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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495315	A. BUILDING ______ B. WING ______	08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF WOODSTOCK	803 SOUTH MAIN ST WOODSTOCK, VA 22664

(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 08/21/18 through 08/23/18. The facility was found to be in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/21/18 through 8/23/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 88 certified bed facility was 84 at the time of the survey. The survey sample consisted of 31 current resident reviews (Residents #68, #78, #19, #43, #1, #134, #13, #138, #12, #46, #34, #40, #35, #62, #15, #20, #79, #14, #8, #81, #137, #61, #10, #54, #55, #41, #66, #69, #11, #77, and #9) and 4 closed record reviews (Residents #84, #57, #51, and #82.)	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	F 550		

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

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

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F 550	Continued From page 1 individuality. The facility must protect and promote the rights of the resident. §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, staff interviews and facility document review, it was determined that the facility staff failed to serve food in a manner to promote resident dignity in one of three dining areas, the Rosewood dining area. Residents were observed sitting at the long dining table and waiting up to between 10 to 55 minutes for their meal trays, in the Rosewood dining room, after the other residents had been	F 550	1.Rosewood Dining Room food service carried out promoting resident dignity. Residents are served meals in a dignified manner. Residents residing in this dining room were served meals in a dignified manner at the preceding meal times. 2.Executive Director/Designee conducted Quality Review of facility Dining Rooms ensuring food service is provided in a dignified manner. Follow up based on findings. 3.Director of Nursing Designee provided re-education for current Nursing Staff regarding food service carried out promoting resident dignity. 4.Quality Improvement Monitoring to be conducted to ensure dining service conducted promoting dignity by Director of Nursing or designee on various meal times 5x/week x 4 weeks, weekly x4 then monthly and as needed thereafter. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. 5.Allegation of compliance date of 10/2/2018.	

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F 550	Continued From page 2 served.	F 550		

served.

The findings include:

On 8/21/18 at 11:56 a.m., observations of staff serving residents meals in the Rosewood dining room were conducted. It was noted that there was a long table with approximately seating for 12 residents. These residents were observed to need either assistance or supervision by staff while eating.

At 11:59 a.m., the first two trays were delivered to residents sitting at the long table. At 12:09 p.m., another resident sitting at the long table was served their tray. At 12:13 p.m., the first two residents served at the long table were observed to have completed their meal. At 12:27 p.m., trays were beginning to be served to the long table, however at 12:33 p.m.; five residents at the long table were observed still waiting to be served their lunch trays. At 12:39 p.m., four residents at long table were still waiting to be served their lunch trays. At 12:44 p.m. two trays were delivered to long table, however two residents were still awaiting their meals. At 12:50 pm., a meal tray was served to one of the residents at the long table. At 12:54 p.m., the last resident at the long table received his meal tray.

On 8/23/18 at 8:10 a.m., an interview was conducted with SAM (administrative staff member) #2, director of nursing. ASM #2 was asked why the residents at the long table were not served at the same time. She stated that these residents needed assistance and that is what may have caused the delay. When informed of the time span in which the first

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F 550	Continued From page 3 residents were served compared to the last resident, ASM #2 stated, "That is upsetting." When asked how she would feel if she sat at a table and had to wait, almost an hour while others received their meal, ASM #2 stated, "That would be awful." When asked if this provided a dignified dining experience for the residents, ASM #2 stated, "No." On 8/23/18 at 3:06 p.m., ASM #1, the administrator and ASM #2, the director of nursing, were made aware of the above findings. The facility staff were asked to provide policies on dignity and the dining experience. Neither policy was provided prior to exit. No further information was presented prior to exit.	F 550		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened	F 583	1.Resident # 14 has care provided maintaining privacy, i.e.; door closed, curtain completely closed as applicable. 2.Director of Nursing/Designee conducted Quality Observation of current residents' care for provision of privacy, i.e.; door closed, curtain completely closed as applicable. Follow up based on findings. 3.Director of Nursing/Designee provided re-education for current facility Nursing Staff regarding provision of privacy during care, i.e.; door closed, curtain completely closed as applicable. . 4.Random Quality Improvement Monitoring/Observation to be conducted by Director of Nursing/Designee weekly x 2, then monthly and as needed during care times to ensure privacy measures, i.e.; door closed, curtain completely closed as applicable are being maintained for residents. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. 5.Allegation of compliance date of 10/2/2018.	

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mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.

§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.
(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.
(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, facility document review, clinical record review, it was determined that the facility staff failed to provide privacy during care for one of 35 residents in the survey sample, Resident # 14.

The facility staff failed to close the door and pull the privacy curtain completely closed when providing wound care for Resident # 14.

The findings include:

Resident # 14 was admitted to the facility on 07/18/17 with diagnoses that included but were not limited to dementia (1), peripheral vascular disease, (2), dysphagia (3) and anxiety (4).

Resident # 14's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/11/18, coded

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Resident # 14 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 14 was coded as requiring extensive assistance of one staff member for activities of daily living.

On 08/22/18 at approximately 10:10 a.m., an observation was conducted of Resident # 14's wound care to her left foot. LPN (licensed practical nurse) # 1 entered Resident # 14's room with the wound care supplies and walked to the B-side of the room where Resident # 14 was sitting in a wheelchair leaving the door to the room open. LPN # 1 set up a barrier using clean paper towels on one side of Resident # 14's over-the-bed table. LPN # 1 then pulled the privacy curtain approximately two-thirds of the way closed, leaving Resident # 14 exposed to people passing by in the hallway and Resident # 14's roommate. LPN # 1 then conducted a dressing change on Resident # 14's left foot.

On 08/22/18 at approximately 10:35 a.m., an interview was conducted with Resident # 14 regarding privacy during her wound care. Resident # 14 stated, "I like to have the curtain closed when I'm being taken care of. It bother me a little when they don't close it."

On 08/22/18 at approximately 10:35 a.m., an interview was conducted with LPN # 1 regarding privacy to Resident # 14 during her wound care. When asked if she pulled the privacy curtain closed or closed Resident # 14's door, LPN # 1 stated, "I didn't pull the curtain closed far enough."

The facility policy "Privacy" documented, "3.

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Facility will provide time and space for privacy." The facility's "Virginia Resident's Rights and Responsibilities" documented, "Privacy. C. To have privacy when care or medical treatment is being provided."

On 08/22/18 at approximately 5:00 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of clinical services were made aware of the findings.

No further information was provided prior to exit.

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

(2) The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html.

(3) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

(4) Fear. This information was obtained from the website:

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F 583	Continued From page 7 https://www.nlm.nih.gov/medlineplus/anxiety.html #summary.	F 583		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature	F 584	1.Meals are currently being served in dining areas in a manner promoting homelike environment, i.e. meals removed from tray. 2.Director of Nursing/Designee conducted Quality Review Observation of facility's dining areas for meal service promoting homelike environment; i.e. not served on trays. Follow up based on findings. 3.Director of Nursing/Designee provided re-education to Nursing Staff regarding promoting homelike environment during meals, i.e.; food not served on trays. Completed by 9/31/18. 4.Quality Improvement Monitoring to be conducted to ensure meal service completed promoting homelike environment by Director of Nursing or designee on various meal times and between dining rooms 5x/week x 4 weeks, weekly x4 then monthly and as needed thereafter. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. 5. Allegation of Compliance date of 10/2/2018.	

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levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interviews and facility document review, it was determined that the facility staff failed to provide a homelike dining experience in two of three dining areas, the Rosewood and the Dogwood dining room.

1. Residents seated at the long table in the Rosewood dining room, were served their meals on a tray, cafeteria/institutional style and their meals were not removed from the tray for a restaurant/home-like dining experience during lunch on 8/21/18.

2. Facility staff failed to provide a homelike dining experience on the Dogwood unit dining room.

The findings include:

1. Residents seated at the long table in the Rosewood dining room, were served their meals on a tray, cafeteria/institutional style and their meals were not removed from the tray for a restaurant/home-like dining experience during lunch on 8/21/18.

On 8/21/18 at 11:56 a.m., observations of staff serving residents meals in the Rosewood dining room were conducted. The staff served residents their meal plates on serving trays and did not remove the trays while the residents ate their

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meals. The meals were served on trays to residents who fed themselves with supervision and to residents who required assistance with feeding. All other tables in the dining room were served their meals without the trays.

On 8/23/18 at 8:10 a.m., an interview was conducted with ASM (administrative staff member) #2, director of nursing. ASM #2 was asked why the residents at the long table were served their meals on the serving trays, cafeteria style, while the rest of the tables in the dining room were served without the trays, restaurant style. ASM #2 stated that these residents needed assistance and that is possibly, why they were served their meals on their trays. When asked if she ate her meals off trays at home, ASM #2 stated, "No." When asked if this provided a homelike dining experience for these residents, ASM #2 stated, "No."

On 8/23/18 at 3:06 p.m., ASM #1, the administrator and ASM #2, the director of nursing, were made aware of the above findings.

The facility staff were asked to provide policies on dignity and the dining experience. Neither policy was provided prior to exit.

No further information was presented prior to exit.

2. The facility staff failed to provide a homelike dining experience in the Dogwood unit dining room. Nine residents were observed with their meals served to them on trays cafeteria style, and not removed from the tray for a homelike dining experience.

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On 8/21/18 at 12:09 p.m., an observation was conducted of the Dogwood unit dining room. There were 10 residents in the dining area. Family had already fed one resident prior to the observation, staff were feeding four, and five were eating independently. Of the nine residents observed eating, all nine had their meal served to them on trays cafeteria style, and not removed from the tray for a homelike dining experience.

On 8/23/18 at 8:05 a.m., in an interview with CNA #4 (Certified Nursing Assistant) she stated, "It has always been that way since I have been here (over a year)". CNA #4 stated she never thought about it not being a homelike dining experience. CNA #4 stated the trays should be removed for serving the food.

On 8/23/18 at 8:10 AM, the ASM #2 (Administrative Staff Member - the Director of Clinical Services) was made aware of the findings. ASM #2 stated, "That is how that side has always been. They have been educated to take the food off the trays, so I will have to do more education with them."

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

F 622 SS=E Transfer and Discharge Requirements F 622
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

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F 622	Continued From page 11 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	F 622	1.Residents # 68, 15, 51, 62, 34 returned to facility. 2.Director of Nursing/Designee to conduct Quality Review of residents with discharge/transfers for the last 30 days regarding care plan goals sent with residents upon discharge. Follow up based on findings. 3.Licensed nursing staff re-educated on requirements for transfers and discharges by Director of Nursing or designee, including but not limited to care plan goals to be sent with residents upon transfer/discharge. 4.Quality Improvement Monitoring to be conducted by Director of Nursing or designee on transfer/discharges to ensure compliance with comprehensive care plan goals being sent 5x/week x 4 weeks, weekly x4 then monthly and as needed thereafter. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. 5. Allegation of compliance date of 10/2/2018.	

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F 622	Continued From page 12 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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Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to meet the appropriate transfer requirements for five of 35 residents in the survey sample, Residents #'s 68, 15, 51, 62, and 34.

1. The facility staff failed to evidence that all required documentation and information was provided to the receiving provider for Resident # 68's facility-initiated transfer to the hospital on 07/31/18.

2. The facility staff failed to evidence that all required documentation and information was provided to the receiving provider for Resident # 15's facility-initiated transfer to the hospital on 06/28/18.

3. The facility staff failed to provide evidence that the comprehensive care plan goals were provided to the receiving hospital for a facility initiated transfer of Resident #51 to the hospital on 8/20/18.

4. The facility staff failed to provide evidence that the comprehensive care plan goals were provided to the receiving hospital for a facility initiated transfer of Resident #62 to the hospital on 7/6/18.

5. The facility staff failed to evidence that the comprehensive care plan goals were provided to the receiving facility when Resident #34 was sent to the hospital on 6/27/18.

The findings include:

1. The facility staff failed to evidence that all

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required documentation and information was provided to the receiving provider for Resident # 68's facility-initiated transfer to the hospital on 07/31/18.

Resident # 68 was admitted to the facility on 06/12/13 and readmitted on 08/03/18, with diagnoses that included but were not limited to diabetes mellitus (1), depressive disorder, (2), dysphagia (3) and hypertension (4).

Resident # 68's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/06/18, coded Resident # 68 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions.

The nurse's "Progress Notes" for Resident # 68 dated 07/31/18 documented in part, "11:00 a.m., Attempted to call ortho (orthopedic) for consult possible for today or seen, unable to schedule Appt (appointment) soon. NP (nurse practitioner) made aware, order to received to send resident to ER (emergency room) for eval (evaluation) of finger. VS (vital signs) 99 (temperature) 140/58 (140 over 58 blood pressure) 90% (percent) RA (room air), denies pain. Resident & Resident's daughter (Name of Daughter) made aware of transport to ER -squad and report to ER called to (Name of ER Staff). Squad arrived at 1050 (10:50 a.m.), resident left for (Name of Hospital) ER at 1055 (10:55 a.m.)."

Review of the facility's transfer form entitled "NURSING HOME TO HOSPITAL TRANSFER FORM" dated 07/31/18 for Resident # 68 failed to evidence the resident's comprehensive care plan

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goals as part of the transfer paperwork.

On 08/23/18 at approximately 10:40 a.m., an interview was conducted with LPN (licensed practical nurse) # 4. When asked what information was sent with the resident for a facility initiated transfer LPN # 4 stated, "We send a copy of the facesheet, advance directive, bed hold, SBAR (Situation, Behavior, Assessment, Recommendation), transfer form, MAR (medication administration record), TAR (treatment administration record) and physician orders." When asked if the resident's comprehensive care plan goals are provided to the receiving facility LPN # 4 stated, "No."

On 08/23/18 at approximately 10:55a.m., an interview was conducted with LPN (licensed practical nurse) # 5. When asked what information was sent with the resident for a facility initiated transfer LPN # 5 stated, "We send a copy of the facesheet, advance directive, bed hold, SBAR (Situation, Behavior, Assessment, Recommendation), transfer form, MAR (medication administration record), TAR (treatment administration record) and physician orders." When asked if the resident's care plan goals are provided to the receiving facility, LPN # 5 stated, "No."

On 08/23/18 at approximately 11:10 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of clinical services. When asked what information was sent with the resident for a facility initiated transfer ASM # 2 stated, "We send a copy of the facesheet, advance directive, bed hold, SBAR (Situation, Behavior, Assessment, Recommendation), transfer form, MAR (medication administration

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record), TAR (treatment administration record), physician notes and physician orders." When asked if the resident's comprehensive care plan goals are provided to the receiving facility ASM # 2 stated, "No."

The facility's policy "Transfer / Discharge Notification & Right to Appeal" documented, "Documentation. Information provided to the receiving provider must include but is not limited to: Comprehensive care plan goals."

On 08/23/18 at approximately 3:05 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of clinical services were made aware of the findings.

No further information was provided prior to exit.

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

(2) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(3) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdi

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sorders.html.

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

2. The facility staff failed to evidence that all required documentation and information was provided to the receiving provider for Resident # 15's facility-initiated transfer to the hospital on 06/28/18.

Resident # 15 was admitted to the facility on 09/26/17 and a readmission of 06/30/18 with diagnoses that included but were not limited to cirrhosis of the liver (1), chronic obstructive pulmonary disease, (2), peripheral vascular disease (3) and anemia (4).

Resident # 15's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/11/18, coded Resident # 14 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions.

The nurse's "Progress Notes" for Resident # 15 dated 06/28/18 documented, "1800 (6:00 p.m.) Was reported to this nurse that pt (patient) was having difficulty breathing, NP (nurse practitioner) assessed to send to ER (emergency room) for resp (respiratory) distress." The nurse's "Progress Notes" for Resident # 15 dated 06/28/18 documented, "2100 (9:00 p.m.) Pt was admitted to (Name of Hospital) for resp distress and COPD (chronic obstructive pulmonary

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F 622	Continued From page 18 disease)." Review of the facility's transfer form entitled "NURSING HOME TO HOSPITAL TRANSFER FORM" dated 06/28/18 for Resident # 15 failed to evidence the resident's care plan goals as part of the transfer paperwork. On 08/23/18 at approximately 10:40 a.m., an interview was conducted with LPN (licensed practical nurse) # 4. When asked what information was sent with the resident for a facility initiated transfer LPN # 4 stated, "We send a copy of the facesheet, advance directive, bed hold, SBAR (Situation, Behavior, Assessment, Recommendation), transfer form, MAR (medication administration record), TAR (treatment administration record) and physician orders." When asked if the resident's comprehensive care plan goals are provided to the receiving facility LPN # 4 stated, "No." On 08/23/18 at approximately 10:55a.m., an interview was conducted with LPN (licensed practical nurse) # 5. When asked what information was sent with the resident for a facility initiated transfer LPN # 5 stated, "We send a copy of the facesheet, advance directive, bed hold, SBAR (Situation, Behavior, Assessment, Recommendation), transfer form, MAR (medication administration record), TAR (treatment administration record) and physician orders." When asked if the resident's care plan goals are provided to the receiving facility, LPN # 5 stated, "No." On 08/23/18 at approximately 11:10 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of clinical services.	F 622		

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When asked what information was sent with the resident for a facility initiated transfer ASM # 2 stated, "We send a copy of the facesheet, advance directive, bed hold, SBAR (Situation, Behavior, Assessment, Recommendation), transfer form, MAR (medication administration record), TAR (treatment administration record), physician notes and physician orders." When asked if the resident's comprehensive care plan goals are provided to the receiving facility ASM # 2 stated, "No."

On 08/23/18 at approximately 3:05 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of clinical services were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A scarring of the liver and poor liver function. It is the last stage of chronic liver disease. Cirrhosis is the end result of chronic liver damage caused by chronic (long-term) liver disease. Common causes of chronic liver disease in the United States are: Hepatitis B or hepatitis C infection or alcohol abuse. This information was obtained from the website: https://medlineplus.gov/ency/article/000255.htm.

(2) Disease that makes it difficult to breath that can lead to shortness of breath). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

(3) The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem

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called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html.

(4) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html.

3. The facility staff failed to provide evidence that the comprehensive care plan goals were provided to the receiving hospital for a facility initiated transfer of Resident #51 to the hospital on 8/20/18.

Resident #51 was admitted to the facility on 7/18/18 with diagnoses that included but were not limited to: Stroke with right sided weakness, high blood pressure, diabetes, and difficulty swallowing.

The most recent MDS (minimum data set) assessment, a 5 day Medicare admission assessment, with an assessment reference date of 7/25/18, coded the resident as scoring a "5" on the BIMS (brief interview for mental status) score, indicating the resident has severe cognitive impairment for daily decision making.

The physician's verbal order dated 8/20/18 at 11:45 p.m. documented in part, "Send to ER (emergency room) for eval (evaluation)."

The "Hospital Transfer Form" dated 8/20/18 at 11:45 p.m. documented in part, "MD (medical doctor) sending over [to hospital] for renal failure."

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The nursing progress notes dated 8/21/18 at 12:30 a.m. documented in part, "[physician's name] call at 11:45 p.m. to send pt (patient) to ER for eval (evaluation) d/t (due to) abnormal labs [laboratory test results]."

Review of the clinical record failed to evidence that Resident #51's comprehensive care plan or comprehensive care plan goals were sent with her upon transfer to the hospital.

On 8/23/18 at 10:40 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #4 stated labs, a face sheet, sbar (situation, background, assessment, recommendation) form, physician order, medication list, dnr (do not resuscitate) form and advanced directives, if applicable, and a hospital transfer form is provided to hospital staff. When asked if residents' comprehensive care plan goals are provided to hospital staff, LPN #4 stated, "No."

On 8/23/18 at 10:52 a.m., and interview was conducted with LPN #5. LPN #5 was asked if the comprehensive care plan goals or comprehensive care plan is sent with the resident upon transfer to the hospital, LPN #5stated, "No."

On 8/23/18 at 11:09 a.m., ASM (administrative staff member) #2, the director of nursing, confirmed that the comprehensive care plan goals were not sent to the facility upon transfer.

On 8/23/18 at 3:06 p.m., ASM #1, the administrator and ASM #2, the director of nursing,

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were made aware of the above findings.

A review of the facility's policy, "Transfer/Discharge Notification & Right to Appeal", documented in part, "Information provided to the receiving provider must include but is not limited to: Comprehensive care plan goals."

No further information was provided prior to exit.

4. The facility staff failed to provide evidence that the comprehensive care plan goals were provided to the receiving hospital for a facility initiated transfer of Resident #62 to the hospital on 7/6/18.

Resident #62 was admitted to the facility on 10/9/13, with a most recent readmission of 7/9/18, with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (a chronic lung disease that makes it difficult to breathe) (1), muscle weakness, arthritis, hypertension, and depression.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 8/5/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident has no cognitive impairment for daily decision making.

The nurse practitioner's verbal order dated 7/6/18 at 2 p.m., "Resident requested to be sent to ER (emergency room) for eval (evaluation) per pt (patient) request."

The nursing progress notes dated 7/6/18 at 1:40

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p.m. documented in part, "RR (respiratory rate) slightly labored. O2 (oxygen) sats (saturation) (how much oxygen is in the blood (2)) down to 89% (percent) on 3 L/min (liters per minute) [of oxygen]. Observed resident with increased anxiety ...Resident requested to be sent at ER at 1340 (1:40 p.m.)."

Review of the clinical record failed to evidence that Resident #62's comprehensive care plan or comprehensive care plan goals were sent with him upon transfer to the hospital.

On 8/23/18 at 10:40 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #4 stated labs, a face sheet, sbar (situation, background, assessment, recommendation) form, physician order, medication list, dnr (do not resuscitate) form and advanced directives, if applicable, and a hospital transfer form is provided to hospital staff. When asked if residents' comprehensive care plan goals are provided to hospital staff, LPN #4 stated, "No."

On 8/23/18 at 10:52 a.m., an interview was conducted with LPN #5. LPN #5 was asked if the comprehensive care plan goals or comprehensive care plan is sent with the resident upon transfer to the hospital, LPN #5 stated, "No."

On 8/23/18 at 11:09 a.m., ASM (administrative staff member) #2, the director of nursing, confirmed that the care plan goals were not sent to the facility upon transfer.

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F 622	Continued From page 24 On 8/23/18 at 3:06 p.m., ASM #1, the administrator and ASM #2, the director of nursing, were made aware of the above findings. A review of the facility's policy, "Transfer/Discharge Notification & Right to Appeal", documented in part, "Information provided to the receiving provider must include but is not limited to: Comprehensive care plan goals." No further information was provided prior to exit. 1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/copd.html 2) This information was obtained from the National Institutes of Health at http://www.thoracic.org/patients/patient-resources/resources/pulse-oximetry.pdf 5. The facility staff failed to evidence that the comprehensive care plan goals were provided to the receiving facility when Resident #34 was sent to the hospital on 6/27/18. Resident #34 was admitted to the facility on 4/6/18 with the diagnoses of but not limited to non-traumatic subdural hemorrhage, dysphagia, benign prostatic hyperplasia, atrial fibrillation, high blood pressure, hypothyroidism, chronic kidney disease, osteoporosis, pelvis fracture, coronary artery disease, and abdominal aortic aneurysm. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 7/13/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions.	F 622		

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A review of the clinical record revealed a nurse's note dated 6/27/18 at 11:40 a.m., that documented, "....Resident c/o (complaining of) HA (headache) and vomiting greenish fluid. (Upwards arrow for elevated / increased) B/P (blood pressure) (See front of sheet) (208/98 was documented on the front of the sheet). Vomited small amt (amount) 4x (four times). (Nurse Practitioner) assessed. 1045 (10:45 a.m.) - new order to send to ER (emergency room). Squad left (with) resident at 1110 (11"10 a.m.).....called (name of responsible party) no answer."

The "Nursing Home to Hospital Transfer Form" that was completed was reviewed. There was no documentation evidencing the resident's comprehensive care plan goals were provided to the hospital for the facility-initiated transfer on 6/27/18.

On 8/23/18 at 10:40 a.m., in an interview with LPN #4 (Licensed Practical Nurse), she stated that the facility sends a copy of face sheet, advanced directives, bed hold policy, SBAR report, transfer form, MARs (medication administration record), TARs (treatment administration record, and physician orders when a resident is sent to the hospital. LPN #4 stated that the Nursing Home to Hospital Transfer Form does not say anything about sending the care plan goals. LPN #4 further stated that she had never been told to send them.

On 8/23/18 at 10:53 a.m., in an interview with LPN #5, she stated that the Nursing Home to Hopsital Transfer Form is sent, the physician's order sheet, SBAR note, and nurse's note, are sent to the hospital. LPN #5 then stated that the advanced directives and bed hold are sent.

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F 622	Continued From page 26 On 8/23/18 at 11:08, in an interview with ASM #2 (Administrative Staff Member - the Director of Clinical Services) ASM #2 stated that the comprehensive care plan goals are not sent. No further information was provided by the end of the survey.	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 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	F 623	1.Belated transfer notices provided to resident/responsible party for identified residents # 68, 15, 51, 62, and 34. 2.Quality Review completed by Medical Records Coordinator/Designee of discharges and transfers for the past 30 days along with the notification of the resident/resident representative and Office of the State Long-Term Care Ombudsman of the transfer/discharge. Follow up based on findings. 3.Licensed Nurses and Social Services staff have been re-educated by Director of Nursing (DON) or designee on completing transfer notices and the required components ensuring each residents transfer is communicated correctly to the appropriate parties. 4. DON/designee to conduct Quality Improvement Monitoring of resident transfer/discharges weekly x4 weeks then monthly and as needed to ensure letters have been sent to resident and resident representative as well as the Office of the State Long-Term Care Ombudsman. Findings to be reviewed at monthly QAPI Committee meeting. Monitoring schedule modified based on findings. 5. Allegation of compliance date of 10/02/2018.	

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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.

§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,

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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 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, facility document review, and clinical record review, it was determined that facility staff failed to provide written notification to the resident and / or the resident's representative of a facility initiated transfer for five of 35 residents in the survey sample, Residents #'s 68, 15, 51, 62, and 34.

1. The facility staff failed to provide Resident # 68 or the resident's representative written notification when the resident was transferred to the hospital

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on 07/31/18.

2. The facility staff failed to provide Resident # 15 or the resident's representative written notification when the resident was transferred to the hospital on 06/28/18.

3. The facility staff failed to provide Resident #51 or the resident's representative written notification when the resident was transferred to the hospital on 8/20/18.

4. The facility staff failed to provide Resident #62 or the resident's representative written notification when the resident was transferred to the hospital on 7/6/18.

5. The facility staff failed to provide Resident #32 or the resident's representative written notification when the resident was transferred to the hospital on 6/27/18 and failed to notify the ombudsman of the transfer.

The findings include:

1. The facility staff failed to provide Resident # 68 or the resident's representative written notification when the resident was transferred to the hospital on 07/31/18.

Resident # 68 was admitted to the facility on 06/12/13 and a readmission of 08/03/18 with diagnoses that included but were not limited to diabetes mellitus (1), depressive disorder, (2), dysphagia (3) and hypertension (4).

Resident # 68's most recent MDS (minimum data set), a quarterly assessment with an ARD

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(assessment reference date) of 06/06/18, coded Resident # 68 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions.

The nurse's "Progress Notes" for Resident # 68 dated 07/31/18 documented in part, "11:00 a.m., Attempted to call ortho (orthopedic) for consult possible for today or seen, unable to schedule Appt (appointment) soon. NP (nurse practitioner) made aware, order to received to send resident to ER (emergency room) for eval (evaluation) of finger. VS (vital signs) 99 (temperature) 140/58 (140 over 58 blood pressure) 90% (percent) RA (room air), denies pain. Resident & Resident's daughter (Name of Daughter) made aware of transport to ER -squad and report to ER called to (Name of ER Staff). Squad arrived at 1050 (10:50 a.m.), resident left for (Name of Hospital) ER at 1055 (10:55 a.m.)."

On 08/23/18 at approximately 10:40 a.m., an interview was conducted with LPN (licensed practical nurse) # 4. When asked if the resident and/or the resident's representative is provided written notification of the facility initiated transfer, LPN # 4 stated, "I've never done a transfer."

On 08/23/18 at approximately 10:55a.m., an interview was conducted with LPN (licensed practical nurse) # 5. When asked if the resident and/or the resident's representative is provided written notification of the facility initiated transfer, LPN # 5 stated, "No we don't."

On 08/23/18 at approximately 11:10 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of clinical services.

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When asked if the resident and/or the resident's representative is provided written notification of the facility initiated transfer, ASM # 2 stated, "No written notification, it's just a phone call to the family or RP (responsible party."

The facility's policy "Transfer / Discharge Notification & Right to Appeal" documented, "Notice Before Transfer. Before a center transfers or discharges a resident the center must: Notify the resident and resident representative(s) of the transfer or discharge and the reason for the move in writing (in a language and manner they understand)."

On 08/23/18 at approximately 3:05 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of clinical services were made aware of the findings.

No further information was provided prior to exit.

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

(2) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

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(3) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

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

2. The facility staff failed to provide Resident # 15 or the resident's representative written notification when the resident was transferred to the hospital on 06/28/18.

Resident # 15 was admitted to the facility on 09/26/17 and a readmission of 06/30/18 with diagnoses that included but were not limited to cirrhosis of the liver (1), chronic obstructive pulmonary disease, (2), peripheral vascular disease (3) and anemia (4).

Resident # 15's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/11/18, coded Resident # 14 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions.

The nurse's "Progress Notes" for Resident # 15 dated 06/28/18 documented, "1800 (6:00 p.m.) Was reported to this nurse that pt (patient) was having difficulty breathing, NP (nurse practitioner) assessed to send to ER (emergency room) for resp (respiratory) distress." The nurse's "Progress Notes" for Resident # 15 dated

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06/28/18 documented, "2100 (9:00 p.m.) Pt was admitted to (Name of Hospital) for resp distress and COPD (chronic obstructive pulmonary disease)."

On 08/23/18 at approximately 10:40 a.m., an interview was conducted with LPN (licensed practical nurse) # 4. When asked if the resident and/or the resident's representative is provided written notification of the facility initiated transfer, LPN # 4 stated, "I've never done a transfer."

On 08/23/18 at approximately 10:55a.m., an interview was conducted with LPN (licensed practical nurse) # 5. When asked if the resident and/or the resident's representative is provided written notification of the facility initiated transfer, LPN # 5 stated, "No we don't."

On 08/23/18 at approximately 11:10 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of clinical services. When asked if the resident and/or the resident's representative is provided written notification of the facility initiated transfer, ASM # 2 stated, "No written notification, it's just a phone call to the family or RP (responsible party."

On 08/23/18 at approximately 3:05 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of clinical services were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A scarring of the liver and poor liver function. It is the last stage of chronic liver disease. Cirrhosis is the result of chronic liver damage

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caused by chronic (long-term) liver disease. Common causes of chronic liver disease in the United States are: Hepatitis B or hepatitis C infection or alcohol abuse. This information was obtained from the website: https://medlineplus.gov/ency/article/000255.htm.

(2) Disease that makes it difficult to breath that can lead to shortness of breath). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

(3) The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html.

(4) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html.

3. The facility staff failed to provide Resident #51 or the resident's representative written notification when the resident was transferred to the hospital on 8/20/18.

Resident #51 was admitted to the facility on 7/18/18 with diagnoses that included but were not limited to: Stroke with right sided weakness, high blood pressure, diabetes, and difficulty swallowing.

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The most recent MDS (minimum data set) assessment, a 5 day Medicare admission assessment, with an assessment reference date of 7/25/18, coded the resident as scoring a "5" on the BIMS (brief interview for mental status) score, indicating the resident has severe cognitive impairment for daily decision making.

The physician's verbal order dated 8/20/18 at 11:45 p.m. documented in part, "Send to ER (emergency room) for eval (evaluation)."

The "Hospital Transfer Form" dated 8/20/18 at 11:45 p.m. documented in part, "MD (medical doctor) sending over [to hospital] for renal failure."

The nursing progress notes dated 8/21/18 at 12:30 a.m. documented in part, "[physician's name] call at 11:45 p.m. to send pt (patient) to ER for eval (evaluation) d/t (due to) abnormal labs [laboratory test results]."

Review of the clinical record failed to evidence that Resident #51's responsible representative was provided written documentation of the resident's transfer to the hospital.

On 8/23/18 at 10:40 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked how the responsible representative was made aware of transfers to the hospital. LPN #4 stated that the staff calls the responsible representative. When asked if the responsible representative was provided written notification of the transfer to the hospital, LPN #4 stated, "No."

On 8/23/18 at 10:52 a.m., an interview was

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conducted with LPN #5. LPN #5 was asked if the responsible representative was provided written notification of the transfer to the hospital, LPN #5 stated, "No."

On 8/23/18 at 11:09 a.m., ASM (administrative staff member) #2, the director of nursing, confirmed that the written notification of the transfer was not provided to the responsible representative.

On 8/23/18 at 3:06 p.m., ASM #1, the administrator and ASM #2, the director of nursing, were made aware of the above findings.

A review of the facility's policy, "Transfer/Discharge Notification & Right to Appeal", documented in part, "Notice Before Transfer: Notify the resident and responsible representative(s) of the transfer or discharge and the reason for the move in writing (in a language and manner they understand)."

No further information was provided prior to exit.

4. The facility staff failed to provide Resident #62 or the resident's representative written notification when the resident was transferred to the hospital on 7/6/18.

Resident #62 was admitted to the facility on 10/9/13, with a most recent readmission of 7/9/18, with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (a chronic lung disease that makes it difficult to breathe) (1), muscle weakness, arthritis, hypertension, and depression.

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The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 8/5/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident has no cognitive impairment for daily decision making.

The nurse practitioner's verbal order dated 7/6/18 at 2 p.m., "Resident requested to be sent to ER (emergency room) for eval (evaluation) per pt (patient) request."

The nursing progress notes dated 7/6/18 at 1:40 p.m. documented in part, "RR (respiratory rate) slightly labored. O2 (oxygen) sats (saturation) (how much oxygen is in the blood (2)) down to 89% (percent) on 3 L/min (liters per minute) [of oxygen]. Observed resident with increased anxiety ...Resident requested to be sent at ER at 1340 (1:40 p.m.)."

Review of the clinical record failed to evidence that Resident #51's responsible representative was provided written documentation of the resident's transfer to the hospital.

On 8/23/18 at 10:40 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked how the responsible representative was made aware of transfers to the hospital. LPN #4 stated that the staff calls the responsible representative. When asked if the resident and/or responsible representative was provided written notification of the transfer to the hospital, LPN #4 stated, "No."

On 8/23/18 at 10:52 a.m., an interview was conducted with LPN #5. LPN #5 was asked if the

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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 623	Continued From page 38 resident and/or responsible representative was provided written notification of the transfer to the hospital, LPN #5stated, "No." On 8/23/18 at 11:09 a.m., ASM (administrative staff member) #2, the director of nursing, confirmed that the written notification of the transfer was not provided to either the resident or the responsible representative. On 8/23/18 at 3:06 p.m., ASM #1, the administrator and ASM #2, the director of nursing, were made aware of the above findings. No further information was provided prior to exit. 1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/copd.html 2) This information was obtained from the National Institutes of Health at http://www.thoracic.org/patients/patient-resources/resources/pulse-oximetry.pdf 5. The facility staff failed to provide Resident #32 or the resident's representative written notification when the resident was transferred to the hospital on 6/27/18 and failed to notify the ombudsman of the transfer. Resident #34 was admitted to the facility on 4/6/18 with the diagnoses of but not limited to non-traumatic subdural hemorrhage, dysphagia, benign prostatic hyperplasia, atrial fibrillation, high blood pressure, hypothyroidism, chronic kidney disease, osteoporosis, pelvis fracture, coronary artery disease, and abdominal aortic aneurysm.	F 623		

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The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 7/13/18. The resident was coded as being severely cognitively impaired in ability to make daily life decisions.

A review of the clinical record revealed a nurse's note dated 6/27/18 at 11:40 a.m., that documented, "...Resident c/o (complaining of) HA (headache) and vomiting greenish fluid. (Upwards arrow for elevated / increased) B/P (blood pressure) (See front of sheet) (208/98 was documented on the front of the sheet). Vomited small amt (amount) 4x (four times). (Nurse Practitioner) assessed. 1045 (a.m.) - new order to send to ER (emergency room). Squad left (with) resident at 1110 (a.m.).....called (name of responsible party) no answer."

There was no evidence of written notification provided to the resident representative and ombudsman of the hospital transfer.

On 8/23/18 at 10:29 AM in an interview with OSM #3 (Other Staff Member - the Admissions Coordinator), she stated that she has no role in notifying the ombudsman and that nurses call to notify the resident representative by phone but does not provide written notification.

On 8/23/18 at 11:03 AM in an interview with OSM #4, the social worker, she stated that, "Mainly I send a weekly statement to the ombudsman of who went to the hospital and why. I put all of them on there." When asked how long she has been following this process, OSM #4 stated, "Been sending it for the last 6 months." When asked about providing the family with written notification of the hospitalization, OSM #4 stated

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F 623	Continued From page 40 she does not follow up with written notices to the family. Evidence of the ombudsman notification for Resident #34's hospitalization of 6/27/18 was requested. On 8/23/18 at 12:10 p.m., OSM #4 stated that she has no evidence the ombudsman was notified in writing. On 8/23/18 at 11:08 a.m., in an interview with ASM #2 (Administrative Staff Member - the Director of Clinical Services) she stated that written notification not provided to the resident representative, and that the social worker notifies the ombudsman. No further information was provided by the end of the survey.	F 623		
F 625 SS=E	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.	F 625	1.Bed Hold Policy reviewed with resident/responsible party of identified residents # 68, 15, 51, and 62. 2.Quality Review has been completed by Medical Records Coordinator/Designee regarding bed hold policy notifications for the past 30 days along with the notification of the resident/resident representative. Follow up based on findings. 3.Licensed Nurses and Social Services staff have been re-educated by Director of Nursing (DON) or designee on completing the notification of bed hold policy to ensure each residents transfer is communicated correctly to the appropriate parties. 4.The DON/designee to conduct Quality Improvement Monitoring of resident transfer/discharges weekly x4 weeks then monthly and as needed to ensure letters have been sent to resident and resident representative as well as the Office of the State Long-Term Care Ombudsman. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. 5. Allegation of compliance date of 10/02/2018	

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§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:
Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide a bed hold policy to the resident or the resident's representative upon a facility initiated transfer for four of 35 residents in the survey sample, Residents #'s 68, 15, 51, and 62.

1. The facility staff failed to provide Resident # 68 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 07/31/18.

2. The facility staff failed to provide Resident # 15 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 06/28/18.

3. The facility staff failed to evidence that a copy of the bed hold policy was provided to the resident and/or resident representative upon a transfer to the hospital on 8/20/18 for Resident #51.

4. The facility staff failed to evidence that a copy of the bed hold policy was provided to the resident and/or resident representative upon a transfer to the hospital on 7/6/18 for Resident #62.

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The findings include:

1. The facility staff failed to provide Resident # 68 or the resident's representative written notification when the resident was transferred to the hospital on 07/31/18.

Resident # 68 was admitted to the facility on 06/12/13 and a readmission of 08/03/18 with diagnoses that included but were not limited to diabetes mellitus (1), depressive disorder, (2), dysphagia (3) and hypertension (4).

Resident # 68's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/06/18, coded Resident # 68 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions.

The nurse's "Progress Notes" for Resident # 68 dated 07/31/18 documented in part, "11:00 a.m., Attempted to call ortho (orthopedic) for consult possible for today or seen, unable to schedule Appt (appointment) soon. NP (nurse practitioner) made aware, order to received to send resident to ER (emergency room) for eval (evaluation) of finger. VS (vital signs) 99 (temperature) 140/58 (140 over 58 blood pressure) 90% (percent) RA (room air), denies pain. Resident & Resident's daughter (Name of Daughter) made aware of transport to ER -squad and report to ER called to (Name of ER Staff). Squad arrived at 1050 (10:50 a.m.), resident left for (Name of Hospital) ER at 1055 (10:55 a.m.)."

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Review of Resident # 68's clinical record failed to evidence documentation of written notification of the bed hold policy for Resident # 68 on 07/31/18.

On 08/23/18 at approximately 10:30 a.m., an interview was conducted with OSM (other staff member) # 3, director of admissions. When asked if they provided the bed hold policy to the resident or the resident's representative upon a facility initiated transfer, OSM # 3 stated, "The nurse sends the bed hold policy with the resident at the time of transfer."

On 08/23/18 at approximately 10:40 a.m., an interview was conducted with LPN (licensed practical nurse) # 4. When asked where it is documented that the resident and/or the resident's representative was provided a copy of the bed hold policy at the time of transfer, LPN # 4 stated, "I've never done a transfer."

On 08/23/18 at approximately 10:55a.m., an interview was conducted with LPN (licensed practical nurse) # 5. When asked where it is documented that the resident and/or the resident's representative was provided a copy of the bed hold policy at the time of transfer, LPN # 5 stated, "Sometimes it is in the nurse's notes." When asked if they document they sent the bed hold policy LPN # 5 stated, "No."

On 08/23/18 at approximately 11:10 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of clinical services. When asked where it is documented that the resident and/or the resident's representative was provided a copy of the bed hold policy at the time of transfer, ASM # 2 stated, "They (nurses) should make a note of what was sent. If it isn't

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documented we don't know what was sent."

The facility's policy "Bed Hold" documented, "PROCEDURE. 2. At the time of transfer to the hospital or therapeutic leave, the center will provide a copy of notification of bed hold."

On 08/23/18 at approximately 3:05 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of clinical services were made aware of the findings.

No further information was provided prior to exit.

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

(2) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(3) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

(4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpr

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essure.html.

2. The facility staff failed to provide Resident # 15 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 06/28/18.

Resident # 15 was admitted to the facility on 09/26/17 and a readmission of 06/30/18 with diagnoses that included but were not limited to cirrhosis of the liver (1), chronic obstructive pulmonary disease, (2), peripheral vascular disease (3) and anemia (4).

Resident # 15's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/11/18, coded Resident # 14 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions.

The nurse's "Progress Notes" for Resident # 15 dated 06/28/18 documented, "1800 (6:00 p.m.) Was reported to this nurse that pt (patient) was having difficulty breathing, NP (nurse practitioner) assessed to send to ER (emergency room) for resp (respiratory) distress." The nurse's "Progress Notes" for Resident # 15 dated 06/28/18 documented, "2100 (9:00 p.m.) Pt was admitted to (Name of Hospital) for resp distress and COPD (chronic obstructive pulmonary disease)."

Review of Resident # 15's clinical record failed to evidence documentation of written notification of the bed hold policy for Resident # 68 on 06/28/18.

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On 08/23/18 at approximately 10:30 a.m., an interview was conducted with OSM (other staff member) # 3, director of admissions. When asked if they provided the bed hold policy to the resident or the resident's representative upon a facility initiated transfer OSM # 3 stated, "The nurse sends the bed hold policy with the resident at the time of transfer."

On 08/23/18 at approximately 10:40 a.m., an interview was conducted with LPN (licensed practical nurse) # 4. When asked where it is documented that the resident and/or the resident's representative was provided a copy of the bed hold policy at the time of transfer LPN # 4 stated, "I've never done a transfer."

On 08/23/18 at approximately 10:55a.m., an interview was conducted with LPN (licensed practical nurse) # 5. When asked where it is documented that the resident and/or the resident's representative was provided a copy of the bed hold policy at the time of transfer LPN # 5 stated, "Sometimes it is in the nurse's notes." When asked if they document they sent the bed hold policy, LPN # 5 stated, "No."

On 08/23/18 at approximately 11:10 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of clinical services. When asked where it is documented that the resident and/or the resident's representative was provided a copy of the bed hold policy at the time of transfer, ASM # 2 stated, "They (nurses) should make a note of what was sent. If it isn't documented we don't know what was sent."

On 08/23/18 at approximately 3:05 p.m., ASM (administrative staff member) # 1, the

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administrator and ASM # 2, director of clinical services were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A scarring of the liver and poor liver function. It is the last stage of chronic liver disease. Cirrhosis is the end result of chronic liver damage caused by chronic (long-term) liver disease. Common causes of chronic liver disease in the United States are: Hepatitis B or hepatitis C infection or alcohol abuse. This information was obtained from the website: https://medlineplus.gov/ency/article/000255.htm.

(2) Disease that makes it difficult to breath that can lead to shortness of breath). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

(3) The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html.

(4) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html.

3. The facility staff failed to evidence that a copy

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of the bed hold policy was provided to the resident and/or resident representative upon a transfer to the hospital on 8/20/18 for Resident #51.

Resident #51 was admitted to the facility on 7/18/18 with diagnoses that included but were not limited to: Stroke with right sided weakness, high blood pressure, diabetes, and difficulty swallowing.

The most recent MDS (minimum data set) assessment, a 5 day Medicare admission assessment, with an assessment reference date of 7/25/18, coded the resident as scoring a "5" on the BIMS (brief interview for mental status) score, indicating the resident has severe cognitive impairment for daily decision making. The resident was coded as requiring extensive assistance of two or more staff members for bed mobility, transfers, locomotion on and off the unit, dressing, toileting, and personal hygiene.

The physician's verbal order dated 8/20/18 at 11:45 p.m. documented in part, "Send to ER (emergency room) for eval (evaluation)." The "Hospital Transfer Form" dated 8/20/18 at 11:45 p.m. documented in part, "MD (medical doctor) sending over [to hospital] for renal failure."

The nursing progress notes dated 8/21/18 at 12:30 a.m. documented in part, "[physician's name] call at 11:45 p.m. to send pt (patient) to ER for eval (evaluation) d/t (due to) abnormal labs [laboratory tests]."

Review of the clinical record failed to evidence that Resident #51was provided written notification of the facility's bed hold policy was provided to

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her or her responsible representative upon transfer to the hospital.

On 8/23/18 at 10:29 a.m., an interview was conducted with OSM (other staff member) #3, director of admissions. OSM #3 stated nursing sends the bed hold policy with the resident upon transfer.

On 8/23/18 at 10:40 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #4 stated labs, a face sheet, sbar (situation, background, assessment, recommendation) form, physician order, medication list, dnr (do not resuscitate) form and advanced directives, if applicable, and a hospital transfer form is provided to hospital staff. When asked if she could provide evidence that a written notification of a bed hold was provided to a resident or their responsible representative upon transfer to the hospital, LPN #4 stated, "No."

On 8/23/18 at 10:52 a.m., an interview was conducted with LPN #5. When LPN #5 was asked if she could provide evidence that a written notification of a bed hold was provided to the resident or their responsible representative upon transfer to the hospital, LPN #5 stated, "No."

On 8/23/18 at 11:09 a.m., ASM (administrative staff member) #2, the director of nursing, confirmed that the facility did not have evidence that written notification of the bed hold policy was provided to either the resident or responsible representative upon transfer to the hospital.

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On 8/23/18 at 3:06 p.m., ASM #1, the administrator and ASM #2, the director of nursing, were made aware of the above findings.

A review of the facility's policy, "Bed Hold", documented in part, "At the time of transfer to the hospital ...the center will provide a copy of notification of bed hold."

No further information was provided prior to exit.

4. The facility staff failed to evidence that a copy of the bed hold policy was provided to the resident and/or resident representative upon a transfer to the hospital on 7/6/18 for Resident #62.

Resident #62 was admitted to the facility on 10/9/13, with a most recent readmission of 7/9/18, with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (a chronic lung disease that makes it difficult to breathe) (1), muscle weakness, arthritis, hypertension, and depression.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 8/5/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident has no cognitive impairment for daily decision making.

The nurse practitioner's verbal order dated 7/6/18 at 2 p.m., "Resident requested to be sent to ER (emergency room) for eval (evaluation) per pt (patient) request."

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The nursing progress notes dated 7/6/18 at 1:40 p.m. documented in part, "RR (respiratory rate) slightly labored. O2 (oxygen) sats (saturation) (how much oxygen is in the blood) (2) down to 89% (percent) on 3 L/min (liters per minute) [of oxygen]. Observed resident with increased anxiety ...Resident requested to be sent at ER at 1340 (1:40 p.m.)."

Review of the clinical record failed to evidence that Resident #51was provided written notification of the facility's bed hold policy was provided to him or his responsible representative upon transfer to the hospital.

On 8/23/18 at 10:29 a.m., an interview was conducted with OSM (other staff member) #3, director of admissions. OSM #3 stated nursing sends the bed hold policy with the resident upon transfer.

On 8/23/18 at 10:40 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #4 stated labs, a face sheet, sbar (situation, background, assessment, recommendation) form, physician order, medication list, dnr (do not resuscitate) form and advanced directives, if applicable, and a hospital transfer form is provided to hospital staff. When asked if she could provide evidence that a written notification of a bed hold was provided to a resident or their responsible representative upon transfer to the hospital, LPN #4 stated, "No."

On 8/23/18 at 10:52 a.m., an interview was

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conducted with LPN #5. When LPN #5 was asked if she could provide evidence that, a written notification of a bed hold was provided to the resident or their responsible representative upon transfer to the hospital, LPN #5stated, "No."

On 8/23/18 at 11:09 a.m., ASM (administrative staff member) #2, the director of nursing, confirmed that the facility did not have evidence that written notification of the bed hold policy was provided to either the resident or responsible representative upon transfer to the hospital.

On 8/23/18 at 3:06 p.m., ASM #1, the administrator and ASM #2, the director of nursing, were made aware of the above findings.

A review of the facility's policy, "Bed Hold", documented in part, "At the time of transfer to the hospital ...the center will provide a copy of notification of bed hold."

No further information was provided prior to exit.

1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/copd.html
2) This information was obtained from the National Institutes of Health at http://www.thoracic.org/patients/patient-resources/resources/pulse-oximetry.pdf

F 656 SS=D — F 656

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

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F 656	Continued From page 53 resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to 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 observation, staff interview and clinical	F 656	1.Resident #13's comprehensive care plan related to sheep skin cover pillow reviewed and implemented. 2.MDS Coordinator/Designee conducted a Quality Review of residents skin prevention care plans for implementation of interventions as listed. Director of Nursing/Designee conducted a Quality review of resident Treatment Administration Records (TARs) ensuring documentation reflects implementation of skin prevention interventions as applicable. Follow up based on findings. 3.Director of Nursing/MDS Coordinator/Designee completed re-education with Licensed Nurses and Certified Nursing Assistants (CNAs) regarding implementation of comprehensive care plan/documentation reflective of interventions implemented. 4.Director of Nursing/MDS Coordinator/designee to complete Quality Improvement Monitoring of residents with identified skin prevention interventions for implementation of comprehensive care plan/documentation reflective of interventions implemented as applicable 5x/week x 4 weeks, weekly x4 then monthly and as needed thereafter. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. 5.Allegation of compliance date of 10/02/2018	

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record review, it was determined that the facility staff failed to implement the comprehensive care plan for one of 35 residents in the survey sample, Resident 13.

The facility staff failed to implement the comprehensive care plan for the use of a physician ordered sheep skin cover pillow to prevent skin break down on the inside of Resident # 13's knees on multiple dates in August 2018.

The findings include:

Resident # 13 was admitted to the facility on 01/07/10 with diagnoses that included but were not limited to dementia (1), peripheral vascular disease, (2), hypertension (3) and contractures (4).

Resident # 13's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/10/18, coded Resident # 13 as scoring a three (three) on the brief interview for mental status (BIMS) of a score of 0 - 15, 3 (three) - being severely impaired of cognition for making daily decisions. Resident # 13 was coded as being totally dependent of one staff member for activities of daily living.

On 08/21/18 at 4:45 p.m., an observation of Resident # 13 was conducted with CNA (certified nursing assistant) # 1. Resident # 13 was lying in bed awake. CNA # 1 pulled back the blanket covering Resident # 13's legs exposing a fleece blanket unfolded laying between Resident # 13's legs from just above the knees to about mid-calf.

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On 08/21/18 at approximately 10:00 p.m., an observation of Resident # 13 was conducted with LPN (licensed practical nurse) # 3. Resident # 13 was lying in bed awake with the head of the bed raised. LPN # 3 pulled up the blanket covering Resident # 13's legs. Observation of Resident # 13's leg failed to evidence a pillow with a sheepskin covering set between Resident # 13's legs. When asked where the pillow with a sheepskin covering was, LPN # 3 stated, "I don't see it." When asked why Resident # 13's was supposed to have the pillow with a sheepskin covering, LPN # 3 stated, "It is used to prevent skin breakdown on the inside of his (Resident # 13) knees." When asked if Resident # 13 has had a pillow for his knees, LPN # 3 stated, "It's probably still down in laundry, it was sent to be cleaned probably yesterday." When asked how often Resident # 13 should have the pillow between his legs, LPN # 3 stated, "All the time." When asked how often Resident # 13's pillow is checked to ensure it is in place, LPN # 3 stated, "It's checked q (every) shift which is two times a day because our shift is 12 hours." After reviewing the TAR with LPN # 3, LPN #3 stated, "He hasn't had it (pillow) in quite a while."

The physician's orders dated 08/01/18 through 08/31/18 for Resident # 13 documented, "06/22/18 Place pillow with sheep skin between BLE (bilateral lower extremity) to decrease pressure when in bed."

The TAR (treatment administration record) dated 08/01/18 through 08/31/18 documented, "06/22/18 Place pillow with sheep skin between BLE to decrease pressure when in bed." Review of the TAR revealed circles on the 7:00 a.m. -7:00 p.m. shift around the dates of 08/02/18, 08/03/18,

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08/09/18, 08/10/18, 08/14/18, 08/15/18, 08/16/18, 08/17/18, 08/19/18, 08/20/18 and 08/21/18 and additional circles on the 7:00 p.m. -7:00 a.m. shift around the dates of 08/06/18, 08/07/18, 08/08/18, 08/09/18, 08/10/18, 08/11/18, 08/12/18, 08/13/18, 08/14/18, 08/15/18, 08/06/18, 08/16/18, 08/18/18, 08/20/18 and 08/21/18.

The comprehensive care plan for Resident # 13 dated 03/23/2016 and a revision of 06/05/2017 documented, "(Resident # 13) has the potential for impaired skin integrity r/t (related to) incontinence and immobility." Under "Interventions" it documented, "Pillow between with sheep skin between legs. Date initiated: 06/23/2017."

On 08/23/18 at11:36 a.m., an interview was conducted with LPN (licensed practical nurse) # 5. When asked to describe the purpose of the care plan, LPN # 5 stated, "To meet the patient's needs and goals, so everyone is aware of what we are trying to do." When asked why it is important to follow the care plan, LPN # 5 stated, "For the care of the patient. To meet all their needs." After review of the TAR and care plan for Resident # 13 for the use of the sheep kin covered pillow, LPN # 5 stated, "The care plan wasn't being followed."

On 08/23/18 at 11:53 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of clinical services. When asked to describe the purpose of the care plan, ASM # 2 stated, "To identify a problem or potential problem and have interventions to prevent further incidents." When asked why it is important to follow the care plan ASM # 2 stated, "To keep them safe & healthy." After review of

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the TAR and care plan for Resident # 13 for the use of the sheep kin covered pillow, ASM # 2 stated, "The care plan wasn't being followed."

On 08/23/18 at approximately 3:05 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of clinical services were made aware of the findings.

No further information was provided prior to exit.

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

(2) The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html.

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

(4) A contracture develops when the normally stretchy (elastic) tissues are replaced by nonstretchy (inelastic) fiber-like tissue. This tissue makes it hard to stretch the area and prevents

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F 656	Continued From page 58 normal movement. Contractures mostly occur in the skin, the tissues underneath, and the muscles, tendons, ligaments surrounding a joint. They affect range of motion and function in a certain body part. Often, there is also pain. This information was obtained from the website: https://medlineplus.gov/ency/article/003185.htm.	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 observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for two of 35 residents in the survey sample, Residents # 14 and # 15. 1. The facility staff failed to clarify Resident # 14's physician order for the use of prn (as needed) Tylenol (1) and oxycodone (2). 2. The facility staff failed to clarify Resident 15's physician's order for Coreg. The findings include: 1. The facility staff failed to clarify Resident # 14's physician order for the use of prn (as needed) Tylenol (1) and oxycodone (2).	F 658	1.Physician and Pharmacist review completed regarding resident # 15's Coreg. Physician's order received/implemented to administer medication per manufacturer's recommendation. Physician/Pharmacist review regarding resident #15's Percocet. Physician's order received/implemented to discontinue the Percocet. . 2.Quality Review conducted by Unit Managers and Licensed Pharmacist to ensure residents with Coreg and Percocet are receiving medications per professional standards. Follow up based on findings. 3.Director of Nursing/Designee provided re-education with Licensed Nurses regarding administration of medications to meet professional standards. 4.Quality Improvement Monitoring to be conducted by Director of Nursing/ designee for medication administration completed meeting professional standards 5x/week x 4 weeks, weekly x4, then monthly as needed thereafter. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. 5.Allegation of compliance date of 10/02/2018	

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F 658	Continued From page 59 Resident # 14 was admitted to the facility on 07/18/17 with diagnoses that included but were not limited to dementia (3), peripheral vascular disease, (4), dysphagia (5) and anxiety (6). Resident # 14's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/11/18, coded Resident # 14 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 14 was coded as requiring extensive assistance of one staff member for activities of daily living. The POS (physician's order sheet) for Resident # 14 dated 08/01/18 through 08/31/18 documented, "MAPAP 325MG (milligram) Tablet for Tylenol. 2 (two) Tabs (tablets) [650MG] by mouth every 6 (six) hours as needed for pain. Order Date 01/02/18." "Oxycodone-acetaminophen 5-325MG Tablet for Percocet. 0.5 tab by mouth every 6 hours as needed for pain. Order Date 07/17/18." The MAR (medication administration record) dated "July 2018" documented, "MAPAP 325MG (milligram) Tablet for Tylenol. 2 (two) Tabs (tablets) [650MG] by mouth every 6 (six) hours as needed for pain. Order Date 01/02/18." "Oxycodone-acetaminophen 5-325MG Tablet for Percocet. 0.5 tab by mouth every 6 hours as needed for pain. Order Date 07/17/18." Further review of the MAR dated July 2018 failed to evidence the administration of MAPAP and evidenced the administration of Oxycodone-acetaminophen on 07/05/18 at 9:45 a.m., 07/09/18 at 8:00 p.m., 07/11/18 at 8:00	F 658		

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p.m., 07/12/18 at 6:00 a.m., 07/20/18 at 9:45 a.m., 07/24/18 at 6:30 a.m. and on 07/25/18 at 6:00 a.m.

The MAR (medication administration record) dated "August 2018" documented, "MAPAP 325MG (milligram) Tablet for Tylenol. 2 (two) Tabs (tablets) [650MG] by mouth every 6 (six) hours as needed for pain. Order Date 01/02/18." "Oxycodone-acetaminophen 5-325MG Tablet for Percocet. 0.5 tab by mouth every 6 hours as needed for pain. Order Date 07/17/18." Further review of the MAR dated August 2018 failed to evidence the administration of MAPAP and evidenced the administration of Oxycodone-acetaminophen on 08/10/18 at 10:40 a.m., 08/15 /18 at 10:00 a.m., 08/16/18 at 8:45 a.m., and on 08/23/18 at 9:25 a.m.

The comprehensive care plan for Resident # 14 dated 01/16/2018 documented, "Focus. (Resident # 14) has alteration in pain/comfort r/t (related to) right hip fracture. Date initiated: 01/16/2018. Under "Interventions" it documented, "Administer analgesia as per orders and prior to treatments or care prn. Date initiated: 01/16/2018."

On 08/23/18 at11:36 a.m., an interview was conducted with LPN (licensed practical nurse) # 5. When asked to describe the process for administering PRN pain medication, LPN # 5 stated, "Ask what scale of pain they have from one to ten, administer the medication as per the doctor order then document what it was given for, time and dates and pain scale then go back in about an hour to see if it was effective." When asked to describe the process of how would you determine what pain medication should be

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administered if there were two prn pain medications ordered. LPN # 5 stated, "You can ask the resident which one they want."

On 08/23/18 at 11:53 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of clinical services. When asked to describe the process for administering PRN pain medication, ASM # 2 stated, "Assess level of pain. For a verbal resident use a one to ten scale , if they are nonverbal use their facial expression like body language, If the pain is ten out of ten I would administer the pain medication, if it's lower I would try non-pharmacological interventions first, reassess about an half an hour. If they are still in pain reassess and give the pain medications." When asked to describe the process of how would you determine which pain medication should be administered if there were two prn pain medications ordered. ASM # 2 stated, "Follow the parameters. If the parameters are not there call the physician and have the order clarified." After reviewing the physician's orders and MARs dated July and August 2018 for Resident # 14's prn pain medication, ASM # 2 stated the order should have been clarified.

On 08/23/18 at approximately 3:05 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of clinical services were made aware of the findings.

No further information was provided prior to exit.

References:
(1) Acetaminophen is used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to

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F 658	Continued From page 62 vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a681004.html. (2) Oxycodone is used to relieve moderate to severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html. (3) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. (4) The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html. (5) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdi	F 658		

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sorders.html.

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

2. The facility staff failed to clarify Resident 15's physician order for Coreg.

Resident #15 was admitted to the facility on 9/26/17 with the diagnoses of but not limited to cirrhosis of the liver, chronic obstructive pulmonary disease, atherosclerotic heart disease, cardiac pacemaker, hypothyroidism, peripheral vascular disease, atrial fibrillation, depression, pelvic fracture, dementia, and high blood pressure. 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 severely cognitively impaired in the ability to make daily life decisions. The resident required total care for bathing; extensive assistance for transfers, dressing, toileting and hygiene; supervision for eating; and was occasionally incontinent of bowel and bladder.

On 8/22/18 at 8:43 a.m., LPN #1 (Licensed Practical Nurse) was observed administering medications to Resident #15. She was observed preparing and administering the following medications:

Aspirin {1}, 81 mg [milligrams] 1 tab [tablet]
Iron {2} 325/65 mg, 1 tab
Lasix {3} 20 mg, 1 tab
Aldactone {4} 100 mg, 1 tab
Coreg {5} 3.125 mg, 1 tab

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Lactulose {6} 30 ml [milliliters]
Levalbuterol {7} 0.63 mg [milligram]/3ml [milliliter] vial, nebulizer treatment
Prednisone {8} 10 mg, 2 tabs
Fentanyl {9} 12 mcg (micrograms] patch

The pharmacy label for the above identified Coreg documented to administer before meals.

A review of the clinical record revealed the POS (Physician's Order Sheet) for June 2018, which documented, "(Coreg) 3.125 mg...take 1 tab by mouth twice daily for hypertension...." This medication was scheduled for 8:00 a.m., and 5:00 p.m. No directions for "with", "before" or "after" meals was identified. This order was written on 3/21/18.

Further review of the clinical record revealed the POS for August 2018, which documented that the Coreg was to be taken twice daily before meals and was scheduled for 7:00 a.m. and 4:30 p.m. These times were earlier than the previously scheduled time. This order was written on 6/30/18 when the resident returned from the hospital.

On 8/22/18 at 9:03 a.m., in an interview with LPN #1, she stated that the resident already had breakfast.

On 8/22/18 at 9:38 a.m., in a follow up interview with LPN #1, she stated she was not sure why the resident was to get the medication before meals.

A review of the pharmacy information provided for Coreg, documented, "....The risk of dizziness is highest within 1 hour after you take your dose. Taking this medication with food and starting

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treatment with a low dose and slowly increasing your dose as directed by your doctor help to reduce the risk of dizziness..." In addition, this information sheet documented, "....If you miss a dose, take it as soon as you remember...."

A review of the manufacturer's information obtained at the web address https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/020297s038lbl.pdf, documented, "COREG should be taken with food to slow the rate of absorption and reduce the incidence of orthostatic effects."

On 8/23/18 at 8:10 a.m., an interview was conducted with ASM #2 (Administrative Staff Member - Director of Clinical Services). ASM #2 stated that the resident was getting the medication with meals per the 8:00 a.m., and 5:00 p.m., schedule, but then went to the hospital for a few days and upon return from the hospital on 6/30/18, the order was changed to before meals per the 7:00 a.m., and 4:30 p.m., schedule. ASM #2 stated the change occurred at the hospital, and that upon return the facility should have clarified the order. ASM #2 stated that the facility clarified the order with the physician last night (8/22/18) and that it was changed to be taken with meals, per manufacturer's instructions.

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

According to "Fundamentals of Nursing" 7th edition, 2009; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 336, "The physician is responsible for directing medical treatment. Nurses follow physician's orders unless they

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believe the orders are in error or would harm clients. Therefore you need to assess all orders... A nurse carrying out an inaccurate or inappropriate order is legally responsible for any harm the client suffers."

{1} Aspirin - "Prescription aspirin is used to relieve the symptoms of rheumatoid arthritis (arthritis caused by swelling of the lining of the joints), osteoarthritis (arthritis caused by breakdown of the lining of the joints), systemic lupus erythematosus (condition in which the immune system attacks the joints and organs and causes pain and swelling) and certain other rheumatologic conditions (conditions in which the immune system attacks parts of the body). Nonprescription aspirin is used to reduce fever and to relieve mild to moderate pain from headaches, menstrual periods, arthritis, colds, toothaches, and muscle aches. Nonprescription aspirin is also used to prevent heart attacks in people who have had a heart attack in the past or who have angina (chest pain that occurs when the heart does not get enough oxygen). Nonprescription aspirin is also used to reduce the risk of death in people who are experiencing or who have recently experienced a heart attack. Nonprescription aspirin is also used to prevent ischemic strokes (strokes that occur when a blood clot blocks the flow of blood to the brain) or mini-strokes (strokes that occur when the flow of blood to the brain is blocked for a short time) in people who have had this type of stroke or mini-stroke in the past. Aspirin will not prevent hemorrhagic strokes (strokes caused by bleeding in the brain). Aspirin is in a group of medications called salicylates. It works by stopping the production of certain natural substances that

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cause fever, pain, swelling, and blood clots."
Information obtained from
https://medlineplus.gov/druginfo/meds/a682878.html

{2} Iron - "Iron is a mineral that our bodies need for many functions. For example, iron is part of hemoglobin, a protein which carries oxygen from our lungs throughout our bodies. It helps our muscles store and use oxygen. Iron is also part of many other proteins and enzymes."
Information obtained from
https://medlineplus.gov/iron.html

{3} Lasix - "Furosemide is used alone or in combination with other medications to treat high blood pressure. Furosemide is used to treat edema (fluid retention; excess fluid held in body tissues) caused by various medical problems, including heart, kidney, and liver disease. Furosemide is in a class of medications called diuretics ('water pills'). It works by causing the kidneys to get rid of unneeded water and salt from the body into the urine."
Information obtained from
https://medlineplus.gov/druginfo/meds/a682858.html

{4} Aldactone - "Spironolactone is used to treat certain patients with hyperaldosteronism (the body produces too much aldosterone, a naturally occurring hormone); low potassium levels; heart failure; and in patients with edema (fluid retention) caused by various conditions, including liver, or kidney disease. It is also used alone or with other medications to treat high blood pressure. Spironolactone is in a class of medications called aldosterone receptor antagonists. It causes the kidneys to eliminate

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unneeded water and sodium from the body into the urine but reduces the loss of potassium from the body."
Information obtained from https://medlineplus.gov/druginfo/meds/a682627.html

{5} Coreg - "Carvedilol is used to treat heart failure (condition in which the heart cannot pump enough blood to all parts of the body) and high blood pressure. It also is used to treat people who have had a heart attack....Carvedilol comes as a tablet and an extended-release (long-acting) capsule to take by mouth. The tablet is usually taken twice a day with food. The extended-release capsule is usually taken once a day in the morning with food...."
Information obtained from https://medlineplus.gov/druginfo/meds/a697042.html

{6} Lactulose - "Lactulose is a synthetic sugar used to treat constipation. It is broken down in the colon into products that pull water out from the body and into the colon. This water softens stools. Lactulose is also used to reduce the amount of ammonia in the blood of patients with liver disease. It works by drawing ammonia from the blood into the colon where it is removed from the body."
Information obtained from https://medlineplus.gov/druginfo/meds/a682338.html

{7} Levalbuterol - "Levalbuterol is used to prevent or relieve the wheezing, shortness of breath, coughing, and chest tightness caused by lung disease such as asthma and chronic obstructive pulmonary disease (COPD; a group of diseases

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F 658	Continued From page 69 that affect the lungs and airways). Levalbuterol is in a class of medications called beta agonists. It works by relaxing and opening air passages to the lungs to make breathing easier." Information obtained from https://medlineplus.gov/druginfo/meds/a603025.html {8} Prednisone - "Prednisone is used alone or with other medications to treat the symptoms of low corticosteroid levels (lack of certain substances that are usually produced by the body and are needed for normal body functioning). Prednisone is also used to treat other conditions in patients with normal corticosteroid levels. These conditions include certain types of arthritis; severe allergic reactions; multiple sclerosis (a disease in which the nerves do not function properly); lupus (a disease in which the body attacks many of its own organs); and certain conditions that affect the lungs, skin, eyes, kidneys blood, thyroid, stomach, and intestines. Prednisone is also sometimes used to treat the symptoms of certain types of cancer. Prednisone is in a class of medications called corticosteroids. It works to treat patients with low levels of corticosteroids by replacing steroids that are normally produced naturally by the body. It works to treat other conditions by reducing swelling and redness and by changing the way the immune system works." Information obtained from https://medlineplus.gov/druginfo/meds/a601102.html {9} Fentanyl - "Fentanyl patches are used to relieve severe pain in people who are expected to need pain medication around the clock for a long time and who cannot be treated with other	F 658		

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F 658	Continued From page 70 medications. Fentanyl is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain." Information obtained from https://medlineplus.gov/druginfo/meds/a601202.html	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility and clinical record review, it was determined that the facility staff failed to provide services to prevent a pressure injury for one of 35 residents in the survey sample, Resident 13. The facility staff failed to provide a physician ordered sheepskin cover pillow to prevent skin break down on the inside of Resident # 13's knees on multiple dates in August 2018.	F 686	1.Director of Nursing completed skin assessment for resident #13 noting no new areas of alteration in skin integrity. 2.Director of Nursing/Designee conducted a Quality Review of current residents to ensure services provided as recommended minimizing risk for pressure injury. Follow up based on findings. 3.Director of Nursing/Designee provided re-education to Licensed Nurses regarding services provided as recommended to prevent pressure injury. 4.Quality Improvement Monitoring to be completed by DON or designee to ensure services provided as recommended to minimize risk for pressure injury 5x/week x 4 weeks, weekly x4, then monthly and as needed thereafter. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. 5.Allegation of compliance date of 10/02/2018	

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The findings include:

Resident # 13 was admitted to the facility on 01/07/10 with diagnoses that included but were not limited to dementia (1), peripheral vascular disease, (2), hypertension (3) and contractures (4).

Resident # 13's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/10/18, coded Resident # 13 as scoring a 3 (three) on the brief interview for mental status (BIMS) of a score of 0 - 15, 3 (three) - being severely impaired of cognition for making daily decisions. Resident # 13 was coded as being totally dependent of one staff member for activities of daily living.

On 08/21/18 at 4:45 p.m., an observation of Resident # 13 was conducted with CNA (certified nursing assistant) # 1. Resident # 13 was lying in bed awake. CNA # 1 pulled back the blanket covering Resident # 13's legs exposing a fleece blanket unfolded laying between Resident # 13's legs from just above the knees to about mid-calf.

On 08/21/18 at approximately 10:00 p.m., an observation of Resident # 13 was conducted with LPN (licensed practical nurse) # 3. Resident # 13 was lying in bed awake with the head of the bed raised. LPN # 3 pulled up the blanket covering Resident # 13's legs. Observation of Resident # 13's leg failed to evidence a pillow with a sheepskin covering set between Resident # 13's legs. When asked where the pillow with a sheepskin covering was, LPN # 3 stated, "I don't see it." When asked why Resident # 13's was supposed to have the pillow with a sheepskin covering, LPN # 3 stated, "It is used to prevent

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F 686	Continued From page 72 skin breakdown on the inside of his (Resident # 13) knees." When asked if Resident # 13 has had a pillow for his knees, LPN # 3 stated, "It's probably still down in laundry, it was sent to be cleaned probably yesterday." When asked how often Resident # 13 should have the pillow between his legs, LPN # 3 stated, "All the time." When asked how often Resident # 13's pillow is checked to ensure it is in place, LPN # 3 stated, "It's checked q (every) shift which is two times a day because our shift is 12 hours." After reviewing the TAR with LPN # 3, LPN #3 stated, "He hasn't had it (pillow) in quite a while." When asked to describe the procedure for checking the TAR, LPN # 3 stated, "They are checked monthly when they are change out and the night shift is supposed to check for any holes." When asked to explain the circle around the dates, LPN # 3 stated, "It means it wasn't done, and then it is put on the 24 hour report. It was probably put on the first 24 hour report and not after that." When asked to describe the procedure staff follows, LPN # 3 stated. "The director of clinical services takes the information from the 24 hour report and refers it to the supply clerk." The physician's orders dated 08/01/18 through 08/31/18 for Resident # 13 documented, "06/22/18 Place pillow with sheep skin between BLE (bilateral lower extremity) to decrease pressure when in bed." The comprehensive care plan for Resident # 13 dated 03/23/2016 and a revision of 06/05/2017 documented, "(Resident # 13) has the potential for impaired skin integrity r/t (related to) incontinence and immobility." Under "Interventions" it documented, "Pillow between with sheep skin between legs. Date initiated:	F 686		

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06/23/2017."

The TAR (treatment administration record) dated 08/01/18 through 08/31/18 documented, "06/22/18 Place pillow with sheep skin between BLE to decrease pressure when in bed." Review of the TAR revealed circles on the 7:00 a.m. -7:00 p.m. shift around the dates of 08/02/18, 08/03/18, 08/09/18, 08/10/18, 08/14/18, 08/15/18, 08/16/18, 08/17/18, 08/19/18, 08/20/18 and 08/21/18 and additional circles on the 7:00 p.m. -7:00 a.m. shift around the dates of 08/06/18, 08/07/18, 08/08/18, 08/09/18, 08/10/18, 08/11/18, 08/12/18, 08/13/18, 08/14/18, 08/15/18, 08/06/18, 08/16/18, 08/18/18, 08/20/18 and 08/21/18.

On 08/21/18 at approximately 10:10 p.m., an interview was conducted with ASM (administrative staff member) # 2, director of clinical services. When asked about the pillow with a sheepskin covering for Resident # 13, ASM #2 stated, "We don't have the sheep skin, they have to order it."

On 08/22/18 at approximately 8:00 a.m., ASM # 2 provided this surveyor with copies of the facility's "24 Hour Report" dated "08/08/18, 08/09/18, 08/10/18, 08/11/18, 08/12/18, 08/13/18, 08/15/18, 08/16/18, 08/17/18, 08/18/18, 08/19/18 and 08/20/18. Review of all the 24 hour reports failed to evidence documentation under the heading "Remarks / Change of Condition" for Resident # 13.

On 08/22/18 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of clinical services were made aware of the findings.

No further information was provided prior to exit.

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F 686	Continued From page 74 References: (1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. (2) The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html. (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (4) A contracture develops when the normally stretchy (elastic) tissues are replaced by nonstretchy (inelastic) fiber-like tissue. This tissue makes it hard to stretch the area and prevents normal movement. Contractures mostly occur in the skin, the tissues underneath, and the muscles, tendons, ligaments surrounding a joint. They affect range of motion and function in a certain body part. Often, there is also pain. This information was obtained from the website: https://medlineplus.gov/ency/article/003185.htm.	F 686		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		

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F 756	Continued From page 75 §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.	F 756	1.Resident's # 12, 62, 54, 11, 81 and 41 medication regimen has been reviewed by pharmacist and physician. Recommendations addressed. 2.Director of Nursing/Consultant Pharmacist/Designee conducted a Quality Review of current facility residents for physician review/address pharmacy recommendations timely. Follow up based on findings. 3.Director of Nursing/Designee provided re-education for Licensed Nurses regarding pharmacy recommendation procedure. 4.Director of Nursing/Designee to conduct Quality Improvement Monitoring of pharmacist medication review recommendations follow up completed timely monthly x 4 months, then quarterly and as needed thereafter. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. 5.Allegation of compliance date of 10/02/2018	

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F 756	Continued From page 76 This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility document review, it was determined that the facility staff failed to develop a medication regimen review policy that included time frames to address recommendations from the pharmacist to the physician for six of 35 residents, residents #12, #62, #54, #11, #81, and #41. 1. For Resident #12, the facility staff failed to ensure the Monthly Regimen Review policy specified time frames in which the physician was to act upon any pharmacy recommendations. 2. For Resident #62, the facility staff failed to ensure the Monthly Regimen Review policy specified time frames in which the physician was to act upon any pharmacy recommendations. 3. For Resident #54, the facility staff failed to ensure the Monthly Regimen Review policy specified time frames in which the physician was to act upon any pharmacy recommendations. 4. For Resident #11, the facility staff failed to ensure the Monthly Regimen Review policy specified time frames in which the physician was to act upon any pharmacy recommendations. 5. For Resident #81, the facility staff failed to ensure the Monthly Regimen Review policy specified time frames in which the physician was to act upon any pharmacy recommendations. 6. For Resident #41, the facility staff failed to ensure the Monthly Regimen Review policy specified time frames in which the physician was	F 756		

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to act upon any pharmacy recommendations.

The findings include:

1. For Resident #12, the facility staff failed to ensure the Monthly Regimen Review policy specified time frames in which the physician was to act upon any pharmacy recommendations.

Resident #12 was admitted to the facility on 12/16/06 with a most recent readmission on 8/19/15, with diagnoses that included but were not limited to: Parkinson's disease (a movement disorder) (1), muscle weakness, lack of coordination, difficulty swallowing, dementia, diabetes, and anxiety.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/10/18, coded the resident as scoring a "13" on the BIMS (brief interview for mental status) score, indicating he has little to no cognitive impairment for daily decision making. In Section N - Medications, the resident was coded as receiving anti-psychotics during the look back period.

A review of Resident #12's clinical record documented communication between the MD (medical doctor) and pharmacist regarding Resident #12's medication regimen.

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 8/23/18 at 11:09 a.m. When asked about the process staff follows for the monthly pharmacy recommendations, ASM #2 stated, "The

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pharmacist sends the recommendation via email to both me and the doctor. I then sign them off and file them." When asked what happens with the recommendations, ASM #2 state, "the staff or the doctor address the recommendation to either follow or document why it is not to be followed." ASM #2 also noted that the pharmacist comes to the facility monthly. ASM #2 further stated that she was not always printing them and providing them to the doctor in a timely manner, which is why the pharmacist emails her, and the doctor now. ASM #2 verified that the medication regimen review, policy does not contain time frames to act on recommendations and that "needs to be addressed in the policy."

On 8/23/18 at 3:06 p.m., ASM #1, the administrator and ASM #2, the director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/parkinsonsdisease.html

2. For Resident #62, the facility staff failed to ensure the Monthly Regimen Review policy specified time frames in which the physician was to act upon any pharmacy recommendations.

Resident #62 was admitted to the facility on 10/9/13, with a most recent readmission of 7/9/18, with diagnoses that included but were not limited to: chronic obstructive pulmonary disease

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(a chronic lung disease that makes it difficult to breathe) (1), muscle weakness, arthritis, hypertension, and depression.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 8/5/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident has no cognitive impairment for daily decision making. In Section N - Medications, the resident was coded as receiving anti-anxiety and anti-depressants during the look back period.

A review of Resident #62's clinical record documented communication between the MD (medical doctor) and pharmacist regarding Resident #62's medication regimen.

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 8/23/18 at 11:09 a.m. When asked about the process staff follows for the monthly pharmacy recommendations, ASM #2 stated, "The pharmacist sends the recommendation via email to both me and the doctor. I then sign them off and file them." When asked what happens with the recommendations, ASM #2 state, "the staff or the doctor address the recommendation to either follow or document why it is not to be followed." ASM #2 also noted that the pharmacist comes to the facility monthly. ASM #2 further stated that she was not always printing them and providing them to the doctor in a timely manner, which is why the pharmacist emails her, and the doctor now. ASM #2 verified that the medication regimen review, policy does not contain time frames to act on recommendations and that "needs to be addressed in the policy."

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On 8/23/18 at 3:06 p.m., ASM #1, the administrator and ASM #2, the director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/copd.html

3. For Resident #54, the facility staff failed to ensure the Monthly Regimen Review policy specified time frames in which the physician was to act upon any pharmacy recommendations.

Resident #54 was admitted to the facility on 2/11/16, with a most recent readmission of 5/9/16, with diagnoses that included but were not limited to: chronic pain, dementia, high blood pressure, delusions (false beliefs that the person thinks are real) (1), anxiety, and depression.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 8/4/18, coded the resident as scoring a "10" on the BIMS (brief interview for mental status) score, indicating the resident has moderate cognitive impairment for daily decision making. The resident was coded as independent for bed mobility, transfers, locomotion on and off the unit, dressing, eating, toileting, and personal hygiene. In Section N - Medications, the resident was coded as receiving

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anti-psychotic and anti-anxiety medications during the look back period.

A review of Resident #54's clinical record documented communication between the MD (medical doctor) and pharmacist regarding Resident #54's medication regimen.

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 8/23/18 at 11:09 a.m. When asked about the process staff follows for the monthly pharmacy recommendations, ASM #2 stated, "The pharmacist sends the recommendation via email to both me and the doctor. I then sign them off and file them." When asked what happens with the recommendations, ASM #2 state, "the staff or the doctor address the recommendation to either follow or document why it is not to be followed." ASM #2 also noted that the pharmacist comes to the facility monthly. ASM #2 further stated that she was not always printing them and providing them to the doctor in a timely manner, which is why the pharmacist emails her, and the doctor now. ASM #2 verified that the medication regimen review, policy does not contain time frames to act on recommendations and that "needs to be addressed in the policy."

On 8/23/18 at 3:06 p.m., ASM #1, the administrator and ASM #2, the director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

1) This information was obtained from the National Institutes of Health at https://www.nia.nih.gov/health/alzheimers-and-hallucinations-delusions-and-paranoia

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4. For Resident #11, the facility staff failed to ensure the Monthly Regimen Review policy specified time frames in which the physician was to act upon any pharmacy recommendations.

Resident #11 was admitted to the facility on 12/16/14, with a most recent readmission of 4/16/17, with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (a chronic lung disease that makes it difficult to breathe) (1), muscle weakness, difficulty swallowing, Parkinson's disease (a movement disorder) (2), chronic pain, diabetes, and anxiety.

The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 6/8/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident has no cognitive impairment for daily decision making. In Section N - Medications, the resident was coded as receiving anti-depressant and anti-anxiety medications during the look back period.

A review of Resident #11's clinical record documented communication between the MD (medical doctor) and pharmacist regarding Resident #11's medication regimen.

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 8/23/18 at 11:09 a.m. When asked about the process staff follows for the monthly pharmacy

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recommendations, ASM #2 stated, "The pharmacist sends the recommendation via email to both me and the doctor. I then sign them off and file them." When asked what happens with the recommendations, ASM #2 state, "the staff or the doctor address the recommendation to either follow or document why it is not to be followed." ASM #2 also noted that the pharmacist comes to the facility monthly. ASM #2 further stated that she was not always printing them and providing them to the doctor in a timely manner, which is why the pharmacist emails her, and the doctor now. ASM #2 verified that the medication regimen review policy does not contain time frames to act on recommendations and that "needs to be addressed in the policy."

On 8/23/18 at 3:06 p.m., ASM #1, the administrator and ASM #2, the director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/copd.html
2) This information was obtained from the National Institutes of Health at https://medlineplus.gov/parkinsonsdisease.html

5. For Resident #81, the facility staff failed to ensure the Monthly Regimen Review policy specified time frames in which the physician was to act upon any pharmacy recommendations.

Resident #81 was admitted to the facility on 8/6/18 with the diagnoses of but not limited to high blood pressure, renal disease, diabetes,

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dementia, Parkinson's disease, ataxia, syncope and collapse, and head injury. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 8/13/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating; and was frequently incontinent.

A review of the clinical record revealed that the pharmacy made recommendations to the resident's medication regimen on 8/15/18. The recommendations were as follows:

"(Resident #81) receives an antipsychotic, Seroquel {1}, but does not have a supporting indication for use documented...."

"During the review of (Resident #81) medical record, the following omissions or errors were noted on the electronic medication administration record (EMAR) / prescriber order sheets (POS):...Diagnosis missing (Medication): Lumigan {2}, Niacin {3}, Rivastigmine {4}, Ropinirole {5}, Sitagliptin {6}..."

Neither recommendation had been acted upon as of 8/23/18.

A review of the facility policy "Monthly Drug Regimen Review" failed to reveal any documented time frames in which the physician must act upon any pharmacy recommendations.

On 8/23/18 at 11:20 AM in an interview with ASM #2 (Administrative Staff Member, the Director of

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F 756	Continued From page 85 Clinical Services) she stated that the process is that the pharmacy will email recommendations and send them to her and to the nurse practitioner or physician to review, and she files them once she gets them back. ASM #2 stated that the doctor or nurse practitioner will write the order if they accepted the recommendation. If not, they write why. ASM #2 stated that the physician or nurse practitioner should act on the recommendations as soon as they get them, but that she was told as long as they are done by the time the pharmacist returns for the next monthly visit. The above identified policy did not document this. ASM #2 verified that the medication regimen review, policy does not contain time frames to act on recommendations and that "needs to be addressed in the policy." No further information was provided by the end of the survey. {1} Seroquel - "Quetiapine tablets and extended-release (long-acting) tablets are used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). Quetiapine tablets and extended-release tablets are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). In addition, quetiapine tablets and extended-release tablets are used with other medications to prevent episodes of mania or depression in patients with bipolar disorder. Quetiapine extended-release tablets are also used along with other	F 756		

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medications to treat depression. Quetiapine tablets may be used as part of a treatment program to treat bipolar disorder and schizophrenia in children and teenagers. Quetiapine is in a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain."
Information obtained from
https://medlineplus.gov/druginfo/meds/a698019.html

{2} Lumigan - "Bimatoprost ophthalmic is used to treat glaucoma (a condition in which increased pressure in the eye can lead to gradual loss of vision) and ocular hypertension (a condition which causes increased pressure in the eye). Bimatoprost is in a class of medications called prostaglandin analogs. It lowers pressure in the eye by increasing the flow of natural eye fluids out of the eye."
Information obtained from
https://medlineplus.gov/druginfo/meds/a602030.html

{3} Niacin - "Niacin is used with diet changes (restriction of cholesterol and fat intake) to reduce the amount of cholesterol (a fat-like substance) and other fatty substances in your blood and to increase the amount of high density lipoprotein (HDL; "good cholesterol")."
Information obtained from
https://medlineplus.gov/druginfo/meds/a682518.html

{4} Rivastigmine - "Rivastigmine is used to treat dementia (a brain disorder that affects the ability to remember, think clearly, communicate, and perform daily activities and may cause changes in mood and personality) in people with Alzheimer's

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disease (a brain disease that slowly destroys the memory and ability to think, learn, communicate and handle daily activities). Rivastigmine is also used to treat dementia in people with Parkinson's disease (a brain and nervous system disease with symptoms of slowing of movement, muscle weakness, shuffling walk, and loss of memory). Rivastigmine is in a class of medications called cholinesterase inhibitors. It improves mental function (such as memory and thinking) by increasing the amount of a certain natural substance in the brain."
Information obtained from
https://medlineplus.gov/druginfo/meds/a602009.html

{5} Ropinirole - "Ropinirole is used alone or with other medications to treat the symptoms of Parkinson's disease (PD; a disorder of the nervous system that causes difficulties with movement, muscle control, and balance), including shaking of parts of the body, stiffness, slowed movements, and problems with balance. Ropinirole is also used to treat restless legs syndrome (RLS or Ekbom syndrome; a condition that causes discomfort in the legs and a strong urge to move the legs, especially at night and when sitting or lying down). Ropinirole is in a class of medications called dopamine agonists. It works by acting in place of dopamine, a natural substance in the brain that is needed to control movement."
Information obtained from
https://medlineplus.gov/druginfo/meds/a698013.html

{6} Sitagliptin - "Sitagliptin is used along with diet and exercise and sometimes with other medications to lower blood sugar levels in

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patients with type 2 diabetes (condition in which blood sugar is too high because the body does not produce or use insulin normally). Sitagliptin is in a class of medications called dipeptidyl peptidase-4 (DPP-4) inhibitors. It works by increasing the amounts of certain natural substances that lower blood sugar when it is high."
Information obtained from https://medlineplus.gov/druginfo/meds/a606023.html

6. For Resident #41, the facility staff failed to ensure the Monthly Regimen Review policy specified time frames in which the physician was to act upon any pharmacy recommendations.

Resident #41 was admitted to the facility on 10/20/16 with the diagnoses of but not limited to Schizophrenia, dementia, Parkinson's disease, dysphagia, diabetes, depression, insomnia, peripheral vascular disease, hypothyroidism, anxiety disorder, high blood pressure, toxic megacolon, and gastrointestinal hemorrhage. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 7/23/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, eating, toileting, and hygiene; and was incontinent.

A review of the clinical record revealed that the pharmacy had made a recommendation on 7/19/18 relating to the resident being on a low dose of aspirin {1} for "Please consider

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monitoring a complete blood count (CBC) {2} on the next convenient lab [laboratory] day and then every 6 months thereafter." The physician did not act on this recommendation until 8/14/18, approximately 4 weeks after the recommendation was made.

A review of the facility policy "Monthly Drug Regimen Review" failed to reveal any documented time frames in which the physician must act upon any pharmacy recommendations.

On 8/23/18 at 11:20 AM in an interview with ASM #2 (Administrative Staff Member, the Director of Clinical Services) she stated that the process is that the pharmacy will email recommendations and send them to her and to the nurse practitioner or physician to review, and she files them once she gets them back. ASM #2 stated that the doctor or nurse practitioner will write the order if they accepted the recommendation. If not, they write why. ASM #2 stated that the physician or nurse practitioner should act on the recommendations as soon as they get them, but that she was told as long as they are done by the time the pharmacist returns for the next monthly visit. The above identified policy did not document this. When asked about it taking a month for the physician to act upon the specific pharmacy recommendation identified above, ASM #2 stated that a month is a little too long for a follow up. ASM #2 stated it was her fault because she had failed to print them and provide them to the physician. ASM #2 verified that the medication regimen review, policy does not contain time frames to act on recommendations and that "needs to be addressed in the policy."

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

{1} Aspirin - "Prescription aspirin is used to relieve the symptoms of rheumatoid arthritis (arthritis caused by swelling of the lining of the joints), osteoarthritis (arthritis caused by breakdown of the lining of the joints), systemic lupus erythematosus (condition in which the immune system attacks the joints and organs and causes pain and swelling) and certain other rheumatologic conditions (conditions in which the immune system attacks parts of the body). Nonprescription aspirin is used to reduce fever and to relieve mild to moderate pain from headaches, menstrual periods, arthritis, colds, toothaches, and muscle aches. Nonprescription aspirin is also used to prevent heart attacks in people who have had a heart attack in the past or who have angina (chest pain that occurs when the heart does not get enough oxygen). Nonprescription aspirin is also used to reduce the risk of death in people who are experiencing or who have recently experienced a heart attack. Nonprescription aspirin is also used to prevent ischemic strokes (strokes that occur when a blood clot blocks the flow of blood to the brain) or mini-strokes (strokes that occur when the flow of blood to the brain is blocked for a short time) in people who have had this type of stroke or mini-stroke in the past. Aspirin will not prevent hemorrhagic strokes (strokes caused by bleeding in the brain). Aspirin is in a group of medications called salicylates. It works by stopping the production of certain natural substances that cause fever, pain, swelling, and blood clots." Information obtained from https://medlineplus.gov/druginfo/meds/a682878.html

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{2} Complete Blood Count (CBC) - "Your blood contains red blood cells (RBC), white blood cells (WBC), and platelets. 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.

Specific types include tests for
· RBC - the numbers, size, and types of RBC in the blood
· WBC - the numbers and types of WBC in the blood
· Platelets - the numbers and size of the platelets
· Hemoglobin - an iron-rich protein in red blood cells that carries oxygen
· Hematocrit - how much space red blood cells take up in your blood
· Reticulocyte count - how many young red blood cells are in your blood
· Mean corpuscular volume (MCV) - the average size of your red blood cells

The complete blood count (CBC) includes most or all of these. The CBC is one of the most common blood tests."

Information obtained from
https://medlineplus.gov/bloodcounttests.html

F 758 SS=D Free from Unnec Psychotropic Meds/PRN Use
CFR(s): 483.45(c)(3)(e)(1)-(5) F 758

§483.45(e) Psychotropic Drugs.
§483.45(c)(3) A psychotropic drug is any drug that

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affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

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

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

F 758

1.Resident 81 was discharged from the facility.
2.Director of Nursing/designee conducted a Quality Review of current residents receiving Seroquel for appropriate diagnosis/indication for use. Follow up based on findings.
3.Director of Nursing/Designee provided re-education for licensed nurses regarding required appropriate diagnosis/indications for use with psychotropic medications, including but not limited to Seroquel.
4.Director of Nursing/Designee to conduct Quality Improvement Monitoring of residents with orders for Seroquel 5x/week x 4 weeks, weekly x 4 weeks, the monthly and as needed thereafter. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.
5.Allegation of compliance date of 10/02/2018

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§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
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 to ensure one of 35 residents in the survey sample was free of unnecessary psychotropic medication; Resident #81.

The facility staff failed to ensure that appropriate diagnoses and indications for use were in place for the use of the antipsychotic medication Seroquel for Resident #81.

The findings include:

Resident #81 was admitted to the facility on 8/6/18 with the diagnoses of but not limited to high blood pressure, renal disease, diabetes, dementia, Parkinson's disease, ataxia, syncope and collapse, and head injury. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 8/13/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating; and was frequently incontinent.

A review of the clinical record revealed the

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hospital records provided at the time of admission, the admission physician's orders dated 8/6/18 which documented "Quetiapine 25 mg (milligrams) (one tab) po (by mouth) hs (at bed time)" and did not include a diagnosis. The admission MDS identified above, daily skilled nurses notes from 8/6/18 to 8/22/18, and August 2018 Medication Administration Record which documented that the resident received the medication on 15 occasions. A "Consent for use of Psychoactive Medication Therapy" form which was signed by the resident representative on 8/7/18 which documented "Seroquel" as the medication being consented for but no other information as to why the medication was being administered. The admission nursing assessment dated 8/6/18, the admission, baseline care plan dated 8/6/18, and the only physician's progress note as of the survey, dated 8/8/18. None of these documents indicated the reason for the use of Seroquel for Resident #81.

In addition, a review of the clinical record revealed that the pharmacy made recommendations to the resident's medication regimen on 8/15/18 that included, "(Resident #81) receives an antipsychotic, Seroquel {1}, but does not have a supporting indication for use documented...." As of 8/23/18 this recommendation had not been acted upon by the physician.

A review of the comprehensive care plan which contained one dated 8/21/18 for the use of psychoactive medication, documented, "Psychoactive Medication Use Antipsychotic medication in use for Dx (diagnoses) of dementia." There was no documented indication such as any behavioral concerns or approved

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diagnosis such as schizophrenia, to warrant the use of Seroquel.

A review of the skilled nurses notes dated 8/6/18 through 8/22/18 failed to reveal any behavioral concerns or indications of schizophrenia-associated symptoms; or a diagnosis supporting the use of Seroquel; and frequently documented, "No behavior issues."

The resident was on Seroquel for approximately 17 days since admission without a single indication for the use of the medication.

On 8/23/18 at 12:20 p.m., in an interview with RN (registered nurse) #1, she stated that she did not know why Resident #81 was on this medication. RN #1 stated that she was not aware of any behaviors, had never seen the resident have any behaviors and had not been told through any shift change reports that the resident had exhibited any behaviors. RN #1stated that the use of the Seroquel should be documented and any targeted behaviors should be identified.

On 8/23/18 at 12:32 p.m., in an interview with ASM #2 (Administrative Staff Member, the Director of Clinical Services) she stated that she had not looked at his chart for a diagnosis. ASM #2 stated that the use for the Seroquel should have already been clarified before this date, and that it is an unnecessary medication for this resident.

A review of the facility policy, "Medication Management - Psychotropic Medications" documented, "Residents who have not used psychotropic medications are not given these medications unless the medication is necessary

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F 758	Continued From page 96 to treat a specific condition as diagnosed, documented in the clinical record and per physician order...." No further information was provided by the end of the survey.	F 758		
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 infections before they can spread to other	F 880	1.Director of Nursing assessed resident#14 post treatment provision. Current treatment removed, new treatment applied utilizing standard infection control practices. 2.Director of Nursing/Designee conducted Quality Review Observation of Licensed Nurses for technique compliant with current infection control practices. Follow up based on findings. 3.Director of Nursing/Designee provided re-education for Licensed Nurses including competency demonstration for treatment technique compliant with current infection control standards/practices, including competency demonstration. 4.Director of Nursing/Designee to complete random Quality Improvement monitoring of Licensed Nurses for treatment provided with technique compliant with current infection control standards/practices 3xweekly x 4 weeks, weekly x 4 weeks, then monthly and as needed thereafter. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. 5.Allegation of compliance date of 10/02/2018	

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F 880	Continued From page 97 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, resident interview, staff interview, facility document review, clinical record review, it was determined that the facility staff	F 880		

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failed to implement infection control practices during wound care for one of 35 residents in the survey sample, Resident # 14.

The facility staff failed to use a clean barrier and wash their hands when providing wound care to Resident # 14.

The findings include:

Resident # 14 was admitted to the facility on 07/18/17 with diagnoses that included but were not limited to dementia (1), peripheral vascular disease, (2), dysphagia (3) and anxiety (4).

Resident # 14's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/11/18, coded Resident # 14 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 14 was coded as requiring extensive assistance of one staff member for activities of daily living.

On 08/22/18 at approximately 10:10 a.m., an observation was conducted of Resident # 14' wound care. LPN (licensed practical nurse) # 1 set up a barrier using clean paper towels on one side of Resident # 14's over-the-bed table. LPN # 1 place several 4 x 4 (four inch by four inch) gauze pads and a can of "Saline Wound Flush" on the paper towels. Observation of the opposite side of the over-the-bed table revealed Resident # 14's personal items including a bottle of iced tea, box of tissues, reading glasses, two uncovered drinking straws and a pitcher of water. LPN # 1 put on a clean pair of plastic disposable

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F 880	Continued From page 99 gloves, removed Resident # 14's left sock, removed the gauze pad from the second toe, placed it in the trashcan, removed her gloves, and placed them in the trashcan. LPN # 1 then put on a clean pair of disposable gloves without washing her hands or using hand sanitizer. LPN # 1 picked up several 4 x 4's and the can of "Saline Wound Flush", spayed the wound flush into the gauze pads, placed the can of wound flush back onto the over-the-bed table but not on the paper towels. LPN #1 then cleaned the top of Resident # 14's second toe, placed the gauze pads into the trash, removed her gloves and placed them on the over-the-bed table but not on the paper towel barrier. LPN # 1 put on a clean pair pf disposable gloves without washing her hands or using hand sanitizer, applied a clean dressing, replaced Resident # 14's sock and picked up the gloves and paper towels, placed them in the trash, removed the wound flush. LPN #1 then placed the wound flush it back into the treatment cart, sanitized her hands, went back into Resident # 14's and repositioned the over-the-bed table in front of Resident # 14. On 08/22/18 at 10:45 am., an interview was conducted with LPN 1 regarding Resident # 14's wound care. When asked to describe the procedure staff follows when changing gloves, LPN # 1 stated, "Wash your hands each time you change gloves." When asked if she washed her hands after changing gloves during Resident # 14 wound care, LPN # 1 stated, "No." When asked why the paper towels were set up on the over-the-bed table, LPN # 1 stated, "To make a clean barrier." When informed of the observation of the used gloves and can of wound flush not being placed on the paper towels during Resident # 14' wound care, LPN # 1 stated, "I wasn't	F 880		

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aware."

The facility's policy "Personal Protective Equipment - Using Gloves" documented, "Miscellaneous. 5. Wash hands after removing gloves."

On 08/22/18 at approximately 5:00 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of clinical services were made aware of the findings.

No further information was provided prior to exit.

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

(2) The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html.

(3) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

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F 880	Continued From page 101 (4) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary.	F 880		