DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/10/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495350		06/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL WISE	9434 COEBURN MOUNTAIN ROAD WISE, VA 24293

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 6/19/18 through 6/22/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No complaint(s) were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 6/19/18 through 06/22/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety survey/report will follow. The census in this 97 certified bed facility, the census was 89 at the time of the survey. The survey sample consisted of 18 current Resident reviews 3 closed record reviews	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550	**F550** **Corrective Action:** The Dietary Manager identified in the deficiency has had individual inservice training on resident rights and dignity including the proper procedure to ensure that privacy is maintained during the resident council meeting. **Identification of Deficient Practice(s) & Corrective Action(s):** All other residents may have potentially been affected. The Activities director will review the Resident Counsel Minutes for the previous 180 days to identify residents with concerns or complaints about privacy not being maintained during the resident council meeting.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: CBaker RN DON — TITLE — (X6) DATE: 7/16/18

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

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and staff interview, the facility staff failed to provide privacy in a manner that maintained or enhanced the dignity of the residents during a group meeting of the resident council. The findings included: During a group interview held on 6/20/18 at approximately 11:00 a.m., the facility staff failed to respect the resident's dignity, privacy, and individuality. The facility staff entered the area that the group meeting was held numerous times	F 550	Any/all concerns noted will be reviewed with the administrator for any corrective action that may be needed. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All staff will be inserviced by the DON, and/or Activities director on Resident Rights and Dignity to include the proper procedure to be maintained during all Resident Council meetings A staff member has been asked to attend the resident council meeting to supervise and ensure that resident privacy and dignity are maintained during the meeting. **Monitoring:** The Administrator is responsible for compliance. The Administrator and/or Activities Director will monitor the Resident Council Meeting to ensure that staff maintain the privacy and dignity of the meeting area. Any/all negative findings will be corrected immediately and disciplinary action will be taken as warranted. Aggregate findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice. **Completion Date: 8/6/18**	

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F 550	Continued From page 2 disturbing the group meeting. The group meeting was held in the dining area in the facility. This meeting was attended by twelve (12) residents of the facility. During this meeting, the dietary manager entered the facility dining area from the kitchen. The dietary manager proceeded to walk from the kitchen door to the location of the group speaking to the residents along the way. She returned to the kitchen and a resident from the resident council followed the dietary manager to the kitchen door and started talking with her. When that resident left, a second resident left the group and engaged in conversation with the dietary manager. At the back of the dining area, a group of approximately ten (10) residents entered the dining room and lined up waiting to exit the room and smoke. A staff member attended the resident council meeting. Prior to the meeting beginning, the group members stated it was ok for the staff member and a visitor to attend. The staff member did not attempt to re-direct the staff members who entered from the kitchen or the group of residents who entered from the back and who were waiting to go outside to smoke. The survey team met with the administrator, the director of nursing and the corporate registered nurse on 6/21/18 at 6:00 p.m. During this meeting, the administrative staff was notified of the above. The administrative staff stated the dietary manager didn't realize the resident council was meeting because there was no signage on the door to that effect. The administrative staff also stated the staff member attending the group	F 550		

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F 550	Continued From page 3 didn't know to say anything to the dietary manager when she came from the kitchen during the meeting. No further information was provided prior to the exit conference on 6/22/18.	F 550		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility document review, facility staff failed to ensure the resident was free from abuse for 1 of 18 residents in the final survey sample (Resident #65). Resident #65 was admitted to the facility on 11/23/16 with diagnoses including rhabdomyolysis, muscle weakness, contractures of muscles, hypertension, dysphagia, major depression, repeated falls, anxiety, cellulitis of lower leg, pain, and unspecified psychosis. On	F 600	**F600** **Corrective Action(s):** Resident #65 has been reassessed by their attending physician, Mental Health services and the Interdisciplinary Care planning team to establish interventions to be implemented to prevent Resident #65 from any further potential mishandling and/or potential abuse from staff. **Identification of Deficient Practice(s) & Corrective Action(s):** All residents maypotentially be affected. The last 120 days of Incident reports and resident council minutes will be reviewed by the administrator to identify any residents at risk. Any/all residents identified will immediately be investigated to determine if corrective action is required to prevent and protect residents from future verbal or physical abuse. Additionally, any/all negatives findings will be reviewed for proper reporting to required State Agencies and that proper interventions were put in place and the attending physician, and the responsible party will be notified. A facility incident&accident report will be completed for each negative finding.	

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F 600	Continued From page 4 the quarterly Minimum Data Set assessment with assessment reference date 8/19/17, the resident scored 15/15 on the brief interview for mental status and was assessed as without signs of delirium or psychosis. The resident was assessed as exhibiting verbal symptoms toward others and rejecting care 1-3 days in the previous 7 days. During survey preparation, surveyors noted a facility reported incident indicating the resident reported being mishandled and sexually abused by a facility employee on 8/8/17. The investigation report completed by the administrator documented an investigation conducted by the administrator and a charge nurse (whose name does not appear in the resident's care record) of an allegation that employees were taking residents' snacks. It did not mention investigating the allegation of sexual abuse. The surveyor was concerned that the investigation report did not address the allegation of sexual abuse. Clinical record review revealed no mention of the resident's allegation in physician's, nurse's, or social worker's progress notes. The resident did not appear to have received psychological support after the incident. During an interview on 6/20/18, the resident reported he no longer had an issue with the two staff members. The administrator and director of nursing employed the facility at the time of the report and investigation were no longer with the facility at the time of the survey. The surveyor interviewed staff caring for the resident on 6/20 and 6/21/18 and	F 600	**Systemic Change(s):** The facility Policy and Procedure for reporting and preventing resident abuse has been reviewed and no changes are warranted at this time. All staff members will be inserviced and given a copy of the policy and procedure by the Administrator and Social Services director. The inservices provided will include information on the procedure for reporting incidents of abuse, interventions and monitoring techniques for residents who are acting out physically, and notification to responsible party and attending physician per policy and procedure. **Monitoring:** The Administrator is responsible for maintaining compliance. Facility Incident/Accidents Reports will be reviewed daily/prn by the DON and Administrator and initialed as reviewed. The Risk management program will review all Incident & Accident reports weekly for proper monitoring and investigation. All negative findings from the meeting will be reported to the administrator for immediate investigation and disciplinary action as required. All findings from the risk meeting will be reported the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice. **Completion Date: 8/6/18**	

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F 600	Continued From page 5 was unable to locate anyone who was aware that the resident had alleged sexual abuse by staff in the past. The surveyor asked the facility administrator for any information available concerning the investigation. The administrator offered a letter from Wise County Department of Social Services dated 9/13/17 addressed to the facility administrator stating "The investigation has been completed and there is a preponderance of evidence that [Resident #65] is in need of protective services. Available and appropriate services will be offered." Because no employees involved in the report or investigation were available, the surveyor interviewed the Adult Protective Services (APS) investigator on 6/21/18. The investigator stated that the letter was the standard letter sent to faculties when allegations were substantiated by APS. The investigator reported that the employee to whom the resident reported the incident stated that the resident reported being sexually abused. The APS worker also stated that the resident made clear to APS and the police investigator that the actions of the employee accused of abuse were different from the actions of other staff providing personal care and gave specific details of the difference. The investigator stated that the investigator, the ombudsman, and the police officer met with the administrator on 9/8/17 to report that the employee could not be cleared of charges and that the resident was afraid of the employee. The administrator was also told that the substantiated abuse allegation would be reported to the Department of Health Professions for action. The investigator also offered the surveyor a copy of the letter sent to the employee at the facility, stating that the employee wanted the administrator to see it. The letter was dated	F 600		

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F 600	Continued From page 6 9/18/17 and stated "This is to notify you that you have been identified as an alleged perpetrator in an Adult Protective Services (APS) case that has been substantiated based on the enclosed information. [The employee] allegedly mishandled and sexually abused [Resident #65] during care." The letter continues to stated that APS cannot revoke a license issued by another entity, but is reporting the substantiated allegation for action. The surveyor checked the employee's license on the Department of Health Professions website. The license expired 3/31/18 with no additional public information available. A call to DHP revealed no additional information. Information about hearings is only available for 90 days after the hearing. The administrator reported during an interview on 6/21/18 that the employee worked at the facility until 4/30/18 and that resident and staff spoke well of him. Payroll records showed the employee did not work from 8/9/17 until returning to work on 9/9/17. The administrator stated that the employee was voluntarily terminated on 4/30/18, with the last day worked 3/31/18. The administrator stated that he did not know why the employee had not renewed the license. He also stated that the facility had been willing to move the employee to another role to remain employed at the facility. A surveyor interviewed the facility's human resources (HR) officer on 6/21/18. The officer stated that neither letter from APS had been forwarded to human resources. If either letter had been filed in HR, the employee would have been terminated.	F 600		

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F 600	Continued From page 7 The administrator and director of nursing were notified of the concern with the abuse prohibition process during a summary meeting on 6/21/18.	F 600		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced	F 604	**F604** **Corrective Action(s):** Resident #64 has been reassessed by nursing and a new accurate restraint assessment and consent form have been obtained for the use of the seat-belt in chair. Resident #64's care plan has been reviewed and revised to reflect current interventions related to the use of seat-belt while in chair. A Facility Incident & Accident form was completed for this incident. **Identification of Deficient Practice(s) & Corrective Action(s):** All other residents utilizing restraints may have been potentially affected. The facility conducted a 100% review of all residents currently utilizing restraints to identify other residents at risk. All residents identified at risk will be corrected at time of discovery. The results of this audit were reviewed by the Risk Management Committee to ensure proper diagnosis, accurate restraint assessment, medical necessity, consent for use and that the least restrictive appliance is being used.	

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F 604	Continued From page 8 by: Based on observation, family interview, staff interview, facility document review and clinical record review, the facility staff failed to ensure 1 of 18 residents (Resident #64) was free of a physical restraint. The findings included: The facility staff failed to ensure the restraint assessment completed 6/1/18 was accurate for Resident #64. The clinical record of Resident #64 was reviewed 6/19/18 through 6/22/18. Resident #64 was admitted to the facility 3/17/17 and readmitted 12/1/17 with diagnoses that included but not limited to unspecified dementia with behavioral disturbances, urinary tract infection, dysphagia, anxiety, cerebrovascular disease, major depressive disorder, hypertension, chronic obstructive pulmonary disease, abdominal aortic aneurysm without rupture, type 2 diabetes mellitus, hyperlipidemia, and hypothyroidism. Resident #64's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/31/18 assessed the resident with short-term memory problem, long-term memory problem, and severely impaired cognitive skills for daily decision-making. Section P restraints was coded for daily use of a trunk restraint. Current comprehensive care plan dated 6/1/18 included "Seatbelt to w/c (wheelchair) as ordered check q (every) 30 minutes and release q hour for 10 minutes to reposition." The June 2018 physician's orders read in part	F 604	**Systemic Change(s):** The facility Policy and Procedure for Restraints has been reviewed and no changes are warranted at this time. Licensed Nursing staff will be inserviced on obtaining consent for use of a restraint, the proper use of restraints and the need for supporting medical diagnosis /medical symptoms to justify the use of the restraints. The Risk Management Committee will review all restraints weekly to verify they have an appropriate medical diagnosis /symptom that warrant the use of the restraint and that consent has been obtained. The committee will also make recommendations to staff for restraint reductions and the least restrictive alternatives. This will be indicated on the risk management committee meeting minutes. **Monitoring:** The DON is responsible for compliance. Residents utilizing restraints will be reviewed weekly in risk management to monitor compliance. The audit findings at the Risk Management meeting will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 8/6/18**	

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F 604	Continued From page 9 "Seatbelt to wc for positioning and safety checks seatbelt q 30 minutes and release q hr (hour) x 10 minutes and reposition." The surveyor observed Resident #64 on 6/21/18 at 9:47 a.m. in the day room. Resident #64 was sitting in a wheelchair with the seatbelt attached. CNA (certified nursing assistant) #1 stated the resident was unable to release and the staff release q hour for 10 minutes. The surveyor reviewed the restraint assessment completed 6/1/18. The restraint assessment has been coded that Resident #64 does not receive antianxiety, antipsychotics or antidepressants. However, the resident received Mirtazapine 15 mg (milligrams) (an antidepressant) 5/31/18 at bedtime, Sertraline 75 mg at bedtime on 5/31/18 and Klonopin 0.5 mg (a benzodiazepine) twice a day on 5/31/18. The surveyor requested copies of the 6/1/18 restraint assessment, June 2018 physician orders and June 2018 MARs (medication administration records) from the ADON (assistant director of nursing) on 6/21/18 9:58 AM. The surveyor interviewed MDS #1 (minimum data set) on 6/21/18 10:26 AM regarding: restraint assessment completed 6/1/18. "I see what I did wrong about the meds and I checked no for #6 and then documented why he needed it." The surveyor informed the administrator, the director of nursing and the corporate registered nurse of the above concern on 6/21/18 at 6:00 p.m. and requested the facility policy on restraints.	F 604		

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F 604	Continued From page 10 The surveyor reviewed the facility policy titled "Restraint Utilization and Reduction" on 6/22/18. The policy read in part, "A detailed assessment must be completed to determine whether a restraint will treat the medical symptom (s). 7. The Restraint Need Assessment Form will also be completed with any significant change in condition assessments." No further information was provided prior to the exit conference on 6/22/18.	F 604		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and facility document review, facility staff failed to ensure the resident was free from abuse for 1 of 18 residents in the	F 610	**F610** **Corrective Action(s)** Resident #65's Allegation of mishandling and abuse FRI that was submitted to the OLC has been reviewed by current administrator and the outcome of the internal investigation was reviewed to ensure the initial allegations of mishandling and abuse were addressed and that the resident no longer had any further issues or concerns related to mishandling or abusive treatment from facility staff. **Identification of Deficient Practices & Corrective Action(s):** All residents may have been potentially affected. A 100% review of all Facility Incident and Accident Forms for the previous 120 days will be reviewed to identify residents at risk. Any/all negative findings of reportable occurrences identified will result in an internal investigation with appropriate notification of outcomes to the State agencies, attending physician and responsible parties.	

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F 610	Continued From page 11 final survey sample (Resident #65). Resident #65 was admitted to the facility on 11/23/16 with diagnoses including rhabdomyolysis, muscle weakness, contractures of muscles, hypertension, dysphagia, major depression, repeated falls, anxiety, cellulitis of lower leg, pain, and unspecified psychosis. On the quarterly Minimum Data Set assessment with assessment reference date 8/19/17, the resident scored 15/15 on the brief interview for mental status and was assessed as without signs of delirium or psychosis. The resident was assessed as exhibiting verbal symptoms toward others and rejecting care 1-3 days in the previous 7 days. During survey preparation, surveyors noted a facility reported incident indicating the resident reported being mishandled and sexually abused by a facility employee on 8/8/17. The investigation report completed by the administrator documented an investigation conducted by the administrator and a charge nurse (whose name does not appear in the resident's care record) of an allegation that employees were taking residents' snacks. It did not mention investigating the allegation of sexual abuse. The surveyor was concerned that the investigation report did not address the allegation of sexual abuse. Clinical record review revealed no mention of the resident's allegation in physician's, nurse's, or social worker's progress notes. The resident did not appear to have received psychological support after the incident. During an interview on 6/20/18, the resident	F 610	**Systemic Change(s):** The facility Policy and Procedure for resident abuse/neglect has been reviewed and no changes are warranted at this time. All staff will be inserviced by social services and/or Administrator on the facility policy and procedures regarding reporting and investigating incidents of abuse, neglect, injuries of unknown origin, and unusual occurrences. The administrator and/or DON are responsible for completing internal investigations of all reported incidents of actual or potential neglect, abuse, complaints and unusual occurrences. The Administrator will review all findings, verify the report, and make the appropriate notification to the State agencies. **Monitoring:** The Administrator is responsible for maintaining compliance. Facility Incident/Accidents Reports will be reviewed daily/prn by the DON and Administrator and initialed as reviewed. The Risk management program will review all Incident & Accident reports weekly for proper monitoring and investigation. All negative findings from the meeting will be reported to the administrator for immediate investigation and disciplinary action as required. All findings from the risk meeting will be reported the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice. **Completion Date: 8/6/18**	

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F 610	Continued From page 12 reported he no longer had an issue with the two staff members. The administrator and director of nursing employed the facility at the time of the report and investigation were no longer with the facility at the time of the survey. The surveyor interviewed staff caring for the resident on 6/20 and 6/21/18 and was unable to locate anyone who was aware that the resident had alleged sexual abuse by staff in the past. The surveyor asked the facility administrator for any information available concerning the investigation. The administrator offered a letter from Wise County Department of Social Services dated 9/13/17 addressed to the facility administrator stating "The investigation has been completed and there is a preponderance of evidence that [Resident #65] is in need of protective services. Available and appropriate services will be offered." Because no employees involved in the report or investigation were available, the surveyor interviewed the Adult Protective Services (APS) investigator on 6/21/18. The investigator stated that the letter was the standard letter sent to faculties when allegations were substantiated by APS. The investigator reported that the employee to whom the resident reported the incident stated that the resident reported being sexually abused. The APS worker also stated that the resident made clear to APS and the police investigator that the actions of the employee accused of abuse were different from the actions of other staff providing personal care and gave specific details of the difference. The investigator stated that the investigator, the ombudsman, and the police officer met with the administrator on 9/8/17 to report that the employee could not be cleared	F 610		

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F 610	Continued From page 13	F 610		

of charges and that the resident was afraid of the employee. The administrator was also told that the substantiated abuse allegation would be reported to the Department of Health Professions for action. The investigator also offered the surveyor a copy of the letter sent to the employee at the facility, stating that the employee wanted the administrator to see it. The letter was dated 9/18/17 and stated "This is to notify you that you have been identified as an alleged perpetrator in an Adult Protective Services (APS) case that has been substantiated based on the enclosed information. [The employee] allegedly mishandled and sexually abused [Resident #65] during care." The letter continues to stated that APS cannot revoke a license issued by another entity, but is reporting the substantiated allegation for action.

The surveyor checked the employee's license on the Department of Health Professions website. The license expired 3/31/18 with no additional public information available. A call to DHP revealed that no additional information. Information about hearings is only available for 90 days after the hearing.

The administrator reported during an interview on 6/21/18 that the employee worked at the facility until 4/30/18 and that resident and staff spoke well of him. Payroll records showed the employee did not work from 8/9/17 until returning to work on 9/9/17. The administrator stated that the employee was voluntarily terminated on 4/30/18, with the last day worked 3/31/18. The administrator stated that he did not know why the employee had not renewed the license. He also stated that the facility had been willing to move the employee to another role to remain employed

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F 610	Continued From page 14 at the facility. A surveyor interviewed the facility's human resources (HR) officer on 6/21/18. The officer stated that neither letter from APS had been forwarded to human resources. If either letter had been filed in HR, the employee would have been terminated. Abuse prohibition policies provided to the surveyor during the survey, Reporting Resident Abuse page 1, Resident Rights Preventing Resident Abuse page 1, Abuse Definitions page 1, did not address action to be taken if allegations of abuse were substantiated. The administrator and director of nursing were notified that surveyors had determined that allegations of sexual abuse were not thoroughly investigated and that appropriate action was not taken in response to verified allegations during a summary meeting on 6/21/18.	F 610		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to complete an accurate Minimum Data Set (MDS) for 2 of 18 residents in the survey sample (Resident #71 and #81). The findings included:	F 641	**F641** **Corrective Action(s):** Resident #71 has had their most recent MDS assessment modified to accurately code section O to reflect that Hospice Care is in place and that Dialysis is not. A facility Incident & Accident form was completed for this incident.	

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F 641	Continued From page 15 1. The facility staff failed to code Hospice Care on the admission MDS with ARD (Assessment Reference Date) of 6/6/18 for Resident #71. Resident #71 was admitted to the facility on 6/1/18 with the following diagnoses of, but not limited to coronary artery disease, high blood pressure, End Stage Renal Disease, diabetes, anxiety disorder and Chronic Obstructive Pulmonary Disease. On the admission MDS with ARD of 6/6/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. Resident #71 was also coded as requiring limited assistance of 1 staff member for dressing, personal care and bathing. The surveyor conducted a clinical record review for Resident #71 on 6/22/18 at 9:00 am. The surveyor noted on the MDS with ARD of 6/6/18, under Section O, Special Treatments, Procedures and Programs, the resident was not coded for Hospice but was coded for Dialysis. At 9:28 am, the surveyor notified LPN (Licensed Practical Nurse) #2 of the above findings. LPN #2 stated that she would look into this and get the MDS nurse to come and speak to the surveyor. At 9:30 am, LPN #1 came into the conference room and the surveyor notified her of the above documented fiindings on the MDS. LPN #1 stated, "Let me go and make a correction on this. Dialysis was accidentally marked and it should have been Hospice." No further informatin was provided to the surveyor prior to the exit conference on 6/22/18.	F 641	Resident #81 has had their most recent MDS modified to accurately code sections I for an active diagnosis of Schizophrenia.Resident #81's comprehensive care plan has been reviewed and revised to include the diagnosis of Schizophrenia. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents may have potentially been affected. A 100% audit of all residents current MDS assessments will be completed by the MDS Coordinator and/or designee to ensure that sections I & O of the MDS are coded correctly. All negative findings will be reported to the MDS department for immediate correction. A Modification will be completed for each discrepancy identifiedon the most current MDS.	

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F 641	Continued From page 16 2. For Resident #81, the minimum data set assessment did not include a serious mental illness for which the resident was receiving treatment in the diagnosis list. Resident #81 was admitted to the facility on 9/12/17. Diagnoses included schizophrenia, unspecified psychosis, femur fracture, atrial fibrillation, primary hypertension, type 2 diabetes mellitus, and depression. On the quarterly minimum data set assessment with assessment reference date 6/12/18, the resident scored 8/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting others. The quarterly minimum data set assessment with assessment reference date 6/12/18 did not include schizophrenia in the diagnosis list. The resident was chosen for unnecessary medication review for receiving antipsychotic medication without a diagnosis. Upon clinical record review, the surveyor discovered that the resident had a diagnosis of schizophrenia. The resident had an order dated 9/29/17 for thioridazine 50 mg (milligram) 1 PO (by mouth) AM (every morning) for diagnosis of schizophrenia. A physician note written 5/18/18 rejected a dose reduction of the thioridazine because the resident has schizophrenia with psychosis and was stable under the current dose. The administrator and director of nursing were notified that the minimum data set assessment was inaccurate during a summary meeting on 6/22/18. (Cross reference to F644)	F 641	**Systemic Change(s):** The Resident Interdisciplinary Care Teamhave been inserviced by the Regional Nurse consultant on the proper assessment and coding of all sections of the MDS. All comprehensive MDS's and quarterly MDS's will now be reviewed each week according to the MDS schedule by the RCC and/or DON to ensure the accuracy and integrity of resident data. **Monitoring:** The DON and RCC are responsible for monitoring compliance. The MDS assessment audit will be completed weekly coinciding with the MDS calendar to monitor for compliance. All negative findings from the audits will be reported to the DON and RCC at the time of discovery for immediate correction. Aggregate findings will be reported to the Quality Assurance Committee monthly for review, analysis, andrecommendations for change in facility policy, procedure, and/or practice. **Completion Date**: 8/6/18	

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F 644	Continued From page 17	F 644		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to fully complete the PASSAR (Screening for Mental Illness, Mental Retardation/Intellectual Disability, or Related Conditions) for 1 of 18 residents in the final survey sample (Resident #81). Resident #81 was admitted to the facility on 9/12/17. Diagnoses included schizophrenia, unspecified psychosis, femur fracture, atrial fibrillation, primary hypertension, type 2 diabetes mellitus, and depression. On the quarterly minimum data set assessment with assessment reference date 6/12/18, the resident scored 8/15 on the brief interview fro mental status and was	F 644	**F644** **Corrective Action(s):** Resident #81 has been rescreened by the local mental provider and a new PASAAR screening form was completed accurately and completely to reflect her current active diagnosis of schizophrenia and her current level of care needs meet nursing facility placement. A facility Incident and accident form was completed for this incident. **Identification of Deficient Practice(s) &Corrective Action(s):** All other residents with a diagnosis of Mental Retardation and/or Mental Illness may have been affected. A 100% audit of all residents with a diagnosis of Mental Illness/Mental Retardation will be completed to identify residents at risk for inaccurate PASAAR assessments. Any/all negative findings were corrected at time of discovery. An Incident & Accident form will be completed for all negative findings.	

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F 644	Continued From page 18 assessed as without signs of delirium, psychosis, or behaviors affecting others. The quarterly minimum data set assessment with assessment reference date 6/12/18 did not include schizophrenia in the diagnosis list. The resident was chosen for unnecessary medication review for receiving antipsychotic medication without a diagnosis. Upon clinical record review, the surveyor discovered that the resident had a diagnosis of schizophrenia. The resident had an order dated 9/29/17 for thioridazine 50 mg (milligram) 1 PO (by mouth) AM (every morning) for diagnosis of schizophrenia. A physician note written 5/18/18 rejected a dose reduction of the thioridazine because the resident has schizophrenia with psychosis and was stable under the current dose. The resident's Screening for Mental Illness, Mental Retardation/Intellectual Disability, or Related Conditions section 2 was checked "no" for serious mental illness. 2a, 2b, and 2c which determine whether the resident has serious mental illness were not answered. The answer to 2a should have been "yes" (schizophrenia is listed on the form as an example of a 'yes' answer). The administrator and director of nursing were notified of the concern during a summary meeting on 6/22/18.	F 644	**Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. The administrator will inservice the Social Service worker and Admissions coordinator on the regulation and procedure for screening all MR/MI residents prior to admission and re-screening when there has been a change in the resident's condition or behavior after admission to the facility. **Corrective Action:** The Social service department is responsible for maintaining compliance. Routine review of these residents will be conducted coinciding with the MDS/Care plan schedule to monitor for changes in behavior that require re-screening from the local mental health provider. Findings will be reported to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 8/6/18**	
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	F 684		

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F 684	Continued From page 19 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 staff interview and clinical record review, the facility staff failed to follow the physician orders for weekly weights beginning 5/14/18 for Resident #59. The findings included: The facility staff failed to obtain weekly weights as ordered by the physician for Resident #59. The clinical record of Resident #59 was reviewed 6/19/18 through 6/22/18. Resident #59 was admitted to the facility 4/6/18 and readmitted 5/8/18 with diagnoses that included but not limited to protein caloric malnutrition, urinary tract infection, dry eye syndrome, hyperlipidemia, hypothyroidism, Parkinson's disease, hip fracture, gastroesophageal reflux disease, constipation, benign prostatic hypertrophy, constipation, chronic pain, hypertension, acute bronchitis, and chronic obstructive pulmonary disease. Resident #59's 30-day minimum data set (MDS) with an assessment reference date (ARD) of 6/5/18 assessed the resident with a cognitive summary of 6/15. Section K weight was recorded as 140 pounds. Resident #59's current comprehensive care plan dated 5/16/18 identified the problem onset of nutrition/dehydration on 5/16/18. Approaches	F 684	**F684** **Corrective Action(s):** Residents #59's attending physician was notified that the facility failed to obtain weekly weights as ordered by the attending physician. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** All other residents with physician ordered weekly weights may have been potentially affected. The DON and/or Unit Manager will conduct a 100% audit of all resident's physician orders and MAR's to identify resident at risk. Residents identified at risk will be corrected at time of discovery and their comprehensive plans of care updated to reflect their resident specific needs. The attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding.	

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F 684	Continued From page 20 included weights as ordered. A physician order dated 5/14/18 read "Weekly weight monitoring-dx (diagnosis) hx (history) of wt (weight) loss & Marinol on med (medication) regimen." The nurse practitioner signed the order on 5/14/18. The surveyor reviewed the electronic weight record from admission through June 2018. There were no recorded weights in the weight record. The surveyor located one weight obtained on 4/6/18 in the progress note, which was 158 pounds. A second weight of 140.2 pounds was obtained 5/9/18 and recorded in the progress note. The surveyor reviewed the paper "Resident Weight Record". There were two (2) recorded weights for April 2018 but none for May 2018 or June 2018. The surveyor was unable to locate any weekly weights from 5/14/18 through June 2018. The surveyor informed the assistant director of nursing of the above concern on 6/21/18 at 1:15 p.m. The ADON stated the nurse who entered the order for weekly weights was called and the facility was waiting a call back. The ADON informed the surveyor 6/21/18 that the nurse who entered the physician order into the computer to start weekly weights on 6/28/18 did not know why she entered the order that way. The ADON stated the weekly weights were not obtained. The surveyor informed the administrator, the director of nursing and the corporate registered nurse of the above concern during the end of the day meeting on 6/21/18 at 6:00 p.m.	F 684	**Systemic Change(s):** The facility policy and procedures have been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hour Report and documentation in the medical record /physician orders remains the source document for the development and monitoring of the provision of care, which includes, obtaining, transcribing and completing physician orders, medication orders, treatment orders. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders. This includes obtaining weekly weights per MD orders. **Monitoring:** The DON will be responsible for maintaining compliance. The DONand/or Unit Managers will perform weekly chart audits coinciding with the care plan calendar to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 8/6/18**	

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F 684	Continued From page 21 No further information was provided prior to the exit conference on 6/22/18.	F 684		
F 757 SS=E	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, the facility staff failed to ensure 2 of 18 residents was free of an unnecessary medication (Resident #60 and Resident #64). The facility staff failed to follow the physician ordered parameters of diabetic management.	F 757	**F757** **Corrective Action(s):** Resident #60's attending physician has been notified that the facility failed to notify the physician of blood sugars greater than 400 per diabetic parameters and per physician order. A facility Medication error form was completed for each incident. Resident #64's attending physician has been notified that the facility failed to recheck the residents blood sugar in 2 hours after a blood sugar reading of 400 or greater per diabetic parameters and per physician order. A facility Medication error form was completed for each incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents receiving Physician ordered Insulin may have potentially been affected. A 100% review of all residents with insulin orders will be conducted by DON and/or designee to identify residents at risk. All residents identified at risk will be corrected at time of discovery and appropriate disciplinary action taken. An Incident and Accident form will be completed for each negative finding.	

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F 757	Continued From page 22 The findings included: 1. The facility staff failed to follow the physician ordered diabetic parameters for sliding scale insulin for Resident #60. The clinical record of Resident #60 was reviewed 6/19/18 through 6/22/18. Resident #60 was admitted to the facility 12/24/12 and readmitted 5/5/18 with diagnoses that included but not limited to type 2 diabetes mellitus, unspecified dementia without behavioral disturbances, atrial fibrillation, acute prostatitis, edema, gastroesophageal reflux disease, hypertension, pain, glaucoma, benign prostatic hypertrophy, acute conjunctivitis, Vitamin D deficiency, major depressive disorder, obstructive and reflux uropathy, and urinary tract infection. Resident #60's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/30/18 assessed the resident with a BIMS (brief interview for mental status) as 11/15. The surveyor reviewed the April 2018 physician orders. The order read "Novolog 100 units/ml (milliliter) Flexpen Accuchecks ac/hs (before meals and at bedtime) with SSI (sliding scale insulin) < (less than) 60 or > 400 notify MD (medical doctor); 180-220-3U (units); 221-260-6U; 261-300-9 U; 301-340-12 U; 341-400-15 U; 401 or greater 17 U DM (diabetes mellitus) Generic: Insulin Aspart." The surveyor reviewed the April 2018 electronic medication administration records (eMARs). The 7:30 a.m. blood sugars were reviewed. Of the 30 days in April, the following days had a	F 757	**Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All Licensed staff will be inserviced on the facility policy and procedure by the DON regarding the administration of medications per physician orders to include the proper administration of insulin to include administering sliding scale insulin as ordered by the physician and following all blood sugar parameters as ordered by the physician. **Monitoring:** The Director of Nursing is responsible for maintaining compliance. The DON and/or designee will do weekly MAR audits to monitor for compliance. Any negative findings will be addressed at the time of discovery and appropriate disciplinary action taken. Detailed findings of these results will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 8/6/18**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495350		06/22/2018

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F 757	Continued From page 23 blood sugar (BS) greater than 400 and there was no notification to the MD: 4/1/18 (BS 420), 4/6/18 (BS 421), 4/20/18 (BS 448), 4/21/18 (BS 448), 4/27/18 (BS 442) and 4/29/18 (BS 515). The 11:30 a.m. blood sugars were reviewed. Of the 30 days in April, the following days had a blood sugar greater than 400 and there was no MD notification: 4/8/18 (BS 459), 4/9/18 (BS 481), 4/11/18 (BS 424), 4/13/18 (BS 540), 4/14/18 (BS 552), 4/20/18 (BS 466), and 4/22/18 (BS 585). The 4:30 p.m. blood sugars were reviewed. Of the 30 days in April, the following blood sugars were greater than 400 and there was no MD notification: 4/2/18 (BS 429), 4/3/18 (BS 413), 4/8/18 (BS 403), 4/9/18 (BS 462), 4/12/18 (BS 461), 4/13/18 (BS 484), 4/14/18 (BS 427), 4/15/18 (BS 484), 4/18/18 (BS 422), 4/19/18 (BS 434), 4/22/18 (BS 482), 4/23/18 (BS 432), 4/24/18 (BS 447), 4/26/18 (BS 485), 4/28/18 (BS 404) and 4/30/18 (BS 448). The 8:30 p.m. blood sugars were reviewed. Of the 30 days in April, the following days had blood sugars greater than 400: 4/2/18 (BS 418), 4/3/18 (BS 488), 4/4/18 (BS 461), 4/10/18 (BS 440), 4/11/18 (BS 488), 4/13/18 (BS 438), 4/15/18 (BS 451), 4/23/18 (BS 440), 4/24/18 (BS 530), 4/28/18 (BS 444), and 4/30/18 (BS 439). The surveyor reviewed the April 2018 departmental notes and found no evidence the physician had been notified when the blood sugars were greater than 400. The surveyor reviewed the detailed notes after the April 2018 eMARs and found no evidence that the physician had been informed of blood sugars greater than 400.	F 757		

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F 757	Continued From page 24 The surveyor informed the administrator, the director of nursing and the corporate registered nurse of the above concern during an end of the day meeting on 6/21/18 at 5:56 p.m. The surveyor requested the facility policy on diabetes management. The surveyor reviewed the facility policy titled "Diabetes-Clinical Protocol" on 6/22/18. The policy read in part "4. The Physician will order desired parameters for monitoring and reporting information related to diabetes or blood sugar management. a. The staff will incorporate such parameters into the Medication Administration Record and care plan." No further information was provided prior to the exit conference on 6/22/18. 2. The facility staff failed to follow the physician ordered diabetic parameters for sliding scale insulin for Resident #64. The clinical record of Resident #64 was reviewed 6/19/18 through 6/22/18. Resident #64 was admitted to the facility 3/17/17 and readmitted 12/1/17 with diagnoses that included but not limited to unspecified dementia with behavioral disturbances, urinary tract infection, dysphagia, anxiety, cerebrovascular disease, major depressive disorder, hypertension, chronic obstructive pulmonary disease, abdominal aortic aneurysm without rupture, type 2 diabetes mellitus, hyperlipidemia, and hypothyroidism. Resident #64's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/31/18 assessed the	F 757		

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F 757	Continued From page 25 resident with short-term memory problem, long-term memory problem, and severely impaired cognitive skills for daily decision-making. The current comprehensive care plan with problem onset dated 6/1/18 read "Nutrition/Dehydration/Fluid maintenance. Approaches: FS (fingerstick) and insulin as ordered. Monitor for s/s (signs/symptoms) of hyper/hypoglycemia." The April 2018-June 2018 physicians orders read in part "Novolog 100 units/ml (milliliter) Flexpen SS#1 (sliding scale insulin #1) AC & HS (before meals and at bedtime). 180-220-2U (units); 221-260-4U; 261-300-6U; 301-340-8U; 341-400-10 U; > (greater than) 400 12 u recheck in 2 hrs if remains above 400 notify MD (medical doctor)." The surveyor reviewed the April 2018 electronic medication administration records. The blood sugar (BS) on 4/13/18 at 8:30 p.m. 421. The surveyor reviewed the progress notes but was unable to locate where the blood sugar was rechecked. The blood sugar (BS) on 5/17/18 at 8:30 p.m. was 536. The surveyor was unable to find documentation of the blood sugar recheck. The blood sugar (BS) on 5/24/18 at 4:30 p.m. was 454. The surveyor was unable to locate the blood sugar recheck. The blood sugar (BS) on 6/15/18 at 4:30 p.m. was 403. The surveyor was unable to locate the blood sugar recheck.	F 757		

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F 757	Continued From page 26 The blood sugar (BS) on 6/17/18 at 6:00 a.m. was 409. The surveyor was unable to locate the blood sugar recheck. The blood sugar (BS) on 6/17/18 11:30 a.m. was 435. The surveyor was unable to locate where the blood sugar had been rechecked. The surveyor informed the assistant director of nursing of the above concerns on 6/21/18 at 9:29 a.m. and requested the April 2018, May 2018, and June 2018 departmental notes and the detailed notes for the April 2018 MAR, May 2018 MAR and June 2018 MAR. The surveyor informed the administrator, the director of nursing and the corporate registered nurse of the above concerns in the end of the day meeting on 6/21/18 at 5:56 p.m. The diabetes management policy was requested. The surveyor reviewed the facility policy titled "Diabetes-Clinical Protocol" on 6/22/18. The policy read in part "4. The Physician will order desired parameters for monitoring and reporting information related to diabetes or blood sugar management. a. The staff will incorporate such parameters into the Medication Administration Record and care plan." No further information was provided prior to the exit conference on 6/22/18.	F 757		
F 761 SS=D	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	F 761		

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F 761	Continued From page 27 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 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to date medications after being opened and failed to discard an expired insulin on 3 of 4 medication carts in the facility (Hallway #1, Hallway #2, and Unit #2). The findings included: The facility staff failed to date insulin after being opened and failed to discard insulin after the expiration date on the medication carts for Hallway #1, Hallway #2 and Unit #2) On 6/19/19 at 4:35 pm, the surveyor inspected the medication cart on Hallway #1 with LPN (Licensed Practical Nurse) #3. The surveyor	F 761	**F761** **Corrective Action(s):** The insulin bottles with no open date on them and all expired insulin Flex pens identified during the medication cart reviews of Hallway #1 medication cart, Hallway #2 medication cart and Unit 2 Medication cart have been removed and discarded. All new insulin vials and Flex pens were obtained and properly dated when opened and put into use. A Facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other unit medication rooms, medication refrigerators used for the storage medications and all medication carts may have been potentially affected. The DON and/or designee will conduct a 100% review of the medication rooms, medication refrigerators and medication carts to identify any undated, expired or unlabeled medications, equipment or biologicals. Any/all negative findings will be corrected at time of discovery. A Facility Incident and Accident Form will be completed for each incident identified.	

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F 761	Continued From page 28 noted the following: Novalog insulin 100 units/1 ml had no open date on the label. There was a "Date Open" tag on the insulin but it was left blank by staff. Novalog FlexPen #1 had an open date tag on it which read "5/20/18". LPN #3 stated, "Oh, that is beyond the 28 days. I will have to reorder that." Novalog FlexPen #2 did not have an open date on the insulin. However, there was a label on it which read, "Discard after 28 days". At 4:49 pm, the surveyor noted the following on Hallway #2 medication cart. LPN #4 was with the surveyor when these observations were made. Novalog insulin 100 units/1 ml had an opened date of 5/18/18 on the label. LPN #3 stated, "It should had been taken off the cart and not used." Levemir FlexPen 100 units/1 ml had an opened date of 5/22/18 on the label. LPN #3 stated, "That was out of date yesterday." At 5:02 pm, the surveyor and LPN #5 inspected the medication cart for rooms 201 through 209 on Unit #2 and the following obeservations were made. Humalin R 100 units/1 ml did not have an opened date on the vial or on the box in which it was stored. LPN #5 stated, "I'll get another one out of the refrigerator and throw this one away." At 5:20 pm, the surveyor notified the corporate nurse and the director of nursing of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 6/22/18.	F 761	**Systemic Change(s):** Facility policy and procedure for medication and biological storage have been reviewed and no changes are warranted at this time. All licensed nurses will be inserviced by the DON on the facility policy and procedure for storing medications and biologicals. The nursing staff will also be inserviced on the Medication Administration Policy and Procedure to include weekly inspection of all medication carts, medication rooms and medication refrigerators to remove and discard all undated and expired mediations. **Monitoring:** The DON is responsible for maintaining compliance. The DON and/or unit manager will perform weekly Medication room and medication cart audits to monitor for compliance. All discrepancies found in these audits will be corrected at the time of discovery and disciplinary action taken as appropriate. Results of these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 8/6/18**	
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.	F 842		

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F 842	Continued From page 29 (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, 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.	F 842	**F842** **Corrective Action(s):** Resident #60'sattending physician has been notified that the facility failed to accurately transcribe physician ordered accuchecks sliding scale insulin orders. A facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents receiving physician ordered sliding scale insulin may have potentially been affected. A 100% review of all resident Medical Records will be conducted by the DON, Unit Manager and/or designee to identify residents at risk. All negative findings will be clarified and/or correct as applicable at time of discovery. A facility Incident & Accident form will be completed for each negative finding.	

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F 842	Continued From page 30 §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 and clinical record review, the facility staff failed to ensure an accurate and complete clinical record for 1 of 33 residents (Resident #60). The findings included: The facility staff failed to ensure the physician orders for sliding scale insulin #2 were accurate for Resident #60. The clinical record of Resident #60 was reviewed 6/19/18 through 6/22/18. Resident #60 was	F 842	**Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff will be inserviced by the Regional Nurse Consultant or DON on the clinical documentation standards per facility policy and procedure. This training will include the standards for maintaining accurate medical records and clinical documentation to include Physician Orders, MAR's, TAR's and departmental notes according to the acceptable professional standards and practices. **Monitoring:** The DON and Medical Records director are responsible for maintaining compliance. The DON, ADON and/or designee will conduct weekly chart audits coinciding with the Care Plan schedule to monitor for compliance. Any/all negative findings will be clarified and corrected at time of discovery and disciplinary action will be taken as needed. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 8/6/18**	

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F 842	Continued From page 31 admitted to the facility 12/24/12 and readmitted 5/5/18 with diagnoses that included but not limited to type 2 diabetes mellitus, unspecified dementia without behavioral disturbances, atrial fibrillation, acute prostatitis, edema, gastroesophageal reflux disease, hypertension, pain, glaucoma, benign prostatic hypertrophy, acute conjunctivitis, Vitamin D deficiency, major depressive disorder, obstructive and reflux uropathy, and urinary tract infection. Resident #60's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/30/18 assessed the resident with a BIMS (brief interview for mental status) as 11/15. The May 2018 physician orders were reviewed. On 5/7/18, a physician order for Novolog sliding scale insulin read "Novolog 100 unit/ml (milliliter) vial Accuchecks with SSI #2 AC &HS (before meals and at bedtime) 0-59 Notify MD (medical doctor); 180-220: 2 units; 261-300: 6 units; 301-340: 8 units; 341-400: 10 units; 401-999: 12 units If > (greater than) 400 recheck in 2 hours and notify MD if still > 400 Generic: Insulin Aspart." While the surveyor was comparing the physician's orders to the blood sugars obtained and the sliding scale administered for May 2018 and June 2018, the surveyor noted that the amount of sliding scale insulin documented as given did not match the amount of sliding scale insulin the physician had ordered for Sliding Scale Insulin #2. The surveyor informed the corporate registered nurse of the above concern on 6/20/18 at 4:18 PM. After researching the identified concern, the	F 842		

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F 842	Continued From page 32 corporate registered nurse stated the sliding scale insulin unit amounts entered on the electronic medication administration records were unit amounts for sliding scale insulin #1 and not SSI #2. The corporate registered nurse stated if one compared the blood sugar and the amount of sliding scale insulin documented, the amount of insulin was for sliding scale insulin #2, which is what was ordered. The corporate registered nurse stated the nurse who entered the sliding scale insulin entered the data incorrectly-sliding scale insulin #1 was entered and shows up on the eMAR but from the nurse's computers, sliding scale insulin #2's units are on the screen. The corporate registered nurse provided the surveyor with the protocol for Subcutaneous Sliding Scale Insulin #1, #2, and #3. The Protocol for Sliding Scale Insulin #1 was as follows: 180-220=2 units; 221-260-4 units; 261-300=6 units; 301-340=8 units; 341-400=10 units; Greater than 400=12 units. Sliding Scale Insulin #1 was entered as SSI #2 on both the May2018 and June 2018 eMARs. The surveyor informed the administrator, the director of nursing and the corporate registered nurse of the above concern in the end of the day meeting on 6/21/18 at 5:56 p.m. No further information was provided to the surveyor prior to the exit conference on 6/22/18.	F 842		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following:	F 849		

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F 849	Continued From page 33 (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following:	F 849	**F849** **Corrective Action(s):** Resident #71's attending physicians have been notified that the facility failed to ensure and coordinate with the Hospice organization that the Hospice plan of care and the Hospice Care plan were in the resident medical record. A Facility Incident/Accident form has been completed for each incident. Resident #71's Hospice Plan of Care has been placed in the resident's clinical record. **Identification of Deficient Practice(s) & Corrective Action(s):** All other residents with Hospice Services may have potentially been affected. A 100% audit of residents receiving Hospice Services will be completed by DON and/or designee to identify residents at risk. All negative findings will be corrected at the time of discovery. A Risk Management Incident & Accident form will be completed and proper notification made to the resident's attending physician. **Systemic Changes:** The facility policy and procedure has been reviewed and no changes are warranted at this time. All Licensed staff will be inserviced by the Administrator and Hospice Director on the policy and procedure for coordinating care and services with the Hospice Agency for all residents receiving Hospice Services.	

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	495350		06/22/2018

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F 849	Continued From page 34 (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.	F 849	**Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON and/or Unit Managers will review all physician Hospice orders to ensure that the facility has a coordinated Hospice Care Plan for all residents receiving Hospice Services. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 8/6/18**	

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F 849	Continued From page 35 (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's	F 849		

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F 849	Continued From page 36 attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to coordinate hospice services for 1 of 18	F 849		

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F 849	Continued From page 37 residents in the survey sample (Resident #71). The findings included: The facility staf failed to ensure that the hospice Plan of Care and care plan could be found in the clinical record for Resident #71. Resident #71 was admitted to the facility on 6/1/18 with the following diagnoses of, but not limited to coronary artery disease, high blood pressure, End Stage Renal Disease, diabetes, anxiety disorder and Chronic Obstructive Pulmonary Disease. On the admission MDS with ARD of 6/6/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. Resident #71 was also coded as requiring limited assistance of 1 staff member for dressing, personal care and bathing. The surveyor conducted a clinical record review on 6/20/18 at 3 pm. It was noted by the surveyor that there was no documentation of the hospice Plan of Care or care plan in the clinical record. At 3:53 pm, the surveyor notified LPN (Licensed Practical Nurse) #2 of the above findings. LPN #2 stated, "I will look into this and get back to you." On 6/21/18 at 8 am, the surveyor was provided copies of the "Team Care Plan" from the hospice company. LPN #2 stated, "We got hospice to fax this over for you." The hospice contract was reviewed by the surveyor on 6/21/18 at 9 am. The hospice contract read in part as follows:	F 849		

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F 849	Continued From page 38 "...At a minimum, Hospice shall provide the following information to the facility for each Hospice Patient residing at the facility...Plan of Care, Medications and Orders..." The surveyor notified the director of nursing and the corporate nurse of the above documented findings on 6/21/18 at 9:30 am. No further information was provided to the surveyor prior to the exit conference on 6/22/18.	F 849		