STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495233	A. BUILDING ______ B. WING ______	C 08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAUQUIER HEALTH REHABILITATION & NURSING CENTER	**360 HOSPITAL DRIVE WARRENTON, VA 20186**

(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 08/07/18 through 08/09/18. The facility was in 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 8/7/18 through 8/9/18. A complaint was investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 113 certified bed facility was 90 at the time of the survey. The survey sample consisted of 31 current resident reviews (Residents #70, #191, #16, #14, #31, #69, #190, #48, #59, #47, #42, #26, #39, #81, #52, #7, #82, #25, #72, #4, #49, #35, #53, #17, #36, #61, #27, #30, #86, #18 and #290) and six closed record reviews (Residents #91, #341, #92, #1, #90 and #240).	F 000		
F 584 SS=D	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	F 584		9/21/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 08/30/2018

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

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F 584	Continued From page 1	F 584		

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 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, resident representative interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a clean, comfortable, homelike environment for one of 37 residents in the survey sample, Resident #53.

The facility staff failed to maintain Resident #53's

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations.

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F 584	Continued From page 2 floor in a clean manner. The findings include: Resident #53 was admitted to the facility on 1/9/18. Resident #53's diagnoses included but were not limited to dementia (1), weakness and high blood pressure. Resident #53's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/2/18, coded the resident's cognition as moderately impaired. Section G coded Resident #53 as requiring supervision with bed mobility, transfers and walking. On 8/8/18 at 2:39 p.m., an interview was conducted with Resident #53's RR (resident representative). Resident #53's RR voiced concern that staff was not cleaning the floor behind the resident's recliner. The floor behind the recliner was observed. The recliner was located approximately one and a half feet from the wall and the floor was accessible without moving the recliner. Dirt and white debris was observed on the floor behind the recliner. On 8/9/18 at 10:41 a.m., dirt and white debris remained on the floor behind Resident #53's recliner. On 8/9/18 at 10:45 a.m., OSM (other staff member) #11 (a housekeeper) was observed cleaning Resident #53's room. OSM #11 was asked to describe the process for cleaning resident rooms. OSM #11 stated she removes trash from the trashcan, sweeps/mops the floor (including under the bed), and wipes down the furniture/light switches and tray tables. OSM #11 was asked if she completes these tasks on a	F 584	The floor in Resident #53s room was re-swept behind the recliner within 45 minutes of the debris being pointed out. All residents have the potential to be affected. All Environmental Services staff will be re-trained on Daily Cleaning Procedures to ensure understanding of the Daily Room Cleaning Procedures policy. Room rounds will be initiated no later than 9/2/18 to audit cleanliness. Rounds will be conducted by Administrator, department heads, and designated staff. A random inspection of resident rooms will be conducted by the EVS Supervisor or designee weekly x4, bi-weekly x2, and then monthly x3. Inspections will be conducted to include all units in each audit and all staff members at least two times during the audit process. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months then quarterly thereafter.	

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F 584	Continued From page 3	F 584		

daily basis. OSM #11 stated she does complete these tasks daily except sometimes she does clean the light switches and door handles.

On 8/9/18 at 11:25 a.m., dirt and white debris remained on the floor behind Resident #53's recliner.

On 8/9/18 at 11:26 a.m., another interview was conducted with OSM #11. OSM #11 confirmed she was done cleaning Resident #53's room. When asked if she cleans behind Resident #53's recliner, OSM #11 stated the resident is usually in the recliner and she had not cleaned behind the recliner on this day or the previous day. OSM #11 stated, "Usually I check and if there are crumbs, I sweep. I'll start checking it." OSM #11 was asked to accompany this surveyor to look at the floor behind Resident #53's recliner. OSM #11 and this surveyor entered Resident #53's room. Resident #53 was sitting in the recliner. This surveyor received permission from Resident #53 to look at the floor behind the recliner. Resident #53 offered to move; however, the area behind the recliner was accessible without having the resident move. Dirt and white debris remained on the floor behind the recliner. At this time, OSM #11 swept the floor behind the recliner.

On 8/9/18 at 12:50 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

The facility policy titled, "Daily-Cleaning Procedures" documented, "This policy provides guidelines for the Housekeeping employees to follow in the daily cleaning of assigned areas of the facility...Procedure: I. Daily Cleaning Steps- A.

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F 584	Continued From page 4 High Dust, B. Sanitizing and spot cleaning, C. Bathroom cleaning, D. Empty wastebaskets/ashtrays, E. Floor dusting (vacuum carpet), and F. Floor sanitizing..." No further information was presented prior to exit. (1) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dementia	F 584		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.	F 585		9/21/18

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F 585	Continued From page 5 §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as	F 585		

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F 585	Continued From page 6 necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, resident representative interview, staff interview, facility document review and clinical record review, it was determined that	F 585	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider	

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F 585	Continued From page 7 the facility staff failed to promptly resolve grievances for one of 37 residents in the survey sample, Residents #53. The facility staff failed to promptly resolve a grievance regarding the cleanliness of Resident #53's floor. The findings include: Resident #53 was admitted to the facility on 1/9/18. Resident #53's diagnoses included but were not limited to dementia (1), weakness and high blood pressure. Resident #53's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/2/18, coded the resident's cognition as moderately impaired. Section G coded Resident #53 as requiring supervision with bed mobility, transfers and walking. On 8/8/18 at 2:39 p.m., an interview was conducted with Resident #53's RR (resident representative). Resident #53's RR voiced concern that staff was not cleaning the floor behind the resident's recliner. Resident #53's RR stated this concern had been an ongoing issue and she talked to ASM (administrative staff member) #2 (the director of nursing) about one month ago and talked to ASM #1 (the administrator) several weeks ago. Resident #53's RR stated the issue would be resolved for the moment when she voices concern but the issue continues to happen. Resident #53's RR stated ASM #1 told her the facility will be completing a deep cleaning but no date was given. At this time, the floor behind Resident	F 585	with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. Social Services worker provided verbal communication to resident #53□s responsible party on 8/30/18 to ensure concern of cleanliness for resident #53□s room has been resolved. All residents have the potential to be affected by this deficient practice. All unresolved grievances (in last 60 days) will be reviewed to ensure actions have been taken and completed by 9/6/18. Any new grievances received will be completed within 10 days, to include a written or verbal response provided to reporting person(s). Grievances will be discussed during daily IDT meeting to ensure timely follow-up and completion. Administrator or designee will audit grievances weekly x 4 weeks and then monthly x 3 to ensure completion, to include communication with responsible party. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months then quarterly thereafter.	

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F 585	Continued From page 8 #53's recliner was observed. The recliner was located approximately one and a half feet from the wall and the floor was accessible without moving the recliner. Dirt and white debris was observed on the floor behind the recliner. Review of the facility grievance logs for the last three months failed to reveal documentation regarding the above concern voiced by Resident #53's RR. On 8/9/18 at 12:47 p.m., an interview was conducted with ASM #1 and ASM #2. ASM #1 and ASM #2 were asked if Resident #53's RR had voiced concern regarding the cleanliness of the room. ASM #1 confirmed Resident #53's RR had voiced this concern. ASM #1 stated she followed up and the staff were educated about the expectations regarding cleaning resident rooms. ASM #1 stated a deep cleaning schedule had been implemented and this information had been discussed with Resident #53's RR. ASM #1 was asked why this concern was not documented in the grievance logs. ASM #1 stated a lot of times, family members and residents come to her with concerns and she follows up but if there is a fairly easy fix regarding the concern then she does not document the concern on a grievance form. ASM #1 was asked to provide evidence of the deep cleaning schedule and staff education regarding cleaning the rooms. On 8/9/18 at 2:02 p.m., ASM #1 provided a deep cleaning log. ASM #1 stated the log was implemented on 7/31/18. Review of the log revealed no room on Resident #53's unit had been deep cleaned. ASM #1 stated she was unable to provide evidence of staff training regarding the cleaning of resident rooms.	F 585		

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F 585	Continued From page 9 On 8/9/18 at 2:14 p.m., ASM #1 was made aware of the concern that Resident #53's RR's concern had not been resolved. The facility policy titled, "Grievance Resolution" documented, "Purpose: To ensure patient awareness of rights and responsibilities and to provide an accountable Patient Representative/Advocacy Program...B. Any person who voices a grievance should receive a written or verbal response of the grievance within one week. The response will include: - the response to the grievance - the name of the facility contact person - steps taken on behalf of the patient's grievance - the results of the grievance process -the date of completion. The person voicing the concern should be kept informed of what action the health system is undertaking on the patient's behalf and an estimate of when a resolution is expected..." No further information was presented prior to exit. (1) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dementia	F 585		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)	F 622		9/21/18

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F 622	Continued From page 10 §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 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	F 622		

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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 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

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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:
Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to evidence that all required documentation was provided to the receiving facility, for facility initiated transfers for eight of 37 residents in the survey sample; Residents #16, 91, 48, 26, 72, 39, 81, and 36.

1. The facility staff failed to provide evidence that all required documentation was provided to the receiving facility for Resident #16's facility initiated transfer to the hospital on 7/21/18.

2. The facility staff failed provide evidence that the care plan goals were sent with the resident upon a transfer to the hospital on 5/29/18, for Resident #91.

3. The facility staff failed to provide evidence that the comprehensive care plan goals were sent with the resident upon a transfer to the hospital on 7/11/18, for Resident #48.

4. The facility staff failed to evidence that all required documentation was provided to the receiving facility for Resident #26's facility initiated transfer to the hospital on 5/2/18.

5. The facility staff failed to evidence that all required documentation was provided to the

Provider's Plan of Correction:

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations.

Unable to correct failure to provide required documentation to receiving facility for residents #16, #91, #48, #26, #72, #81, #39 and #36.

All residents that transfer out of the facility to a hospital or for therapeutic leave have the potential to be affected.

Facility initiated Transfer and Discharge policy will be implemented to meet requirements and clarify roles/ responsibilities of facility staff. Admissions and nursing staff will be educated on the policy. Nursing will provide required documentation to receiving facility and document accordingly

Admissions personnel or designee will audit 100% of residents EMR to ensure documentation is evident of providing

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F 622	Continued From page 13 receiving facility for Resident #72's facility initiated transfer to the hospital transfer on 6/15/18 and 7/1/18. 6. The facility staff failed to provide evidence that all required information (including physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals) was provided to the hospital staff when Resident #39 was transferred to the hospital on 5/13/18. 7. The facility staff failed to evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer on 06/26/18 for Resident # 81. 8. The facility staff failed to evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer on 07/13/18 for Resident # 36. The findings include: 1. The facility staff failed to provide evidence that all required documentation was provided to the receiving facility for Resident #16's facility initiated transfer to the hospital on 7/21/18. Resident #16 was admitted to the facility on 5/10/18, with a most recent readmission of 7/26/18, with diagnoses that included but were not limited to: altered mental status (confusion) (1), acute respiratory infection, ataxia (trouble coordinating movements), (2), high blood pressure, muscle weakness, diabetes, difficulty	F 622	required documentation to appropriate facility weekly x4 weeks, then 50% bi-weekly x2, then 25% monthly x3 . Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months then quarterly thereafter.	

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F 622	Continued From page 14 swallowing, a pressure ulcer of the sacrum (areas of damaged skin caused by staying in one position for too long.) (3), and hydrocephalus (a problem with the flow of the fluid that surrounds the brain. This fluid is called the cerebrospinal fluid, or CSF. The fluid surrounds the brain and spinal cord and helps cushion the brain. Too much CSF puts pressure on the brain. This pushes the brain up against the skull and damages brain tissue.) (4). The most recent MDS (minimum data set) assessment, a five day Medicare assessment, with an assessment reference date of 8/2/18, coded the resident as scoring a "4" on the BIMS (brief interview for mental status) score, indicating he has severe cognitive impairment for daily decision making. The nurse's note dated 7/20/18 at 3:52 p.m. documented in part, "According to nurse's aids [sic], patient is not acting like himself. He has refused his meds [medications] a few times this week. He will not eat or get out of bed. Concern written to [medical doctor's name] regarding patient not wanting to eat or get out of bed. VS (vital signs): 122/88, 97.6, 94% (percent) on RA (room air), 19, 67. Awaiting response from MD (medical doctor)." The resident transfer form dated 7/21/18 at 2:24 p.m. documented in part, "Reason for Transfer: Family concerned Pt (patient) is declining." Review of the resident transfer form, failed to evidence the residents comprehensive care plan and care plan goals were provided to the receiving hospital at the time of transfer. Review of the clinical record failed to evidence	F 622		

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what resident information, including clinical information, was included in the resident's transfer documentation.

An interview was conducted on 8/8/18 at 4:37 p.m. with LPN (licensed practical nurse) #5. LPN #5 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #5 stated she provides a list of physician's orders, a face sheet, the resident's diagnoses, information on what is going on, and the resident's history and physical. LPN #5 stated she also fills out and sends a transfer sheet and sends a copy of the resident's DNR (do not resuscitate) form. When asked if she provides the resident's comprehensive care plan goals, LPN #5 stated, "I never did that." When asked how she evidences the information she provides to hospital staff, LPN #5 stated she writes, "report called to ER (emergency room)" in the nurse's notes. When asked if she documents the specific information provided, LPN #5 stated she does not because the information is documented on the transfer form. LPN #5 stated the transfer form is sent to the hospital and a copy is placed in a box to be scanned into the resident's chart.

An interview was conducted on 8/8/18 at 5:52 p.m. with RN (registered nurse) #1. RN #1 was asked to describe the process staff follows when transferring a resident to the hospital. RN #1 stated they first obtain a physician's order and notify the Responsible Representative. RN #1 was asked when the physician documents information related to a resident's transfer to the hospital, she stated, "The doctor documents when he comes in to building. If he is in the building at time of transfer, that is when he will

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write his note." When asked if the Resident's comprehensive care plan or comprehensive care plan goals are sent, RN #1 stated, "No". When asked if the facility maintained copies of the documentation sent with Resident #16 upon transfer, she stated "No".

ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above findings on 8/8/18 at 6:00 p.m.

No further information was provided prior to exit.

1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/003205.htm

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

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

4) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/001571.
2. The facility staff failed provide evidence that the comprehensive care plan goals were sent with the resident upon a transfer to the hospital on 5/29/18, for Resident #91.

Resident #91 was admitted to the facility on 4/20/18 with diagnoses that included but were not limited to: fever, Parkinson's disease, (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture,

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rolling motions of the fingers, drooling and muscle weakness, sometimes with emotional instability) (1), dementia, high blood pressure, diabetes, anxiety and gastroesophageal reflux disease (backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the esophagus, commonly known as heartburn) (2).

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 4/30/18, coded the resident as scoring as being unable to complete the questions, so the resident was coded as having both short and long-term memory difficulties and being moderately impaired to make daily cognitive decisions.

The nurse's note dated, 5/29/18 at 12:44 p.m. documented in part, "Patient unresponsive to sternal rub, no output from Foley since 0700 (7:00 a.m.) per primary nurse; vitals 99.4 (temperature) axillary, BP (blood pressure) 83/53, HR (heart rate) 64, SaO2 (oxygen saturation) 91% on room air, resp (respirations) 18, BS (blood sugar) 140. Primary nurse states patient was last seen at baseline mentation at 0300 (3:00 a.m.) when he was put to bed. MD (medical doctor) notified order to send to ED (emergency department) for evaluation. EMS (emergency medical system) notified report to (name of nurse at ED). Patient transferred out of facility without incident. (Name of wife) at bedside and aware, to accompany husband to ED."

On 8/8/18 at 4:37 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 was asked to describe the information

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provided to hospital staff when a resident is transferred to the hospital. LPN #5 stated she provides a list of physician's orders, a face sheet, the resident's diagnoses, information on what is going on, and the resident's history and physical. LPN #5 stated she also fills out and sends a transfer sheet and sends a copy of the resident's DNR (do not resuscitate) form. When asked if she provides the resident's comprehensive care plan goals, LPN #5 stated, "I never did that." When asked how she evidences the information provided to hospital staff, LPN #5 stated she writes, "report called to ER" in the nurse's notes. When asked if she documents the specific information she provides, LPN #5 stated she does not because the information is documented on the transfer form. LPN #5 stated the transfer form is sent to the hospital and a copy is placed in a box to be scanned into the resident's chart.

The copy of the "Resident Transfer Form" dated 5/29/18, documented in part, "Reason for transfer: AMS (altered mental status), hypotension (low blood pressure), no urinary output in 8 hours." There was no documentation that the comprehensive care plan goals or comprehensive care plan was sent with the resident.

The administrator (administrative staff member - ASM #1) and ASM #2, the director of nursing, were made aware of the above concern on 8/9/18 at 12:32 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437.

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(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243.

3. The facility staff failed to provide evidence that the comprehensive care plan goals were sent with the resident upon a transfer to the hospital on 7/11/18, for Resident #48.

Resident #48 was admitted to the facility on 6/13/18 with diagnoses that included but were not limited to; hypothermia, urinary tract infection, heart failure, fractures of the left humerus (arm) and left femur (hip) and atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria) (1).

The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 6/27/18, coded Resident #48 as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions.

The nurse's note dated, 7/10/18 at 11:59 p.m. documented in part, "Temperature 92.9, O2 (oxygen) saturation 94%, breath sounds: mild expiratory wheeze. Bowel sounds active: reports she had a BM (bowel movement) this morning. 1-2 pitting edema of BLE (bilateral lower extremities). Daughter reports she has developed a dry cough. She had felt nauseated earlier in the day. MD (medical doctor) notified of low temperature. At 2345 (11:45 p.m.) patient c/o

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(complained of), 'I can't breathe.' and suspected she had swallowed a toothpick. Daughter was contacted and said she had thrown out the toothpick when the patient was brushing her teeth, and then CNA (certified nursing assistant) then placed the C-Pap mask on the patient without the tooth pick in her mouth. However, the patient requested to be sent to the ER (emergency room). Patient was in no apparent distress, repositioned, her mouth was inspected with no excoriation, or foreign objects seen. Breathing was even at a rate of 16 and not labored. O2 (oxygen) saturation 94% on room air, pulse 52. Family informed, 911 (emergency services) contacted, report given to ED (emergency department), message left for MD and DON (director of nursing)."

The nurse's note dated, 7/11/18 at 12:45 a.m. documented "EMS (emergency management services) arrived at 0015 (12:15 a.m.) putting patient on gurney and transporting her to (name of hospital) Hospital ED. Daughter in parking lot to accompany her mother."

On 8/8/18 at 4:37 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #5 stated she provides a list of physician's orders, a face sheet, the resident's diagnoses, information on what is going on, and the resident's history and physical. LPN #5 stated she also fills out and sends a transfer sheet and sends a copy of the resident's DNR (do not resuscitate) form. When asked if she provides the resident's comprehensive care plan goals, LPN #5 stated, "I never did that." When asked how she evidences the information

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provided to hospital staff, LPN #5 stated she writes, "report called to ER" in the nurse's notes. When asked if she documents the specific information she provides, LPN #5 stated she does not because the information is documented on the transfer form. LPN #5 stated the transfer form is sent to the hospital and a copy is placed in a box to be scanned into the resident's chart.

The "Resident Transfer Form" for Resident #48 dated for 7/11/18 was requested and was not received by the time of exit.

The administrator (administrative staff member - ASM #1) and ASM #2, the director of nursing, were made aware of the above concern on 8/9/18 at 12:32 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.
4. The facility staff failed to evidence that all required documentation was provided to the receiving facility for Resident #26's facility initiated transfer to the hospital on 5/2/18.

Resident #26 was admitted to the facility on 5/1/18 with the diagnoses of but not limited to toxic encephalopathy, acute and chronic respiratory failure, chronic obstructive pulmonary disease, paranoid schizophrenia, atrial fibrillation, pulmonary embolism, diabetes, high blood pressure, and asthma. The most recent MDS (Minimum Data Set) was an admission assessment with an ARD (Assessment Reference Date) of 5/31/18. Resident #26 was coded as cognitively intact in ability to make daily

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life decisions.

A review of the clinical record revealed a physician's note dated 5/2/18 which documented, "....drowsy....lethargic....confused....Assessment and Plan:....5. AMS (altered mental status)/lethargy, needs ABG (arterial blood gas {1}) will send to ER (emergency room)...."

Further review of the clinical record revealed a "Resident Transfer Form" dated 5/2/18. The form was not completed for the following areas: payment source, name and address of transferring facility, relative or guardian information, diagnoses at time of transfer, vitals at time of transfer, reason for transfer, disabilities, incontinence status, impairments, activity tolerance, diet, medications, other therapy, immunization status, advanced directives and code status, bed hold policy given (yes or no).

Further review of the clinical record also failed to evidence any documentation that all the required information was provided to the receiving facility.

On 8/8/18 at 4:37 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #5 stated she provides a list of physician's orders, a face sheet, the resident's diagnoses, information on what is going on, and the resident's history and physical. LPN #5 stated she also fills out and sends a transfer sheet and sends a copy of the resident's DNR (do not resuscitate) form. When asked if she provides the resident's comprehensive care plan goals, LPN #5 stated, "I never did that." When asked how she evidences the information

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provided to hospital staff, LPN #5 stated she writes, "report called to ER" in the nurse's notes. When asked if she documents the specific information she provides, LPN #5 stated she does not because the information is documented on the transfer form. LPN #5 stated the transfer form is sent to the hospital and a copy is placed in a box to be scanned into the resident's chart.

On 8/8/18 at 6:00 p.m., at the end of day meeting, the administrator (ASM #1 - Administrative Staff Member) was made aware of the findings. No further information was provided by the end of the survey.

{1} ABG - Blood gases are a measurement of how much oxygen and carbon dioxide are in your blood. They also determine the acidity (pH) of your blood.
Information obtained from
https://medlineplus.gov/ency/article/003855.htm

5. The facility staff failed to evidence that all required documentation was provided to the receiving facility for Resident #72's facility initiated transfer to the hospital transfer on 6/15/18 and 7/1/18.

Resident #72 was admitted to the facility on 6/13/18 and most recently readmitted on 7/5/18 with the diagnoses of but not limited to gastrostomy (feeding tube), dysphagia, seizures, Parkinson's disease, dementia, hypothyroidism, rhabdomyolysis, acute kidney failure, and hypoxemia. The most recent MDS (Minimum Data Set) was a 5-day assessment with an ARD (Assessment Reference Date) of 7/12/18. Resident #72 was coded as severely cognitively

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impaired in ability to make daily life decisions.

A review of the nurse's notes revealed one dated 6/15/18 at 11:55 p.m., which documented, "Resident sent to (name of hospital) ER (emergency room) for eval (evaluation) after episode of seizure. Daughter was notified."

Further review failed to reveal any evidence of what documentation was sent to the hospital with the resident.

On 7/1/18, Resident #72 was sent to the hospital again. A nurse's note dated 7/1/18 documented, "G-tube [gastrostomy feeding tube*] clogged or possibly dislodged....Called PA (physician's assistant) and informed her the G-tube is clogged and nurses not able to unclog the tube. Gave order to send pt (patient) to the (name of hospital) for eval (evaluation) of G-tube."

A "Resident Transfer Form" was completed for this hospitalization (but not for the 6/15/18 hospitalization). This form was not completely filled in. The data that was not completed included payment source, relative or guardian information, disabilities, incontinence status, impairments, activity tolerance, immunization status, advanced directives and code status, bed hold policy given (yes or no).

Further review of the clinical record also failed to evidence any documentation that all the required information was provided to the receiving facility.

On 8/8/18 at 4:37 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 was asked to describe the information provided to hospital staff when a resident is

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transferred to the hospital. LPN #5 stated she provides a list of physician's orders, a face sheet, the resident's diagnoses, information on what is going on, and the resident's history and physical. LPN #5 stated she also fills out and sends a transfer sheet and sends a copy of the resident's DNR (do not resuscitate) form. When asked if she provides the resident's comprehensive care plan goals, LPN #5 stated, "I never did that." When asked how she evidences the information provided to hospital staff, LPN #5 stated she writes, "report called to ER" in the nurse's notes. When asked if she documents the specific information she provides, LPN #5 stated she does not because the information is documented on the transfer form. LPN #5 stated the transfer form is sent to the hospital and a copy is placed in a box to be scanned into the resident's chart.

On 8/8/18 at 6:00 p.m., at the end of day meeting, the administrator (ASM #1 - Administrative Staff Member) was made aware of the findings. No further information was provided by the end of the survey.

* This information was obtained from the following website: https://medlineplus.gov/ency/article/002937.htm

6. The facility staff failed to provide evidence that all required information (including physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals) was provided to the hospital staff when Resident #39 was transferred to the hospital on 5/13/18.

Resident #39 was admitted to the facility on

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F 622	Continued From page 26 6/6/17. Resident #39's diagnoses included but were not limited to stroke, major depressive disorder and altered mental status. Resident #39's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/19/18, coded the resident as being cognitively intact. Review of Resident #39's clinical record revealed a nurse's note dated 5/13/18 that documented, "Resident was sent to ER (emergency room) due to slurred speech. Resident AOx1 (alert and oriented times one), c/o (complained of) headache but temperature is normal 96.8. BP (Blood pressure): 124/56, 82 (pulse), 18 (respirations), 96.8 (temperature), 96% RA (oxygen saturation level on room air). Resident continue nero (neurological) check r/t (related to) post fall. Notify DON (director of nursing), MD (medical doctor) and RP (responsible party)." Further review of Resident #39's clinical record failed to reveal evidence of the information provided to hospital staff. On 8/8/18 at 4:37 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #5 stated she provides a list of physician's orders, a face sheet, the resident's diagnoses, information on what is going on, and the resident's history and physical. LPN #5 stated she also fills out and sends a transfer sheet and sends a copy of the resident's DNR (do not resuscitate) form. When asked if she provides the resident's comprehensive care plan goals, LPN #5 stated, "I never did that." When asked how she evidences the information	F 622		

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provided to hospital staff, LPN #5 stated she writes, "report called to ER" in the nurse's notes. When asked if she documents the specific information she provides, LPN #5 stated she does not because the information is documented on the transfer form. LPN #5 stated the transfer form is sent to the hospital and a copy is placed in a box to be scanned into the resident's chart.

Further review of Resident #39's clinical record failed to reveal a transfer form for when the resident was sent to the hospital on 5/13/18.

On 8/8/18 at 6:13 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

On 8/9/18 at 2:10 p.m., OSM (other staff member) #9 (the director of admissions) confirmed that no transfer form was completed for Resident #39's transfer to the hospital on 5/13/18.

No further information was presented prior to exit.

7. The facility staff failed to evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer on 06/26/18 for Resident # 81.

Resident # 81 was admitted to the facility on 05/20/18 with a readmission on 06/27/18 with diagnoses that included but were not limited to hypertension (1), hemiplegia, (2), diabetes mellitus (3), and atrial fibrillation (4).

Resident # 81's most recent MDS (minimum data

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F 622	Continued From page 28 set), a quarterly assessment with an ARD (assessment reference date) of 07/16/18, coded Resident # 81 as scoring a (01) one on the brief interview for mental status (BIMS) of a score of 0 - 15, (1) one - being severely impaired of cognition for making daily decisions. The nurse's "Progress Notes" for Resident # 81 dated 06/26/18 documented, "14:54 (2:54 p.m.) SBAR (Situation, Background Assessment Recommendation) Change in status note. Assessment/Appearance: Patient nonverbal. Only (Sic.) opens eyes in response to sternal rub. Skin warm to touch, moist. Facial color grey/ashen. Recommendations/Request: NP (nurse practitioner) notified, ordered to send patient to ED (emergency department) for eval (evaluation)." On 8/8/18 at 4:37 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #5 stated she provides a list of physician's orders, a face sheet, the resident's diagnoses, information on what is going on, and the resident's history and physical. LPN #5 stated she also fills out and sends a transfer sheet and sends a copy of the resident's DNR (do not resuscitate) form. When asked if she provides the resident's comprehensive care plan goals, LPN #5 stated, "I never did that." When asked how she evidences the information provided to hospital staff, LPN #5 stated she writes, "Report called to ER" in the nurse's notes. When asked if she documents the specific information she provides, LPN #5 stated she does not because the information is documented on the transfer form. LPN #5 stated the transfer	F 622		

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form is sent to the hospital and a copy is placed in a box to be scanned into the resident's chart.

Review of the facility's transfer form entitled "Resident Transfer Form" for Resident # 81, without a date, failed to evidence the resident's care plan goals as part of the transfer paperwork.

On 08/09/18 at approximately 12:35 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

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

(2) Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread This information was obtained from the website: https://medlineplus.gov/paralysis.html.

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

(4) A problem with the speed or rhythm of the

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heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

8. The facility staff failed to evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer on 07/13/18 for Resident # 36.

Resident # 36 was admitted to the facility on 04/06/15 with a readmission on 07/15/18 with diagnoses that included but were not limited to hypertension (1), dementia, (2), anxiety (3), and cerebrovascular disease (4).

Resident # 36's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/12/18, coded Resident # 36 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.

The nurse's "Progress Notes" for Resident # 81 dated 07/13/18 documented, "12:20 p.m. SBAR (Situation, Background Assessment Recommendation) Change in status note. Assessment/Appearance: Resident assessed by this nurse, resident noted to be wheezing and her breathing is labored, lung sounds diminished x (times) all lobes. Resident has emesis (vomiting) x 1 (one), feeding held at this time ... Recommendations/Request: NP (nurse practitioner) notified, family notified and DON (director of nursing) notified, NP recommended resident be sent out to ER (emergency room)."

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F 622	Continued From page 31 On 8/8/18 at 4:37 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #5 stated she provides a list of physician's orders, a face sheet, the resident's diagnoses, information on what is going on, and the resident's history and physical. LPN #5 stated she also fills out and sends a transfer sheet and sends a copy of the resident's DNR (do not resuscitate) form. When asked if she provides the resident's comprehensive care plan goals, LPN #5 stated, "I never did that." When asked how she evidences the information provided to hospital staff, LPN #5 stated she writes, "Report called to ER" in the nurse's notes. When asked if she documents the specific information she provides, LPN #5 stated she does not because the information is documented on the transfer form. LPN #5 stated the transfer form is sent to the hospital and a copy is placed in a box to be scanned into the resident's chart. Review of the facility's transfer form entitled "Resident Transfer Form" for Resident # 36 dated 07/13/18 failed to evidence the resident's care plan goals as part of the transfer paperwork. On 08/09/18 at approximately 12:35 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. References: (1) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpr	F 622		

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F 622	Continued From page 32 essure.html. (2) 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. (3) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary. (4) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm.	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	F 623		9/21/18

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F 623	Continued From page 33 (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §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	F 623		

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F 623	Continued From page 34 completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon 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 §	F 623		

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F 623	Continued From page 35 483.70(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, resident representative, and or ombudsman upon transfer to the hospital for eight of 37 residents in the survey sample; Residents #16, 91, 48, 26, 72, 39, 81, and 36. 1. The facility staff failed to provide written notification to Resident/Responsible Representative of a transfer to hospital for Resident #16 on 7/21/18. 2. The facility staff failed to provide written documentation to the resident and/or resident representative and notify the ombudsman for a transfer to the hospital on 5/29/18 for Resident #91. 3. The facility staff failed to provide written documentation to the resident and/or resident representative and notify the ombudsman for a transfer to the hospital on 7/11/18 for Resident #48. 4. The facility staff failed to evidence that written notification of a hospital transfer was provided to For Resident #26's resident representative and ombudsman upon a hospital transfer on 5/2/18. 5. The facility staff failed to evidence that written notification of a hospital transfer was provided to Resident #72's resident representative and ombudsman upon a hospital transfer on 6/15/18 and 7/1/18.	F 623	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. Unable to correct failure to provide required documentation to receiving facility for residents #16, #91, #48, #26, #72, #81, #39 and #36. All residents that transfer out of the facility to a hospital or for therapeutic leave have the potential to be affected. Facility initiated Transfer and Discharge policy will be implemented to meet requirements and clarify roles/ responsibilities of facility staff. Admissions and nursing staff will be educated on the policy. Nursing will provide required documentation to resident representative at time of transfer and social services will notify ombudsman of discharges weekly. Admissions personnel or designee will audit 100% of residents EMR to ensure documentation is evident of providing required documentation to appropriate resident representative and/or ombudsman weekly x4 weeks, then 50% bi-weekly x2, then 25% monthly x3 . Results of audits will be reviewed for	

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F 623	Continued From page 36 6. Resident #39 was transferred to the hospital on 5/13/18. The facility staff failed to provide written notification of the facility initiated transfer to the resident's representative, and failed to send a copy of such notice to the ombudsman. 7. The facility staff failed to provide written notification to the ombudsman, the resident and responsible party (RP) of a facility initiated transfer to the hospital on 06/26/18 for Resident # 81. 8. The facility staff failed to provide written notification to the ombudsman, the resident and responsible party (RP) of a facility initiated transfer to the hospital on 07/13/18 for Resident # 36. The findings include: 1. The facility staff failed to provide written notification to a Resident/Responsible Representative of a transfer to hospital for Resident #16 on 7/21/18. Resident #16 was admitted to the facility on 5/10/18, with a most recent readmission of 7/26/18, with diagnoses that included but were not limited to: altered mental status (confusion) (1), acute respiratory infection, ataxia (trouble coordinating movements), (2), high blood pressure, muscle weakness, diabetes, difficulty swallowing, a pressure ulcer of the sacrum (areas of damaged skin caused by staying in one position for too long.) (3), and hydrocephalus (a problem with the flow of the fluid that surrounds the brain. This fluid is called the cerebrospinal fluid, or CSF. The fluid surrounds the brain and	F 623	patterns and/or trends and reported at QAPI monthly for three months then quarterly thereafter.	

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spinal cord and helps cushion the brain. Too much CSF puts pressure on the brain. This pushes the brain up against the skull and damages brain tissue.) (4).

The most recent MDS (minimum data set) assessment, a five day Medicare assessment, with an assessment reference date of 8/2/18, coded the resident as scoring a "4" on the BIMS (brief interview for mental status) score, indicating he has severe cognitive impairment for daily decision making.

The nurse's note dated 7/20/18 at 3:52 p.m. documented in part, "According to nurse's aids [sic], patient is not acting like himself. He has refused his meds [medications] a few times this week. He will not eat or get out of bed. Concern written to [medical doctor's name] regarding patient not wanting to eat or get out of bed. VS (vital signs): 122/88, 97.6, 94% (percent) on RA (room air), 19, 67. Awaiting response from MD (medical doctor)."

The resident transfer form dated 7/21/18 at 2:24 p.m. documented in part, "Reason for Transfer: Family concerned Pt (patient) is declining." The resident transfer form failed to document if the resident representative was provided written notification for this transfer to the hospital.

Review of the clinical record failed to reveal any documentation evidencing the resident representative was provided written notification for this facility initiated transfer to the hospital.

On 8/8/18 at 4:37 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated she calls residents'

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representatives when residents are transferred to the hospital but she does not provide written notification of the transfers to residents' representatives.

On 8/8/18 at 4:30 p.m., an interview was conducted with OSM (other staff member) #7 (the social worker). OSM #7 stated she does not notify residents' representatives when residents are transferred to the hospital.

On 8/8/18 at 5:16 p.m., an interview was conducted with OSM #9 (the director of admissions). OSM #9 stated she does not notify residents' representatives when residents are transferred to the hospital.

ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above findings on 8/8/18 at 6:00 p.m.

No further information was provided prior to exit.

1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/003205.htm

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

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

4) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/001571.htm

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2. The facility staff failed to provide written documentation to the resident and/or resident representative and notify the ombudsman for a transfer to the hospital on 5/29/18 for Resident #91.

Resident #91 was admitted to the facility on 4/20/18 with diagnoses that included but were not limited to: fever, Parkinson's disease, (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling and muscle weakness, sometimes with emotional instability) (1), dementia, high blood pressure, diabetes, anxiety and gastroesophageal reflux disease (backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the esophagus, commonly known as heartburn) (2).

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 4/30/18, coded the resident as scoring as being unable to complete the questions, so the resident was coded as having both short and long-term memory difficulties and being moderately impaired to make daily cognitive decisions.

The nurse's note dated, 5/29/18 at 12:44 p.m. documented in part, "Patient unresponsive to sternal rub, no output from Foley since 0700 (7:00 a.m.) per primary nurse; vitals 99.4 (temperature) axillary, BP (blood pressure) 83/53, HR (heart rate) 64, SaO2 (oxygen saturation) 91% on room air, resp (respirations) 18, BS (blood sugar) 140. Primary nurse states patient

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was last seen at baseline mentation at 0300 (3:00 a.m.) when he was put to bed. MD (medical doctor) notified, order to send to ED (emergency department) for evaluation. EMS (emergency medical system) notified report to (name of nurse at ED). Patient transferred out of facility without incident. (Name of wife) at bedside and aware, to accompany husband to ED."

The copy of the "Resident Transfer Form" dated 5/29/18, documented in part, "Reason for transfer: AMS (altered mental status), hypotension (low blood pressure), no urinary output in 8 hours." There was no documentation that the resident and/or resident representative and ombudsman were notified in writing for Resident #91 transfer to the hospital on 5/29/18.

On 8/8/18 at 4:37 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated she calls residents' representatives when residents are transferred to the hospital but she does not provide written notification of the transfers to residents' representatives or the ombudsman.

On 8/8/18 at 4:30 p.m., an interview was conducted with OSM (other staff member) #7 (the social worker). OSM #7 stated she does not notify residents' representatives or the ombudsman when residents are transferred to the hospital.

On 8/8/18 at 5:16 p.m., an interview was conducted with OSM #9 (the director of admissions). OSM #9 stated she does not notify residents' representatives or the ombudsman when residents are transferred to the hospital.

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The administrator (administrative staff member - ASM #1) and ASM #2, the director of nursing, were made aware of the above concern on 8/9/18 at 12:32 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243.

3. The facility staff failed to provide written documentation to the resident and/or resident representative and notify the ombudsman for a transfer to the hospital on 7/11/18 for Resident #48.

Resident #48 was admitted to the facility on 6/13/18 with diagnoses that included but were not limited to; hypothermia, urinary tract infection, heart failure, fractures of the left humerus (arm) and left femur (hip) and atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria) (1).

The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 6/27/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions.

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The nurse's note dated, 7/10/18 at 11:59 p.m. documented in part, "Temperature 92.9, O2 (oxygen) saturation 94%, breath sounds: mild expiratory wheeze. Bowel sounds active: reports she had a BM (bowel movement) this morning. 1-2 pitting edema of BLE (bilateral lower extremities). Daughter reports she has developed a dry cough. She had felt nauseated earlier in the day. MD (medical doctor) notified of low temperature. At 2345 (11:45 p.m.) patient c/o (complained of), 'I can't breathe.' and suspected she had swallowed a toothpick. Daughter was contacted and said she had thrown out the toothpick when the patient was brushing her teeth, and then CNA (certified nursing assistant) then placed the C-Pap mask on the patient without the toothpick in her mouth. However, the patient requested to be sent to the ER (emergency room). Patient was in no apparent distress, repositioned, her mouth was inspected with no excoriation, or foreign objects seen. Breathing was even at a rate of 16 and not labored. O2 (oxygen) saturation 94% on room air, pulse 52. Family informed, 911 (emergency services) contacted, report given to ED (emergency department), message left for MD and DON (director of nursing)."

The nurse's note dated, 7/11/18 at 12:45 a.m. documented "EMS (emergency management services) arrived at 0015 (12:15 a.m.) putting patient on gurney and transporting her to (name of hospital) Hospital ED. Daughter in parking lot to accompany her mother."

There was no documentation in the clinical record evidencing the resident and/or resident representative and the ombudsman were provided written notification for Resident #48's

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transfer to the hospital on 7/11/18.

On 8/8/18 at 4:37 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated she calls residents' representatives when residents are transferred to the hospital but she does not provide written notification of the transfers to residents' representatives or the ombudsman.

On 8/8/18 at 4:30 p.m., an interview was conducted with OSM (other staff member) #7 (the social worker). OSM #7 stated she does not notify residents' representatives or the ombudsman when residents are transferred to the hospital.

On 8/8/18 at 5:16 p.m., an interview was conducted with OSM #9 (the director of admissions). OSM #9 stated she does not notify residents' representatives or the ombudsman when residents are transferred to the hospital.

The "Resident Transfer Form" for Resident #48 dated for 7/11/18 was requested and was not received by the time of exit.

The administrator (administrative staff member - ASM #1) and ASM #2, the director of nursing, were made aware of the above concern on 8/9/18 at 12:32 p.m.

No further information was provided prior to exit.

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

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4. The facility staff failed to evidence that written notification of a hospital transfer was provided to For Resident #26's resident representative and ombudsman upon a hospital transfer on 5/2/18.

Resident #26 was admitted to the facility on 5/1/18 with the diagnoses of but not limited to toxic encephalopathy, acute and chronic respiratory failure, chronic obstructive pulmonary disease, paranoid schizophrenia, atrial fibrillation, pulmonary embolism, diabetes, high blood pressure, and asthma. The most recent MDS (Minimum Data Set) was an admission assessment with an ARD (Assessment Reference Date) of 5/31/18. Resident #26 was coded as cognitively intact in ability to make daily life decisions.

A review of the clinical record revealed a physician's note dated 5/2/18 which documented, "....drowsy....lethargic....confused....Assessment and Plan:....5. AMS (altered mental status)/lethargy, needs ABG (arterial blood gas {1}) will send to ER (emergency room)...."

Further review of the clinical record failed to reveal any evidence that the resident's representative and ombudsman were notified of the transfer in writing.

On 8/8/18 at 4:37 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated she calls residents' representatives when residents are transferred to the hospital but she does not provide written notification of the transfers to residents' representatives or the ombudsman.

On 8/8/18 at 4:30 p.m., an interview was

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conducted with OSM (other staff member) #7 (the social worker). OSM #7 stated she does not notify residents' representatives or the ombudsman when residents are transferred to the hospital.

On 8/8/18 at 5:16 p.m., an interview was conducted with OSM #9 (the director of admissions). OSM #9 stated she does not notify residents' representatives or the ombudsman when residents are transferred to the hospital.

On 8/8/18 at 6:00 p.m., at the end of day meeting, the administrator (ASM #1 - Administrative Staff Member) was made aware of the findings. No further information was provided by the end of the survey.

{1} ABG - Blood gases are a measurement of how much oxygen and carbon dioxide are in your blood. They also determine the acidity (pH) of your blood.
Information obtained from
https://medlineplus.gov/ency/article/003855.htm

5. The facility staff failed to evidence that written notification of a hospital transfer was provided to Resident #72's resident representative and ombudsman upon a hospital transfer on 6/15/18 and 7/1/18.

Resident #72 was admitted to the facility on 6/13/18 and most recently readmitted on 7/5/18 with the diagnoses of but not limited to gastrostomy (feeding tube), dysphagia, seizures, Parkinson's disease, dementia, hypothyroidism, rhabdomyolysis, acute kidney failure, and

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F 623	Continued From page 46 hypoxemia. The most recent MDS (Minimum Data Set) was a 5-day assessment with an ARD (Assessment Reference Date) of 7/12/18. Resident #72 was coded as being severely cognitively impaired in ability to make daily life decisions. A review of the nurse's notes revealed one dated 6/15/18 at 11:55 p.m., which documented, "Resident sent to (name of hospital) ER (emergency room) for eval (evaluation) after episode of seizure. Daughter was notified." Further review of the clinical record failed to reveal any evidence that the resident's representative and ombudsman were notified of the 6/15/18, transfer in writing. On 7/1/18, Resident #72 was sent to the hospital again. A nurse's note dated 7/1/18 documented, "G-tube [gastrostomy feeding tube*] clogged or possibly dislodged....Called PA (physician's assistant) and informed her the G-tube is clogged and nurses not able to unclog the tube. Gave order to send pt (patient) to the (name of hospital) for eval (evaluation) of G-tube." A second nurse's note on 7/1/18 at 10:42 p.m., documented, "Resident send to ER to eval her G-tube for clogging at 1500 p.m., (3:00 p.m.), called her daughter (name of daughter) and left her voice mail to call back. Daughter has not returned call." Further review of the clinical record failed to reveal any evidence that the resident's representative and ombudsman were notified of the transfer in writing.	F 623		

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On 8/8/18 at 4:37 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated she calls residents' representatives when residents are transferred to the hospital but she does not provide written notification of the transfers to residents' representatives or the ombudsman.

On 8/8/18 at 4:30 p.m., an interview was conducted with OSM (other staff member) #7 (the social worker). OSM #7 stated she does not notify residents' representatives or the ombudsman when residents are transferred to the hospital.

On 8/8/18 at 5:16 p.m., an interview was conducted with OSM #9 (the director of admissions). OSM #9 stated she does not notify residents' representatives or the ombudsman when residents are transferred to the hospital.

On 8/8/18 at 6:00 p.m., at the end of day meeting, the administrator (ASM #1 - Administrative Staff Member) was made aware of the findings. No further information was provided by the end of the survey.

* This information was obtained from the following website: https://medlineplus.gov/ency/article/002937.htm
6. Resident #39 was transferred to the hospital on 5/13/18. The facility staff failed to provide written notification of the facility initiated transfer to the resident's representative, and failed to send a copy of such notice to the ombudsman.

Resident #39 was admitted to the facility on 6/6/17. Resident #39's diagnoses included but were not limited to stroke, major depressive

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F 623	Continued From page 48 disorder and altered mental status. Resident #39's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/19/18, coded the resident as being cognitively intact. Review of Resident #39's clinical record revealed a nurse's note dated 5/13/18 that documented, "Resident was sent to ER (emergency room) due to slurred speech. Resident AOx1 (alert and oriented times one), c/o (complained of) headache but temperature is normal 96.8. BP (Blood pressure): 124/56, 82 (pulse), 18 (respirations), 96.8 (temperature), 96% RA (oxygen saturation level on room air). Resident continue nero (neurological) check r/t (related to) post fall. Notify DON (director of nursing), MD (medical doctor) and RP (responsible party)." Further review of Resident #39's clinical record failed to reveal written notification of the transfer was provided to the resident's representative, or the ombudsman. On 8/8/18 at 4:37 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated she calls residents' representatives when residents are transferred to the hospital but she does not provide written notification of the transfers to residents' representatives or the ombudsman. On 8/8/18 at 4:30 p.m., an interview was conducted with OSM (other staff member) #7 (the social worker). OSM #7 stated she does not notify residents' representatives or the ombudsman when residents are transferred to the hospital.	F 623		

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On 8/8/18 at 5:16 p.m., an interview was conducted with OSM #9 (the director of admissions). OSM #9 stated she does not notify residents' representatives or the ombudsman when residents are transferred to the hospital.

On 8/8/18 at 6:13 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

7. The facility staff failed to provide written notification to the ombudsman, the resident and responsible party (RP) of a facility initiated transfer to the hospital on 06/26/18 for Resident # 81.

Resident # 81 was admitted to the facility on 05/20/18 with a readmission on 06/27/18 with diagnoses that included but were not limited to hypertension (1), hemiplegia, (2), diabetes mellitus (3), and atrial fibrillation (4).

Resident # 81's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/16/18, coded Resident # 81 as scoring a (01) one on the brief interview for mental status (BIMS) of a score of 0 - 15, (1) one - being severely impaired of cognition for making daily decisions.

The nurse's "Progress Notes" for Resident # 81 dated 06/26/18 documented, "14:54 (2:54 p.m.) SBAR (Situation, Background Assessment Recommendation) Change in status note. Assessment/Appearance: Patient nonverbal. Only (Sic.) opens eyes in response to sternal rub. Skin

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warm to touch, moist. Facial color grey/ashen. Recommendations/Request: NP (nurse practitioner) notified, ordered to send patient to ED (emergency department) for eval (evaluation)."

Review of Resident # 81's clinical record failed to evidence written notification to the ombudsman, Resident # 81 and Resident # 81's responsible party.

On 8/8/18 at 4:37 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated she calls residents' representatives when residents are transferred to the hospital but she does not provide written notification of the transfers to resident's representatives or the ombudsman.

On 8/8/18 at 4:30 p.m., an interview was conducted with OSM (other staff member) #7 (the social worker). OSM #7 stated she does not notify resident's representatives or the ombudsman when residents are transferred to the hospital.

On 8/8/18 at 5:16 p.m., an interview was conducted with OSM #9 (the director of admissions). OSM #9 stated she does not notify resident's representatives or the ombudsman when residents are transferred to the hospital.

On 08/09/18 at approximately 12:35 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

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F 623	Continued From page 51 References: (1) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (2) Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html. (3) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. (4) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html. 8. The facility staff failed to provide written notification to the ombudsman, the resident and responsible party (RP) of a facility initiated transfer to the hospital on 07/13/18 for Resident # 36. Resident # 36 was admitted to the facility on 04/06/15 with a readmission on 07/15/18 with diagnoses that included but were not limited to hypertension (1), dementia, (2), anxiety (3), and	F 623		

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F 623	Continued From page 52 cerebrovascular disease (4). Resident # 36's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/12/18, coded Resident # 36 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. The nurse's "Progress Notes" for Resident # 81 dated 07/13/18 documented, "12:20 p.m. SBAR (Situation, Background Assessment Recommendation) Change in status note. Assessment/Appearance: Resident assessed by this nurse, resident noted to be wheezing and her breathing is labored, lung sounds diminished x (times) all lobes. Resident has emesis (vomiting) x 1 (one), feeding held at this time ... Recommendations/Request: NP (nurse practitioner) notified, family notified and DON (director of nursing) notified, NP recommended resident be sent out to ER (emergency room)." Review of Resident # 36's clinical record failed to evidence written notification to the ombudsman, Resident # 36 and Resident # 36's responsible party. On 8/8/18 at 4:37 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated she calls residents' representatives when residents are transferred to the hospital but she does not provide written notification of the transfers to resident's representatives or the ombudsman. On 8/8/18 at 4:30 p.m., an interview was conducted with OSM (other staff member) #7 (the	F 623		

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social worker). OSM #7 stated she does not notify resident's representatives or the ombudsman when residents are transferred to the hospital.

On 8/8/18 at 5:16 p.m., an interview was conducted with OSM #9 (the director of admissions). OSM #9 stated she does not notify resident's representatives or the ombudsman when residents are transferred to the hospital.

On 08/09/18 at approximately 12:35 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

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

(2) 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.

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

(4) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and

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F 623	Continued From page 54 oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm.	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. §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 and clinical record	F 625	Preparation and/or execution of this plan	9/21/18

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review, and facility document review, it was determined that the facility staff failed to evidence that a written bed hold notification was provided upon a hospital transfer for seven of 37 residents in the survey sample, Resident #16, 91, 48, 26, 72, 81, and 36.

1. The facility staff failed to provide Resident #16's responsible representative written notification of the bed hold policy when the resident was transferred to the hospital on 7/21/18.

2. The facility staff failed to evidence documentation that a copy of the bed hold policy was provided to the resident and/or resident representative upon a transfer to the hospital on 5/29/18 for Resident #91.

3. The facility staff failed to evidence documentation that a copy of the bed hold policy was provided to the resident and/or resident representative upon a transfer to the hospital on 7/11/18 for Resident #48.

4. The facility staff failed to evidence that a written bed hold notice was provided to Resident #26 or the resident representative upon transfer to the hospital on 5/2/18.

5. The facility staff failed to evidence that a written bed hold notice was provided to Resident #72 or the resident representative upon transfer to the hospital on 6/15/18 and 7/1/18.

6. The facility staff failed to provide Resident # 81 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 06/26/18.

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of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations.

Unable to correct failure to provide written notification of bed hold policy for residents #16, #91, #48, #26, #72, #81 and #36.

All residents that transfer out of the facility to a hospital or for therapeutic leave have the potential to be affected.

Bed hold policy will be revised to meet requirements and clarify roles/ responsibilities of facility staff. Admissions, social services and nursing staff will be educated on the policy. Nursing will provide bed hold agreement to resident or responsible party at time of transfer to hospital or therapeutic leave. Social Services or designee will follow up within 24hours to determine bed hold decision.

Admissions personnel or designee will audit 100% of residents EMR, of those discharged to hospital or therapeutic leave, for documentation of bed hold and provision of written notice weekly x4 weeks, then 50% bi-weekly x2, then 25% monthly x3 to ensure the facility meets regulatory requirements for bed hold notifications. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months then quarterly thereafter.

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7. The facility staff failed to provide Resident # 36 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 07/13/18.

The findings include:

1. The facility staff failed to provide Resident #16's responsible representative written notification of the bed hold policy when the resident was transferred to the hospital on 7/21/18.

Resident #16 was admitted to the facility on 5/10/18, with a most recent readmission of 7/26/18, with diagnoses that included but were not limited to: altered mental status (confusion) (1), acute respiratory infection, ataxia (trouble coordinating movements), (2), high blood pressure, muscle weakness, diabetes, difficulty swallowing, a pressure ulcer of the sacrum (areas of damaged skin caused by staying in one position for too long.) (3), and hydrocephalus (a problem with the flow of the fluid that surrounds the brain. This fluid is called the cerebrospinal fluid, or CSF. The fluid surrounds the brain and spinal cord and helps cushion the brain. Too much CSF puts pressure on the brain. This pushes the brain up against the skull and damages brain tissue.) (4).

The most recent MDS (minimum data set) assessment, a five day Medicare assessment, with an assessment reference date of 8/2/18, coded the resident as scoring a "4" on the BIMS (brief interview for mental status) score, indicating

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he has severe cognitive impairment for daily decision making.

The nurse's note dated 7/20/18 at 3:52 p.m. documented in part, "According to nurse's aids [sic], patient is not acting like himself. He has refused his meds (medications) a few times this week. He will not eat or get out of bed. Concern written to [medical doctor's name] regarding patient not wanting to eat or get out of bed. VS (vital signs): 122/88, 97.6, 94% (percent) on RA (room air), 19, 67. Awaiting response from MD (medical doctor)."

The resident transfer form dated 7/21/18 at 2:24 p.m. documented in part, "Reason for Transfer: Family concerned Pt (patient) is declining." The form failed to document if the bed hold policy was provided to the resident or resident representative at the time of transfer.

On 8/8/18 at 5:16 p.m., an interview was conducted with OSM (other staff member) #9 (the director of admissions). OSM #9 stated nurses are supposed to staple the bed hold notice to a transfer form that is sent with residents to the hospital and the hospital staff are supposed to provide the bed hold notice to residents' families. OSM #9 stated if residents' stay in the hospital is more than 24 hours then she calls the residents' families to see if they want a bed hold. OSM #9 stated she emails the management team with the families' decision.

ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above findings on 8/8/18 at 6:00 p.m.

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No further information was provided by completion of the survey.

A review of the facility's "Bed Hold Policy", failed to evidence that the resident and/or responsible party are notified in writing of the bed hold policy upon transfer to a facility.

No further information was provided prior to exit.

1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/003205.htm

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

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

4) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/001571.htm

2. The facility staff failed to evidence documentation that a copy of the bed hold policy was provided to the resident and/or resident representative upon a transfer to the hospital on 5/29/18 for Resident #91.

Resident #91 was admitted to the facility on 4/20/18 with diagnoses that included but were not limited to: fever, Parkinson's disease, (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling and muscle weakness, sometimes with emotional instability)

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(1), dementia, high blood pressure, diabetes, anxiety and gastroesophageal reflux disease (backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the esophagus, commonly known as heartburn) (2).

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 4/30/18, coded the resident as scoring as being unable to complete the questions, so the resident was coded as having both short and long-term memory difficulties and being moderately impaired to make daily cognitive decisions.

The nurse's note dated, 5/29/18 at 12:44 p.m. documented in part, "Patient unresponsive to sternal rub, no output from Foley since 0700 (7:00 a.m.) per primary nurse; vitals 99.4 (temperature) axillary, BP (blood pressure) 83/53, HR (heart rate) 64, SaO2 (oxygen saturation) 91% on room air, resp (respirations) 18, BS (blood sugar) 140. Primary nurse states patient was last seen at baseline mentation at 0300 (3:00 a.m.) when he was put to bed. MD (medical doctor) notified, order to send to ED (emergency department) for evaluation. EMS (emergency medical system) notified report to (name of nurse at ED). Patient transferred out of facility without incident. (Name of wife) at bedside and aware, to accompany husband to ED."

The copy of the "Resident Transfer Form" dated 5/29/18, documented in part, "Reason for transfer: AMS (altered mental status), hypotension (low blood pressure), no urinary output in 8 hours." There was no documentation

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that a copy of the bed hold policy was provided to the resident and/or resident representative upon a transfer to the hospital on 5/29/18 for Resident #91.

There was no documentation in the clinical record evidencing the bed hold policy was provided to the resident and/or resident representative upon a transfer to the hospital on 5/29/18 for Resident #91.

On 8/8/18 at 5:16 p.m., an interview was conducted with OSM (other staff member) #9 (the director of admissions). OSM #9 stated nurses are supposed to staple the bed hold notice to a transfer form that is sent with residents to the hospital and the hospital staff are supposed to provide the bed hold notice to residents' families. OSM #9 stated if residents' stay in the hospital is more than 24 hours then she calls the residents' families to see if they want a bed hold. OSM #9 stated she emails the management team with the families' decision.

The administrator (administrative staff member - ASM #1) and ASM #2, the director of nursing, were made aware of the above concern on 8/9/18 at 12:32 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243.

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3. The facility staff failed to evidence documentation that a copy of the bed hold policy was provided to the resident and/or resident representative upon a transfer to the hospital on 7/11/18 for Resident #48.

Resident #48 was admitted to the facility on 6/13/18 with diagnoses that included but were not limited to; hypothermia, urinary tract infection, heart failure, fractures of the left humerus (arm) and left femur (hip) and atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria) (1).

The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 6/27/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions.

The nurse's note dated, 7/10/18 at 11:59 p.m. documented in part, "Temperature 92.9, O2 (oxygen) saturation 94%, breath sounds: mild expiratory wheeze. Bowel sounds active: reports she had a BM (bowel movement) this morning. 1-2 pitting edema of BLE (bilateral lower extremities). Daughter reports she has developed a dry cough. She had felt nauseated earlier in the day. MD (medical doctor) notified of low temperature. At 2345 (11:45 p.m.) patient c/o (complained of), 'I can't breathe.' and suspected she had swallowed a toothpick. Daughter was contacted and said she had thrown out the toothpick when the patient was brushing her

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teeth, and then CNA (certified nursing assistant) then placed the C-Pap mask on the patient without the toothpick in her mouth. However, the patient requested to be sent to the ER (emergency room). Patient was in no apparent distress, repositioned, her mouth was inspected with no excoriation, or foreign objects seen. Breathing was even at a rate of 16 and not labored. O2 (oxygen) saturation 94% on room air, pulse 52. Family informed, 911 (emergency services) contacted, report given to ED (emergency department), message left for MD and DON (director of nursing)."

The nurse's note dated, 7/11/18 at 12:45 a.m. documented "EMS (emergency management services) arrived at 0015 (12:15 a.m.) putting patient on gurney and transporting her to (name of hospital) Hospital ED. Daughter in parking lot to accompany her mother."

There was no documentation in the clinical record evidencing the bed hold policy was provided to the resident and/or resident representative upon a transfer to the hospital on 7/11/18 for Resident #48.

On 8/8/18 at 5:16 p.m., an interview was conducted with OSM (other staff member) #9 (the director of admissions). OSM #9 stated nurses are supposed to staple the bed hold notice to a transfer form that is sent with residents to the hospital and the hospital staff are supposed to provide the bed hold notice to residents' families. OSM #9 stated if residents' stay in the hospital is more than 24 hours then she calls the residents' families to see if they want a bed hold. OSM #9 stated she emails the management team with the families' decision.

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The "Resident Transfer Form" for Resident #48 dated for 7/11/18 was requested and was not received by the time of exit.

The administrator (administrative staff member - ASM #1) and ASM #2, the director of nursing, were made aware of the above concern on 8/9/18 at 12:32 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.
4. The facility staff failed to evidence that a written bed hold notice was provided to Resident #26 or the resident representative upon transfer to the hospital on 5/2/18.

Resident #26 was admitted to the facility on 5/1/18 with the diagnoses of but not limited to toxic encephalopathy, acute and chronic respiratory failure, chronic obstructive pulmonary disease, paranoid schizophrenia, atrial fibrillation, pulmonary embolism, diabetes, high blood pressure, and asthma. The most recent MDS (Minimum Data Set) was an admission assessment with an ARD (Assessment Reference Date) of 5/31/18. The resident was coded as as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for hygiene, toileting, dressing and transfers; supervision for eating; and was incontinent of bowel and bladder.

A review of the clinical record revealed a physician's note dated 5/2/18 which documented,

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F 625	Continued From page 64 "....drowsy....lethargic....confused....Assessment and Plan:....5. AMS (altered mental status)/lethargy, needs ABG (arterial blood gas {1}) will send to ER (emergency room)...." Further review of the clinical record revealed a "Resident Transfer Form" dated 5/2/18. The form was not completely filled in. The section for whether the bed hold policy was given (mark yes or no) was not completed. Further review of the clinical record also failed to evidence anywhere else that a bed hold notification was provided. On 8/8/18 at 5:16 p.m., an interview was conducted with OSM (other staff member) #9 (the director of admissions). OSM #9 stated nurses are supposed to staple the bed hold notice to a transfer form that is sent with residents to the hospital and the hospital staff are supposed to provide the bed hold notice to residents' families. OSM #9 stated if residents' stay in the hospital is more than 24 hours then she calls the residents' families to see if they want a bed hold. OSM #9 stated she emails the management team with the families' decision. On 8/8/18 at 6:00 PM at the end of day meeting, the administrator (ASM #1 - Administrative Staff Member) was made aware of the findings. No further information was provided by the end of the survey. {1} ABG - Blood gases are a measurement of how much oxygen and carbon dioxide are in your blood. They also determine the acidity (pH) of your blood. Information obtained from	F 625		

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https://medlineplus.gov/ency/article/003855.htm

5. The facility staff failed to evidence that a written bed hold notice was provided to Resident #72 or the resident representative upon transfer to the hospital on 6/15/18 and 7/1/18.

Resident #72 was admitted to the facility on 6/13/18 and most recently readmitted on 7/5/18 with the diagnoses of but not limited to gastrostomy (feeding tube), dysphagia, seizures, Parkinson's disease, dementia, hypothyroidism, rhabdomyolysis, acute kidney failure, and hypoxemia. The most recent MDS (Minimum Data Set) was a 5-day assessment with an ARD (Assessment Reference Date) of 7/12/18. The resident was coded as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, transfers, and eating; extensive assistance for toileting and dressing; and was incontinent of bowel and bladder.

A review of the nurse's notes revealed one dated 6/15/18 at 11:55 PM which documented, "Resident sent to (name of hospital) ER (emergency room) for eval (evaluation) after episode of seizure. Daughter was notified."

Further review of the clinical record also failed to any evidence that a bed hold notice was provided.

On 7/1/18, Resident #72 was sent to the hospital again. A nurse's note dated 7/1/18 documented, "G-tube [gastrostomy feeding tube*] clogged or possibly dislodged....Called PA (physician's assistant) and informed her the G-tube is clogged

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and nurses not able to unclog the tube. Gave order to send pt (patient) to the (name of hospital) for eval (evaluation) of G-tube."

A "Resident Transfer Form" was completed for this hospitalization (but not for the 6/15/18 hospitalization). This form was not completely filled in. The section for whether the bed hold policy was given (mark yes or no) was not completed.

Further review of the clinical record also failed to evidence anywhere else that a bed hold notice was provided.

On 8/8/18 at 5:16 p.m., an interview was conducted with OSM (other staff member) #9 (the director of admissions). OSM #9 stated nurses are supposed to staple the bed hold notice to a transfer form that is sent with residents to the hospital and the hospital staff are supposed to provide the bed hold notice to residents' families. OSM #9 stated if residents' stay in the hospital is more than 24 hours then she calls the residents' families to see if they want a bed hold. OSM #9 stated she emails the management team with the families' decision.

On 8/8/18 at 6:00 PM at the end of day meeting, the administrator (ASM #1 - Administrative Staff Member) was made aware of the findings. No further information was provided by the end of the survey.
6. The facility staff failed to provide Resident # 81 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 06/26/18.

Resident # 81 was admitted to the facility on

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F 625	Continued From page 67 05/20/18 with a readmission on 06/27/18 with diagnoses that included but were not limited to hypertension (1), hemiplegia, (2), diabetes mellitus (3), and atrial fibrillation (4). Resident # 81's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/16/18, coded Resident # 81 as scoring a (01) one on the brief interview for mental status (BIMS) of a score of 0 - 15, (1) one - being severely impaired of cognition for making daily decisions. The nurse's "Progress Notes" for Resident # 81 dated 06/26/18 documented, "14:54 (2:54 p.m.) SBAR (Situation, Background Assessment Recommendation) Change in status note. Assessment/Appearance: Patient nonverbal . only (Sic.) opens eyes in response to sternal rub. Skin warm to touch, moist. Facial color grey/ashen. Recommendations/Request: NP (nurse practitioner) notified, ordered to send patient to ED (emergency department) for eval (evaluation)." Review of Resident # 81's clinical record failed to evidence documentation of written notification the bed hold policy was provided to Resident # 81 or the resident's representative on 06/26/18. On 8/8/18 at 5:16 p.m., an interview was conducted with OSM (other staff member) # 9, director of admissions. OSM # 9 stated nurses are supposed to staple the bed hold notice to a transfer form that is sent with residents to the hospital and the hospital staff are supposed to provide the bed hold notice to residents' families. OSM # 9 stated if resident's stay in the hospital is more than 24 hours then she calls the residents'	F 625		

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F 625	Continued From page 68 families to see if they want a bed hold. OSM # 9 stated she emails the management team with the families' decision. When asked if there was evidence of a bed hold policy provided for Resident # 81 or their responsible party OSM # 9 stated no. On 08/09/18 at approximately 12:35 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. References: (1) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpr essure.html. (2) Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html. (3) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. (4) A problem with the speed or rhythm of the heartbeat. This information was obtained from	F 625		

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F 625	Continued From page 69 the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html. 7. The facility staff failed to provide Resident # 36 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 07/13/18. Resident # 36 was admitted to the facility on 04/06/15 with a readmission on 07/15/18 with diagnoses that included but were not limited to hypertension (1), dementia, (2), anxiety (3), and cerebrovascular disease (4). Resident # 36's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/12/18, coded Resident # 36 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 # 36 was coded as requiring extensive assistance of two staff members for activities of daily living. The nurse's "Progress Notes" for Resident # 81 dated 07/13/18 documented, "12:20 p.m. SBAR (Situation, Background Assessment Recommendation) Change in status note. Assessment/Appearance: Resident assessed by this nurse, resident noted to be wheezing and her breathing is labored, lung sounds diminished x (times) all lobes. Resident has emesis (vomiting) x 1 (one), feeding held at this time ... Recommendations/Request: NP (nurse practitioner) notified, family notified and DON (director of nursing) notified, NP recommended	F 625		

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F 625	Continued From page 70 resident be sent out to ER (emergency room)." Review of Resident # 36's clinical record failed to evidence documentation of written notification of the bed hold policy for Resident # 36 on 06/26/18. On 8/8/18 at 5:16 p.m., an interview was conducted with OSM (other staff member) # 9, director of admissions. OSM # 9 stated nurses are supposed to staple the bed hold notice to a transfer form that is sent with residents to the hospital and the hospital staff are supposed to provide the bed hold notice to resident's families. OSM # 9 stated if residents' stay in the hospital is more than 24 hours then she calls the residents' families to see if they want a bed hold. OSM # 9 stated she emails the management team with the families' decision. When asked if there was evidence of a bed hold policy provided for Resident # 36 or their responsible party OSM # 9 stated no. On 08/09/18 at approximately 12:35 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. References: (1) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (2) 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:	F 625		

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F 625	Continued From page 71 https://medlineplus.gov/ency/article/000739.htm. (3) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary. (4) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm.	F 625		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph	F 645		9/21/18

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F 645	Continued From page 72 (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental	F 645		

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F 645	Continued From page 73 disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure a level I PASARR (Preadmission Screening and Resident Review) was complete for one of 37 residents in the survey sample, Resident #39. The facility staff failed to ensure Resident #39's PASARR was completed to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs. The findings include: Resident #39 was admitted to the facility on 6/6/17. Resident #39's diagnoses included but were not limited to stroke, major depressive disorder and bipolar disorder (1). Resident #39's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/19/18, coded the resident as being cognitively intact. Review of Resident #39's clinical record failed to reveal the resident's PASARR. On 8/8/18 at 2:55 p.m., ASM (administrative staff member) #1 (the administrator) stated she could not provide evidence that Resident #39's PASARR was completed.	F 645	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. MDS Coordinator will complete a PASARR on the Resident #39 by 9/5/18. All residents admitted to the facility have the potential to be affected. Admissions will ensure every resident has a PASARR prior to being admitted. The records of all current residents will be reviewed and a PASARR will be completed for any resident not having one. Medical Records will monitor to ensure there is a PASARR on every new admission when scanning admission documentation into the medical record. Any records found not to contain a PASARR will be reported to the MDS Coordinator for completion. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months then quarterly thereafter.	

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F 645	Continued From page 74 On 8/8/18 at 5:16 p.m., an interview was conducted with OSM (other staff member) #9 (the director of admissions). OSM #9 stated she is supposed to ask for a patient's PASARR prior to the patient being admitted from the hospital or another health setting. OSM #9 stated she scans the PASARR into the computer system once she receives it. OSM #9 stated Resident #39 came from another long-term care facility and the resident's PASARR was not obtained. When asked if a PASARR should have been obtained although Resident #39 transferred from another long-term care facility, OSM #9 confirmed it should have. On 8/8/18 at 6:13 p.m., ASM #1 and ASM #2 (the director of nursing) were made aware of the above concern. On 8/9/18 at 5:05 p.m., ASM #1 stated the facility did not have a policy regarding PASARRs. No further information was presented prior to exit. (1) "Bipolar disorder is a serious mental illness. People who have it go through unusual mood changes. They go from very happy, "up," and active to very sad and hopeless, "down," and inactive, and then back again. They often have normal moods in between..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=bipolar	F 645		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	F 655		9/21/18

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F 655	Continued From page 75 §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be	F 655		

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F 655	Continued From page 76 administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to develop a baseline care plan within 48 hours for one of 37 residents in the survey sample, Resident # 191. The facility staff failed to develop the baseline care plan to address Resident #191's care needs within 48 hours. The findings include: Resident #191 was admitted to the facility on 8/3/18 with diagnoses that included but were not limited to: diabetes, high blood pressure, anxiety and chronic kidney disease requiring hemodialysis (a procedure used in toxic conditions and renal [kidney] failure, in which wastes and impurities are removed from the blood by a special machine) (1). There was no MDS (minimum data set) assessment completed by the time of survey. The "Admission Screener" documented in part, the resident was alert and oriented. She was documented as requiring assistance of one staff member for most of her activities of daily living, except eating, in which she was independent. The baseline care plan documented the following areas and dates: The area for "General Information and Initial Goals," was documented as completed on 8/9/18,	F 655	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. Baseline care plan was completed for resident #191 on 8/8/18. All new residents admitted to the facility have the potential to be affected. Nursing staff will be educated on how to initiate the baseline care plan assessment and care plan. The IDT will review new admissions records during clinical meeting to ensure they have been initiated. Baseline care plan assessment and care plan for admissions who arrive late Friday, Saturday, Sunday and/or holidays will be reviewed the next business day. The IDT will complete baseline care plan assessment and care plan within 48 hours, with coordination by MDS Coordinator. The Administrator or designee will review 100% new admissions records for baseline care plan completion weekly x 4 weeks, then 50% x 2 weeks and then 25% monthly for 3 months to ensure	

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F 655	Continued From page 77	F 655		

five days after admission. The "Functional Status," was documented as completed on 8/6/18, three days after admission. The "Health Conditions" section was documented as completed on 8/6/18. The "Dietary, Therapy and Social Services" section was documented as completed on 8/9/18, five days after admission.

The baseline care plan for the focus area of "(Resident #191) has elected the have a code status of FULL CODE," was dated 8/6/18. The focus area for (Resident #191) needs hemodialysis r/t (related to) renal failure" was initiated on 8/6/18. The focus area of "Alteration in metabolism r/t diabetes) was developed on 8/6/18. The focus area of "Potential for altered participation r/t new surroundings" was dated 8/7/18.

An interview was conducted with RN (registered nurse) #1, the unit manager, on 8/9/18 at 8:29 a.m. When asked when the baseline care plan is initiated, RN #1 stated the baseline care plan must have the five criteria; code status, falls, pain, skin and ADL (activities of daily living) and must be started within the first 24 hours." RN #1 was asked when the baseline care plan is given to the resident and/or resident representative, RN #1 stated, "Five days."

An interview was conducted with other staff member (OSM) #7, the social worker, on 8/9/18 at 2:33 p.m. When asked when the baseline care plan is developed, OSM # 7 stated, "It's opened in two days. I need a clarification on this. I did my part today."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing,

compliance. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months then quarterly thereafter.

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F 655	Continued From page 78 on 8/9/18 at 2:34 p.m. When asked when the baseline care plan is supposed to be developed, ASM #2 stated the baseline care plan should be started when they (the resident) is admitted to the facility. When asked what should be on the baseline care plan, ASM #2 stated, "The baseline care plan should have the ADLs, skin, pain, diet, general information, initial goals, health status, dietary and social services. Basically, it should be how to take care of the resident, how much they need and any health conditions, such as oxygen." An interview was conducted with RN #3, the MDS nurse. When asked when the baseline care plan is initiated, RN #3 stated the baseline care plan should be initiated the day the residents are admitted. RN #3 stated, "I open it up. From there I try to read the history and physical. I start to fill in the health conditions." When asked when the baseline care plan was opened for Resident #191, RN #3 stated, "I opened it up on 8/3/18." When asked when the care plan should be completed, RN #3 stated, "Hopefully by Monday." RN #3 reviewed the care plan and stated that it was not completed by the five day meeting." The administrator (administrative staff member - ASM #1) and ASM #2, the director of nursing, were made aware of the above concern on 8/9/18 at 12:32 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 266.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		9/21/18

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F 656	Continued From page 79 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for 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	F 656		

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F 656	Continued From page 80 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, clinical record review, facility document review, and in the course of a complaint investigation, it was determined that the facility staff failed to develop and/or implement the comprehensive care plan for nine of 37 residents in the survey sample; Residents #30, #16, #290, #49, #48, #7, #42, #27, and #39. 1. The facility staff failed to implement and follow the comprehensive care plan for the care of Resident #30's Foley catheter. 2. The facility staff failed to follow the comprehensive care plan for the treatment of a pressure ulcer for Resident #16. 3. The facility staff failed to follow Resident # 290's comprehensive care plan for the administration of oxygen. 4a. The facility staff failed to follow Resident #49's comprehensive care plan for the administration of Carvedilol (1) on 05/01/18, 05/21/18, 05/25/18, 06/30/18 and 07/12/18, 07/31/18 and 08/01/18. 4b. The facility staff failed to follow Resident #49's comprehensive care plan to obtain vital signs, blood pressure, for the administration of Carvedilol on 06/24/18. 5. a. The facility staff failed to develop a care plan for the use of oxygen for Resident #48.	F 656	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. Corrected deficient practice for Resident #30□s foley by covering the foley catheter with a privacy bag and placing the bag below level of bladder and off the floor as care planned on 8/8/18. Resident #16: unable to correct missing documentation on the TAR regarding pressure ulcer on 8/6/18 Oxygen flow rate was adjusted per physicians order and care plan for Resident #290 on 8/8/18. Resident #49: unable to correct omissions for MAR documentation dated 5/1, 5/21, 5/25, 6/24, 6/30, 7/12, 7/31 and 8/1. Care plan was revised for Resident #48 to include oxygen use on 8/8/18. Resident #7: unable to correct omission of blood pressure reading prior to administering blood pressure medication on 8/8/18.	

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6. The facility staff failed to implement Resident #7's comprehensive care plan for blood pressure medication administration per physician's order.

7. The facility staff failed to implement Resident #42's comprehensive care plan for speech therapy recommendations.

8. The facility staff failed to implement Resident #27's comprehensive care plan for podiatry services.

9. The facility staff failed to implement Resident #39's comprehensive care plan for pain management.

The findings include:

1. The facility staff failed to implement and follow the comprehensive care plan for the care of Resident #30's Foley catheter.

Resident #30 was admitted to the facility on 11/1/17 with the diagnoses of but not limited to end stage renal disease, chronic obstructive pulmonary disease, diabetes, stroke, high blood pressure, macular degeneration, and prostate cancer. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 5/14/18. The resident was coded as being moderately impaired 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; and was independent for eating.

Observed adherence of care plan interventions being implemented for Resident #42 on 8/8/18. Observation made during medication pass while giving resident fluids and resident□s bed was elevated to 90 degrees per care plan and speech therapy recommendations.

Resident #27s nails were trimmed on 8/8/18 by the Director of Nursing.

Resident #39: Unable to correct July and August MAR on pain medication administration and documentation of non-pharmacological interventions.

All residents in the facility have the potential to be affected.

Nursing staff will be educated on care plan process and requirement to implement care plan interventions.

Nurse Manager or Designee will audit 25% residents care plans for residents with foley catheters, pressure ulcers, oxygen use, podiatry consults, blood pressure medication and management, speech recommendations and pain management weekly x 4 weeks, then 10% monthly. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter.

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A review of the clinical record revealed an order dated 5/8/18 for the use of a Foley catheter {1} related to prostate cancer with urinary retention.

A review of the comprehensive care plan revealed one dated 5/9/18 for "Potential for infection r/t (related to) use of foley {sic}..." This care plan included an intervention dated 5/9/18 for "keep foley {sic} bag below level of bladder and off floor."

On 8/07/18 at 3:27 p.m., an observation of Resident #30 revealed the Foley catheter bag lying flat on the floor under the edge of his bed and not hanging on the side of the bed.

On 8/8/18 at 2:54 p.m., in an interview with LPN #4 (Licensed Practical Nurse), she stated the Foley catheter bag should not be lying on the floor. When asked if Resident #30's care plan was followed, if it documented to keep the Foley off the floor, but the Foley was lying directly on the floor, LPN #4 stated no.

On 8/8/18 at 6:00 PM at the end of day meeting, the administrator (ASM #1 - Administrative Staff Member) was made aware of the findings. No further information was provided by the end of the survey.
2. The facility staff failed to follow the comprehensive care plan for the treatment of a pressure ulcer for Resident #16.

Resident #16 was admitted to the facility on 5/10/18, with a most recent readmission of 7/26/18, with diagnoses that included but were not limited to: altered mental status (confusion) (1), acute respiratory infection, ataxia (trouble coordinating movements), (2), high blood

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pressure, muscle weakness, diabetes, difficulty swallowing, a pressure ulcer of the sacrum (areas of damaged skin caused by staying in one position for too long.) (3), and hydrocephalus (a problem with the flow of the fluid that surrounds the brain. This fluid is called the cerebrospinal fluid, or CSF. The fluid surrounds the brain and spinal cord and helps cushion the brain. Too much CSF puts pressure on the brain. This pushes the brain up against the skull and damages brain tissue.) (4).

The most recent MDS (minimum data set) assessment, a five day Medicare assessment, with an assessment reference date of 8/2/18, coded Resident #16 as scoring a "4" on the BIMS (brief interview for mental status) score, indicating he has severe cognitive impairment for daily decision making. The resident was coded as requiring extensive assistance of at least one or more staff members for bed mobility, transfers, locomotion on and off the unit, dressing, eating, toileting, and personal hygiene. In Section M - Skin conditions, the resident was coded as having one or more unhealed pressure ulcers, which were not present in the prior assessment, during the look back period.

A review of the comprehensive care plan dated 5/15/18, with a most recent revision on 8/3/18, documented in part, "Focus: [Resident #16's name] has an US (unstageable) (pressure sores covered in dead skin that is yellow, tan, green, or brown. The dead skin makes it hard to tell how deep the sore is. This type of pressure sore is "unstageable.") (5) pressure ulcer." In the Interventions/Tasks section of this focus it is documented in part, "Administer treatments as ordered and monitor for effectiveness."

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A review of Resident #16's clinical record documented the MD (medical doctor) order stating "Left buttock (unstageable) pressure ulcer, cleanse w/ NS (with normal saline), apply Santyl (an ointment that assists in the dissolving of dead wound tissue) (6) to wound bed and cover with foam dressing. Change daily, every day shift."

The "Weekly Wound Notes" dated 8/1/18 at 3:12 p.m., documented in part, "Left buttock: Wound bed 100% (percent) yellow slough, edges defined and intact. Left buttock (unstageable) pressure injury, cleanse w/NS, apply Santyl to wound bed and cover with foam dressing. Change daily."

A review of TAR (treatment administration record), documented that the wound care, as ordered, was provided on 8/3/18, 8/4/18, 8/5/18, 8/7/18 and 8/8/18. The TAR did not have any check marks or initial for 8/6/18.

An interview was conducted with LPN (licensed practical nurse) #1 on 8/9/18 at 9:05 a.m. When asked if wound care should be documented, LPN #1 stated, "Yes." The above TAR was shown to LPN #1, and she was asked about the blanks for wound care on 8/6/18. LPN #1 stated, "Either they (the nurse) forgot to document it or it was not done." LPN #1 was then asked to explain the purpose of a care plan. She stated that it documents the individual care needs for each resident. When asked if it was important to follow the care plan, LPN #1 stated, "Yes."

An interview was conducted with RN (registered nurse) #1 on 8/09/18 and 9:15 a.m. RN #1 stated, "On admit a skin assessment is done. If there is a wound, the wound care protocol/policy

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F 656	Continued From page 85 is put into place. Then when wound care doctor comes in [per RN #1, he comes in every Wednesday], the wound is assessed and the wound care doctor sends in his notes which are scanned into the [resident's] medical record." The TAR was shown to RN #1. RN #1 was asked if the treatment was performed as ordered on 8/6/18. Per RN #1, "If is not documented it was not done ...if the treatment cannot be done for some reason, the nurse should document in the nursing notes the reason it was not done. In addition, if it is not done, the nurse should contact the family and the doctor." RN #1 was asked if the treatment was not provided would that be considered not following the physician's order. RN #1 stated, "Yes, if the treatment is not done the nurse is not following the doctor's orders." When asked to describe the purpose of the care plan, RN #1 stated that the care plan provides individual resident needs and goals. When asked if the care plan should be followed, RN #1 stated, "Of course." ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above findings on 8/9/18 at 12:32 p.m. A review of the facility's "Assessment and Care of Patient/Resident through Care Plan" policy documented in part, "The goal if the assessment of residents function is to determine what kind of care is required to meet patient/resident initial needs, as well as the needs as they change in response to care." According to "Lippincott Manual of Nursing Practice", Seventh Edition: by Lippincott Williams & Wilkins, pg. 276 read: "The plan of nursing	F 656		

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care (patient care plan) is the written guide that directs the efforts of the nursing team as nurses work with patients to meet their health goals ...Is responsive to the individual characteristics and needs of the patient."

No further information was provided prior to exit.

1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/003205.htm

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

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

4) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/001571.htm

5) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/patientinstructions/000740.htm

6) This information was obtained from the National Institutes of Health at https://www.ncbi.nlm.nih.gov/pubmed/19918145
3. The facility staff failed to follow Resident # 290's comprehensive care plan for the administration of oxygen.
Resident # 290 was admitted to the facility on 07/19/18 with diagnoses that included but were not limited to Parkinson's disease (1), dementia

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F 656	Continued From page 87 without behavioral disturbance, (2), heart failure, gastroesophageal reflux disease (3), and dysphagia (4). Resident # 290's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 07/30/18, coded Resident # 290 as scoring a two on the brief interview for mental status (BIMS) of a score of 0 - 15, two - being severely impaired of cognition for making daily decisions. Resident # 290 was coded as requiring extensive assistance of one staff member for activities of daily living. Under section "O. Special Treatment, Procedures and Programs" Resident # 290 was coded for "C. Oxygen therapy." On 08/07/18 at approximately 11:36 a.m., an observation of Resident # 290 revealed she was lying in her bed, receiving oxygen by nasal cannula connected to an oxygen concentrator. An observation of the oxygen flow meter on the oxygen concentrator revealed that it was set between two and two and a half liter per minute. On 08/08/18 at approximately 8:15 a.m., an observation of Resident # 290 revealed she was lying in her bed, receiving oxygen by nasal cannula connected to an oxygen concentrator. An observation of the oxygen flow meter on the oxygen concentrator revealed that it was set between two and two and a half liter per minute. On 08/09/18 at approximately 7:30 a.m., an observation of Resident # 290 revealed she was lying in her bed, receiving oxygen by nasal cannula connected to an oxygen concentrator. An observation of the oxygen flow meter on the oxygen concentrator revealed that it was set	F 656		

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between two and two and a half liter per minute.

The physician's orders for Resident # 290 dated August 2018 documented, "Oxygen via (by) nasal cannula 2L (two liters per minute). Order Date: 07/20/2018. Start Date: 07/20/2018."

The eMAR (electronic medication administration record) dated August 2018 for Resident # 290 documented, "Oxygen via (by) nasal cannula 2L (two liters per minute). Start Date: 07/20/2018." Further review of the eMAR documented Resident # 290 received oxygen at two liters per minute.

The comprehensive care plan for Resident # 290 dated 07/23/2018 documented, "Focus. (Resident # 290) was admitted with (Name of Hospice) services for senile degeneration of brain." Under "Interventions" it documented, "Oxygen via nasal cannula 2L (two liters per minute). Date initiated: 07/31/2018."

On 08/09/18 at approximately 8:00 a.m., an interview was conducted with RN (registered nurse) # 1, unit manager. When asked to describe how the O2 (oxygen) flow meter is read, RN # 1 stated, "The line should be in the middle of the ball and it should read it at eye level." RN # 1 was asked to read the O2 flow rate on Resident # 290's oxygen concentrator. Upon entering Resident #290's room, LPN (licensed practical nurse) # 3 was walking out of the room. RN # 1 read the flow meter and stated, "It's at two liters." LPN # 3 was asked if she had adjusted Resident # 290's oxygen flow rate. LPN # 3 stated, "I just adjusted the oxygen to two liters." When asked what the oxygen flow rate should be for Resident # 290, LPN # 3 stated, "It should be at two liters."

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On 08/09/18 at 10:18 a.m., an interview was conducted with RN (registered nurse) # 1, unit manager. When asked to describe the purpose of the care plan RN # 1 stated, "It is the care the facility is providing to the resident." RN # 1 was asked to review the oxygen care plan for Resident # 290. When asked if the care plan was being followed for the administration of oxygen, RN # 1 stated, "It's not being followed for oxygen."

On 08/09/18 at approximately 12:35 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

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

(2) 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.

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

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

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F 656	Continued From page 90 sorders.html. 4a. The facility staff failed to follow Resident #49's comprehensive care plan for the administration of Carvedilol (1) on 05/01/18, 05/21/18, 05/25/18, 06/30/18 and 07/12/18, 07/31/18 and 08/01/18. Resident # 49 was admitted to the facility on 03/02/18 with diagnoses that included but were not limited to hypertension (2), dementia without behavioral disturbance, (3), diabetes mellitus (4), and depressive disorder (5). Resident # 49's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 06/28/18, coded Resident # 49 as scoring an (11) eleven on the brief interview for mental status (BIMS) of a score of 0 - 15, (11) eleven - being cognitively intact for making daily decisions. Resident # 49 was coded as requiring extensive assistance of one staff member for activities of daily living. The POS (physician's order sheet) for Resident # 49 dated March 2018 documented, "Carvedilol Tablet 12.5 MG (milligrams). Give 1 (one) tablet by mouth two times a day for HTN (hypertension). HOLD FOR SBP (systolic blood pressure) < (less than) 100. Start Date: 03/20/2018." The POS (physician's order sheet) for Resident # 49 dated August 2018 documented, "Carvedilol Tablet 6.25 MG (milligrams). Give 1 (one) tablet by mouth two times a day for HTN (hypertension). HOLD FOR SBP (systolic blood pressure) < (less than) 100. Order Date: 06/01/2018. Start Date: 06/01/2018." The eMAR (electronic medication administration	F 656		

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record) for Resident # 49 dated May 2018 documented the above physician's order for Carvedilol Tablet 12.5 MG (milligrams). Further review of the eMAR revealed the number four on 05/01/18 at 5:00 p.m., indicating Resident # 49's Carvedilol was not administered on 05/01/18 at 5:00 p.m. with a SBP of 119. The eMAR also documented the number nine on 05/25/18 at 5:00 p.m. for a SBP of 100. The "Chart Codes/Follow Up Codes" on the eMAR documented, "9 (nine) = Other/See Nurse's Notes."

The nurse's notes for Resident # 49 dated 05/25/18 documented, "Carvedilol Tablet 12.5 MG. Give 1 (one) tablet by mouth two times a day for HTN (hypertension). HOLD FOR SBP (systolic blood pressure) < (less than) 100. Med (medication) held SBP 100/60 (one hundred over sixty)."

Further review of the May 2018 eMAR revealed a check mark on 05/21/18 at 5:00 p.m., indicating Resident # 49 was administered Carvedilol on 05/21/18 at 5:00 p.m. with a SBP of 98.

The eMAR (electronic medication administration record) for Resident # 49 dated June 2018 documented the above physician order for Carvedilol Tablet 6.25 MG (milligrams). Further review of the eMAR revealed a check mark on 06/30/18 at 9:00 a.m. indicating Resident # 49 was administered Carvedilol on 06/30/18 at 9:00a.m., with a SBP of 94 and at 9:00 p.m. with a SBP of 94. Further review of the eMAR revealed a check mark on 07/12/18 at 9:00 p.m. indicating Resident # 49 was administered Carvedilol on 07/12/18 at 9:00 p.m. with a SBP of 98.

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F 656	Continued From page 92 The eMAR (electronic medication administration record) for Resident # 49 dated July 2018 documented the above orders for Carvedilol Tablet 6.25 MG (milligrams). Further review of the eMAR documented the number five on 07/31/18 at 9:00 a.m. and no documentation of a SBP and at 9:00 p.m. for a SBP of 100. The "Chart Codes/Follow Up Codes" on the eMAR documented, "5 (five) = Hold/See Nurse's Notes." The facility's "Weights and Vitals Summary" for Resident # 49 documented, "07/31/2018 20:48 (8:48 p.m.) 100/25 (one hundred over fifty-two)." The nurse's notes for Resident # 49 dated 07/31/18 at 11:18 a.m. documented, "Carvedilol Tablet 12.5 MG. Give 1 (one) tablet by mouth two times a day for HTN (hypertension). HOLD FOR SBP (systolic blood pressure) < (less than) 100. hold." Further review of the nurse's notes for Resident # 49 dated 07/31/18 failed to evidence documentation of Carvedilol being held at 9:00 p.m." The eMAR (electronic medication administration record) for Resident # 49 dated August 2018 documented the above physician's orders for Carvedilol Tablet 6.25 MG (milligrams). Further review of the eMAR documented the number five on 08/01/18 at 9:00 p.m. for a SBP of 108. The "Chart Codes/Follow Up Codes" on the eMAR documented, "5 (five) = Hold/See Nurse's Notes." The nurse's notes for Resident # 49 dated 08/01/18 at 11:18 a.m. documented, "Carvedilol Tablet 12.5 MG. Give 1 (one) tablet by mouth two times a day for HTN (hypertension). HOLD FOR SBP (systolic blood pressure) < (less than) 100. hold." Further review of the nurse's notes for	F 656		

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Resident # 49 dated 08/01/18 failed to evidence documentation of Carvedilol being held at 9:00 p.m."

The comprehensive care plan for Resident # 49 dated 03/22/2018 documented, "Focus. (Resident # 49) has altered cardiovascular status r/t (related to A-Fib (atrial fibrillation), CHF (congestive heart failure), Hypertension." Under "Interventions/Tasks" it documented, "Administer medications as ordered. Monitor for effectiveness. Date initiated 03/22/2018. Revision on: 06/01/2018."

On 08/09/18 at 10:18 a.m., an interview was conducted with RN (registered nurse) # 1, unit manager. When asked to describe the purpose of the care plan RN # 1 stated, "It is the care the facility is providing to the resident." RN # 1 was asked to review the above care plan for Resident # 49. When asked if the care plan was being followed for the administration of Resident # 49's Carvedilol, RN # 1 stated, "No, It's not being followed for medication or documenting the vital signs."

On 08/09/18 at approximately 12:35 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:
(1) 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 is often used in combination with other

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medications. Carvedilol is in a class of medications called beta-blockers. It works by relaxing blood vessels and slowing heart rate to improve blood flow and decrease blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697042.html.

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

(5) 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.

4b. The facility staff failed to follow Resident #49's comprehensive care plan to obtain vital signs, blood pressure, for the administration of Carvedilol on 06/24/18.

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F 656	Continued From page 95 The eMAR (electronic medication administration record) for Resident # 49 dated June 2018 documented, "Carvedilol Tablet 6.25 MG (milligrams). Give 1 (one) tablet by mouth two times a day for HTN (hypertension). Hold for SBP (systolic blood pressure) < (less than) 100. Start Date: 06/01/2018." Further review of the eMAR for 06/24/18 was blank. The facility's "Weights and Vitals Summary" for Resident # 49 failed to evidence a blood pressure at 9:00 p.m. The nurse's notes for Resident # 49 dated 06/24/18 failed to evidence a blood pressure or documentation of the medication being held, or administered. The comprehensive care plan for Resident # 49 dated 03/22/2018 documented, "Focus. (Resident # 49) has altered cardiovascular status r/t (related to A-Fib (atrial fibrillation), CHF (congestive heart failure), Hypertension." Under "Interventions/Tasks" it documented, "Vital signs as ordered. Notify physician of any abnormal readings. Date initiated 03/22/2018. Revision on: 03/22/2018." On 08/09/18 at 10:18 a.m., an interview was conducted with RN (registered nurse) # 1, unit manager. When asked to describe the purpose of the care plan RN # 1 stated, "It is the care the facility is providing to the resident." Rn # 1 was asked to review the above care plan for Resident # 49. When asked if the care plan was being followed for obtaining Resident # 49 blood pressure RN # 1 stated, "No, It's not being followed for documenting the vital signs."	F 656		

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On 08/09/18 at approximately 12:35 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.
5. The facility staff failed to develop a care plan for the use of oxygen for Resident #48.

Resident #48 was admitted to the facility on 6/13/18 with diagnoses that included but were not limited to; hypothermia, urinary tract infection, heart failure, fractures of the left humerus (arm) and left femur (hip) and atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria) (1).

The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 6/27/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. The resident was coded as requiring limited to extensive assistance of one or more staff members for all of her activities of daily living.

The physician order dated, 8/9/18, documented, "Oxygen at 2L (liters) via nasal cannula every shift."

Observation was made of Resident #48 on 08/08/18 at 10:29 a.m. The Resident was in her bed with the oxygen on via the nasal cannula

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connected to an oxygen concentrator. The oxygen flow meter on the concentrator was set with the top of the ball on the 2 line and the bottom of the ball on the 1.5 line.

A second observation was made of Resident # 48 on 8/8/18 at 4:53 p.m. The resident was in her bed with the oxygen on at the correct rate of 2 L/min.

The third observation of the resident was made on 8/9/18 at approximately 8:30 a.m. The resident was sitting up in her wheelchair, eating breakfast. She did not have her oxygen on.

The comprehensive care plan dated 6/13/18 and revised on 8/3/18 did not evidence documentation related to oxygen.

An interview was conducted with LPN (licensed practical nurse) #4 on 8/9/18 at 8:43 a.m. When asked who updates the resident care plans, LPN #4 stated, the MDS nurses.

An interview was conducted with RN (registered nurse) 1, the unit manager, on 8/9/18 at 8:44 a.m. When asked who updates the care plans, RN #1 stated, "MDS. I will if I can. It's MDS's responsibility." When asked if a resident on oxygen would have a care plan addressing the use of oxygen, RN #1 stated yes it should be on the care plan.

The administrator (administrative staff member - ASM #1) and ASM #2, the director of nursing, were made aware of the above concern on 8/9/18 at 12:32 p.m.

No further information was provided prior to exit.

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

6. The facility staff failed to implement Resident #7's care plan for blood pressure medication administration per physician's order.

Resident #7 was admitted to the facility on 4/30/12. Resident #7's diagnoses included but were not limited to high blood pressure, diabetes, and major depressive disorder. Resident #7's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 5/8/18, coded the resident's cognition as severely impaired. Section G coded Resident #7 as requiring extensive assistance of one staff with dressing, eating and personal hygiene.

Review of Resident #7's clinical record revealed a physician's order dated 10/24/16 for Lotrel (1) 5-10 mg (milligrams) - one tablet by mouth one time a day. The order further documented to hold the medication for a systolic blood pressure less than 120. Review of Resident #7's August 2018 eMAR (electronic medication administration record) revealed the same physician's order. Resident #7's comprehensive care plan initiated on 5/16/12, documented, "(Name of Resident #7) has hypertension (high blood pressure). Give anti hypertensive medications as ordered..."

On 8/8/18 at 9:17 a.m., LPN (licensed practical nurse) #7 was observed preparing Resident #7's medications. LPN #7 prepared one capsule of Lotrel. LPN #7 attempted to administer Resident #7's medications but the resident was in a reclined chair with her eyes closed so LPN #7

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stated she would wait to give the resident her medications. During this time, LPN #7 did not assess Resident #7's blood pressure. On 8/8/18 at 10:07 a.m., LPN #7 stated she gave Resident #7 her medications. On 8/8/18 at 2:05 p.m., LPN #7 confirmed she administered Lotrel to Resident #7 without assessing the resident's blood pressure.

On 8/8/18 at 4:37 p.m., an interview was conducted with LPN #5. LPN #5 was asked the purpose of the care plan. LPN #5 stated, "To formulate a plan of care so you can give the resident individualized care based on his needs." When asked about the facility process for ensuring staff implement residents' care plans, LPN #5 stated care cards are located in residents' closets and staff has access to review care plans. LPN #5 was asked what should be done if medication administration was dependent on parameters such as to hold the medication for a blood pressure less than 120. LPN #5 stated, "I need to take their blood pressure."

On 8/8/18 at 6:13 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

(1) Lotrel is used to treat high blood pressure. This information was obtained from the website: https://www.fda.gov/ForConsumers/ByAudience/ForWomen/ucm118594.htm

7. The facility staff failed to implement Resident #42's care plan for speech therapy recommendations.

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Resident #42 was admitted to the facility on 9/29/16. Resident #42's diagnoses included but were not limited to Alzheimer's disease (1), major depressive disorder and anxiety disorder. Resident #42's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 6/20/18, coded the resident's cognition as severely impaired. Section G coded Resident #42 as requiring extensive assistance of one staff with eating.

Resident #42's comprehensive care plan initiated on 10/7/16 documented, "(Name of Resident #42) has need for mechanically altered food and fluids r/t (related to) swallowing difficulties (hx CVA [history of cerebrovascular accident-stroke])...Speech recommendations, see inside closet door for the most current recommendations..."

A speech therapy screening dated 3/1/17 documented, "Pocketing MS (mechanical soft) meat; excessive and effort for muscle chew-downgrade diet to pureed. Dependent for feeding..."

A document dated 6/27/17, titled, "SWALLOWING PRECAUTIONS" located inside Resident #42's closet door documented, "LIQUIDS: All liquids allowed." A check mark was documented beside, "Upright at 90 degrees for p.o. (by mouth) intake."

On 8/8/18 at 8:24 a.m., LPN (licensed practical nurse) #7 was observed giving Resident #42 a supplemental beverage with a straw. Resident #42 was in bed and the head of the bed was

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elevated at 45 degrees. LPN #7 placed the straw to Resident #42's mouth and the resident took sips of the beverage. While LPN #7 was assisting Resident #42 with the beverage, a CNA (certified nursing assistant) entered the room. LPN #7 removed the beverage from Resident #42's mouth. The CNA lowered the head of Resident #42's bed. The CNA and LPN #7 repositioned Resident #42 then the CNA elevated the head of the bed to 30 degrees. LPN #7 proceeded to give Resident #42 more sips of the beverage while the head of the bed was positioned at 30 degrees.

On 8/8/18 at 11:53 a.m., an interview was conducted with OSM (other staff member) #12 (a speech therapist). OSM #12 stated she had not worked with Resident #42. OSM #12 was asked to read the speech therapy screening dated 3/1/17 and describe what the screening meant. OSM #12 read the screening and stated per the screening, Resident #42 was pocketing food and presented with delayed chewing. When asked to explain the swallowing precautions, OSM #12 stated the swallowing precautions are standards used for anyone who is dependent for feeding. OSM #12 stated there is a standard that anyone who is dependent for feeding should be positioned at 90 degrees (if possible) when being assisted with foods and liquids. When asked to explain the risks for a dependent resident who is given liquids while he is positioned at 30 degrees, OSM #12 stated the risks would depend on the resident's diagnoses and if the resident had a history of aspiration pneumonia (2). Review of Resident #42's clinical record failed to reveal a history of aspiration pneumonia.

On 8/8/18 at 4:37 p.m., an interview was

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conducted with LPN #5. LPN #5 was asked the purpose of the care plan. LPN #5 stated, "To formulate a plan of care so you can give the resident individualized care based on his needs." When asked about the facility process for ensuring staff implement residents' care plans, LPN #5 stated care cards are located in residents' closets and staff has access to review care plans. LPN #5 was asked the facility process for following speech therapy recommendations. LPN #5 stated, "She (the speech therapist) recommends you notify the doctor. If they write orders, you implement." When asked if the recommendations should be followed even if there is not a physician's order, LPN #5 stated, 'Yes."

On 8/8/18 at 6:13 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

(1) "Alzheimer's disease (AD) is the most common form of dementia among older people. Dementia is a brain disorder that seriously affects a person's ability to carry out daily activities." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=alzheimers+disease&_ga=2.59104493.193292090.1533897219-139120270.1477942321

(2) "Pneumonia is a breathing condition in which there is swelling or an infection of the lungs or large airways.
Aspiration pneumonia occurs when food, saliva,

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liquids, or vomit is breathed into the lungs or airways leading to the lungs, instead of being swallowed into the esophagus and stomach." This information was obtained from the website: https://medlineplus.gov/ency/article/000121.htm

8. The facility staff failed to implement Resident #27's care plan for podiatry.

Resident #27 was admitted to the facility on 5/24/18. Resident #27's diagnoses included but were not limited to diabetes, heart failure and high blood pressure. Resident #27's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 5/31/18, coded the resident as being cognitively intact.

Resident #27's comprehensive care plan initiated 5/28/18 documented, "(Name of Resident #27) has Diabetes Mellitus...Refer to podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails..."

Review of Resident #27's clinical record failed to reveal a podiatry consult.

On 8/8/18 at 8:50 a.m., LPN (licensed practical nurse) #7 was observed applying medicated cream on Resident #27's legs. Resident #27 removed his shoes. The resident's right first, second, third and fifth toenails were grown out approximately 0.25 inch from the tip of the resident's toes. Resident #27's right fourth toenail was grown out approximately 0.5 inch from the tip of the resident's toe. The left second and third toenails were grown out approximately 0.25 inch from the tip of the resident's toes. LPN #7 was asked if Resident #27's toenails needed

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F 656	Continued From page 104 to be cut. LPN #7 stated, "I think a little on the right foot and yes on the left foot." Resident #27 stated he had not seen a podiatry since his admission and his toenails really needed to be cut but he thought the podiatrist was coming this Saturday. LPN #7 was asked how staff ensures residents receive toenail care. LPN #7 stated normally the CNAs (certified nursing assistants) cut residents' toenails but she would look into a podiatry consult for Resident #27. When asked how often the podiatrist comes to the facility, LPN #7 stated she had been employed at the facility for four or five weeks and she had not seen a podiatrist. On 8/8/18 at 4:37 p.m., an interview was conducted with LPN #5. LPN #5 was asked the purpose of the care plan. LPN #5 stated, "To formulate a plan of care so you can give the resident individualized care based on his needs." When asked the facility process for ensuring staff implements residents' care plans, LPN #5 stated care cards are located in residents' closets and staff has access to review care plans. LPN #5 was asked the facility process for ensuring residents receive toenail care. LPN #5 stated, "We will trim on shower days and there is also a podiatry book, especially for diabetics." LPN #5 did not know how often the podiatrist comes to the facility. On 8/8/18 at 6:13 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. 9. The facility staff failed to implement Resident	F 656		

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F 656	Continued From page 105 #39's care plan for pain management. Resident #39 was admitted to the facility on 6/6/17. Resident #39's diagnoses included but were not limited to stroke, major depressive disorder and altered mental status. Resident #39's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/19/18, coded the resident as being cognitively intact. Section J documented Resident #39 reported frequent pain during the last five days. Review of Resident #39's clinical record revealed physician's orders dated 6/22/18 for oxycodone/acetaminophen (1) 5-325 mg (milligrams)- one tablet every six hours as needed for moderate pain and two tablets every six hours as needed for severe pain. Review of Resident #39's July 2018 and August 2018 eMARs (electronic medication administration records) revealed the resident was administered one tablet of oxycodone/acetaminophen ten times in July 2018 and twice in August 2018. Further review of Resident #39's July 2018 and August 2018 eMARs revealed the resident was administered two tablets of oxycodone/acetaminophen three times in July 2018 and once in August 2018. Further review of Resident #39's clinical record (including July 2018/August 2018 eMARs and July 2018/August 2018 nurses' notes) failed to reveal the facility staff provided non-pharmacological interventions prior to administering oxycodone/acetaminophen each time the medication was administered to Resident #39 in July 2018 and August 2018.	F 656		

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Resident #39's comprehensive care plan initiated on 6/9/17 documented, "(Name of Resident #39) has potential for pain related to S/P (status post) Left Hip FX (fracture) repair, Left Hemi (hemiparesis [paralysis]) S/P CVA (cardiovascular accident [stroke]), Depression and other generalized discomforts such as neuropathic pain s/p CVA...Provide non-pharmacologic interventions for pain relief prior to administering PRN (as needed) medications such as change in position, cool compress or heat, diversional activities such as tv, snack, drink, others as desired..."

On 8/8/18 at 4:37 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 was asked the purpose of the care plan. LPN #5 stated, "To formulate a plan of care so you can give the resident individualized care based on his needs." When asked the facility process for ensuring staff implements residents' care plans, LPN #5 stated care cards are located in residents' closets and staff has access to review care plans.

On 8/9/18 at 10:17 a.m., an interview was conducted with LPN #7 (a nurse who administered oxycodone/acetaminophen to Resident #39 on multiple occasions in July 2018). LPN #7 stated she assesses residents' pain prior to administering as needed pain medication. When asked if she does anything else, LPN #7 stated she could always check residents' vital signs. When asked if she provides non-pharmacological interventions, LPN #7 stated she gave ginger ale to a resident with nausea this morning. LPN #7 was asked to describe Resident #39's pain. LPN #7 stated the

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F 656	Continued From page 107 resident has pain in her left ankle. When asked if she provided non-pharmacological interventions prior to administering as needed pain medication to Resident #39, LPN #7 stated, "I did not." When asked why, LPN #7 stated she did not because of the grimace on the resident's face. On 8/9/18 at 11:16 a.m., an interview was conducted with LPN #3. LPN #3 was asked what should be done prior to administering as needed pain medication to a resident. LPN #3 stated she provides non-pharmacological interventions such as turning/repositioning, music and television. When asked why she does this, LPN #3 stated because at times, the non-pharmacological interventions are effective and relieve the pain. On 8/9/18 at 11:20 a.m., an interview was conducted with Resident #39. Resident #39 stated the nurses do not provide non-pharmacological interventions prior to administering as needed pain medication to her. On 8/9/18 at 12:50 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. No further information was presented prior to exit. (1) Oxycodone/acetaminophen is used to treat pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		9/21/18

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F 657	Continued From page 108 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to review and revise the comprehensive care plan for two of 37 residents in the survey sample, Residents #69 and #48. 1. The facility staff failed to review and revise Resident #69's comprehensive care plan when staff was aware the resident's daughter brings	F 657	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. Care plan for resident #48 was updated	

F 657

Continued From page 109
medications to the resident.

2. The facility staff failed to review and revise the comprehensive care plan after a hospitalization for the treatment of hypothermia, sepsis and urinary tract infection for Resident #48.

The findings include:

1. The facility staff failed to review and revise Resident #69's comprehensive care plan when staff was aware the resident's daughter brings medications to the resident.

Resident #69 was admitted to the facility on 5/2/16. Resident #69's diagnoses included but were not limited to dementia (1), anxiety disorder and high blood pressure. Resident #69's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/16/18, coded the resident as being cognitively intact. Section G coded Resident #69 as requiring supervision with bed mobility, transfers and walking.

Review of Resident #69's clinical record revealed a self-medication administration assessment dated 2/2/17 that documented,
"A. THE RESIDENT
1. Can state the name, dose, times, strength, and frequency of his/her medication- No.
2. Can recognize all of his/her medications- No.
3. Can read the prescription label (including his/her name & drug information) - No.
4. Can state common side effects of medications- No.
5. Can state and measure proper dosage- No.
6. Can demonstrate secure storage in room- No.
7. Can demonstrate proper handwashing

F 657

on 8/9/18.

A medication self-administration assessment was completed with resident #69 on 8/9/18. Resident was not approved to self-medicate. Medication removed from room. Education provided that medications cannot be brought in to resident without a physician order. Care plan updated 9/4/18 to include quarterly medication self- administration assessment and resident/family educated that self-administration of medication not indicated. All medication brought in by family is to be given to nurse for evaluate and possible administration in consultation with the physician.

All residents that have a change in plan of care have the potential to be affected.

MDS staff will educate nursing staff on updating care plans with changes, to include new diagnoses. During morning clinical meeting, new diagnoses will be discussed and added to resident□s care plan by MDS Coordinator. MDS coordinator will review care plans for all residents that readmitted in the last 60 days to ensure all pertinent diagnoses are care planned and will review all care plans for residents that are approved to self-administer medications to ensure accuracy of care plan.

The Director of Nursing or designee will audit 100% of care plans, for residents that are readmitted and/or approved to self-administer medications weekly for 4

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F 657	Continued From page 110 technique before & after administration- No. 8. Reviewed by Interdisciplinary Team on: 02/02/2017 00:00 9. Approved for Self-Administration of Medications- No." Review of Resident #69's, current physician's orders on 8/7/18 failed to reveal an order for antacid liquid. On 8/7/18 at 1:45 p.m. and 3:34 p.m., a bottle of generic maximum strength (400 milligrams) antacid liquid was observed on Resident #69's dresser. On 8/7/18 at 3:34 p.m., an interview was conducted with Resident #69. Resident #69 stated her daughter had brought the antacid liquid to her. Resident #69 stated she gets heartburn at night so she takes "a swig" of the antacid liquid and it helps. On 8/8/18 at 2:39 p.m., the antacid liquid remained on Resident #69's dresser. On 8/8/18 at 4:37 p.m., an interview was conducted with LPN (licensed practical nurse) #5 (a nurse who routinely cared for Resident #69). LPN #5 was asked what should be done if a resident has medication in his/her room. LPN #5 stated, "You have to do a self-medication evaluation." When asked why, LPN #5 stated, "To see if he is able to administer the medication safely, he knows what it is, how to apply, make sure he is alert and oriented times three." LPN #5 was asked if antacid liquid was a medication. LPN #5 stated it was. When asked if there is a facility process for ensuring residents do not have medications in their room (unless deemed safe),	F 657	weeks and then 50% monthly for 3 months to ensure accuracy of care plan. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months then quarterly thereafter.	

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LPN #5 stated she looks for medications when she is in residents' rooms. LPN #5 was asked if she has ever noticed medication in Resident #69's room. LPN #5 stated, "I swear I saw something but I can't remember what it was because her daughter brings stuff in and I have to watch for it."

Resident #69's comprehensive care plan initiated on 5/4/16 failed to document information regarding the resident's daughter bringing medication to the resident.

On 8/9/18 at 10:23 a.m., an interview was conducted with RN (registered nurse) #4 (MDS coordinator). RN #4 stated the MDS coordinators review, revise care plans in relation to quarterly, annual, and significant change MDS assessments but the nursing staff should update care plans with day-to-day concerns. When asked if a resident's care plan should be revised if staff is aware that a resident's daughter is bringing medication to the resident, RN #4 stated, "I believe so but we (MDS coordinators) wouldn't know unless we were notified by nursing."

On 8/9/18 at 10:32 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated, "MDS is the owner of the care plan. It is within the nurses' scope of practice to update but realistically it's probably not going to happen." When asked if a resident's care plan should be revised if staff is aware that a resident's daughter is bringing medication to the resident, RN #1 stated, "Yeah. I would have that included so all staff are aware this behavior happens and all staff can look out for that."

On 8/9/18 at 12:50 p.m., ASM (administrative

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F 657	Continued From page 112 staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. The facility policy titled, "Assessment and Care of Patient/Resident Through Care Plan" documented, "The care plan is evaluated and changed in reference to the resident's response to treatment and whenever there is a change in the resident. All disciplines participate in maintaining the care plan so that it reflects the current status of the resident..." No further information was presented prior to exit. (1) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=deme 2. The facility staff failed to review and revise the comprehensive care plan after a hospitalization for the treatment of hypothermia, sepsis and urinary tract infection for Resident #48. Resident #48 was admitted to the facility on 6/13/18 with diagnoses that included but were not limited to; hypothermia, urinary tract infection, heart failure, fractures of the left humerus (arm) and left femur (hip) and atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in	F 657		

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decreased heart output and frequently clot formation in the atria) (1).

The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 6/27/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. The resident was coded as requiring limited to extensive assistance of one or more staff members for all of her activities of daily living.

The nurse's note dated, 7/26/18 at 7:19 p.m. documented in part, "85 yo (year old) WF (white female) arrived at 5:50 p.m. via medical transport on gurney from (Name of Hospital) where she was treated for Hypothermia (body temperature less than 95 degrees), r/t (related to) sepsis from UTI (urinary tract infection)."

Review of the comprehensive care plan dated 6/13/18 and revised on 8/3/18 failed to evidence documentation of the resident having had sepsis, urinary tract infections or hypothermia.

An interview was conducted with LPN (licensed practical nurse) #4 on 8/9/18 at 8:43 a.m. When asked who updates the care plans, LPN #4 stated, the MDS nurses.

An interview was conducted with RN (registered nurse) 1, the unit manager, on 8/9/18 at 8:44 a.m. When asked who updates the care plans, RN #1 stated, "MDS nurses. I will if I can. It's MDS's responsibility." When asked if it important to update a residents care plan after hospitalization to include why they were in the hospital, RN #1

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F 657	Continued From page 114 stated, "Yes, it should be." When asked about Resident #48's admission to the hospital for hypothermia, UTI and sepsis, and if these things should be addressed on the care plan, RN #1 stated, "Her daughter told me that she has had, over the years, multiple episodes of hypothermia over the years." When asked if that is important to be care planned, RN #1 stated, "Yes." An interview was conducted with RN #3 and RN #4, the MDS nurses, on 8/9/18 at 8:52 a.m. When asked if a resident is admitted to the hospital with a urinary tract infection, sepsis, and hypothermia, would the care plan to be updated to reflect this after readmission to the facility, RN #3 stated, "Yes." RN #4 reviewed the care plan. RN #4 stated, "I don't see anything on the care plan related to her hospitalization." The administrator (administrative staff member - ASM #1) and ASM #2, the director of nursing, were made aware of the above concern on 8/9/18 at 12:32 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.	F 657		
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	F 658		9/21/18

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F 658	Continued From page 115 by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to follow professional standards of practice for one of 37 residents in the survey sample, Resident #190. The facility staff failed to clarify two medication orders prescribed for pain for Resident #190. The findings include: Resident #190 was admitted to the facility 7/25/18 with diagnoses that included but were not limited to: auditory hallucinations (perception of something that is not actually present - hearing noises or voices that are not present) (1), repeated falls, depression, high blood pressure, and pain. The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 8/1/18, coded the resident as scoring a "15' on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring supervision to extensive assistance for all of his activities of daily living. In Section J - Health Conditions, the resident was coded as having frequent pain. The physician order dated, 7/26/18, documented, "Hydrocodone-Acetaminophen Tablet (Used to treat pain) (2) 5-325 MG (milligrams); Give 1 tablet by mouth every 4 hours as needed for pain." A physician order dated, 7/25/18, documented, "Tramadol Tablet (used to treat moderate to moderately severe pain) (3), 50 MG;	F 658	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. Unable to clarify pain medication orders for patient #190 due to discharge on 8/23/18. All residents receiving PRN pain medication have the potential to be affected. Pain management policy will be updated to include transcription of PRN pain medication orders and clarification process. Nurses will be educated on policy by Director of Nursing or designee. All orders of current residents with orders for PRN pain medication(s) will be reviewed and corrected as needed. Unit manager or designee will audit physician orders of PRN pain medication(s) for 10 residents weekly x4, then biweekly x2, and then monthly x2 to ensure accuracy of orders. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter.	

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give 50 mg by mouth every 8 hours as needed for pain.

The July 2018 medication administration record (MAR) documented the above medications. The Hydrocodone-Acetaminophen Tablets was administered on the following days with the documented pain scale:
7/26/18 at 10:45 a.m. - pain level of "8."
7/26/18 at 6:00 p.m. - pain level of "7."
7/26/18 at 11:00 p.m. - pain level of "7."
7/27/18 at 8:46 a.m. - pain level of "6."
7/27/18 at 7:41 p.m. - pain level of "8."
7/28/18 at 3:18 a.m. - pain level of "4."
7/28/18 at 11:00 a.m. - pain level of "7."
7/28/18 at 7:30 p.m. - pain level of "5."
7/29/18 at 12:00 a.m. - pain level of "5."
7/29/18 at 6:06 a.m. - pain level of "5."
7/29/18 at 4:49 p.m. - pain level of "6."
7/30/18 at 5:39 a.m. - pain level of 7."
7/31/18 at 8:47 a.m. - pain level of "4."
7/31/18 at 5:24 p.m. - pain level of 6."
The July 2018 MAR documented the Tramadol was administered on the following days with the documented pain scale:
7/26/18 at 12:47 a.m. - pain level of "9."
7/28/18 at 8:00 a.m. - pain level of "8."
7/28/18 at 4:00 p.m. - pain level of "6."

The August 2018 MAR documented the above medications. The Hydrocodone-Acetaminophen Tablets were administered on the following days with the documented pain scale:
8/1/18 at 2:09 a.m. - pain level of "8."
8/1/18 at 8:45 a.m. - pain level of "7."
8/1/18 at 2:28 p.m. - pain level of "8."
8/2/18 at 1:14 p.m. - pain level of "7."
8/2/18 at 9:00 p.m. - pain level of "8."
8/3/18 at 6:44 p.m. - pain level of "6."

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8/4/18 at 8:14 a.m. - pain level of "8."
8/4/18 at 8:33 p.m. - pain level of "5."
8/5/18 at 1:51 p.m. - pain level of "6."
8/5/18 at 9:02 p.m. - pain level of "4."
8/6/18 at 5:25 a.m. - pain level of "3."
8/6/18 at 7:35 p.m. - pain level of "4."
8/7/18 at 12:59 a.m. - pain level of "0."
8/7/18 at 4:54 p.m. - pain level of "8."
8/8/18 at 12:32 p.m. - pain level of "7."
8/8/18 at 2:26 p.m. - pain level of "8."

The comprehensive care plan dated, 8/2/18, documented in part, "Focus: (Resident #190) has complaints of chronic pain r/t DJD (degenerative joint disease - any of several conditions that lead to progressive loss of function, of the joints) (4) - L (left) shoulder, L knee, and back pain." The "Interventions" documented in part, "Administer analgesia as per orders. Give 1/2 hour before treatments or care. (Resident #190) prefers to have pain controlled by (tramadol and hydrocodone prn [as needed])."

An interview was conducted with LPN (licensed practical nurse) #6 on 8/8/18 at 2:55 p.m. LPN #6 was asked how staff know which medication to administer if a resident has orders for two pain medications. LPN #6 stated, "I will ask them to rate the pain on the pain scale. If it's a 8, 9, 10, I'll go to the stronger medication. Many times it's in the order." LPN #6 was asked what process is followed if the pain medication orders do not include parameters indicating which medication should be administered. LPN #6 stated, "I just had that happen today. I would start with the tramadol and then go to the more potent medication. With him (Resident #190), the tramadol hasn't been effective and he rated his pain as an eight. I work with him pretty regularly; I

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went with the medication that would be effective for him." LPN #6 was asked if a nurse could make the decisions as to which pain medication to give if it is not in the physician's orders. LPN #6 stated, "If I have two valid orders, based on the resident's vital signs, how's he presenting and the signs and symptoms he's exhibiting; I believe it is in my scope of practice to do that."

An interview was conducted with RN (registered nurse) #1 on 8/8/18 at 2:59 p.m. RN #6 was asked how staff know which medication to administer if a resident has orders for two pain medications. RN #1 stated, "It should be spelled out in the orders for what pain level, 1-5 give one medication or 6-10 give another medication." When asked if it's in the nurse's scope of practice to decide which medication to administer if there is nothing in the order to direct the nurse, RN #1 stated, "No. If a resident has an order for Vicodin (hydrocodone with acetaminophen) and Tramadol, I can ask the resident which works better but it really should be spelled out in the orders."

ASM #1, the administrator and ASM #2, the director of nursing, were made aware of the above concern on 8/8/18 at 6:01 p.m.

On 8/9/18 at 1:13 p.m. administrative staff member (ASM) #1, the administrator, stated the facility uses their policies and Fundamentals of Nursing by Lippincott as their standard of practice.

A policy on clarifying physician orders was requested on 8/9/18 at 1:15 p.m. from the administrator. At approximately 5:00 p.m., the administrator stated they did not have a policy on

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F 658	Continued From page 119 clarifying physician orders. According to Fundamentals of Nursing, 5th edition, Lippincott, Williams & Wilkins, documented, "Always clarify with the prescriber any medication order that is unclear or seems inappropriate." (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 257. (2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010590/?report=details. (3) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012486/?report=details. (4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 157.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it	F 684	Preparation and/or execution of this plan of correction does not constitute	9/21/18

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F 684	Continued From page 120 was determined that the facility staff failed to maintain residents' highest level of wellbeing in accordance with professional standards of care for two of 37 residents in the survey sample, Residents #42 and #49. 1. The facility staff failed to implement speech therapy recommendations for Resident #42's swallowing precautions. 2a. The facility staff failed to administer Resident #49's medication Carvedilol (1) per physician's order on 05/01/18, 05/25/18, 07/31/18 and 08/01/18. 2b. The facility staff failed to obtain Resident # 49's blood pressure for the administration of Carvedilol on 06/24/18. The findings include: 1. The facility staff failed to implement speech therapy recommendations for Resident #42's swallowing precautions. Resident #42 was admitted to the facility on 9/29/16. Resident #42's diagnoses included but were not limited to Alzheimer's disease (1), major depressive disorder and anxiety disorder. Resident #42's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 6/20/18, coded the resident's cognition as severely impaired. Section G coded Resident #42 as requiring extensive assistance of one staff with eating. Resident #42's comprehensive care plan initiated on 10/7/16 documented, "(Name of Resident #42)	F 684	admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. Resident #42: Unable to correct implementing speech therapy recommendations on 8/8/18. Educated staff member on Speech therapy recommendations on 8/9/18. Resident #49: Unable to correct failing to administer blood pressure medication on 5/1/18, 5/25/18, 7/31/18, and 8/1/18. Educated licensed nurse on omission(s) on 8/8/18. Resident #49: Unable to correct the failure to obtain blood pressure prior to administration of blood pressure medication on 6/24/18. Educated licensed nurse on omission(s) on 8/9/18. Any resident that has speech therapy recommendation and/or swallowing difficulties has the potential to be affected. All residents taking blood pressure medication have the potential to be affected. All staff will be educated regarding following speech therapy recommendations. All licensed nurses will be educated on the requirement to follow physician□s orders regarding blood pressure medication parameters, when to hold medications and when to obtain and record blood pressure reading prior to	

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F 684	Continued From page 121 has need for mechanically altered food and fluids r/t (related to) swallowing difficulties (hx CVA [history of cerebrovascular accident-stroke])...Speech recommendations, see inside closet door for the most current recommendations..." A speech therapy screening dated 3/1/17 documented, "Pocketing MS (mechanical soft) meat; excessive and effort for muscle chew-downgrade diet to pureed. Dependent for feeding..." A document dated 6/27/17 and titled, "SWALLOWING PRECAUTIONS" located inside Resident #42's closet door documented, "LIQUIDS: All liquids allowed." A check mark was documented beside, "Upright at 90 degrees for p.o. (by mouth) intake." On 8/8/18 at 8:24 a.m., LPN (licensed practical nurse) #7 was observed giving Resident #42 a supplemental beverage with a straw. Resident #42 was in bed and the head of the bed was elevated at 45 degrees. LPN #7 placed the straw to Resident #42's mouth and the resident took sips of the beverage. While LPN #7 was assisting Resident #42 with the beverage, a CNA (certified nursing assistant) entered the room. LPN #7 removed the beverage from Resident #42's mouth. The CNA lowered the head of Resident #42's bed. The CNA and LPN #7 repositioned Resident #42 then the CNA elevated the head of the bed to 30 degrees. LPN #7 proceeded to give Resident #42 more sips of the beverage while the head of the bed was positioned at 30 degrees. On 8/8/18 at 11:53 a.m., an interview was	F 684	administering blood pressure medication. The Nurse Manager or designee will observe three residents that have speech therapy recommendations weekly x 4 weeks and then monthly x3 to ensure recommendations are being followed. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months then quarterly thereafter. The Nurse Manager or designee will audit 5 resident with orders for blood pressure medication weekly x4 weeks, then bi-weekly x2 and then monthly x3 to ensure physician orders were followed. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months then quarterly thereafter.	

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conducted with OSM (other staff member) #12 (a speech therapist). OSM #12 stated she had not worked with Resident #42. OSM #12 was asked to read the speech therapy screening dated 3/1/17 and describe what the screening meant. OSM #12 read the screening and stated per the screening, Resident #42 was pocketing food and presented with delayed chewing. When asked to explain the swallowing precautions, OSM #12 stated the swallowing precautions are standards used for anyone who is dependent for feeding. OSM #12 stated there is a standard that anyone who is dependent for feeding should be positioned at 90 degrees (if possible) when being assisted with foods and liquids. When asked to explain the risks for a dependent resident who is given liquids while he is positioned at 30 degrees, OSM #12 stated the risks would depend on the resident's diagnoses and if the resident had a history of aspiration pneumonia (2). Review of Resident #42's clinical record failed to reveal a history of aspiration pneumonia.

On 8/8/18 at 4:37 p.m., an interview was conducted with LPN #5. LPN #5 was asked the facility process for following speech therapy recommendations. LPN #5 stated, "She (the speech therapist) recommends you notify the doctor. If they write orders, you implement." When asked if the recommendations should be followed even if there is not a physician's order, LPN #5 stated, 'Yes."

On 8/8/18 at 6:13 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Therapy Screenings"

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documented, "Purpose: To provide guidelines for therapy staff to assess all patients and residents for therapy needs on a regular basis. To formalize the manner in which appropriate patients are referred for Therapy treatment." The policy did not document information regarding nurses following speech therapy recommendations.

No further information was presented prior to exit.

(1) "Alzheimer's disease (AD) is the most common form of dementia among older people. Dementia is a brain disorder that seriously affects a person's ability to carry out daily activities." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=alzheimers+disease&_ga=2.59104493.193292090.1533897219-139120270.1477942321

(2) "Pneumonia is a breathing condition in which there is swelling or an infection of the lungs or large airways.
Aspiration pneumonia occurs when food, saliva, liquids, or vomit is breathed into the lungs or airways leading to the lungs, instead of being swallowed into the esophagus and stomach." This information was obtained from the website: https://medlineplus.gov/ency/article/000121.htm

2a. The facility staff failed to administer Resident #49's medication Carvedilol (1) per physician's order on 05/01/18, 05/25/18, 07/31/18 and 08/01/18.

Resident # 49 was admitted to the facility on 03/02/18 with diagnoses that included but were

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not limited to hypertension (2), dementia without behavioral disturbance, (3), diabetes mellitus (4), and depressive disorder (5).

Resident # 49's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 06/28/18, coded Resident # 49 as scoring an (11) eleven on the brief interview for mental status (BIMS) of a score of 0 - 15, (11) eleven - being cognitively intact for making daily decisions. Resident # 49 was coded as requiring extensive assistance of one staff member for activities of daily living.

The POS (physician's order sheet) for Resident # 49 dated March 2018 documented, "Carvedilol Tablet 12.5 MG (milligrams). Give 1 (one) tablet by mouth two times a day for HTN (hypertension). HOLD FOR SBP (systolic blood pressure) < (less than) 100. Start Date: 03/20/2018."

The POS (physician's order sheet) for Resident # 49 dated August 2018 documented, "Carvedilol Tablet 6.25 MG (milligrams). Give 1 (one) tablet by mouth two times a day for HTN (hypertension). HOLD FOR SBP (systolic blood pressure) < (less than) 100. Order Date: 06/01/2018. Start Date: 06/01/2018."

The eMAR (electronic medication administration record) for Resident # 49 dated May 2018 documented the above physician's order for Carvedilol Tablet 12.5 MG (milligrams). Further review of the eMAR revealed the number four on 05/01/18 at 5:00 p.m., indicating Resident # 49's Carvedilol was not administered on 05/01/18 at 5:00 p.m. with a SBP of 119. The eMAR also documented the number nine on 05/25/18 at 5:00 p.m. for a SBP of 100. The "Chart Codes/Follow

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Up Codes" on the eMAR documented, "9 (nine) = Other/See Nurse's Notes."

The nurse's notes for Resident # 49 dated 05/25/18 documented, "Carvedilol Tablet 12.5 MG. Give 1 (one) tablet by mouth two times a day for HTN (hypertension). HOLD FOR SBP (systolic blood pressure) < (less than) 100. Med (medication) held SBP 100/60 (one hundred over sixty)."

Further review of the May 2018 eMAR revealed a check mark on 05/21/18 at 5:00 p.m., indicating Resident # 49 was administered Carvedilol on 05/21/18 at 5:00 p.m. with a SBP of 98.

The eMAR (electronic medication administration record) for Resident # 49 dated June 2018 documented the above physician order for Carvedilol Tablet 6.25 MG (milligrams). Further review of the eMAR revealed a check mark on 06/30/18 at 9:00 a.m. indicating Resident # 49 was administered Carvedilol on 06/30/18 at 9:00a.m., with a SBP of 94 and at 9:00 p.m. with a SBP of 94. Further review of the eMAR revealed a check mark on 07/12/18 at 9:00 p.m. indicating Resident # 49 was administered Carvedilol on 07/12/18 at 9:00 p.m. with a SBP of 98.

The eMAR (electronic medication administration record) for Resident # 49 dated July 2018 documented the above orders for Carvedilol Tablet 6.25 MG (milligrams). Further review of the eMAR documented the number five on 07/31/18 at 9:00 a.m. and no documentation of a SBP and at 9:00 p.m. for a SBP of 100. The "Chart Codes/Follow Up Codes" on the eMAR documented, "5 (five) = Hold/See Nurse's Notes."

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The facility's "Weights and Vitals Summary" for Resident # 49 documented, "07/31/2018 20:48 (8:48 p.m.) 100/25 (one hundred over fifty-two)."

The nurse's notes for Resident # 49 dated 07/31/18 at 11:18 a.m. documented, "Carvedilol Tablet 12.5 MG. Give 1 (one) tablet by mouth two times a day for HTN (hypertension). HOLD FOR SBP (systolic blood pressure) < (less than) 100. hold." Further review of the nurse's notes for Resident # 49 dated 07/31/18 failed to evidence documentation of Carvedilol being held at 9:00 p.m."

The eMAR (electronic medication administration record) for Resident # 49 dated August 2018 documented the above physician's orders for Carvedilol Tablet 6.25 MG (milligrams). Further review of the eMAR documented the number five on 08/01/18 at 9:00 p.m. for a SBP of 108. The "Chart Codes/Follow Up Codes" on the eMAR documented, "5 (five) = Hold/See Nurse's Notes."

The nurse's notes for Resident # 49 dated 08/01/18 at 11:18 a.m. documented, "Carvedilol Tablet 12.5 MG. Give 1 (one) tablet by mouth two times a day for HTN (hypertension). HOLD FOR SBP (systolic blood pressure) < (less than) 100. hold." Further review of the nurse's notes for Resident # 49 dated 08/01/18 failed to evidence documentation of Carvedilol being held at 9:00 p.m."

The comprehensive care plan for Resident # 49 dated 03/22/2018 documented, "Focus. (Resident # 49) has altered cardiovascular status r/t (related to A-Fib (atrial fibrillation), CHF (congestive heart failure), Hypertension." Under

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"Interventions/Tasks" it documented, "Administer medications as ordered. Monitor for effectiveness. Date initiated 03/22/2018. Revision on: 06/01/2018."

On 08/09/18 at 10:18 a.m., an interview was conducted with RN (registered nurse) # 1. RN # 1 was asked to review the eMARs dated May, June, and July 2018 for Resident # 49. When asked about the medication Carvedilol not being administered to Resident # 49 on 05/01/18, 05/25/18, 07/31/18 and 08/01/18 with systolic blood pressures at 100 and above, RN # 1 stated, "They should have been given."

On 08/09/18 at approximately 12:35 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:
(1) 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 is often used in combination with other medications. Carvedilol is in a class of medications called beta-blockers. It works by relaxing blood vessels and slowing heart rate to improve blood flow and decrease blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697042.html.

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

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F 684	Continued From page 128 essure.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) 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. (5) 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. 2b. The facility staff failed to obtain Resident # 49's blood pressure for the administration of Carvedilol on 06/24/18. The eMAR (electronic medication administration record) for Resident # 49 dated June 2018 documented, "Carvedilol Tablet 6.25 MG (milligrams). Give 1 (one) tablet by mouth two times a day for HTN (hypertension). Hold for SBP (systolic blood pressure) < (less than) 100. Start Date: 06/01/2018." Further review of the eMAR for 06/24/18 was blank. The facility's "Weights and Vitals Summary" for Resident # 49 failed to evidence a blood pressure	F 684		

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F 684	Continued From page 129 at 9:00 p.m. The nurse's notes for Resident # 49 dated 06/24/18 failed to evidence a blood pressure or documentation of the medication being held or administered. The comprehensive care plan for Resident # 49 dated 03/22/2018 documented, "Focus. (Resident # 49) has altered cardiovascular status r/t (related to A-Fib (atrial fibrillation), CHF (congestive heart failure), Hypertension." Under "Interventions/Tasks" it documented, "Vital signs as ordered. Notify physician of any abnormal readings. Date initiated 03/22/2018. Revision on: 03/22/2018." On 08/09/18 at 10:18 a.m., an interview was conducted with RN (registered nurse) # 1. RN # 1 was asked to review the eMARs dated May June and July 2018 for Resident # 49. When asked about the blank of the June eMAR dated 06/24/18 RN # 1 stated, "If it is blank it means there was no documentation and the medication wasn't given." On 08/09/18 at approximately 12:35 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit.	F 684		
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	F 686		9/21/18

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F 686	Continued From page 130 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 staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide care and services to promote the healing of a pressure ulcer for Resident #16. The facility staff failed to provide wound treatment to Resident #16's pressure sore as ordered by the physician on 8/6/18. The findings include: Resident #16 was admitted to the facility on 5/10/18, with a most recent readmission of 7/26/18, with diagnoses that included but were not limited to: altered mental status (confusion) (1), acute respiratory infection, ataxia (trouble coordinating movements), (2), high blood pressure, muscle weakness, diabetes, difficulty swallowing, a pressure ulcer of the sacrum (areas of damaged skin caused by staying in one position for too long.) (3), and hydrocephalus (a problem with the flow of the fluid that surrounds the brain. This fluid is called the cerebrospinal fluid, or CSF. The fluid surrounds the brain and spinal cord and helps cushion the brain. Too	F 686	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. Wound care was provided as per physician order for Resident #16 on 8/9/18. All residents with pressure ulcer/injuries are at risk for this deficient practice. Nursing staff will be educated on the importance of wound care proper documentation of the wound treatment process. The Nurse Manager or designee will audit 100% residents with pressure wounds weekly x4, then 50% bi-weekly x2, then 25% monthly x3 to ensure treatment was completed as ordered. Results of audits	

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F 686	Continued From page 131 much CSF puts pressure on the brain. This pushes the brain up against the skull and damages brain tissue.) (4). The most recent MDS (minimum data set) assessment, a five day Medicare assessment, with an assessment reference date of 8/2/18, coded the resident as scoring a "4" on the BIMS (brief interview for mental status) score, indicating he has severe cognitive impairment for daily decision making. The resident was coded as requiring extensive assistance of at least one or more staff members for bed mobility, transfers, locomotion on and off the unit, dressing, eating, toileting, and personal hygiene. In Section M - Skin conditions, the resident was coded as having one or more unhealed pressure ulcers, which were not present in the prior assessment, during the look back period. The admission nursing note dated 7/26/18 at 10:27 p.m., documented in part, "Small open area on sacrum and left buttock. No drainage noted [sic] Venalex oint [ointment] (wound dressing ointment that helps to deodorize and protectively cover pressure wounds) (5) applied and covered with foam patch." A telephone physician order dated 7/26/18, documented in part "Weekly skin assessment every day shift [sic] every Thu (Thursday) for 7-3 (day shift) assessment." The physician's note dated 7/28/18 at 5:53 p.m. documented in part, "Sacral wound: wound care." The "Weekly Wound Notes" dated 8/1/18 at 3:12 p.m., documented in part, "Left buttock: Wound bed 100% (percent) yellow slough, edges defined	F 686	will be reviewed for patterns and/or trends and reported at QAPI monthly for three months then quarterly thereafter.	

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F 686	Continued From page 132 and intact. Left buttock (unstageable) pressure injury, cleanse w/NS (with normal saline), apply Santyl (an ointment that assists in the dissolving of dead wound tissue) (6) to wound bed and cover with foam dressing. Change daily." The physician's order dated 8/2/18 documented in part, "Left buttock (unstageable) pressure injury, cleanse w/NS, apply Santyl to wound bed and cover with foam dressing. Change daily every day shift." A review of the August 2018 TAR (treatment administration record), documented that the wound care, as ordered, was provided on 8/3/18, 8/4/18, 8/5/18, 8/7/18 and 8/8/18. The TAR did not have any check marks or initial for 8/6/18. An interview was conducted with LPN (licensed practical nurse) #1 on 8/9/18 at 9:05 a.m. LPN #1 was asked to describe the wound care process. She stated in part, "Open a skin assessment, then stage the ulcer, notify the doctor, notify the family, consult with wound doctor." When asked if the wound care should be documented, LPN #1 stated, "Yes." The August 2018 TAR was shown to LPN #1, and she was asked about the blanks for wound care on 8/6/18. LPN #1 stated, "Either they (the nurse) forgot to document it or it was not done." An interview was conducted with RN (registered nurse) #1 on 8/09/18 and 9:15 a.m. RN #1 stated, "On admit a skin assessment is done. If there is a wound, the wound care protocol/policy is put into place. Then when wound care doctor comes in [per RN #1, he comes in every Wednesday], the wound is assessed and the wound care doctor sends in his notes which are	F 686		

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F 686	Continued From page 133 scanned into the [resident's] medical record." The August 2018 TAR was shown to RN #1. RN #1 was asked if the treatment was performed as ordered on 8/6/18. RN #1 stated, "If is not documented it was not done ...if the treatment cannot be done for some reason, the nurse should document in the nursing notes the reason it was not done. In addition, if it is not done, the nurse should contact the family and the doctor." RN #1 was asked if the treatment was not provided would that be considered not following the physician's order. RN #1 stated, "Yes, if the treatment is not done the nurse is not following the doctor's orders." A review of the care plan, with a most recent revision date of 8/3/18, documents in part, "Focus: [Resident #16's name] has an US, (unstageable) (sores covered in dead skin that is yellow, tan, green, or brown. The dead skin makes it hard to tell how deep the sore is. This type of sore is "unstageable.") (7), pressure ulcer to his L (left) buttock". Interventions documented in part, "Administer treatment as ordered and monitor for effectiveness." ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above findings on 8/9/18 at 12:32 p.m. A review of the facility's "Skin and Wound Care" policy documents in part, "Upon assessment and identification of a pressure ulcer or wound, treatment orders are obtained, transcribed to EMAR (electronic medication administration record) and implemented ...Documentation will be completed in the progress notes".	F 686		

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F 686	Continued From page 134 On 8/9/18 at 3:35 p.m., ASM #2 stated she had spoken with the nurse who was responsible for doing the treatment on 8/6/18. Per ASM #2, "she [LPN #7], stated she did not do it." No further information was obtained prior to exit. 1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/003205.htm 2) This information was obtained from the National Institutes of Health at https://medlineplus.gov/friedreichsataxia.html 3) This information was obtained from the National Institutes of Health at https://medlineplus.gov/pressuresores.html 4) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/001571.htm 5) This information was obtained from the National Institutes of Health at https://dailymed.nlm.nih.gov/venalex 6) This information was obtained from the National Institutes of Health at https://www.ncbi.nlm.nih.gov/pubmed/19918145 7) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/patientinstructions/000740.htm	F 686		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii)	F 687		9/21/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 687	Continued From page 135 §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide foot care for one of 37 residents in the survey sample, Resident #27. The facility staff failed to ensure Resident #27's toenails were trimmed. The findings include: Resident #27 was admitted to the facility on 5/24/18. Resident #27's diagnoses included but were not limited to diabetes, heart failure and high blood pressure. Resident #27's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 5/31/18, coded the resident as being cognitively intact. Resident #27's comprehensive care plan initiated 5/28/18 documented, "(Name of Resident #27) has Diabetes Mellitus...Refer to podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails..."	F 687	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. Resident #27: Director of Nursing trimmed nails of resident #27 on 8/8/18. Podiatrist saw resident on 8/23/18. All residents have the potential to be affected. Nursing staff will be educated regarding the assessment of nails during weekly skin assessments, nail care, podiatry consult process and follow-up with visit information scanned into resident chart. Consults with podiatrist to be scheduled monthly. Medical records will ensure podiatry consult notes are scanned in to EMR.	

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F 687	Continued From page 136 Review of Resident #27's clinical record failed to reveal a podiatry consult. On 8/8/18 at 8:50 a.m., LPN (licensed practical nurse) #7 was observed applying medicated cream on Resident #27's legs. Resident #27 removed his shoes. The resident's right first, second, third and fifth toenails were grown out approximately 0.25 inch from the tip of the resident's toes. Resident #27's right fourth toenail was grown out approximately 0.5 inch from the tip of the resident's toe. The left second and third toenails were grown out approximately 0.25 inch from the tip of the resident's toes. LPN #7 was asked if Resident #27's toenails needed to be cut. LPN #7 stated, "I think a little on the right foot and yes on the left foot." Resident #27 stated he had not seen a podiatry since his admission and his toenails really needed to be cut but he thought the podiatrist was coming this Saturday. LPN #7 was asked how staff ensures residents receive toenail care. LPN #7 stated normally the CNAs (certified nursing assistants) cut residents' toenails but she would look into a podiatry consult for Resident #27. When asked how often the podiatrist comes to the facility, LPN #7 stated she had been employed at the facility for four or five weeks and she had not seen a podiatrist. On 8/8/18 at 4:37 p.m., an interview was conducted with LPN #5. LPN #5 was asked the facility process for ensuring residents receive toenail care. LPN #5 stated, "We will trim on shower days and there is also a podiatry book, especially for diabetics." LPN #5 did not know how often the podiatrist comes to the facility.	F 687	Director of nursing or designee will audit podiatry consults monthly to ensure nail care is provided and podiatrist documentation is noted in EMR. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months then quarterly. Corrective actions to be completed by 9/21/18.	

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F 687	Continued From page 137 On 8/8/18 at 6:13 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. On 8/9/18 at 12:50 p.m., ASM #2 stated she cut Resident #27's toenails. The facility policy titled, "Bathing" documented, "14. Care of finger and toenails is part of the bath. Be certain nails are clean. If toenails would be difficult, advise Charge Nurse. Charge Nursing or Podiatrist will cut toenails..." No further information was presented prior to exit.	F 687		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a safe environment for two of 37 residents in the survey sample, Residents #69 and #81. 1. The facility staff failed to secure a bottle of maximum strength antacid liquid in Resident #69's room and the resident was not approved for	F 689	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. A medication self-administration assessment was completed with resident	9/21/18

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medication self-administration.

2. The facility staff failed to utilize a medical grade surge protector for Resident # 81's medical equipment.

The findings include:

1. The facility staff failed to secure a bottle of maximum strength antacid liquid in Resident #69's room and the resident was not approved for medication self-administration.

Resident #69 was admitted to the facility on 5/2/16. Resident #69's diagnoses included but were not limited to dementia (1), anxiety disorder and high blood pressure. Resident #69's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/16/18, coded the resident as being cognitively intact. Section G coded Resident #69 as requiring supervision with bed mobility, transfers and walking.

Review of Resident #69's clinical record revealed a self-medication administration assessment dated 2/2/17 that documented,
"A. THE RESIDENT
1. Can state the name, dose, times, strength, and frequency of his/her medication- No.
2. Can recognize all of his/her medications- No.
3. Can read the prescription label (including his/her name & drug information) - No.
4. Can state common side effects of medications- No.
5. Can state and measure proper dosage- No.
6. Can demonstrate secure storage in room- No.
7. Can demonstrate proper handwashing technique before & after administration- No.

F 689

#69 on 8/9/18. Resident was not approved to self-medicate. Medication removed from room.
On 8/9/18, maintenance staff corrected the issue by removing the surge protector in Resident #81□s room. Medical equipment was plugged into red plug outlet powered by emergency generator in the event of a power failure.

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

Nursing staff will be educated on self-administration assessment process and requirement to ensure a safe environment to include ensuring medications are not kept at bedside and any medications that family brings in requires a physician order.
EVS and nursing staff will be educated on the requirement that all medical equipment be plugged into red outlet or medical grade surge protector. All non-medical grade surge protectors will be removed and replaced with medical grade surge protectors as needed.

Nurse manager or designee will audit 5 rooms per week x 4 weeks, and then monthly to ensure medications are not found at bedside. EVS Supervisor or designee will conduct room inspections of 10 resident rooms weekly x4, then monthly x 3. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months then quarterly thereafter

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8. Reviewed by Interdisciplinary Team on: 02/02/2017 00:00
9. Approved for Self-Administration of Medications- No."

No further self-medication administration assessments were in Resident #69's clinical record.

Review of Resident #69's, current physician's orders on 8/7/18 failed to reveal an order for antacid liquid.

On 8/7/18 at 1:45 p.m. and 3:34 p.m., a bottle of generic maximum strength (400 milligrams) antacid liquid was observed on Resident #69's dresser.

On 8/7/18 at 3:34 p.m., an interview was conducted with Resident #69. Resident #69 stated her daughter had brought the antacid liquid to her. Resident #69 stated she gets heartburn at night so she takes "a swig" of the antacid liquid and it helps.

On 8/8/18 at 2:39 p.m., the antacid liquid remained on Resident #69's dresser.

On 8/8/18 at 4:37 p.m., an interview was conducted with LPN (licensed practical nurse) #5 (a nurse who routinely cared for Resident #69). LPN #5 was asked what should be done if a resident has medication in his/her room. LPN #5 stated, "You have to do a self-medication evaluation." When asked why, LPN #5 stated, "To see if he is able to administer the medication safely, he knows what it is, how to apply, make sure he is alert and oriented times three." LPN #5 was asked if antacid liquid was a medication.

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LPN #5 stated it was. When asked if there is a facility process for ensuring residents do not have medications in their room (unless deemed safe), LPN #5 stated she looks for medications when she is in residents' rooms. LPN #5 was asked if she has ever noticed medication in Resident #69's room. LPN #5 stated, "I swear I saw something but I can't remember what it was because her daughter brings stuff in and I have to watch for it." LPN #5 was made aware of this surveyor's observations. LPN #5 stated she had not worked at the facility for the last week. When asked if nurses should be looking for medications in residents' rooms, LPN #5 stated, "Yes." Resident #69's self-medication administration assessment was reviewed with LPN #5 and LPN #5 was asked if antacid liquid should be in the resident's room. LPN #5 stated, "Absolutely not. I will reassess."

Resident #69's comprehensive care plan initiated on 5/4/16 failed to document information regarding the resident's daughter bringing medication to the resident.

On 8/8/18 at 6:13 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

On 8/9/18 at 2:00 p.m., ASM #2 provided a self-medication administration assessment completed for Resident #69 on 8/9/18. The assessment documented Resident #69 was not approved for self-administration of medications.

The facility policy titled, "Medication Administration" documented, "Patients Own Medications (POM) (Non-Formulary Only): 1. In

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general, medications are not left at the bedside. 2. Medications brought from home by patients to the hospital- a. The medications, if not needed to be used by Pharmacy while the patient is in-house, are returned to the patient's family, at the time of admission, if possible. b. If there is no family member present, medications are placed in a bedside bag, sealed in front of the patient, labeled with the patient's name, patient's room number and sent to Pharmacy, with documentation made in the medical record. c. At time of discharge, it is the nurse's responsibility to call Pharmacy to retrieve the medications, return them to patient, and document. d. A physician's order is required when patient's own medication for a non-formulary drug is to be used. The medications must be inspected by a staff pharmacist to determine the drug name, strength, and dosage form, matches the in-house chart order, and that the medication contained within the patient's prescription bottle matches the label on the bottle. The medications are secured either in the medication cart or if a controlled substance in (name of a medication dispensing machine)..."

No further information was presented prior to exit.
2. The facility staff failed to utilize a medical grade surge protector for Resident # 81's medical equipment.

Resident # 81 was admitted to the facility on 05/20/18 with a readmission on 06/27/18 with diagnoses that included but were not limited to hypertension (1), hemiplegia, (2), diabetes mellitus (3), and atrial fibrillation (4).

Resident # 81's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/16/18, coded

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F 689	Continued From page 142 Resident # 81 as scoring a (01) one on the brief interview for mental status (BIMS) of a score of 0 - 15, (1) one - being severely impaired of cognition for making daily decisions. Resident # 81 was coded as requiring extensive assistance of two staff members for activities of daily living. On 08/07/18 at approximately 11:40 a.m., an observation of Resident # 81 room revealed she was not in the room. Further observation of the room revealed a multi-outlet surge protector on the floor, under the head of the bed, and plugged into the electrical wall outlet. Observation of the multi-outlet surge protector revealed Resident # 81's hospital bed and tube feeding pump were plugged into the multi-outlet surge protector. On 08/08/18 at approximately 8:30 a.m., an observation of Resident # 81 room revealed she was lying in her bed. Further observation of the room revealed a multi-outlet surge protector on the floor, under the head of the bed and plugged into the electrical wall outlet. Observation of the multi-outlet surge protector revealed Resident # 81's hospital bed and tube feeding pump were plugged into the multi-outlet surge protector. On 08/09/18 at approximately 7:35 a.m., an observation of Resident # 81 room revealed she was lying in her bed. Further observation of the room revealed a multi-outlet surge protector on the floor, under the head of the bed and plugged into the electrical wall outlet. Observation of the multi-outlet surge protector revealed Resident # 81's hospital bed and tube feeding pump were plugged into the multi-outlet surge protector. On 08/09/18 at approximately 7:25 a.m., an interview was conducted with OSM (other staff	F 689		

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member) # 3, environmental technician. When asked if the surge protector for Resident # 81 was medical grade OSM # 3 stated he wasn't sure. OSM # 3 was asked to obtain additional information about the surge protector. At approximately 12:00 p.m., OSM # 3 informed this surveyor that he spoke with OSM # 6, maintenance technician from (Name of Hospital). OSM # 3 stated, "(OSM # 6) said the surge protectors are nothing more than an extension cord. They're not medical grade."

In its Standard for Health Care Facilities (NFPA 99), (1) NFPA defines a patient care area as "any portion of a health care facility wherein patients are intended to be examined or treated." For equipment intended to be used within these areas-which include patient, examining, and treatment rooms, as well as any similar areas in which the patient is likely to come into contact with electrical devices-NFPA specifies that chassis leakage currents should not exceed 300 microamperes. (Note that this limit was increased from the pre-1993 limit of 100 microamperes.) However, NFPA does permit exceptions under certain conditions; for example, leakage currents up to 500 microamperes are permitted if the leakage current does not represent a hazard to the patient and if the grounding connection remains intact. Also, when chassis leakage from equipment that will be used in the area exceeds 500 microamperes, NFPA permits the use of leakage current reduction methods, such as adding an isolation transformer or redundant ground.

Within the patient care area, NFPA further requires that any equipment intended for placement near the patient meet additional

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requirements. NFPA refers to the area near the patient as the patient care vicinity, which it defines as "a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, . . . or other device that supports the patient . . . [and] vertically to 7 ft 6 in (2.3 m) above the floor." For equipment to be used in this space, NFPA requires that the resistance between conductive chassis surfaces and a reference grounding point not exceed 0.50 W. (NFPA established the concept of a patient care vicinity so that the entire room would not need to meet the stricter requirement.) This information was obtained from: http://www.mdsr.ecri.org/summary/detail.aspx?doc_id=8286

On 08/09/18 at approximately 12:35 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

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

(2). Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information

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F 689	Continued From page 145 was obtained from the website: https://medlineplus.gov/paralysis.html. (3) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. (4) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html. (1) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dementia	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary	F 690		9/21/18

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F 690	Continued From page 146 incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to maintain a Foley catheter in a sanitary manner to prevent infections. The facility staff failed to ensure Resident #30's Foley catheter bag was maintained in a manner to prevent infection. The findings include:	F 690	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. Resident #30: Foley catheter bag was covered with privacy bag and attached bag to side of bed frame off the floor on	

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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 690 Continued From page 147

Resident #30 was admitted to the facility on 11/1/17 with the diagnoses of but not limited to end stage renal disease, chronic obstructive pulmonary disease, diabetes, stroke, high blood pressure, macular degeneration, and prostate cancer. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 5/14/18. The resident was coded as being moderately impaired 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; and was independent for eating.

A review of the clinical record revealed an order dated 5/8/18 for the use of a Foley catheter {1} related to prostate cancer with urinary retention.

A review of the comprehensive care plan revealed one dated 5/9/18 for "Potential for infection r/t (related to) use of foley {sic}..." This care plan included an intervention dated 5/9/18 for "keep foley {sic} bag below level of bladder and off floor."

On 8/07/18 at 3:27 p.m., an observation of Resident #30 revealed the Foley catheter bag lying flat on the floor under the edge of his bed and not hanging on the side of the bed.

On 8/8/18 at 2:54 p.m., in an interview with LPN #4 (Licensed Practical Nurse), she stated the Foley catheter bag should not be lying on the floor. When asked if Resident #30's care plan was followed, if it documented to keep the Foley off the floor, but the Foley was lying directly on the floor, LPN #4 stated no.

F 690

8/8/18.

All residents with foley catheters have the potential to be affected.

Nursing staff education to be completed regarding foley catheters, privacy covers and proper location of the catheters.

The Nurse Manager or designee will observe all residents with foley catheters weekly for proper covering and placement. Audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter.

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F 690	Continued From page 148 On 8/8/18 at 6:00 p.m., at the end of day meeting, the administrator (ASM #1 - Administrative Staff Member) was made aware of the findings. No further information was provided by the end of the survey. According to Fundamentals of Nursing Lippincott Williams and Wilkins Eighth Edition 2006, Lippincott Company, page 757, titled Renal and Urinary Disorders, under the heading "Management of a Patient with an Indwelling Catheter and Closed Drainage System" the subheading: "Maintaining a closed drainage system:...c. Keep the bag off the floor to prevent bacterial contamination." {1} According to Fundamentals of Nursing Lippincott Williams and Wilkins page 593. "An indwelling urinary catheter also called a Foley catheter provides the patient with continuous urine drainage. It is a latex or silicone tube, which is inserted into the bladder and a small balloon, is inflated at the catheter's distal end to prevent it from slipping out. A catheter is used for numerous reasons, but usually when there is a problem resulting in the inability to pass urine, such as in an obstruction or neurological (nerve, brain or spinal cord) disease or injury..."	F 690		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy	F 695		9/21/18

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F 695	Continued From page 149 care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review it was determined that the facility staff failed to provide respiratory care and services for four of 37 residents in the survey sample, Residents # 290, # 39, # 191 and # 48. 1. The facility staff failed to administer Resident # 290's oxygen according to the physician's orders. 2. The facility staff failed to store Resident #39's nebulizer mask in a clean and sanitary manner. 3. The facility staff failed to administer oxygen, per the physician order, for Resident #191. 4. The facility staff failed to administer oxygen, per the physician order for Resident #48. The findings include: 1. The facility staff failed to administer Resident # 290's oxygen according to the physician's orders. On 08/07/18 at approximately 11:36 a.m., an observation of Resident # 290 revealed she was lying in her bed, receiving oxygen by nasal cannula connected to an oxygen concentrator. An observation of the oxygen flow meter on the oxygen concentrator revealed that it was set between two and two and a half liter per minute.	F 695	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. Resident #290: oxygen level was adjusted immediately to ordered flow rate on 8/7/18. Resident #39 nebulizer mask was cleaned and placed in a plastic bag with resident name and date on bag on 8/8/18. Resident #191 oxygen level was adjusted to ordered flow rate on 8/9/18. Resident #48 oxygen was adjusted to ordered flow rate on 8/9/18. All residents prescribed oxygen have the potential to be affected. All residents with prescribed oxygen were observed with flow rates set as ordered, All residents using nebulizers were checked to ensure all parts of the nebulizer were clean and stored properly. Tubing and bag to be changed weekly. Nursing staff will be educated on proper oxygen flow rates and storage of residents□ respiratory tubing.	

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F 695	Continued From page 150 On 08/08/18 at approximately 8:15 a.m., an observation of Resident # 290 revealed she was lying in her bed, receiving oxygen by nasal cannula connected to an oxygen concentrator. An observation of the oxygen flow meter on the oxygen concentrator revealed that it was set between two and two and a half liter per minute. On 08/09/18 at approximately 7:30 a.m., an observation of Resident # 290 revealed she was lying in her bed, receiving oxygen by nasal cannula connected to an oxygen concentrator. An observation of the oxygen flow meter on the oxygen concentrator revealed that it was set between two and two and a half liter per minute. The physician's orders for Resident # 290 dated August 2018 documented, "Oxygen via (by) nasal cannula 2L (two liters per minute). Order Date: 07/20/2018. Start Date: 07/20/2018." The eMAR (electronic medication administration record) dated August 2018 for Resident # 290 documented, "Oxygen via (by) nasal cannula 2L (two liters per minute). Start Date: 07/20/2018." Further review of the eMAR documented Resident # 290 received oxygen at two liters per minute. The comprehensive care plan for Resident # 290 dated 07/23/2018 documented, "Focus. (Resident # 290) was admitted with (Name of Hospice) services for senile degeneration of brain." Under "Interventions" it documented, "Oxygen via nasal cannula 2L (two liters per minute). Date initiated: 07/31/2018." On 08/09/18 at approximately 7:40 a.m., an interview was conducted with LPN (licensed	F 695	. The Nurse Manager or designee will observe 100% residents with oxygen weekly x4, then bi-weekly x2 and then monthly x3 to ensure residents flow rate is set to physician order. Nurse Manager or designee will audit 100% resident□s with nebulizer treatments weekly to ensure proper storage of nebulizer equipment. Audits will be reviewed for patterns and/or trends and reported QAPI meeting monthly for three months then quarterly thereafter.	

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F 695	Continued From page 151 practical nurse) # 1. When asked to describe how the O2 (oxygen) flow meter is read LPN # 1 stated, "The top of the ball should touch the liter line." On 08/09/18 at approximately 7:50 a.m., an interview was conducted with LPN (licensed practical nurse) # 3. When asked to describe how the O2 (oxygen) flow meter is read, LPN # 3 stated, "The line should be in the middle of the ball and it should read it at eye level." LPN # 3 was asked to read the O2 flow rate on Resident # 290's oxygen concentrator. LPN # 3 read the flow meter and stated, "It's between two and two and half liters." On 08/09/18 at approximately 8:00 a.m., an interview was conducted with RN (registered nurse) # 1, unit manager. When asked to describe how the O2 (oxygen) flow meter is read, RN # 1 stated, "The line should be in the middle of the ball and it should read it at eye level." RN # 1 was asked to read the O2 flow rate on Resident # 290's oxygen concentrator. Upon entering Resident #290's room, LPN # 3 was walking out of the room. RN # 1 read the flow meter and stated, "It's at two liters." LPN # 3 was asked if she had adjusted Resident # 290's oxygen flow rate. LPN # 3 stated, "I just adjusted the oxygen to two liters." When asked what the oxygen flow rate should be for Resident # 290, LPN # 3 stated, "It should be at two liters." On 08/09/18 at approximately 12:35 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit.	F 695		

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F 695	Continued From page 152	F 695		

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

(2) 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.

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

(4) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.
2. The facility staff failed to store Resident #39's nebulizer mask (1) in a clean and sanitary manner.

Resident #39 was admitted to the facility on 6/6/17. Resident #39's diagnoses included but were not limited to stroke, major depressive disorder and altered mental status. Resident #39's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/19/18, coded the resident as being cognitively intact.

Review of Resident #39's clinical record revealed a physician's order for a medication to be administered via nebulizer every four hours as needed for wheezing and shortness of breath.

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F 695	Continued From page 153 On 8/7/18 at 11:31 a.m., Resident #39's nebulizer mask was observed attached to the nebulizer machine. The mask was not covered and was exposed to potential contaminates in the air. On 8/7/18 at 1:48 p.m., Resident #39' nebulizer mask remained attached to the nebulizer machine, uncovered. Resident #39 was asked if the facility staff ever covers the nebulizer mask. Resident #39 stated the facility staff does not cover the mask but it probably should be covered. On 8/8/18 at 2:37 p.m., Resident #39's nebulizer mask remained attached to the nebulizer machine, uncovered. Resident #39's comprehensive care plan initiated on 6/9/17 failed to document information regarding the storage of the resident's nebulizer mask. On 8/8/18 at 4:37 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 was asked how a nebulizer mask should be stored when the nebulizer is not in use. LPN #5 stated, "In a baggie. Sealed." On 8/8/18 at 6:13 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Administering Respiratory Therapy with a Nebulizer" documented, "15. Cleanse equipment and return to designated area. Nebulizer kit needs to air dry after cleaning and then be stored in clean, storage container..."	F 695		

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F 695	Continued From page 154	F 695		

No further information was presented prior to exit.

(1) A nebulizer is a machine that turns liquid medicine into a mist that can be inhaled through a mouthpiece or mask. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000006.htm

3. The facility staff failed to administer oxygen, per the physician order, for Resident #191.

Resident #191 was admitted to the facility on 8/3/18 with diagnoses that included but were not limited to: diabetes, high blood pressure, anxiety and chronic kidney disease requiring hemodialysis (a procedure used in toxic conditions and renal [kidney] failure, in which wastes and impurities are removed from the blood by a special machine) (1).

There MDS (minimum data set) assessment had not yet been completed by the time of survey. The "Admission Screener" documented in part, the resident was alert and oriented. She was documented as requiring assistance of one staff member for most of her activities of daily living, except eating, in which she was independent.

The physician order dated, 8/3/18, documented, "Oxygen at (2) L/Min (liters per minute) nasal cannula (a plastic tubing with two prongs that rest inside the nose) every shift."

Observation was made of Resident #191 on 8/8/18 at 9:09 a.m. The resident had her oxygen on via the nasal cannula connected to an oxygen concentrator. The oxygen was set between the 1

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F 695	Continued From page 155	F 695		

and the 2.5 lines. That ball was sitting on the 2 line with the top of the ball sitting on the 2.5 line.

Observation was made of Resident #191 on 8/8/18 at 4:53 p.m. The resident was in bed with her oxygen on via the nasal cannula connected to an oxygen concentrator. The oxygen was set on 2.5 L/min. At 4:56 p.m., LPN (licensed practical nurse) #6 was asked to verify the rate of oxygen Resident #191 was receiving. LPN #6 stated the resident was currently on 2.5 L/min. When asked what flow rate the physician prescribed for Resident #191, LPN #6 stated, "She's supposed to be on 2 liters per minute. When asked how to read the flow meter, LPN #6 stated the ball should be in the middle of the prescribed rate. A yellow round sticker was on the flow meter with 2L/Min written on it. When asked what the sticker was for, LPN #6 stated, "That's so anyone that enters the room can verify her prescribed rate."

Review of the care plan, dated 8/6/18, failed to evidence documentation of the use of oxygen for Resident #191.

The Medication Administration Record for August 2018 documented the above order for oxygen. It was documented as having been administered every shift at the prescribed rate from 8/3/18 through the day shift on 8/8/18.

According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed

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F 695	Continued From page 156	F 695		

oxygen concentration. The six rights of medication administration also pertain to oxygen administration."

The administrator (administrative staff member - ASM #1) and ASM #2, the director of nursing, were made aware of the above concern on 8/9/18 at 12:32 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 266.

4. The facility staff failed to administer oxygen, per the physician order for Resident #48.

Resident #48 was admitted to the facility on 6/13/18 with diagnoses that included but were not limited to; hypothermia, urinary tract infection, heart failure, fractures of the left humerus (arm) and left femur (hip) and atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria) (1).

The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 6/27/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. The resident was coded as requiring limited to extensive assistance of one or more staff members for all of her activities of daily living.

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F 695	Continued From page 157 The physician order dated, 8/9/18, documented, "Oxygen at 2L (liters) via nasal cannula every shift." Observation was made of Resident #48 on 08/08/18 at 10:29 a.m. The Resident was in her bed with the oxygen on via the nasal cannula. The oxygen flow meter was set with the ball set with the top of the ball on the 2 line and the bottom of the ball is on the 1.5 line. A second observation was made of Resident # 48 on 8/8/18 at 4:53 p.m. The resident was in her bed with the oxygen on at the correct rate of 2 L/min. The third observation of the resident was made on 8/9/18 at approximately 8:30 a.m. The resident was sitting up in her wheelchair, eating breakfast. She did not have her oxygen on. The comprehensive care plan dated 6/13/18 and revised on 8/3/18 did not evidence documentation related to oxygen. The administrator (administrative staff member - ASM #1) and ASM #2, the director of nursing, were made aware of the above concern on 8/9/18 at 12:32 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.	F 695		
F 697 SS=E	Pain Management CFR(s): 483.25(k)	F 697		9/21/18

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F 697	Continued From page 158 §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide a complete pain management program for one of 37 residents in the survey sample, Resident #39. The facility staff failed to provide non-pharmacological interventions prior to as needed pain medication administration to Resident #39 on multiple occasions in July 2018 and August 2018. The findings include: Resident #39 was admitted to the facility on 6/6/17. Resident #39's diagnoses included but were not limited to stroke, major depressive disorder and altered mental status. Resident #39's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/19/18, coded the resident as being cognitively intact. Section J documented Resident #39 reported frequent pain during the last five days. Review of Resident #39's clinical record revealed physician's orders dated 6/22/18 for oxycodone/acetaminophen (1) 5-325 mg (milligrams)- one tablet every six hours as	F 697	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. Resident #39: Unable to correct failing to provide non-pharmacological interventions prior to PRN pain medication on multiple occasions. All residents taking PRN pain medication have the potential to be affected. Nursing education to be completed regarding offering non-pharmacologic interventions prior to administering PRN pain medication and documenting non-pharmacologic interventions in the EMR. The MDS coordinator or designee will review 10 residents charts of whom receive PRN pain medication weekly x4 weeks, then bi-weekly x2 and then monthly x3. Results of audits will be reviewed for patterns and/or trends and	

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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 697	Continued From page 159 needed for moderate pain and two tablets every six hours as needed for severe pain. Review of Resident #39's July 2018 and August 2018 eMARs (electronic medication administration records) revealed the resident was administered one tablet of oxycodone/acetaminophen ten times in July 2018 and twice in August 2018. Further review of Resident #39's July 2018 and August 2018 eMARs revealed the resident was administered two tablets of oxycodone/acetaminophen three times in July 2018 and once in August 2018. Further review of Resident #39's clinical record (including July 2018/August 2018 eMARs and July 2018/August 2018 nurses' notes) failed to reveal the facility staff provided non-pharmacological interventions prior to administering oxycodone/acetaminophen each time the medication was administered to Resident #39 in July 2018 and August 2018. Resident #39's comprehensive care plan initiated on 6/9/17 documented, "(Name of Resident #39) has potential for pain related to S/P (status post) Left Hip FX (fracture) repair, Left Hemi (hemiparesis [paralysis]) S/P CVA (cardiovascular accident [stroke]), Depression and other generalized discomforts such as neuropathic pain s/p CVA...Provide non-pharmacologic interventions for pain relief prior to administering PRN (as needed) medications such as change in position, cool compress or heat, diversional activities such as tv, snack, drink, others as desired..." On 8/9/18 at 10:17 a.m., an interview was conducted with LPN (licensed practical nurse) #7	F 697	reported at QAPI monthly for three months and then quarterly thereafter.	

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F 697	Continued From page 160 (a nurse who administered oxycodone/acetaminophen to Resident #39 on multiple occasions in July 2018). LPN #7 stated she assesses residents' pain prior to administering as needed pain medication. When asked if she does anything else, LPN #7 stated she could always check residents' vital signs. When asked if she provides non-pharmacological interventions, LPN #7 stated she gave ginger ale to a resident with nausea this morning. LPN #7 was asked to describe Resident #39's pain. LPN #7 stated the resident has pain in her left ankle. When asked if she provided non-pharmacological interventions prior to administering as needed pain medication to Resident #39, LPN #7 stated, "I did not." When asked why, LPN #7 stated she did not because of the grimace on the resident's face. On 8/9/18 at 11:16 a.m., an interview was conducted with LPN #3. LPN #3 was asked what should be done prior to administering as needed pain medication to a resident. LPN #3 stated she provides non-pharmacological interventions such as turning/repositioning, music and television. When asked why she does this, LPN #3 stated because at times, the non-pharmacological interventions are effective and relieve the pain. On 8/9/18 at 11:20 a.m., an interview was conducted with Resident #39. Resident #39 stated the nurses do not provide non-pharmacological interventions prior to administering as needed pain medication to her. On 8/9/18 at 12:50 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.	F 697		

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F 697	Continued From page 161 The facility policy titled, "Pain Management" documented, "3. Document present and past treatments utilized by the resident for the treatment of pain include: A. Medications both prescription and OTC (over the counter). B. Alternative treatments such as positioning, heat and cold applications, music, aroma therapy (Sic.), massage, acupuncture, etc...Non-pharmacological interventions should be attempted before or in addition to medications..." No further information was presented prior to exit. (1) Oxycodone/acetaminophen is used to treat pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.h tml	F 697		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757		9/21/18

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F 757	Continued From page 162 §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure residents were free of unnecessary medication for three of 37 residents in the survey sample, Residents #7, Resident #39, and #49. 1. The facility staff failed administered Lotrel (a blood pressure medication Resident #7 without obtaining the residents blood pressure prior to administering the medication to determine if the medication should be administered per physician's order. 2. The facility staff administered pain medication to Resident #39 without attempting or providing non-pharmacological interventions prior to administering the medications on multiple occasions in July and August 2018. 3. The facility staff failed administered the medication Carvedilol (1) to Resident #49's on 05/21/18, 06/30/18 and 07/12/18, when the medication should have been held per physician's order. The findings include: 1. Resident #7 was admitted to the facility on 4/30/12. Resident #7's diagnoses included but	F 757	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. Resident #7: Unable to correct getting blood pressure prior to administering medication on 8/8/18. Resident #39: Unable to correct not providing non-pharmacological intervention prior to administering pain medication in July and August 2018. Resident #49: Unable to correct on failing to hold medication Carvedilol on 5/21, 6/30, and 7/12 per physicians order. Any resident with orders for blood pressure medication and/or pain medication has the potential to be affected by this deficient practice. Nursing staff will be educated on following physician order regarding obtaining and documenting blood pressure prior to administering blood pressure medication, when to hold medication according to	

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F 757	Continued From page 163 were not limited to high blood pressure, diabetes, and major depressive disorder. Resident #7's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 5/8/18, coded the resident's cognition as severely impaired. Section G coded Resident #7 as requiring extensive assistance of one staff with dressing, eating and personal hygiene. Review of Resident #7's clinical record revealed a physician's order dated 10/24/16 for Lotrel 5-10 mg (milligrams) - one tablet by mouth one time a day. The order further documented to hold the medication for a systolic blood pressure less than 120. Review of Resident #7's August 2018 eMAR (electronic medication administration record) revealed the same physician's order. Resident #7's comprehensive care plan initiated on 5/16/12, documented, "(Name of Resident #7) has hypertension (high blood pressure). Give anti hypertensive medications as ordered..." On 8/8/18 at 9:17 a.m., LPN (licensed practical nurse) #7 was observed preparing Resident #7's medications. LPN #7 prepared one capsule of Lotrel. LPN #7 attempted to administer Resident #7's medications but the resident was in a reclined chair with her eyes closed so LPN #7 stated she would wait to give the resident her medications. During this time, LPN #7 did not assess Resident #7's blood pressure. On 8/8/18 at 10:07 a.m., LPN #7 stated she gave Resident #7 her medications. On 8/8/18 at 2:05 p.m., LPN #7 confirmed she administered Lotrel to Resident #7 without assessing the resident's blood pressure. On 8/8/18 at 4:37 p.m., an interview was conducted with LPN #5. LPN #5 was asked what	F 757	parameters and providing non-pharmacologic intervention prior to administering PRN pain medication. Nurse manager or designee will audit 5 residents charts of whom have orders for blood pressure medication and/or PRN pain medication weekly x 4 weeks, then bi-weekly x2 and then monthly x3 to ensure physician orders are followed. Audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter.	

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should be done if medication administration was dependent on parameters such as to hold the medication for a blood pressure less than 120. LPN #5 stated, "I need to take their blood pressure."

On 8/8/18 at 6:13 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Medication Administration" documented, "5. The patient must be assessed prior to administering any medication. 6. The Healthcare Provider is responsible for ensuring his/her assigned patients receive their medications, and verifies that the patient has taken the medication before leaving the bedside..."

No further information was presented prior to exit.

(1) Lotrel is used to treat high blood pressure. This information was obtained from the website: https://www.fda.gov/ForConsumers/ByAudience/ForWomen/ucm118594.htm

2. The facility staff administered pain medication to Resident #39 without attempting or providing non-pharmacological interventions prior to administering the medications on multiple occasions in July and August 2018

Resident #39 was admitted to the facility on 6/6/17. Resident #39's diagnoses included but were not limited to stroke, major depressive disorder and altered mental status. Resident #39's most recent MDS (minimum data set), a

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F 757	Continued From page 165 quarterly assessment with an ARD (assessment reference date) of 6/19/18, coded the resident as being cognitively intact. Section J documented Resident #39 reported frequent pain during the last five days. Review of Resident #39's clinical record revealed physician's orders dated 6/22/18 for oxycodone/acetaminophen (1) 5-325 mg (milligrams)- one tablet every six hours as needed for moderate pain and two tablets every six hours as needed for severe pain. Review of Resident #39's July 2018 and August 2018 eMARs (electronic medication administration records) revealed the resident was administered one tablet of oxycodone/acetaminophen ten times in July 2018 and twice in August 2018. Further review of Resident #39's July 2018 and August 2018 eMARs revealed the resident was administered two tablets of oxycodone/acetaminophen three times in July 2018 and once in August 2018. Further review of Resident #39's clinical record (including July 2018/August 2018 eMARs and July 2018/August 2018 nurses' notes) failed to reveal the facility staff provided non-pharmacological interventions prior to administering oxycodone/acetaminophen each time the medication was administered to Resident #39 in July 2018 and August 2018. Resident #39's comprehensive care plan initiated on 6/9/17 documented, "(Name of Resident #39) has potential for pain related to S/P (status post) Left Hip FX (fracture) repair, Left Hemi (hemiparesis [paralysis]) S/P CVA (cardiovascular accident [stroke]), Depression and other	F 757		

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generalized discomforts such as neuropathic pain s/p CVA...Provide non-pharmacologic interventions for pain relief prior to administering PRN (as needed) medications such as change in position, cool compress or heat, diversional activities such as tv, snack, drink, others as desired..."

On 8/9/18 at 10:17 a.m., an interview was conducted with LPN (licensed practical nurse) #7 (a nurse who administered oxycodone/acetaminophen to Resident #39 on multiple occasions in July 2018). LPN #7 stated she assesses residents' pain prior to administering as needed pain medication. When asked if she does anything else, LPN #7 stated she could always check residents' vital signs. When asked if she provides non-pharmacological interventions, LPN #7 stated she gave ginger ale to a resident with nausea this morning. LPN #7 was asked to describe Resident #39's pain. LPN #7 stated the resident has pain in her left ankle. When asked if she provided non-pharmacological interventions prior to administering as needed pain medication to Resident #39, LPN #7 stated, "I did not." When asked why, LPN #7 stated she did not because of the grimace on the resident's face.

On 8/9/18 at 11:16 a.m., an interview was conducted with LPN #3. LPN #3 was asked what should be done prior to administering as needed pain medication to a resident. LPN #3 stated she provides non-pharmacological interventions such as turning/repositioning, music and television. When asked why she does this, LPN #3 stated because at times, the non-pharmacological interventions are effective and relieve the pain.

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On 8/9/18 at 11:20 a.m., an interview was conducted with Resident #39. Resident #39 stated the nurses do not provide non-pharmacological interventions prior to administering as needed pain medication to her.

On 8/9/18 at 12:50 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

The facility policy titled, "Pain Management" documented, "3. Document present and past treatments utilized by the resident for the treatment of pain include: A. Medications both prescription and OTC (over the counter). B. Alternative treatments such as positioning, heat and cold applications, music, aroma therapy (Sic.), massage, acupuncture, etc...Non-pharmacological interventions should be attempted before or in addition to medications..."

No further information was presented prior to exit.

(1) Oxycodone/acetaminophen is used to treat pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html

2. The facility staff failed administered the medication Carvedilol (1) to Resident #49's on 05/21/18, 06/30/18 and 07/12/18, when the medication should have been held per physician's order.

Resident # 49 was admitted to the facility on 03/02/18 with diagnoses that included but were not limited to hypertension (2), dementia without

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behavioral disturbance, (3), diabetes mellitus (4), and depressive disorder (5).

Resident # 49's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 06/28/18, coded Resident # 49 as scoring an (11) eleven on the brief interview for mental status (BIMS) of a score of 0 - 15, (11) eleven - being cognitively intact for making daily decisions. Resident # 49 was coded as requiring extensive assistance of one staff member for activities of daily living.

The POS (physician's order sheet) for Resident # 49 dated March 2018 documented, "Carvedilol Tablet 12.5 MG (milligrams). Give 1 (one) tablet by mouth two times a day for HTN (hypertension). HOLD FOR SBP (systolic blood pressure) < (less than) 100. Start Date: 03/20/2018."

The POS (physician's order sheet) for Resident # 49 dated August 2018 documented, "Carvedilol Tablet 6.25 MG (milligrams). Give 1 (one) tablet by mouth two times a day for HTN (hypertension). HOLD FOR SBP (systolic blood pressure) < (less than) 100. Order Date: 06/01/2018. Start Date: 06/01/2018."

The eMAR (electronic medication administration record) for Resident # 49 dated May 2018 documented the above physician's order for the medication Carvedilol Tablet 12.5 MG (milligrams). Further review of the eMAR revealed a check mark on 05/21/18 at 5:00 p.m., indicating Resident # 49 was administered Carvedilol on 05/21/18 at 5:00 p.m. with a SBP of 98.

The eMAR (electronic medication administration

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F 757	Continued From page 169 record) for Resident # 49 dated June 2018 documented the above physician's order for the medication Carvedilol Tablet 12.5 MG (milligrams). Further review of the eMAR revealed a check mark on 06/30/18 at 9:00 a.m. indicating Resident # 49 was administered Carvedilol on 06/30/18 at 9:00a.m., with a SBP of 94 and at 9:00 p.m. with a SBP of 94. The eMAR (electronic medication administration record) for Resident # 49 dated July 2018 documented the above physician's order for the medication Carvedilol Tablet 12.5 MG (milligrams). Further review of the eMAR revealed a check mark on 07/12/18 at 9:00 p.m. indicating Resident # 49 was administered Carvedilol on 07/12/18 at 9:00 p.m. with a SBP of 98. The comprehensive care plan for Resident # 49 dated 03/22/2018 documented, "Focus. (Resident # 49) has altered cardiovascular status r/t (related to A-Fib (atrial fibrillation), CHF (congestive heart failure), Hypertension." Under "Interventions/Tasks" it documented, "Administer medications as ordered. Monitor for effectiveness. Date initiated 03/22/2018. Revision on: 06/01/2018." On 08/09/18 at 10:18 a.m., an interview was conducted with RN (registered nurse) # 1. When asked describe the coding on the eMAR (electronic medication administration record) for Resident # 49, RN # 1 stated, "A check mark indicates the medication was given. If it is blank it means there was no documentation and the medication wasn't given." RN # 1 was asked to review the eMARs dated May June and July 2018 for Resident # 49. When asked about the medication Carvedilol being administered to	F 757		

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Resident # 49 on 05/21/18, 06/30/18 and 07/12/18 with systolic blood pressures below 100, RN # 1 stated, "They (the medication) should have not been given."

On 08/09/18 at approximately 12:35 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:

(1) 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 is often used in combination with other medications. Carvedilol is in a class of medications called beta-blockers. It works by relaxing blood vessels and slowing heart rate to improve blood flow and decrease blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697042.html.

(2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.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) A chronic disease in which the body cannot

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F 757	Continued From page 171 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. (5) 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.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic 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	F 758		9/21/18

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F 758	Continued From page 172 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. §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 37 residents was free of unnecessary psychotropic medications, Residents # 290. The facility staff failed to ensure a proper diagnosis for Resident #290's use of Seroquel [Quetiapine Fumarate] (1). The findings include:	F 758	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. Resident #290: diagnosis was not obtained prior to discharge (expired) on 8/12/18.	

F 758 Continued From page 173 F 758

Resident # 290 was admitted to the facility on 07/19/18 with diagnoses that included but were not limited to Parkinson's disease (2), dementia without behavioral disturbance, (3), heart failure, gastroesophageal reflux disease (4), and dysphagia (5).

Resident # 290's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 07/30/18, coded Resident # 290 as scoring a two on the brief interview for mental status (BIMS) of a score of 0 - 15, two - being severely impaired of cognition for making daily decisions. Resident # 290 was coded as requiring extensive assistance of one staff member for activities of daily living.

The physician's orders dated August 2018 for Resident # 290 documented, "Seroquel Tablet 50 MG (milligram) [Quetiapine Fumarate]. Give 1 (one) tablet by mouth at bed time for ANTIPSYCHOTICS/ANTIMANIC. Start Date: 07/20/2018."

The eMAR (electronic medication administration record) dated August 2018 for Resident # 290 documented, "Seroquel Tablet 50 MG (milligram) [Quetiapine Fumarate]. Give 1 (one) tablet by mouth at bed time for ANTIPSYCHOTICS/ANTIMANIC. Start Date: 07/20/2018." Further review of the eMAR dated 08/01/18 through 08/07/18 revealed Resident # 290 received Quetiapine Fumarate seven of seven opportunities.

The comprehensive care plan for Resident # 290 dated 07/31/2018 documented, "Focus. (Resident # 290) uses psychotropic medications

Residents who receive antipsychotic medications have the potential to be affected.

Nurses will be educated on proper diagnosis for antipsychotic medications and the process for obtaining contacting the physician to obtain a proper diagnosis.

The Director of Nursing or designee will audit 100% of antipsychotic medication orders for appropriate diagnosis, weekly for 30 days and then 50% monthly for 60 days. Results of audits will be reviewed for patterns and/or trends and reported at QAPI meetings monthly for three months and then quarterly thereafter.

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Seroquel r/t (related to) disease process end stage dementia and parkinsons (Sic.)."

The physician's "History & Physical" for Resident # 290 dated 07/20/18 failed to evidence an appropriate diagnosis for the use of Seroquel.

On 08/09/18 at approximately 12:45 p.m., RN (registered nurse) # 1, unit manager provided this surveyor with a copy of the "Consultant Pharmacist Communication to Physician" for Resident # 290 and stated that it was noted filled out by the physician.

Review of the clinical record for Resident # 290 revealed a pharmacy recommendation form entitled "Consultant Pharmacist Communication to Physician." The "Consultant Pharmacist Communication to Physician" form documented, "Dated 7/24/18. To: (Name of ASM # 3, medical director); Patient: (Resident # 290). ANTI-PSYCHOTIC DX (diagnosis) NEEDED (check below): Seroquel 50mg QHS (at hours of sleep)." Under "CMS (centers for medicare/medicaid services) EXEMPT INDICATIONS:" it documented, "[ ] Schizophrenia, [ ] Schizo-affective Disorder, [ ] Tourette's Disorder, [ ] Huntington's Disease. Under "CMS ACCEPTABLE DIAGNOSES WITH GRADUAL ATTEMPTS AT DISCONTINUATION: [ ] Delusional Disorder, [ ] Psychotic Mood Disorder/Depression, [ ] Acute Psychotic Episodes, [ ] Brief Reactive Psychosis, [ ] Atypical psychosis, [ ] Bipolar Disorder." Under "PHYSICIAN RESPONSE TO RECOMMENDATION/FINDING, the form was blank.

Review of Resident # 290's EHR (electronic

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health record) failed to evidence documentation of the indicated use of Seroquel for Resident #290.

On 08/08/18 at 5:12 p.m., an interview was conducted with LPN (licensed practical nurse) # 1. When asked if she was Resident # 290's nurse for the 3:00 p.m. to 11:00 p.m. shift, LPN # 1 stated, "Yes." When asked what the indicated use for Seroquel was for Resident #290, LPN # 1 stated, "It's an antipsychotic drug. The psychiatrist decides why the resident would be on it." When asked why Resident # 290 was prescribed Seroquel, LPN # 1 stated, "I don't know her that well, I'll check her chart." After reviewing the EHR (electronic health record) for Resident # 290, LPN # 1 stated, "It doesn't say, I don't know. I'll check with my supervisor." When asked who her supervisor was, LPN # 1 stated, "(Name of ASM [administrative staff member] # 2), director of nursing.

On 08/08/18 at 5:30 p.m., an interview was conducted with ASM # 2 regarding the use of Seroquel for Resident # 290. ASM # 2 stated she called Resident # 290's daughter to find out why Resident # 290 was prescribed Seroquel. ASM # 2 stated, "The daughter said she was put on it by her PCP (primary care physician) or her neurologist because she was getting up at night and not sleeping." ASM # 2 stated, "I reviewed the discharge summary from hospital and current medication list and I did not see a diagnosis of schizophrenia for the use of Seroquel." ASM # 2 then looked up Seroquel in the MPR (monthly prescribing reference) and stated, "It's prescribed for mood disorders and psychosis." When asked if sleeping was the correct indication for the use of Seroquel, ASM # 2 stated, "It's not in my scope

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of practice to make that judgement or determination."

On 08/09/18 at approximately 11:45 a.m., a telephone interview was conducted with ASM (administrative staff member) # 3, medical director regarding the appropriate diagnosis for the use of Seroquel for Resident # 290. When asked why Resident # 290 was being administered Seroquel, ASM # 3 stated, "I would need to look at the chart and I won't be back into the facility until next week." ASM # 3 further stated, "It should be mentioned in the progress notes or the psych (psychiatric) notes."

On 08/09/18 at approximately 12:00 p.m., RN (registered nurse) # 1, unit manager was asked to provide Resident # 290's notes from the psychiatrist. At approximately 12:45 p.m., RN # 1 stated, "She (Resident # 290) doesn't get psychiatric services so there are no notes."

On 08/09/18 at approximately 12:35 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:
(1) 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

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(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 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. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698019.html.

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

(5) A swallowing disorder. This information was obtained from the website:

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F 758	Continued From page 178 https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; 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 ensure a medication error rate less than five percent for one of six residents in the medication administration observation, Resident #7. Two errors out of 25 opportunities resulted in an error rate of eight percent. 1. The facility staff failed to assess Resident #7's blood pressure per physician's order, prior to administering Lotrel. 2. The facility staff failed to administer methimazole to Resident #7, per physician's order. The findings include: 1. The facility staff failed to assess Resident #7's blood pressure per physician's order, prior to administering Lotrel (1). Resident #7 was admitted to the facility on 4/30/12. Resident #7's diagnoses included but were not limited to high blood pressure, diabetes,	F 759	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. Resident #7: Unable to correct getting blood pressure prior to administering medication and failing to administer medication as ordered on 8/8/18. All residents who receive medications have the potential to be affected. All nurses will be educated on following physician orders to include obtaining ordered vital signs prior to administration of medications. Nurse manager or designee will complete medication pass observation on 2 nurses weekly x 4 weeks, then bi-weekly x2	9/21/18

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F 759	Continued From page 179 and major depressive disorder. Resident #7's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 5/8/18, coded the resident's cognition as severely impaired. Section G coded Resident #7 as requiring extensive assistance of one staff with dressing, eating and personal hygiene. Review of Resident #7's clinical record revealed a physician's order dated 10/24/16 for Lotrel 5-10 mg (milligrams) - one tablet by mouth one time a day. The order further documented to hold the medication for a systolic blood pressure less than 120. Review of Resident #7's August 2018 eMAR (electronic medication administration record) revealed the same physician's order. Resident #7's comprehensive care plan initiated on 5/16/12, documented, "(Name of Resident #7) has hypertension (high blood pressure). Give anti hypertensive medications as ordered..." On 8/8/18 at 9:17 a.m., LPN (licensed practical nurse) #7 was observed preparing Resident #7's medications. LPN #7 prepared one capsule of Lotrel. LPN #7 attempted to administer Resident #7's medications but the resident was in a reclined chair with her eyes closed so LPN #7 stated she would wait to give the resident her medications. During this time, LPN #7 did not assess Resident #7's blood pressure. On 8/8/18 at 10:07 a.m., LPN #7 stated she gave Resident #7 her medications. On 8/8/18 at 2:05 p.m., LPN #7 confirmed she administered Lotrel to Resident #7 without assessing the resident's blood pressure. On 8/8/18 at 4:37 p.m., an interview was conducted with LPN #5. LPN #5 was asked what should be done if medication administration was	F 759	weeks and then monthly. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter.	

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dependent on parameters such as to hold the medication for a blood pressure less than 120. LPN #5 stated, "I need to take their blood pressure."

On 8/8/18 at 6:13 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Medication Administration" documented, "5. The patient must be assessed prior to administering any medication. 6. The Healthcare Provider is responsible for ensuring his/her assigned patients receive their medications, and verifies that the patient has taken the medication before leaving the bedside..."

No further information was presented prior to exit.

(1) Lotrel is used to treat high blood pressure. This information was obtained from the website: https://www.fda.gov/ForConsumers/ByAudience/ForWomen/ucm118594.htm

2. The facility staff failed to administer methimazole (1) to Resident #7, per physician's order.

Resident #7 was admitted to the facility on 4/30/12. Resident #7's diagnoses included but were not limited to high blood pressure, diabetes, and major depressive disorder. Resident #7's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 5/8/18, coded the resident's cognition as severely impaired. Section G coded Resident #7 as requiring extensive assistance of one staff with

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F 759	Continued From page 181 dressing, eating and personal hygiene. Review of Resident #7's clinical record revealed a physician's order dated 9/26/17 for methimazole 10 mg (milligrams) by mouth two times a day. Review of Resident #7's August 2018 eMAR (electronic medication administration record) revealed the same physician's order. Resident #7's comprehensive care plan initiated on 5/16/12 failed to document information regarding methimazole administration. On 8/8/18 at 9:17 a.m., LPN (licensed practical nurse) #7 was observed preparing Resident #7's medications. LPN #7 dropped a pill on the cart then removed the pill and stated she was going to discard it. The pill was identified as methimazole. LPN #7 prepared other medications but did not prepare another tablet of methimazole. LPN #7 attempted to administer the other medications to Resident #7 but the resident was in a reclined chair with her eyes closed so LPN #7 stated she would wait to give the resident her medications. On 8/8/18 at 10:07 a.m., LPN #7 stated she gave Resident #7 the medications she had prepared. On 8/8/18 at 1:46 p.m., an interview was conducted with LPN #7. LPN #7 stated she disposed of the methimazole tablet in a sharps container. When asked if she ever administered methimazole to Resident #7 this day, LPN #7 stated she retrieved the tablet from the electronic medication kiosk and administered it to the resident. LPN #7 was asked to provide evidence that she retrieved methimazole from the kiosk. On 8/8/18 at 2:05 p.m., observation of the kiosk was conducted with LPN #7. This observation confirmed LPN #7 did not retrieve methimazole from the kiosk. LPN #7 stated she thought she pulled the medication from the kiosk but	F 759		

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F 759	Continued From page 182 confirmed she did not. On 8/8/18 at 6:13 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. (1) "Methimazole is used to treat hyperthyroidism, a condition that occurs when the thyroid gland produces too much thyroid hormone." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682464.html	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 761		9/21/18

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F 761	Continued From page 183 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that facility staff failed to ensure the secure storage of controlled substances in one of six medication carts. During an observation of the Willow Hall medication cart, conducted with RN (registered nurse) #2, the lid to the controlled substance drawer was observed unlocked. The findings include: On 8/8/18 at 10:34 a.m., observation of the Willow Hall medication cart was conducted with RN (registered nurse) #2. The following was observed: RN #2 unlocked the main cart and the contents were reviewed;prior to RN #2 unlocking the second lock which secures the controlled substance (drugs with abuse potential such as narcotics) drawer, it was noted that the lid to the controlled substance drawer could be lifted up and the controlled substances exposed. The ability to lift this lid indicated that the second lock of the controlled substance drawer was not engaged and the controlled substance drawer was open, with the contained medications available for dispensing. After rearranging the hard plastic cards which divides residents' controlled substance/narcotic medications, RN #2 was able to demonstrate that the narcotic box	F 761	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. The narcotic drawer on the Willow unit medication cart was properly locked immediately by removing the heavy plastic divider on 8/8/18.. All residents who receive controlled substances/narcotics have the potential to be affected. All medication carts were checked to ensure narcotic boxes were locked on 8/9/18. All nurses will be educated on how to properly lock the narcotic drawers on the med carts and to ensure that the drawers are closed completely. The Director of Nursing or designee will inspect all medication carts weekly x4, then bi-weekly x2, then monthly x3. Results of audits will be reviewed for patterns and/or trends and reported at QAPI meetings monthly for three months and then quarterly thereafter.	

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F 761	Continued From page 184 could be locked and not just pulled open. On 8/8/18 at 10:38 a.m., ASM (administrative staff member) #2, the director of nursing, was advised that the controlled substance/narcotic drawer was not locked on initial inspection. RN #2 demonstrated how the heavy plastic card got wedged and prevented the narcotic drawer from locking. Both ASM #2 and RN #2 acknowledged that the controlled substance/narcotics drawer should always be locked except when in use. On 8/8/18 at 10:39 a.m., OSM (other staff member) #5, pharmacy technician, was also advised of the issue with controlled substance/narcotic drawer not locking. ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above findings on 8/8/18 at 6:00 p.m. A review of the facility's "Pharmaceutical Services" policy documents in part, "14. Storage of Medications: i. All controlled drugs are stored under double-lock and key." According to "Lippincott Manual of Nursing Practice", Seventh Edition: by Lippincott Williams & Wilkins, pg. 739 read: "Medication dispensing rooms [and carts] should be locked. In addition, controlled substances are kept in a locked drawer or container as an added safety measure, providing for a 'double locked" system." No further information was obtained prior to exit.	F 761		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		9/21/18

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F 812	Continued From page 185 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review ,it was determined that the facility staff failed to store food in a sanitary manner. The facility staff failed to cover one package of cinnamon muffins and one package of corn muffins stored in the walk-in freezer and failed to seal a bag of cookies in the dry storage room. The findings include: On 08/07/18 at 11:00 a.m., an observation of the kitchen and dry storage room was conducted with OSM (other staff member) # 1, dietary manager. Observation of the walk-in freezer revealed two packages of frozen muffins, one package of	F 812	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. The items found to be improperly wrapped were immediately discarded on 8/7/18. All residents receiving food from dietary services have the potential to be affected by this practice. Policies impacting this requirement were	

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F 812	Continued From page 186 cinnamon muffins and one package of corn muffins on the top shelf inside the freezer. Observation of the package of cinnamon muffins revealed eleven muffins in the box. The plastic wrap covering the box was torn open at one end exposing the muffins to the open air. Observation of the package of corn muffins revealed twenty-three muffins in the box. The plastic wrap covering the box was torn open at one end exposing the muffins to the open air. When asked if the muffins were stored correctly, OHM # 1 stated, "No, they should be covered." OHM # 1 immediately removed the boxes of muffins from the walk-in freezer. Observation of the dry storage room revealed a bag of chocolate chip cookies lying on the storage shelf. Further observation of the bag of cookies revealed it was opened, exposing the cookies to the open air. When asked if the cookies were being stored correctly, OSM # 1 stated, "No the bag should be closed." OSM # 1 removed the bag of chocolate chip cookies from the dry storage room. The facility policy "Storage of Frozen Food" documented, "Leftovers that may be frozen are secured with foil or freezer bags and are labeled with the product name and discard date, if not utilized within 4 months it will be discarded." The facility policy "Dry Storage" documented, " 3. Keep food tightly covered and protected from contamination; when possible, store in their original packaging; if it is necessary to repackage food, clearly label the new package." On 08/08/18 at approximately 6:00 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.	F 812	reviewed: Storage of Frozen Food- no changes made; Dry Storage- added requirement to date mark any open food. Cooks will be required to observe the frozen storage and dry storage areas at end of shift to identify any open undated items. Dietary staff will review the food storage policies and will be in-serviced by the Dietary Manager or Team Lead. A thorough walkthrough of the refrigerated storage areas will be conducted on the freezer and dry storage area on 9/5/18 by the Dietary Manager and Team Leads. The walk in freezer and dry storage room will be monitored twice a week for 30 days and then weekly for 60 days by the Dietary Manager or designee. Improperly wrapped food will be immediately discarded and recorded and variances will be reported to Dietary team lead for corrections. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter	

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F 812	Continued From page 187 No further information was provided prior to exit.	F 812		
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to maintain the dumpster area in a sanitary manner. Eight pairs of used plastic gloves were found lying on the ground around the facility's trash compactor. The findings include: On 08/07/18 at 11:25 a.m., an observation of the facility's trash compactor was conducted with OSM (other staff member) # 1, dietary manager. The facility's trash compactor was located approximately 60 feet from the back of the facility. Observation of the trash compactor area revealed it was a compactor, inside a wooden fence enclosure. Further observation of the trash compactor area inside the fence enclosure revealed eight pairs of used plastic gloves lying on the ground around the trash compactor. When asked who was responsible for keeping the trash compactor area cleaned and picked up, OSM # 1 stated, "The kitchen and housekeeping." When asked how often the trash compactor area is cleaned up, OSM # 1 stated, "Once a month for my part." When asked why it was important to keep the trash compactor area cleaned and picked up OSM # 1 stated, "To prevent contamination." At approximately 11:30	F 814	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. The grounds around the dumpster were immediately cleaned by removing and disposing of the eight pairs of gloves found in the area. Residents, staff and visitors have the potential to be affected. The EVS Supervisor or designee will ensure rounds are done of the dumpster area daily including weekends, to ensure grounds are free of trash. Staff conducting rounds will be educated on purpose and remediation if trash is found. An audit tool will be maintained documenting the daily rounds. Results of audit will be reviewed for patterns and/or trends and reported at QAPI monthly for three months then quarterly thereafter.	9/21/18

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F 814	Continued From page 188 a.m., an interview was conducted with OSM # 2 housekeeping supervisor in the presence of OSM # 1. When asked if housekeeping was responsible with the kitchen in keeping the trash compactor area clean OSM # 2 stated, "Yes, it's done on a regular basis. Every morning we clean up the area and police the grounds." When asked why it was important to keep the trash compactor area cleaned and picked up OSM # 2 stated, "To keep rodents away and for inspection." When informed of the observation of the trash compactor area, OSM # 2 stated, "We'll get it clean up." On 08/08/18 at approximately 6:00 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit.	F 814		
F 880 SS=F	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,	F 880		9/21/18

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F 880	Continued From page 189 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 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	F 880		

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F 880	Continued From page 190 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to maintain an infection control program, as evidenced by incomplete infection control tracking logs and the lack of a legionella protocol; and failed to maintain infection control practices in the laundry department; and failed to follow infection control practices for two of 37 residents in the survey sample; Residents #86, and #18. 1. The facility staff failed to maintain an infection control program. The infection control, tracking logs, for January 2018 through May 2018 were incomplete. 2. The facility staff failed to develop a legionella protocol. 3. The facility staff failed to keep the floor fan free of dust and lint when drying, folding and transporting clean linens and resident's personal clothing. 4. The facility staff failed to implement infection control practices for isolation for Resident #86.	F 880	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. Unable to correct previous infection control logs prior to June. An infection control program was implemented in June and will continue with tracking and logging all infections along with interventions. Unable to correct failure to develop legionella protocol prior to survey. A protocol for tracking is now in place. Housekeeping staff removed the fan from the laundry, disassembled it and cleaned all parts then reassembled the fan and repositioned the fan so the air was not blowing over clean laundry. Staff member was educated on the	

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F 880	Continued From page 191 5. The facility staff failed to implement infection control practices for isolation for Resident #18. The findings include: 1. The facility staff failed to maintain an infection control program. On 8/8/18 at 11:00 a.m., a review of the infection control program was conducted. This review included reviewing the facility's infection control tracking logs for the last 6 months prior to survey. A review of these logs revealed that only June 2018 and July 2018, were completely maintained, as these were hand-written logs with all the required categories identified. Logs for January 2018 through May 2018 were digital logs and were missing entire columns of data, including infection onset date, infection related diagnoses, whether or not a culture was done, any identified organisms, whether or not any x-rays were done for identifying an infection, and whether or not isolation precautions were required. On 8/08/18 at 11:05 AM, in an interview with RN #5 (Registered Nurse, the ADON - Assistant Director of Nursing) she stated that she was in charge of the infection control program and antibiotic stewardship program. When asked about the logs being incomplete before June 2018, RN #5 stated, "As far as I know, the logs are incomplete. I have been here 6 weeks, and do not know what they were doing before, and so far I have not located any other infection control related tracking, surveillance and monitoring data." A copy of a policy for the operationalizing and maintaining an infection control program was requested.	F 880	importance of wearing protective isolation gear at all times when entering room of resident #86 and following PPE protocols with all resident rooms even if just passing trays. Staff member was educated on the importance of wearing protective isolation gear at all times when entering room of resident #18 and following PPE protocols with all resident rooms even if just passing trays. All residents with infection or possible infection have the potential be to be affected. The legionella protocol will be completed by the Director of Nursing in coordination with the Director of Environmental Services, Supervisor of EVS and Director of Facilities. Laundry staff will be educated on the importance of turning the fan off when transporting wet linen/clothing to the dryer and folding table. Staff will be educated on the importance of covering clean linen and personal laundry when transporting through the facility. The fan in the laundry room will be cleaned at a minimum of weekly and more often if needed. All staff will be educated on the necessity of putting on isolation PPE prior to entering an isolation room and identifying the type of PPE required for various infections. Education will be completed by	

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F 880

Continued From page 192

The facility policy that was provided, "Infection Control Surveillance" documented, "Purpose: To have knowledge of patient and employee infections so appropriate actions/follow-up may be done and to guide prevention activities. Policy: The Infection Control Practitioner does surveillance of infections among patients and employees. 1. The Infection Control Practitioner does surveillance of nosocomial infections by: Review of culture reports and other pertinent lab data; Nurse consultation and referral; Chart Review; Personal consultation by employees; Follow-up on communicable disease exposure; Review of employee's physical assessments; Maintenance of the employee infection record; Physician consultation. 2. Nosocomial infections are reported monthly on the nosocomial infection summary. 3. Nosocomial infections are reported weekly on the infectious disease report. 4. Reporting of infections to the health department is done as required by law."

On 8/8/18 at 6:00 PM at the end of day meeting, the administrator (ASM #1 - Administrative Staff Member) was made aware of the findings. No further information was provided by the end of the survey.
2. The facility staff failed to develop a legionella protocol.

On 08/09/18 at approximately 3:30 p.m., an interview was conducted with ASM (administrative staff member) # 1 administrator and OSM (other staff member) # 15, director of plant operations regarding the facility's legionella protocol. ASM # 1 and OSM # 15 stated, "We don't have a legionella protocol. We're in the process of developing one."

F 880

the Director of Nursing or designee.

An audit of all residents with infections and on antibiotics will be completed by the Director of Nursing or designee weekly x4, then bi-weekly x2, then monthly x3 to ensure proper logging and tracking. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months then quarterly thereafter.

An audit of all water systems will be completed by the Director of Facilities or designee on a monthly basis to ensure the water systems are not growing legionella and spreading to susceptible hosts. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months then quarterly thereafter.

An audit of all laundry service staff to ensure proper handling of linens and personal clothing cleaned by the facility will be completed by the Environmental Services Supervisor or designee weekly x4, then bi-weekly x2, then monthly x3 to ensure no contamination has occurred during transfer from washer to dryer, during folding or while transporting through the facility.

An audit of all residents on isolation will be completed by the Director of Nursing or designee weekly x4, then bi-weekly x2, then monthly x3 to ensure isolation

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F 880	Continued From page 193 No further information was provided prior to exit. 3. The facility staff failed to keep the floor fan free of dust and lint when drying, folding and transporting clean linens and resident's personal clothing. On 08/07/18 at 2:35 p.m., an observation of the clean laundry room revealed a floor fan positioned at the entrance door of the room, directed toward a row of three clothes dryers and a table for clean laundry. Two laundry aides were observed folding resident's personal clothing and placing it on the table. Further observation of the fan revealed the fan blades and front finger guard was coated with grey lint and dust. On 08/08/18 at 8:30 a.m., an observation of the clean laundry room revealed a floor fan positioned at the entrance door of the room, directed toward a row of three clothes dryers and a table for clean laundry. Further observation revealed a laundry aide placing clean linens into the clothes dryers directly in front of the fan. Observation of the fan revealed the fan blades and front finger guard was coated with grey lint and dust. On 08/08/18 at 8:55 a.m., an observation of the clean laundry room revealed a floor fan positioned at the entrance door of the room, directed toward a row of three clothes dryers and a table for clean laundry. Two laundry aides were observed folding resident's personal clothing and placing it on the table. On 08/08/18 at 9:10 a.m., an observation of the	F 880	precautions are being followed properly. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months then quarterly thereafter.	

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F 880	Continued From page 194	F 880		

clean laundry room revealed a floor fan positioned at the entrance door of the room, directed toward a row of three clothes dryers and a table for clean laundry. Observation of the fan revealed the fan blades and front finger guard was coated with grey lint and dust. Further observation revealed a laundry aide folding clean linens in front of the fan and placing them on the table.

On 08/08/18 at 9:00 a.m., OSM (other staff member) # 4, environmental services associate, was observed folding and placing resident clothing on several hangers in front of the floor fan. The fan was blowing in the direction of the clothing. OSM # 4 then carried the resident's clean clothing from the laundry room on several hangers, uncovered to the Magnolia Unit of the facility, entered the resident's room and hung the clothes in the resident's closet.

On 08/08/18 at 11:15 a.m., an observation of the clean laundry room revealed a floor fan positioned at the entrance door of the room, directed toward a row of three clothes dryers and a table for clean laundry. Observation of the fan revealed the fan blades and front finger guard was coated with grey lint. Further observation revealed a laundry aide folding clean linens in front of the fan and placing them on the table.

On 08/08/18 at approximately 1:10 p.m., an interview was conducted with OSM # 4, environmental services associate. When asked to describe the procedure for transporting resident's clean clothing, OSM # 4 stated, "Put them on the hangers, or fold them if they don't want their under garments on the hangers and carry them to their room." When asked if the

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clothes should be covered OSM # stated, "If they are clean no, but it's dirty it gets covered." When asked if she recalled taking a set of resident's clothes to their room earlier this morning uncovered OSM # 4 stated, "Yes."

On 08/08/18 at 1:30 p.m., an interview was conducted with OSM # 2, housekeeping supervisor. When asked how he ensure linens and resident clothing are kept clean after it has been washed, OSM # 2 stated, "Fold the linens and put them in the blue laundry bins, cover them and transport the linens covered. As soon as the resident's clothes are dried we put them on hangers and take them directly to the resident's rooms." When asked if the resident's clothes are covered when they are taken to the resident's rooms OSM # 2 stated, "No." OSM # 2 was asked to turn off the fan positioned at the entrance door of the clean laundry room. When the fan stopped OSM # 2 was asked to observe the fan blades and the back and front finger guards. When asked to describe the condition of the fan blades and finger guards OSM # 2 stated, "It's dirty." When asked if the fan was coated with lint and dust OSM # 2 stated, yes." When asked in what direction the fan was blowing, OSM # 2 stated, "Toward the clean linens and clothes." When asked why the resident's clean clothing should be covered when being transported, OSM # 2 stated, "To prevent any type of contamination." When asked why the fan should be kept clean, OSM # 2 stated, "To keep from blowing dirt and contaminating the clothes and linens." When asked what size the fan was, OSM # 2 asked OSM # 3, environmental technician. OSM # 3stated, "Looks like a 24 inch fan."

On 08/09/18 at approximately 12:35 p.m., ASM

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(administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.
4. The facility staff failed to implement infection control practices for isolation, for Resident #86.

Resident #86 was admitted to the facility on 4/19/18 with diagnoses that included but were not limited to: amputation of two or more right toes, atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria) (1), high blood pressure, diabetes, stroke and palliative care.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/23/18, coded the resident as scoring a "13" on the BIMS (brief interview for mental status) score, indicating she was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living. In Section I - Active Diagnoses, the resident was coded as having a Mulitdrug-Resistent Organism.

Observation was made on 8/7/18 at approximately 12:00 p.m. on the Willow unit. The staff members were passing the lunch meal trays. CNA (certified nursing assistant) #2 walked into Resident #86's room carrying the lunch tray. She did not stop to put on isolation gown or gloves. The isolation equipment was attached to the door in a hanging with pouches for all of the supplies for isolation. There were no supplies in the room.

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The physician order dated, 4/19/18, documented, "Contact Isolation for MRSA (MRSA stands for methicillin-resistant Staphylococcus aureus. It causes a staph infection (pronounced 'staff infection' that is resistant to several common antibiotics. (2) + (positive) wound to R (right) foot every shift."

The nurse's note dated, 8/8/18 at 9:59 a.m. documented in part, "Hospice and primary MD (medical doctor) electing not to re-culture wound again at this time, elect not to continue with antibiotic therapy due to risk for CDIFF (clostridium difficele), RP (responsible party) is in agreement, goal is for local wound care only and pain control. Continues on contact isolation as wound continues to drain."

The comprehensive care plan dated, 4/25/18, documented in part, "Focus: (Resident #86) has MRSA of the R (right) foot wound." The "Interventions" documented in part, "CONTACT ISOLATION."

An interview was conducted with CNA #1 on 8/9/18 at 8:24 a.m. When asked if she has to put on the isolation gowns and gloves when delivering meal trays to a resident on isolation, CNA #1 stated, "I always gown up regardless of what I am doing for the resident."

An interview was conducted with LPN (licensed practical nurse) #2 on 8/9/18 at 8:26 a.m. When asked if staff have to wear any protective gear when delivering a meal tray to a resident is on isolation, LPN #2 stated, "Yes, You have to wear a gown, and gloves at all times.

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An interview was conducted with RN (registered nurse) #1, the unit manager, on 8/9/18 at 8:27 a.m. When asked about the precautions staff have to take when delivering a meal tray to a resident is on isolation, RN #1 stated, "You have to wear gowns and gloves. The CNA the other day told me she saw you watching and she didn't have any isolation gear on."

The sign outside posted outside the resident's room, documented in part, "Isolation Room: Before entering the patient room, please: 1. Put on a gown, with the opening at the back. 2. Put on gloves, available in small, medium and large. 3. Put on a face mask (pinch the portion over your nose for a snug fit)....These instructions must be followed every time you enter or leave the patient room."

The administrator (administrative staff member - ASM #1) and ASM #2, the director of nursing, were made aware of the above concern on 8/9/18 at 12:32 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.
(2) This information was obtained from the following website:
https://medlineplus.gov/mrsa.html

5. The facility staff failed to implement infection control practices for isolation, for Resident #18.

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Resident #18 was admitted to the facility on 9/5/12, with diagnoses that included but were not limited to: cerebral palsy (loss or deficiency of muscle control due to permanent, nonprogressive brain damage occurring before or at the time of birth) (1), high blood pressure, depression, dementia, pain, and peripheral vascular disease any abnormal condition, including atherosclerosis, affecting blood vessels outside the heart) (2).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/16/18, coded the resident as scoring an "8" on the BIMS (brief interview for mental status) score indicating the resident was moderately impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living except eating in which he only required supervision after set up assistance was provided.

Observation was made on 8/7/18 at approximately 12:00 p.m. on the Willow unit. The staff members were passing the lunch meal trays. CNA (certified nursing assistant) #3 walked into Resident #18's room carrying the lunch tray. She did not stop to put on isolation gown or gloves. The isolation equipment was attached to the door in a hanging with pouches for all of the supplies for isolation. There were no supplies in the room.

The physician order dated, 5/20/18, documented, "Contact precautions every shift for MRSA to cyst right flank."

The nurse's note dated, 8/7/18 at 10:50 p.m. documented in part, "Suspected Infection: MRSA

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on back wound...Follow - up: Will continue contact isolation."

The comprehensive care plan dated, 6/18/18, documented in part, "Focus: (Resident #18) has an infection to R (right) buttock cyst (MRSA + [positive])." The "Interventions" documented in part, "Contact isolation as ordered."

An interview was conducted with CNA #1 on 8/9/18 at 8:24 a.m. When asked if she has to put on the isolation gowns and gloves when delivering meal trays to a resident on isolation, CNA #1 stated, "I always gown up regardless of what I am doing for the resident."

An interview was conducted with LPN (licensed practical nurse) #2 on 8/9/18 at 8:26 a.m. When asked if staff have to wear any protective gear when delivering a meal tray to a resident is on isolation, LPN #2 stated, "Yes, You have to wear a gown, and gloves at all times.

An interview was conducted with RN (registered nurse) #1, the unit manager, on 8/9/18 at 8:27 a.m. When asked if I was delivering meal trays to a resident on contact isolation, what precautions should I take, RN #1 stated, "You have to wear gowns and gloves. The CNA the other day told me she saw you watching and she didn't have any isolation gear on."

The sign outside posted outside the resident's room, documented in part, "Isolation Room: Before entering the patient room, please: 1. Put on a gown, with the opening at the back. 2. Put on gloves, available in small, medium and large. 3. Put on a face mask (pinch the portion over your nose for a snug fit)....These instructions

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F 880	Continued From page 201 must be followed every time you enter or leave the patient room." The administrator (administrative staff member - ASM #1) and ASM #2, the director of nursing, were made aware of the above concern on 8/9/18 at 12:32 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 114. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 447.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to develop and operationalize and maintain an Antibiotic Stewardship Program. The findings include:	F 881	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations.	9/21/18

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F 881	Continued From page 202 On 8/8/18 at 11:00 a.m., a review of the antibiotic stewardship program was conducted. This review included reviewing the facility's policies and procedures related to operationalizing and maintaining an Antibiotic Stewardship Program. A review of the 4-page document that was provided, "Antibiotic Stewardship Program" revealed a faxed date stamp of 8/8/18, where it was faxed from the pharmacy the date of this survey review. On 8/8/18 at 11:05 a.m., in an interview with RN #5 (Registered Nurse, the ADON - Assistant Director of Nursing) she stated that she was in charge of the infection control program and antibiotic stewardship program. When asked if the facility had an Antibiotic Stewardship Program in place before the pharmacy faxed this document over on this date, RN #5 stated, "Before today, I didn't have an antibiotic stewardship program." The facility policy that was provided, "Antibiotic Stewardship Program" which was provided to the facility by the pharmacy on 8/8/18 revealed an "Effective Date" of 11/28/17. Further review of the policy documented, "Procedure: 1. Leadership: a. The Administrator, DHS (Director of Health Services), and the Medical Director will commit to supporting safe and appropriate antibiotic utilization.....1. Accountability: a. The ASP (Antibiotic Stewardship Program) Team will be established to be accountable for promoting and overseeing antibiotic stewardship activities. b. The ASP Team will consist of the following partners: i. Medical Director/designee, ii. Director of Health Services (DHS)/designee, iii. Infection	F 881	An Antibiotic Stewardship Program is currently being implemented to include antibiotic use protocols and a system to monitor antibiotic use. All residents have the potential to be affected by this deficient practice. The Antibiotic Stewardship program team will be established to be accountable for promoting and overseeing antibiotic stewardship activities. Proper tracking and logging infections/antibiotics in the ASP binder will continue and be closely monitored. The Director of Nursing or designee will audit 5 residents with infections and /or orders for antibiotics weekly x4, then bi-weekly x2, then monthly x3. Results of audits will be reviewed for patterns and/or trends and reported at QAPI monthly for three months and then quarterly thereafter.	

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F 881	Continued From page 203 Preventionist (IP)/designee {note: RN #4 stated this was her role in the facility}, iv. Consultant Pharmacist, v. Prescribing Physician/Provider." On 8/8/18 at 6:00 p.m., at the end of day meeting, the administrator (ASM #1 - Administrative Staff Member) was made aware of the findings. No further information was provided by the end of the survey.	F 881		