c-diff and use of approved products for cleaning.

2. All residents receiving medications have the potential to be affected by handling of medications.

All residents on contact precautions have the potential to be affected by this deficient practice.

3. The DON or designee educated licensed nurses and physical therapists to policy titled Infection Control on contact precautions.

4. DON or designee to conduct quality monitoring to ensure staff is following Infection control practices: contact premedication: weekly for twelve weeks.

Findings to be reported to QAPI committee for 3 months and updated as indicated. Quality monitoring schedule based on findings

5. Date of Compliance: August 13, 2018

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Tablet Extended Release 24 Hour 1 MG Give 2 tablet by mouth two times a day for Kidney Transplant."

A medication administration observation was conducted on 7/11/18 at 8:40 a.m. with LPN (licensed practical nurse) #16. LPN #16 was preparing medications for Resident #108. LPN #16 took out the Tacrolimus pill package from the cart and when she popped out the pill it fell onto a piece of paper on the top of the medication cart. LPN #16 then picked up the pill with her bare fingers and put it into the medication cup. LPN #16 took the medication to Resident #108 and administered the medication.

An interview was conducted on 7/11/18 at 2:50 p.m. with LPN #16. When asked if it is appropriate to pick up medications off a surface with bare fingers and administer to a resident, LPN #16 stated, "Never." When asked why, LPN #16 stated, "Infection control." LPN #16 stated, "I know I shouldn't have done it."

On 7/11/18 at 6:45 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the assistant administrator and ASM #3, the director of nursing were made aware of the findings.

Review of the facility's policy titled, "General Dose Preparation and Medication Administration" documented, "Applicability This Policy 6.0 sets forth the procedures relating to general dose preparation and medication administration. Procedure. 3. Dose Preparation: Facility should take all measures required by facility policy and applicable law, including but not limited to the follow: 3.4 Facility staff should not touch the medication when opening a bottle or unit dose

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package. 3.5 If a medication which is not in a protective container is dropped, facility staff should discard it according to facility policy."

No further information was provided prior to exit.

1. Tacrolimus capsules are indicated for the prophylaxis of organ rejection in patients receiving allogeneic kidney transplants. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=45af3eda-caaa-4478-9372-95aa65adc9b3

2. The facility staff failed to follow contact precautions for C-Diff (1) while interacting with Resident #102 in the resident's room.

Resident #102 was admitted to the facility on 4/16/18 and readmitted on 6/20/18. Resident #102's diagnoses included but were not limited to urinary tract infection, high blood pressure and acute kidney failure. Resident #102's most recent MDS (minimum data set) assessment, an admission assessment with an ARD (assessment reference date) of 6/27/18, coded the resident as being cognitively intact.

Review of Resident #102's clinical record revealed a physician's note dated 7/7/18 that documented, "CC (Chief Complaint): Diarrhea, S/p (Status post) severe sepsis from C. diff colitis...The patient is very adamant that he is having severe diarrhea again. The patient is at high risk for colitis. He has had C. diff in the past. Plan is to recheck stools for C. diff and immediately start the patient on vancomycin (2)..."

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A physician's order form dated 7/7/18 documented orders to check Resident #102's stool for C. Diff toxin and Vancomycin 250 milligrams per five milliliters- 2.5 milliliters by mouth every six hours for 14 days.

Resident #102's care plan dated 6/21/18 documented, "At risk for infection R/T (related to) hx. (history) of C-diff...Isolation as ordered..." There was no specific physician's order for contact precautions.

On 7/10/18 at 10:20 a.m., Resident #102 was observed lying on the bed. Isolation gowns and gloves were observed in a storage device hanging on the room door. OSM (other staff member) #4 (an occupational therapist) was observed in the room wearing gloves but no gown. Resident #102 asked OSM #4 to remove his shoes. OSM #4 placed a clipboard on the resident's dresser and removed the resident's shoes.

On 7/10/18 at 2:41 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated Resident #102 was on isolation for C-diff. When asked what should be done before entering the resident's room, LPN #1 stated. "Put on gown and gloves." When asked if this surveyor could take any objects into the room, LPN #1 stated, "No. If you take anything, it has to go in the trash or stay in the room."

On 7/11/18 at 10:37 a.m., an interview was conducted with OSM #4 and OSM #2 (the rehabilitation director). OSM #4 was asked to describe the interactions she had with Resident #102 in the room during the previous day. OSM #4 stated she knocked on the room door, walked

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in the room, approached the resident and asked if he was ready. OSM #4 stated Resident #102 said he was tired, not feeling well and wanted to close his eyes. When asked if she removed Resident #102's shoes, OSM #4 stated the resident asked her to take his shoes off and cover his feet so she did. OSM #4 was made aware this surveyor observed her place a clipboard on Resident #102's dresser. OSM #4 was asked if she sanitized the clipboard before leaving the room. OSM #4 stated she sanitized the clipboard with the purple top sani wipes after she left the room. When asked if Resident #102 was on isolation, OSM #4 stated the resident was on isolation for C-diff. When asked what type of precautions should be followed, OSM #4 stated she wears a gown and gloves if she is taking the resident to the bathroom, bathing the resident or conducting any activity that involves fecal matter. OSM #4 was asked what precautions should be followed if removing the resident's shoes, OSM #4 stated gloves should be worn. When asked if a gown should also be worn, OSM #4 stated no.

On 7/11/18 at 4:49 p.m., an interview was conducted with ASM (administrative staff member) #3 (the director of nursing). ASM #3 stated the facility staff initiates isolation when C-diff is suspected. When asked if a clipboard should be taken into an isolation room, ASM #3 stated it is okay to take a clipboard in the room if one is going to hold the clipboard the entire time and not touch anything but typically, one should not take a clipboard in the room because you never know what you will bump or touch. ASM #3 stated if one does take a clipboard into the room, then the clipboard must be cleaned with specific bleach wipes that will kill the germ. When asked if the purple top sani wipes will kill the germ, ASM

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 132 #3 stated she would check. When asked what should be worn while going into an isolation room, ASM #3 stated one should wear gloves and a gown if they are going to touch the patient or touch any surfaces. On 7/11/18 at 5:12 p.m., ASM #3 stated the purple top sani wipes could not be used to clean items in a C-diff isolation room. On 7/11/18 at 6:55 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the assistant administrator), ASM #3 (the director of nursing), ASM #4 (the regional director of clinical services) and ASM #5 (the director of clinical education) were made aware of the above concern. The facility policy titled, "INFECTION CONTROL-TRANSMISSION BASED PRECAUTIONS" documented, "1. Contact Precautions- intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the patient or the patient's environment. Contact precautions also apply where the presence of excessive wound drainage, urine or fecal incontinence, or other discharges from the body suggest an increased potential for environmental contamination and risk of transmission. Personal Protective Equipment recommended: a. Gloves- whenever touching the resident's intact skin or surfaces and articles in close proximity to the resident. b. Gowns- whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the resident...d. Resident-Care equipment- use disposable non-critical equipment (thermometers, B/P (blood pressure) cuffs, stethoscope etc.) or implement	F 880		

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 07/12/2018

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F 880	Continued From page 133 resident-dedicated equipment. If common use of equipment is unavoidable, clean and disinfect equipment before use on another resident..." The CDC (Centers for Disease Control) documented, "III.B.1. Contact precautions. Contact Precautions are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the patient or the patient's environment as described in I.B.3.a...Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Donning PPE (personal protective equipment) upon room entry and discarding before exiting the patient room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination (e.g., C. difficile, noroviruses and other intestinal tract pathogens..." This information was obtained from the website: https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines.pdf The CDC further documented, "How can Clostridium difficile infection be prevented in hospitals and other healthcare settings? Use Contact Precautions: for patients with known or suspected Clostridium difficile infection: Use gloves when entering patients' rooms and during patient care. Use gowns when entering patients' rooms and during patient care. Dedicate or perform cleaning of any shared medical equipment. Ensure adequate cleaning and disinfection of environmental surfaces and reusable devices,	F 880		

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F 880	Continued From page 134	F 880		

especially items likely to be contaminated with feces and surfaces that are touched frequently. Consider using an Environmental Protection Agency (EPA)-registered disinfectant with a sporicidal claim for environmental surface disinfection after cleaning in accordance with label instructions; generic sources of hypochlorite (e.g., household chlorine bleach) also may be appropriately diluted and used. (Note: Standard EPA-registered hospital disinfectants are not effective against Clostridium difficile spores)..." This information was obtained from the website: https://www.cdc.gov/hai/organisms/cdiff/cdiff_faqs_hcp.html

The manufacturer's documentation on the container of the purple top sani wipes documented a list of bacteria and viruses that the wipes were effective against. C-diff was not on the list.

No further information was presented prior to exit.

(1) "Clostridium difficile (C. diff) is a bacterium that causes diarrhea and more serious intestinal conditions such as colitis. Symptoms include
o Watery diarrhea (at least three bowel movements per day for two or more days)
o Fever
o Loss of appetite
o Nausea
o Abdominal pain or tenderness
C. difficile is more common in people who need to take antibiotics for a long period of time. The elderly also have a higher risk of getting it. The infection can spread in hospitals and nursing homes." This information was obtained from the website:
https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-

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F 880	Continued From page 135 meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=c-diff&_ga=2.141934257.221670695.1531740484-139120270.1477942321 (2) Vancomycin is an antibiotic used to treat C-diff. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a604038.html	F 880		