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	495391	A. BUILDING ______ B. WING ______	C 08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENBURNIE REHAB & NURSING CENTER	1901 LIBBIE AVE RICHMOND, VA 23226

(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 08/14/18 through 08/16/18. 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 8/14/18 through 8/16/18. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety code survey/report will follow. The census in this 120 certified bed facility was 93 at the time of the survey. The survey sample consisted of 29 current resident reviews (Residents #250, #1, #50, # 54, #51, #20, #52, #251, #33, #32, #67, #75, #35, #65, #24, #63, #70, #91, #45, #82, #64, #61, #13, #74, #78, #44, #40, #12 and #47) and six closed record reviews (Residents #69, #101, #299, #300, #99 and #200.)	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that	F 550		9/26/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/07/2018

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 550	Continued From page 1 promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interviews and facility document review, it was determined that the facility staff failed to serve food in a manner to promote resident dignity in one of three dining areas, (Trellis two, dining area). The facility staff failed to treat residents in a	F 550	1. Corrective Action for those residents found to be affected by the alleged deficient practice. Immediate education was completed with the Director of Culinary services on the timeliness of tray delivery and CNA #4, CNA #5 on resident rights to include eating meals at the same time.	

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dignified manner, waiting for 25-30 minutes for their trays, in the Trellis Two dining room, after the other residents had been served.

The findings include:

The facility staff failed to treat residents in a dignified manner, several residents were observed waiting for 25-30 minutes for their trays, in the Trellis Two dining room, after the other residents had already been served their meals.

Observation was made on 8/14/18 at 11:44 a.m. of the Trellis Two dining room for the lunch meal. There were five tables. Table #1 had three residents, one male and two females, and one family member at the table. Table #2 had one female resident in a wheelchair at the table. Table #3 had two residents, one male and one female, at the table. Table #4 had two male residents and a family member at the table. Table #5 had two female residents.

All residents but one female resident at table #1, one female at table #5, and one male from table #4, and one female from table #3 were not served their food when all the other residents were served their meal. This was at 12:16 p.m. CNA (certified nursing assistant) #4 stated to CNA #5 that the trays for those residents without trays was "On the next cart."

The second cart arrived at 12:35 p.m. The female resident (Resident #1) at table #1 was served her tray of food at 12:37 p.m. The female resident at table #5 received her tray at 12:39 p.m. The female resident at table # 3 received her tray at 12:38 p.m. and the male resident at table #4 received his tray at 12:39 p.m.

F 550

2. Corrective actions taken for residents with potential to be affected by alleged deficient practice.
Residents admitting into the facility who eat meals from the dining service department have the potential to be affected. Audit completed by the Director of Culinary Services on tray delivery times for breakfast, lunch, and dinner to ensure residents who elect to eat in the dining room(s) eat at the same time.

3. Systemic changes put into place to ensure the alleged deficient practice does not recur.
Education completed by the Director of Culinary services to include culinary services staff on the timely delivery of meal carts and education completed by the Director of Nursing to nursing staff on ensuring residents in the dining area are eating meals at the same time.

4. Monitoring of corrective action to ensure the alleged deficient practice does not recur.
Director of nursing or designee will perform audits of meal service delivery and dining service to ensure residents are eating at the same time 3x week x4 weeks and then monthly x2.

Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions.

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F 550	Continued From page 3 An interview was conducted with CNA #4 on 8/16/18 at 7:46 a.m. When asked why it is a concern that the residents waited on 8/14/18 at the lunch meal for their trays to come, CNA #4 stated, "It shouldn't be that way. It's because of the way the kitchen sends the carts. I tried to get those without a tray soup to tide them over until their trays arrived." An interview was conducted with CNA #5 on 8/16/18 at 7:57 a.m. When asked if the residents should be served their meals at the same time in the dining room, CNA #5 stated, "Yes, they should but it's the kitchen that doesn't send them out that way." An interview was conducted with OSM (other staff member) #3, the dietary manager, on 8/16/18 at 8:28 a.m. The above observation was shared with OSM #3. When asked if all residents should be served their food at the same time, OSM #3 stated, "All residents at the table should be eating at the same time." An interview was conducted with administrative staff member (ASM) #1, the administrator, on 8/16/18 at 9:01 a.m., regarding the process for serving residents meals. ASM #1 stated, "Ideally at the same time." The above concern was shared with ASM #1 at this time. An interview was conducted with Resident #1 on 8/16/18 at 9:25 a.m. When asked how it made her feel on Tuesday when her tray was late, Resident #1 stated, "I didn't like it. She stated she was wondering what was going on because her two tablemates had finished their food and she hadn't even gotten hers. I took it in stride."	F 550	Date if Compliance: 9/26/18	

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Resident #1 was admitted to the facility on 7/31/18 with diagnoses that included but were not limited to: high blood pressure and end stage renal 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).

The most recent MDS (minimum data set) assessment, a Medicare 5 day assessment, with an assessment reference date of 8/7/18, 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.

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 580 SS=D — Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) — F 580 — 9/26/18

§483.10(g)(14) Notification of Changes.
(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or

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F 580	Continued From page 5 clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the	F 580	1. Corrective Action for those residents found to be affected by the alleged	

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F 580

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facility staff failed to notify the medical doctor of a change in condition for one of 35 residents in the survey sample, Resident #61.

The facility staff failed to notify the physician when the resident's blood sugars were out of the prescribed parameters for Resident #61.

The findings include:

Resident #61 was admitted to the facility on 6/27/18 with a readmission on 7/23/18 with diagnoses that included but were not limited to: fracture of the arm, infection in the joint, heart failure, diabetes, depression, high blood pressure 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 8/5/18, coded the resident as scoring a 12 on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make daily cognitive decisions. The resident was coded as requiring minimum to extensive assistance for all of her activities of daily living.

The physician order dated, 6/27/18, documented, "Blood sugars AC (before meals) and at HS (at bedtime). Notify MD (medical doctor) for FSBS (finger stick blood sugar) less than 60 or greater than 350."

The blood sugar readings on 7/20/18 at 9:00 p.m. documented, "HI."

F 580

deficient practice.
Physician was contacted regarding Resident #61's recurrent blood sugar readings being above 350 with new orders obtained.

2. Corrective actions taken for residents with potential to be affected by alleged deficient practice.
Residents who admit into the facility that have blood sugar checks ordered have the potential to be affected. Immediate education to licensed nursing staff by Director of Nursing regarding the diabetic protocol to include notifying the physician when blood sugar checks are out of the specified parameters.

3. Systemic changes put into place to ensure the alleged deficient practice does not recur.
Education by the Director of Nursing to licensed nursing personnel to include the diabetic protocol and ensuring that appropriate notifications are complete when blood sugar checks are out of physician ordered parameters.

4. Monitoring of corrective action to ensure the alleged deficient practice does not recur.
Director of nursing will audit 5 resident blood sugar logs weekly x4 weeks and then 10 residents monthly x2 to ensure documentation and physician notifications when blood sugar checks are outside specified parameters.

Plan of correction information and audits

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F 580	Continued From page 7 The physician order dated, 7/23/18, documented, "Blood sugars AC and at HS. Notify MD for FSBS less than 60 or greater than 350." Resident #61's blood glucose monitoring sheet for August 2018 documented the resident's blood sugar readings on the following days as follows: 8/1/18 at 11:30 a.m. - 358 8/2/18 at 4:30 p.m. - 520 8/3/18 at 9:00 p.m. - 353 8/5/18 at 4:30 p.m. - 574 8/5/18 at 9:00 p.m. - 462 8/8/18 at 9:00 p.m. - 540 8/10/18 at 4:30 p.m. - 360 8/10/18 at 9:00 p.m. - 378 8/11/18 at 6:30 a.m. - 360 8/14/18 at 11:30 a.m. - 415 8/14/18 at 9:00 p.m. - 440 Review of the MARs (medication administration records), and nurse's note failed to evidence documentation the physician was notified of the above blood sugar reading per the physician orders. The comprehensive care plan dated, 6/28/18, documented in part, "Focus: Endocrine system related to diabetes." The "Interventions" documented in part, "Administer medications per physician orders. Report symptoms of hyperglycemia; excessive thirst/urination, hunger, weakness, nausea and vomiting or acetone breath. Report symptoms of hypoglycemia; weakness, pallor, diaphoresis, vision changes, changing consciousness." An interview was conducted with LPN (licensed practical nurse) #6 on 8/15/18 at 12:59 p.m. LPN	F 580	will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. Date if Compliance: 9/26/18	

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#6 was asked what it means when the blood sugar machine reads "HI". LPN #6 stated, "I believe it means the blood sugar is over 600." The physician ordered parameters for notifying the physician were reviewed with LPN #6. When asked, what is expected of the nurse, if the resident's blood sugar is greater than 350, LPN #6 stated, "If it's greater than 350 you have to call the doctor and let him know. Then you follow his orders and write a SBAR (situation, background, assessment recommendation) note and notify the RP (responsible party)." When asked if the SBAR was the nurse's documentation, LPN #6 stated, "Yes, every time the blood sugar goes over 350 you are supposed to call the doctor." When asked how staff can tell if the doctor was called if there are no SBAR or nurse's notes, LPN #6 stated, "You don't." LPN #6 further stated, "The resident is non-compliant, she had regular Pepsi in there now." When asked if her non-compliance should be care planned and documented, LPN #6 stated, "Yes, absolutely."

An interview was conducted with administrative staff member (ASM) #3, the medical director, on 8/15/18 at 1:13 p.m. When asked why he or the other physicians order parameters for notification of blood sugars, ASM #3 stated, "So we are reminded to make adjustments to their medications."

An interview was conducted with LPN #3, the unit manager, on 8/15/18 at 1:16 p.m. When asked what is expected of staff if a resident has parameters ordered for blood sugar readings, and a blood sugar reading is outside of the parameters, LPN #3 stated, "Normally the parameters are to notify for less than 60 and greater than 350. If the blood sugar is outside of

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those parameters the nurse is to contact the physician, write an SBAR, and follow the physician orders." When asked if there is no SBAR or nurse's note how do you know if staff called the doctor, LPN #6 stated, "We don't."

The facility policy, "Change in a Resident's Condition or Status," documented in part, "1. The nurse will notify the resident's Attending Physician or physician on call when there has been a (an): i. specific instructions to notify the Physician of changes in the resident's condition...3. Prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form."

In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient.

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, RN (registered nurse) #2, the assistant director of nursing, LPN #1, a unit manager, and ASM #4, the Clinical Services Coordinator, were made aware of the above findings.

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F 580	Continued From page 10 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 580		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs 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 622		9/26/18

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(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

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

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F 622	Continued From page 12 (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide required documentation to the receiving hospital and required documentation in the clinical record for a facility initiated-transfers for eight of 35 residents in the survey sample, Residents #13, #50, #75, #74, #63, #64, #40 and #65. 1. The facility staff failed to provide evidence that all required information (comprehensive care plan goals) was provided to the hospital staff when Resident #13 was transferred to the hospital on 4/20/18, and failed to ensure the physician documented why a facility-initiated transfer was necessary for Resident #13. 2. The facility staff failed to provide evidence that all required information (comprehensive care plan goals) was provided to the hospital staff when Resident #50 was transferred to the hospital on 3/14/18, and failed to ensure the physician	F 622	1. Corrective Action for those residents found to be affected by the alleged deficient practice. Immediate education with licensed nursing staff regarding sending care plan goals with residents at time of acute transfer and education with medical director to include rationale on why acute transfer was necessary. 2. Corrective actions taken for residents with potential to be affected by alleged deficient practice. Residents admitted into the facility have the potential to be affected. A checklist will be implemented for acute transfers to include ensuring care plan goals are included in the patient file that goes to the receiving acute facility. A note will be placed into the physician rounding book to remind physicians for document on residents who have transferred out for	

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documented why a facility-initiated transfer was necessary for Resident #50.

3. Resident #75 was transferred and admitted to the hospital on 6/19/18. The clinical record failed to evidence physician notes justifying the reason for the transfer, and why the facility was not able to manage the resident's condition; and there was no evidence in the clinical record that all required documentation was provided to the receiving facility.

4. Resident #74 was transferred and admitted to the hospital on 5/19/18. The clinical record failed to evidence that all required documentation including the comprehensive care plan goals were provided to the receiving facility.

5. Resident #63 was transferred and admitted to the hospital on 7/1/18. The clinical record failed to evidence physician notes justifying the reason for the transfer, and why the facility was not able to manage the resident's condition; and there was no evidence in the clinical record that all required documentation was provided to the receiving facility.

6. The facility staff failed to provide evidence that Resident #64's comprehensive care plan goals were sent with the resident upon transfer to the hospital on 7/16/18.

7. The facility staff failed provide evidence that Resident #40's comprehensive care plan goals were sent with the resident upon a transfer to the hospital on 5/21/18.

8. The facility staff failed to send the comprehensive care plan goals to the receiving

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evaluation and treatment.

3. Systemic changes put into place to ensure the alleged deficient practice does not recur.
Education completed by the Director of Nursing to licensed staff of ensuring the care plan goals are included at time of acute transfer and education with the medical director to include nurse practitioners on documenting reasoning for the transfers.

4. Monitoring of corrective action to ensure the alleged deficient practice does not recur.
Director of nursing will audit acute transfers weekly x4 then monthly x2 to ensure care plan goals are supplied and physician documentation supports rationale for transfer.

Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions.

Allegation of compliance: 9/26/18

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hospital for Resident #65's facility initiated transfer on 6/13/18.

The findings include:

1. The facility staff failed to provide evidence that all required information (comprehensive care plan goals) was provided to the hospital staff when Resident #13 was transferred to the hospital on 4/20/18, and failed to ensure the physician documented why a facility-initiated transfer was necessary for Resident #13.

Resident #13 was admitted to the facility on 3/6/18. Resident #13's diagnoses included but were not limited to muscle weakness, high blood pressure and aftercare following joint replacement surgery. Resident #13's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/31/18, coded the resident's cognition as severely impaired.

Review of Resident #13's clinical record revealed nurses note dated 4/20/18 that documented the resident was transferred to the hospital for a complaint of hip/pelvic pain and confirmation the resident had fallen in her son's presence.

Further review of Resident #13's clinical record (including nurses' notes and a nursing home to hospital transfer form) failed to reveal evidence that the facility staff provided the resident's comprehensive care plan goals to hospital staff. Further review of Resident #13's clinical record failed to reveal documentation by the physician to explain why the transfer was necessary.

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On 8/15/18 at 12:16 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #1 stated labs [laboratory tests], a face sheet, sbar (situation, background, assessment, recommendation) form, physician order, medication list, dnr (do not resuscitate) form and advanced directives, if applicable, and a hospital transfer form is provided to hospital staff. LPN #1 stated the physician and resident representative information is documented on the face sheet and the bottom of the sbar form, and advanced directives, special precautions/instructions for care is documented on the transfer form. When asked if residents' comprehensive care plan goals are provided to hospital staff, LPN #1 stated, "We have never had to transfer that over." When asked to confirm the comprehensive care plan goals are not provided, LPN #1 stated, "Not unless they directly ask us for them."

On 8/15/18 at 3:07 p.m., an interview was conducted with ASM (administrative staff member) #3 (the medical director). ASM #3 was asked if the facility physicians document the reason and necessity for hospital transfers. ASM #3 stated the physicians' document for sure if they are in the facility, especially if they evaluate the patient. ASM #3 stated the physicians typically do not document if they do not complete an evaluation of the patient but the transfers are discussed with the nurse managers and in the QAPI (quality assessment and performance improvement) meetings.

On 8/15/18 at 6:01 p.m., ASM (administrative

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staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Transfer or Discharge Documentation" documented, "5. Should the resident be transferred or discharged for any of the following reasons, the basis for the transfer or discharge will be documented in the resident's clinical record by the resident's Attending Physician: a. The transfer or discharge is necessary for the resident's welfare, and the resident's needs cannot be met in the facility..." The facility policy titled, "Transfer or Discharge Documentation" further documented: "7. Should a resident be transferred or discharged for any reason, the following information will be communicated to the receiving facility or provider: a. The basis for the transfer or discharge...b. Contact information of the practitioner responsible for the care of the resident; c. Resident representative information including contact information; d. Advance Directive information; e. All special instructions or precautions for ongoing care, as appropriate; f. Comprehensive care plan goals..."

No further information was presented prior to exit.

2. The facility staff failed to provide evidence that all required information (comprehensive care plan goals) was provided to the hospital staff when Resident #50 was transferred to the hospital on 3/14/18, and failed to ensure the physician documented why a facility-initiated transfer was necessary for Resident #50.

Resident #50 was admitted to the facility on

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3/16/16. Resident #50's diagnoses included but were not limited to paralysis, muscle weakness and urinary retention. Resident #50's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 7/1/18, coded the resident as being cognitively intact.

Review of Resident #50's clinical record revealed a nurse's note dated 3/14/18 that documented the resident presented with bright red rectal bleeding and the resident was transferred to the hospital.

Further review of Resident #50's clinical record (including nurses' notes and a nursing home to hospital transfer form) failed to reveal evidence that the facility staff provided the resident's comprehensive care plan goals to hospital staff. Further review of Resident #50's clinical record failed to reveal documentation by the physician to explain why the transfer was necessary.

On 8/15/18 at 12:16 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #1 stated labs, a face sheet, sbar (situation, background, assessment, recommendation) form, physician order, medication list, dnr (do not resuscitate) form and advanced directives, if applicable, and a hospital transfer form is provided to hospital staff. LPN #1 stated the physician and resident representative information is documented on the face sheet and the bottom of the sbar form, and advanced directives, special precautions/instructions for care is documented on the transfer form. When asked if residents' comprehensive care plan goals are provided to

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hospital staff, LPN #1 stated, "We have never had to transfer that over." When asked to confirm the comprehensive care plan goals are not provided, LPN #1 stated, "Not unless they directly ask us for them."

On 8/15/18 at 3:07 p.m., an interview was conducted with ASM (administrative staff member) #3 (the medical director). ASM #3 was asked if the facility physicians document the reason and necessity for hospital transfers. ASM #3 stated the physicians' document for sure if they are in the facility, especially if they evaluate the patient. ASM #3 stated the physicians typically do not document if they do not complete an evaluation of the patient but the transfers are discussed with the nurse managers and in the QAPI (quality assessment and performance improvement) meetings.

On 8/15/18 at 6:01 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.
3. Resident #75 was transferred and admitted to the hospital on 6/19/18. The clinical record failed to evidence physician notes justifying the reason for the transfer, and why the facility was not able to manage the resident's condition; and there was no evidence in the clinical record that all required documentation was provided to the receiving facility.

Resident #75 was admitted to the facility on 6/12/18 with the diagnoses of but not limited to sepsis, ataxia, Parkinson's disease, diabetes,

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pneumonia, glaucoma, and high blood pressure. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 7/2/18. The resident was coded as cognitively intact in ability to make daily life decisions.

A review of the clinical record revealed a nurse's note dated 6/19/18 at 8:03 p.m., which documented, "....Change in condition....patient seems to be sluggish and leaning more towards the left....(name of doctor) was notified....Interventions: ....transfer to hospital.... (name of resident representative)....was notified on 6/19/18 at 8:00 p.m."

A review of the "Nursing Home to Hospital Transfer Form" that was completed revealed there was no information documented indicating the resident's comprehensive care plan goals were provided to the hospital.

Further review of the clinical record failed to reveal any evidence of physician documentation of why the facility was not able to treat the resident and the necessity for Resident #75's hospital transfer on 6/19/18.

On 8/15/18 at 12:16 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #1 stated labs [laboratory tests], a face sheet, sbar (situation, background, assessment, recommendation) form, physician order, medication list, DNR (do not resuscitate) form and advanced directives, if applicable, and a hospital transfer form is provided to hospital staff. LPN #1 stated the

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physician and resident representative information is documented on the face sheet and the bottom of the sbar form, and advanced directives, special precautions/instructions for care is documented on the transfer form. When asked if residents' comprehensive care plan goals are provided to hospital staff, LPN #1 stated, "We have never had to transfer that over." When asked to confirm the comprehensive care plan goals are not provided, LPN #1 stated, "Not unless they directly ask us for them."

On 8/15/18 at 3:07 p.m., an interview was conducted with ASM (administrative staff member) #3 (the medical director). ASM #3 was asked if the facility physicians document the reason for hospital transfers and the necessity for the transfers. ASM #3 stated the physicians' document for sure if they are in the facility, especially if they evaluate the patient. ASM #3 stated the physicians typically don't document if they don't complete an evaluation of the patient but the transfers are discussed with the nurse managers and in the QAPI (quality assessment and performance improvement) meetings.

On 8/15/18 at approximately 6:20 p.m., the Administrator (administrative staff member (ASM#1)) and Director of Nursing, ASM #2, were made aware of the findings. No further information was provided by the end of the survey.

4. Resident #74 was transferred and admitted to the hospital on 5/19/18. The clinical record failed to evidence that all required documentation including the comprehensive care plan goals were provided to the receiving facility.

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Resident #74 was admitted to the facility on 5/12/18 with the diagnoses of but not limited to hemiplegia, enterocolitis related to clostridium difficile (CDiff), depression, diabetes, atrial fibrillation, pressure ulcer, rheumatoid arthritis, and chronic kidney disease. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 6/1/18. The resident was coded as being cognitively intact in ability to make daily life decisions.

A review of the clinical record revealed a nurse's note dated 5/19/18 at 10:49 a.m., which documented, "....dislodged rectal tube....NP (nurse practitioner) (name of NP) was notified on 5/19/2018 10:40 a.m., transfer to hospital.... (contact person) was notified on 5/19/2018 10:40 a.m."

A physician's note dated 5/26/18 at 5:35 p.m., documented, "S/P (status post) fecal transplant...admitted to hospital for chronic recurrent CDiff colitis that had failed Vancomycin {1} and Dificid {2} therapy in the past. He was admitted for fecal transplant which was performed by GI (gastroenterologist) on 5/23/18..."

A review of the "Nursing Home to Hospital Transfer Form" that was completed revealed there was no information documented indicating the resident's comprehensive care plan goals were provided to the hospital.

On 8/15/18 at 12:16 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked to describe the information

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provided to hospital staff when a resident is transferred to the hospital. LPN #1 stated labs [laboratory tests], a face sheet, sbar (situation, background, assessment, recommendation) form, physician order, medication list, DNR (do not resuscitate) form and advanced directives, if applicable, and a hospital transfer form is provided to hospital staff. LPN #1 stated the physician and resident representative information is documented on the face sheet and the bottom of the sbar form, and advanced directives, special precautions/instructions for care is documented on the transfer form. When asked if residents' comprehensive care plan goals are provided to hospital staff, LPN #1 stated, "We have never had to transfer that over." When asked to confirm the comprehensive care plan goals are not provided, LPN #1 stated, "Not unless they directly ask us for them."

On 8/15/18 at approximately 6:20 p.m., the Administrator (administrative staff member (ASM#1)) and Director of Nursing, ASM #2, were made aware of the findings. No further information was provided by the end of the survey.

{1} Vancomycin - Vancomycin is used to treat colitis (inflammation of the intestine caused by certain bacteria) that may occur after antibiotic treatment. Vancomycin is in a class of medications called glycopeptide antibiotics. It works by killling bacteria in the intestines. Information obtained from https://medlineplus.gov/druginfo/meds/a604038.html

{2} Dificid - Fidaxomicin is used to treat diarrhea caused by Clostridium difficile (C. difficile; a type

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of bacteria that my cause severe or life-threatening diarrhea.) Fidaxomicin is in a class of medications called macrolide antibiotics. It works by killing bacteria in the intestines. Information obtained from https://medlineplus.gov/druginfo/meds/a611040.html

5. Resident #63 was transferred and admitted to the hospital on 7/1/18. The clinical record failed to evidence physician notes justifying the reason for the transfer, and why the facility was not able to manage the resident's condition; and there was no evidence in the clinical record that all required documentation was provided to the receiving facility.

Resident #63 was admitted to the facility on 6/20/18 with the diagnoses of but not limited to traumatic hemorrhage of the cerebrum with loss of consciousness, dysphagia, traumatic subdural hemorrhage, deep vein thrombosis, seizures, atrial fibrillation, depression, osteoporosis, breast cancer and traumatic brain injury. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 7/11/18. The resident was coded as mildly cognitively impaired in ability to make daily life decisions.

A review of the clinical record revealed a nurse's note dated 7/1/18 at 10:28 a.m., that documented, "....Resident became unresponsive and foaming at the mouth, family today noted resident not at baseline, poor trunk control, Left sided facial droop, slurred speech, unable to hold food in mouth, L (left) arm flaccid....On call (physician) was notified on 07/01/2018 12:00

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a.m. ....transfer to hospital....(name of resident representative) was notified on 07/01/2018 10:34 a.m. ...."

A review of the "Nursing Home to Hospital Transfer Form" that was completed revealed there was no information documented indicating the resident's comprehensive care plan goals were provided to the hospital.

Further review of the clinical record failed to reveal any evidence of physician documentation of why the facility was not able to treat the resident and the necessity for hospital transfer of Resident #63 on 7/1/18.

On 8/15/18 at 12:16 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #1 stated labs [laboratory tests], a face sheet, sbar (situation, background, assessment, recommendation) form, physician order, medication list, DNR (do not resuscitate) form and advanced directives, if applicable, and a hospital transfer form is provided to hospital staff. LPN #1 stated the physician and resident representative information is documented on the face sheet and the bottom of the sbar form, and advanced directives, special precautions/instructions for care is documented on the transfer form. When asked if residents' comprehensive care plan goals are provided to hospital staff, LPN #1 stated, "We have never had to transfer that over." When asked to confirm the comprehensive care plan goals are not provided, LPN #1 stated, "Not unless they directly ask us for them."

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On 8/15/18 at 3:07 p.m., an interview was conducted with ASM (administrative staff member) #3 (the medical director). ASM #3 was asked if the facility physicians document the reason for hospital transfers and the necessity for the transfers. ASM #3 stated the physicians' document for sure if they are in the facility, especially if they evaluate the patient. ASM #3 stated the physicians typically don't document if they don't complete an evaluation of the patient but the transfers are discussed with the nurse managers and in the QAPI (quality assessment and performance improvement) meetings.

On 8/15/18 at approximately 6:20 p.m., the Administrator (administrative staff member (ASM#1)) and Director of Nursing, ASM #2, were made aware of the findings. No further information was provided by the end of the survey.

6. The facility staff failed to provide evidence that Resident #64's comprehensive care plan goals were sent with the resident upon transfer to the hospital on 7/16/18.

Resident #64 was admitted to the facility on 4/16/18, with a most recent readmission of 7/16/18, with diagnoses that included but were not limited to: heart failure, high blood pressure, chronic kidney disease, cardiogenic shock (when the heart has been damaged so much that it is unable to supply enough blood to the organs of the body) (1), anxiety, arthritis, and the presence of an implanted automatic cardiac defibrillator (a device that is put inside the body to restore normal heartbeats by sending an electric pulse or shock to the heart.) (2).

The most recent MDS (minimum data set)

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assessment, a quarterly assessment, with an assessment reference date of 7/12/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident is cognitively intact for daily decision making.

The nurse practitioner's note dated 7/16/18 at 2:54 p.m. documented in part, "CC (chief complaint): Lip Abscess ...has taken meds [medications] upper lip still swollen, erythema (reddened), pain, lip abscess discussed with MD (medical doctor). Will sent to ED (emergency department)."

The resident transfer form dated 7/16/18 at 11:05 a.m. documented in part, "Possible abcess [sic] right side of upper lip."

Review of the clinical record and transfer form failed to evidence that Resident #64's comprehensive care plan or comprehensive care plan goals were sent with him upon transfer to the hospital.

On 8/15/18 at 12:16 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #1 stated labs [laboratory tests], a face sheet, sbar (situation, background, assessment, recommendation) form, physician order, medication list, DNR (do not resuscitate) form and advanced directives, if applicable, and a hospital transfer form is provided to hospital staff. LPN #1 stated the physician and resident representative information is documented on the face sheet and the bottom of the sbar form, and advanced directives, special

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precautions/instructions for care is documented on the transfer form. When asked if residents' comprehensive care plan goals are provided to hospital staff, LPN #1 stated, "We have never had to transfer that over." When asked to confirm the comprehensive care plan goals are not provided, LPN #1 stated, "Not unless they directly ask us for them."

On 8/15/18 at 6:01 p.m., ASM (administrative staff member) #1,the administrator, ASM #2, the director of nursing, ASM #4, the clinical services coordinator, RN (registered nurse) #2, the assistant director of nursing, and LPN #1, the unit manager, were made aware of the above findings.

A review of the facility's policy, "Transfer or Discharge Documentation", documented in part, "7. Should a resident be transferred or discharged for any reason, the following information will communicated to the receiving facility or provider: f. Comprehensive care plan goals."

No further information was provided prior to exit.

1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/000185.htm

2) This information was obtained from the National Institutes of Health at https://www.nhlbi.nih.gov/health-topics/defibrillato rs

7. The facility staff failed provide evidence that Resident #40's comprehensive care plan goals were sent with the resident upon a transfer to the hospital on 5/21/18.

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Resident #40 was admitted to the facility on 3/11/18 with diagnoses that included but were not limited to: end stage renal 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), stroke, heart disease, high blood pressure, diabetes and depression.

The most recent MDS (minimum data set) assessment, a Medicare five day admission assessment, with an assessment reference date of 6/23/18, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating he was capable of making daily cognitive decisions.

The nurse's note dated, 5/21/18 at 10:20 a.m. documented in part, "Change in condition noted related to resident has elevated temp (temperature) tachycardia (rapid heartbeat) and hypertension (high blood pressure). This change in condition started on 5/21/18. Since it started it has gotten worse." The nurse's note dated, 5/21/18 at 12:30 p.m. documented, "Sent to (initials of hospital) ER (emergency room) per NP (nurse practitioner), (name of family member) emergency contact made aware."

The physician order dated, 5/21/18, documented, "Send to (initials of hospital) ER for Eval (evaluation)."

The "Nursing Home to Hospital Transfer Form" dated, 5/21/18, documented in part, "Vital signs: BP (blood pressure) - 230/114, HR (heart rate) - 110, Temp - 102.0...Resident is experiencing

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tachycardia, fever, hypertension, NP in to eval patient, request to send to (initials of hospital." There was no documentation of the resident care plan goals being sent with the resident.

On 8/15/18 at 12:16 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #1 stated labs, a face sheet, SBAR (situation, background, assessment, recommendation) form, physician order, medication list, DNR (do not resuscitate) form and advanced directives, if applicable, and a hospital transfer form is provided to hospital staff. LPN #1 stated the physician and resident representative information is documented on the face sheet and the bottom of the SBAR form, and advanced directives, special precautions/instructions for care is documented on the transfer form. When asked if residents' comprehensive care plan goals are provided to hospital staff, LPN #1 stated, "We have never had to transfer that over." When asked to confirm the comprehensive care plan goals are not provided, LPN #1 stated, "Not unless they directly ask us for them."

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, RN (registered nurse) #2, the assistant director of nursing, LPN #1, a unit manager, and ASM #4, the Clinical Services Coordinator, were made aware of the above findings.

No further information was provided prior to exit.

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

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Chapman, page 266.
8. The facility staff failed to send the comprehensive care plan goals to the receiving hospital for Resident #65's facility initiated transfer on 6/13/18.

Resident #65 was admitted to the facility on 5/18/18 and readmitted on 6/18/18 with diagnoses
that included but were not limited to: fracture of the left ankle, difficulty walking, irregular heartbeat and heart failure.

The most recent MDS (minimum data set), a 30 day assessment, with an ARD (assessment reference date) of 7/17/18 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact.

Review of the nurse's notes dated 6/13/17 at 7:27 p.m. documented, "Resident discharged from facility at 1715 (5:15 p.m.) for Direct admission to (name of hospital). Left via stretcher transport. Residents sister in facility and gathered belongings of resident."

On 8/15/18 at 12:16 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. LPN #1 stated labs (laboratory results), a face sheet, sbar (situation, background, assessment, recommendation) form, physician order, medication list, dnr (do not resuscitate) form and advanced directives, if applicable, and a hospital transfer form is provided to hospital staff. LPN #1 stated the physician and resident representative information

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is documented on the face sheet and the bottom of the sbar form, and advanced directives, special precautions/instructions for care is documented on the transfer form. When asked if residents' comprehensive care plan goals are provided to hospital staff, LPN #1 stated, "We have never had to transfer that over." When asked to confirm the comprehensive care plan goals are not provided, LPN #1 stated, "Not unless they directly ask us for them."

On 8/15/18 at 5:55 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

F 623 SS=E — F 623 — 9/26/18

Notice Requirements Before Transfer/Discharge
CFR(s): 483.15(c)(3)-(6)(8)

§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.

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F 623	Continued From page 32 (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 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	F 623		

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F 623	Continued From page 33 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 § 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	F 623	1. Corrective Action for those residents found to be affected by the alleged	

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the facility staff failed to provide written notification to the RR (resident representative) and/or ombudsman for a facility-initiated transfer for eight of 35 residents in the survey sample, Residents #13, #50, #75, #74, #63, #64, #40 and #65.

1. Resident #13 was transferred to the hospital on 4/20/18. 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.

2. Resident #50 was transferred to the hospital on 3/14/18. 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.

3. The facility staff failed to provide the required written notification to the resident representative (RR) regarding the reasons for the transfer, when Resident #75 was transferred to the hospital on 6/19/18.

4. The facility staff failed to provide the required written notification to the resident representative (RR) regarding the reasons for the transfer, when Resident #74 was transferred to the hospital on 5/19/18.

5. The facility staff failed to provide the required written notification to the resident representative (RR) regarding the reasons for the transfer, when Resident #63 was transferred to the hospital on 7/1/18.

6. The facility staff failed to provide written notification to resident/responsible (RR)

F 623

deficient practice.
Immediate education with nursing leadership, and social services department regarding sending written notification of discharge to resident representative(s), and the state long-term care ombudsman discharge list monthly.

2. Corrective actions taken for residents with potential to be affected by alleged deficient practice.
Residents admitted into the facility have the potential to be affected. Audit completed on current month discharges to ensure written notification to resident representative were completed and addressed as necessary. Audit completed for previous month discharges to ensure receipt by long term care ombudsman.

3. Systemic changes put into place to ensure the alleged deficient practice does not recur.
A checklist will be added to the morning meeting sheet to discuss acute discharges ensuring that written notification of discharge was sent.
Education completed by the Director of Nursing to social services, and business office departments on providing written notification of discharges.

4. Monitoring of corrective action to ensure the alleged deficient practice does not recur.
Director of nursing will audit acute transfer(s) to ensure written notification(s) were completed weekly x4 weeks and monthly x2.

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representative of a transfer to the hospital on 7/16/18, for Resident #64.

7. The facility staff failed to provide written documentation to Resident #40 and/or the resident representative for a transfer to the hospital on 5/21/18.

8. The facility staff failed to provide written notification of the facility initiated transfer to Resident #65's resident representative for the facility initiated transfer to the hospital on 6/13/18.

The findings include:

1. Resident #13 was transferred to the hospital on 4/20/18. 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 #13 was admitted to the facility on 3/6/18. Resident #13's diagnoses included but were not limited to muscle weakness, high blood pressure and aftercare following joint replacement surgery. Resident #13's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/31/18, coded the resident's cognition as severely impaired.

Review of Resident #13's clinical record revealed nurses note dated 4/20/18 that documented the resident was transferred to the hospital for a complaint of hip/pelvic pain and confirmation the resident had fallen in her son's presence.

Further review of Resident #13's clinical record failed to reveal written notification of the transfer

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Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions.

Date if Compliance: 9/26/18

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was provided to the resident's representative, or the ombudsman.

On 8/15/18 at 12:16 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 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 8/15/18 at 1:12 p.m., an interview was conducted with OSM (other staff member) #1 (the assistant director of social services). OSM #1 stated she does not notify residents' representatives when residents are transferred to the hospital but she does fax a monthly list to the ombudsman that contains the names of all resident discharges, including hospitalizations. OSM #1 stated this process was started when she began employment in April 2018. Review of the April 2018 list of discharged residents that was faxed to the ombudsman failed to reveal Resident #13's name. On 8/15/18 at 1:50 p.m., OSM #1 was asked to provide an explanation why Resident #13's name was not on the April 2018 list faxed to the ombudsman. On 8/15/18 at 2:24 p.m., OSM #1 confirmed Resident #13's name was not on the list faxed to the ombudsman in April 2018. OSM #1 stated there was a computer glitch and the facility staff would reach out to the computer software company.

On 8/15/18 at 6:01 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 document titled, "Transfer or

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Discharge, Emergency" documented the resident's representative should be notified but failed to document information regarding written notice to the representative and ombudsman.

No further information was presented prior to exit.

2. Resident #50 was transferred to the hospital on 3/14/18. 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 #50 was admitted to the facility on 3/16/16. Resident #50's diagnoses included but were not limited to paralysis, muscle weakness and urinary retention. Resident #50's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 7/1/18, coded the resident as being cognitively intact.

Review of Resident #50's clinical record revealed a nurse's note dated 3/14/18 that documented the resident presented with bright red rectal bleeding and the resident was transferred to the hospital.

Further review of Resident #50's clinical record failed to reveal written notification of the transfer was provided to the resident's representative, or the ombudsman.

On 8/15/18 at 12:16 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 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.

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On 8/15/18 at 1:12 p.m., an interview was conducted with OSM (other staff member) #1 (the assistant director of social services). OSM #1 stated she does not notify residents' representatives when residents are transferred to the hospital but she does fax a monthly list that contains the names of all resident discharges, including hospitalizations. OSM #1 stated this process was started when she began employment in April 2018. OSM #1 was unable to provide evidence that the ombudsman was made aware of March 2018 hospital discharges.

On 8/15/18 at 6:01 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.

3. The facility staff failed to provide the required written notification to the resident representative (RR) regarding the reasons for the transfer, when Resident #75 was transferred to the hospital on 6/19/18.

Resident #75 was admitted to the facility on 6/12/18 with the diagnoses of but not limited to sepsis, ataxia, Parkinson's disease, diabetes, pneumonia, glaucoma, and high blood pressure. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 7/2/18. The resident was coded as cognitively intact in ability to make daily life decisions.

A review of the clinical record revealed a nurse's note dated 6/19/18 at 8:03 p.m., which

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documented, "....Change in condition....patient seems to be sluggish and leaning more towards the left....(name of doctor) was notified....Interventions: ....transfer to hospital....(name of resident representative)....was notified on 6/19/18 at 8:00 p.m.."

Further review of the clinical record failed to reveal any evidence that the resident representative was provided with written notification of the hospital transfer.

On 8/15/18 at 12:16 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 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 8/15/18 at 1:12 p.m., an interview was conducted with OSM (other staff member) #1 (the assistant director of social services). OSM #1 stated she does not notify residents' representatives when residents are transferred to the hospital but she does fax a monthly list that contains the names of all resident discharges, including hospitalizations. OSM #1 stated this process was started when she began employment in April 2018.

On 8/15/18 at approximately 6:20 p.m., the Administrator, ASM (administrative staff member) #1 and Director of Nursing, ASM #2, were made aware of the findings. No further information was provided by the end of the survey.

4. The facility staff failed to provide the required

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written notification to the resident representative (RR) regarding the reasons for the transfer, when Resident #74 was transferred to the hospital on 5/19/18.

Resident #74 was admitted to the facility on 5/12/18 with the diagnoses of but not limited to hemiplegia, enterocolitis related to clostridium difficile (CDiff), depression, diabetes, atrial fibrillation, pressure ulcer, rheumatoid arthritis, and chronic kidney disease. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 6/1/18. The resident was coded as cognitively intact in ability to make daily life decisions.

A review of the clinical record revealed a nurse's note dated 5/19/18 at 10:49 a.m., which documented, "....dislodged rectal tube....NP (nurse practitioner) (name of NP) was notified on 5/19/2018 10:40 a.m.,....transfer to hospital.... (contact person) was notified on 5/19/2018 10:40 a.m.."

A physician's note dated 5/26/18 at 5:35 p.m., documented, "S/P (status post) fecal transplant....admitted to hospital for chronic recurrent CDiff colitis that had failed Vancomycin {1} and Dificid {2} therapy in the past. He was admitted for fecal transplant which was performed by GI (gastroenterologist) on 5/23/18..."

Further review of the clinical record failed to reveal any evidence that the resident representative was provided with written notification of the hospital transfer.

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On 8/15/18 at 12:16 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 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 8/15/18 at 1:12 p.m., an interview was conducted with OSM (other staff member) #1 (the assistant director of social services). OSM #1 stated she does not notify residents' representatives when residents are transferred to the hospital but she does fax a monthly list that contains the names of all resident discharges, including hospitalizations. OSM #1 stated this process was started when she began employment in April 2018.

On 8/15/18 at approximately 6:20 p.m., the Administrator, ASM (administrative staff member) #1 and Director of Nursing, ASM #2, were made aware of the findings. No further information was provided by the end of the survey.

{1} Vancomycin - Vancomycin is used to treat colitis (inflammation of the intestine caused by certain bacteria) that may occur after antibiotic treatment. Vancomycin is in a class of medications called glycopeptide antibiotics. It works by killling bacteria in the intestines. Information obtained from https://medlineplus.gov/druginfo/meds/a604038.html

{2} Dificid - Fidaxomicin is used to treat diarrhea caused by Clostridium difficile (C. difficile; a type of bacteria that my cause severe or life-threatening diarrhea.) Fidaxomicin is in a

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class of medications called macrolide antibiotics. It works by killing bacteria in the intestines. Information obtained from https://medlineplus.gov/druginfo/meds/a611040.html

5. The facility staff failed to provide the required written notification to the resident representative (RR) regarding the reasons for the transfer, when Resident #63 was transferred to the hospital on 7/1/18.

Resident #63 was admitted to the facility on 6/20/18 with the diagnoses of but not limited to traumatic hemorrhage of the cerebrum with loss of consciousness, dysphagia, traumatic subdural hemorrhage, deep vein thrombosis, seizures, atrial fibrillation, depression, osteoporosis, breast cancer and traumatic brain injury. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 7/11/18. The resident was coded as mildly cognitively impaired in ability to make daily life decisions.

A review of the clinical record revealed a nurse's note dated 7/1/18 at 10:28 a.m., that documented, "....Resident became unresponsive and foaming at the mouth, family today noted resident not at baseline, poor trunk control, Left sided facial droop, slurred speech, unable to hold food in mouth, L (left) arm flaccid....On call (physician) was notified on 07/01/2018 12:00 a.m.,....transfer to hospital....(name of resident representative) was notified on 07/01/2018 10:34 a.m....."

Further review of the clinical record failed to

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reveal any evidence that the resident representative was provided with written notification of the hospital transfer.

On 8/15/18 at 12:16 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 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 8/15/18 at 1:12 p.m., an interview was conducted with OSM (other staff member) #1 (the assistant director of social services). OSM #1 stated she does not notify residents' representatives when residents are transferred to the hospital but she does fax a monthly list that contains the names of all resident discharges, including hospitalizations. OSM #1 stated this process was started when she began employment in April 2018.

On 8/15/18 at approximately 6:20 p.m., the Administrator, ASM (administrative staff member) #1 and Director of Nursing, ASM #2, were made aware of the findings. No further information was provided by the end of the survey.

6. The facility staff failed to provide written notification to resident/responsible (RR) representative of a transfer to the hospital on 7/16/18, for Resident #64.

Resident #64 was admitted to the facility on 4/16/18, with a most recent readmission of 7/16/18, with diagnoses that included but were not limited to: heart failure, high blood pressure, chronic kidney disease, cardiogenic shock (when

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the heart has been damaged so much that it is unable to supply enough blood to the organs of the body) (1), anxiety, arthritis, and the presence of an implanted automatic cardiac defibrillator (a device that is put inside the body to restore normal heartbeats by sending an electric pulse or shock to the heart.) (2).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/12/18, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident is cognitively intact for daily decision making.

The nurse practitioner's note dated 7/16/18 at 2:54 p.m. documented in part, "CC (chief complaint): Lip Abscess ...has taken meds upper lip still swollen, erythema (reddened), pain, lip abscess discussed with MD (medical doctor). Will sent to ED (emergency department)."

The nursing note dated 7/16/18 at 10:58 a.m. documents in part, "Patient presents with possible abscess on right side of upper lip. MD (medical doctor), notified, hospice notified, Family notified. Resident is own R/P (responsible party)."

The resident transfer form dated 7/16/18 at 11:05 a.m. documented that the "Contact Person" was notified of the transfer via telephone.

On 8/15/18 at 12:16 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated she calls residents' representatives when residents are transferred to the hospital but she does not provide written notification of the transfers to residents'

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representatives.

On 8/15/18 at 1:12 p.m., an interview was conducted with OSM (other staff member) #1 (the assistant director of social services). OSM #1 stated she does not notify residents' representatives when residents are transferred to the hospital.

On 8/15/18 at 6:01 p.m., ASM (administrative staff member) #1,the administrator, ASM #2, the director of nursing, ASM #4, the clinical services coordinator, RN (registered nurse) #2, the assistant director of nursing, and LPN #1, the unit manager, were made aware of the above findings.

No further information was provided prior to exit.

1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/000185.htm

2) This information was obtained from the National Institutes of Health at https://www.nhlbi.nih.gov/health-topics/defibrillato rs

7. The facility staff failed to provide written documentation to Resident #40 and/or the resident representative for a transfer to the hospital on 5/21/18.

Resident #40 was admitted to the facility on 3/11/18 with diagnoses that included but were not limited to: end stage renal disease requiring hemodialysis (a procedure used in toxic conditions and renal [kidney] failure, in which wastes and impurities are removed from the

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blood by a special machine) (1), stroke, heart disease, high blood pressure, diabetes and depression.

The most recent MDS (minimum data set) assessment, a Medicare five day admission assessment, with an assessment reference date of 6/23/18, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating he was capable of making daily cognitive decisions.

The nurse's note dated, 5/21/18 at 10:20 a.m. documented in part, "Change in condition noted related to resident has elevated temp (temperature) tachycardia (rapid heartbeat) and hypertension (high blood pressure). This change in condition started on 5/21/18. Since it started it has gotten worse." The nurse's note dated, 5/21/18 at 12:30 p.m. documented, "Sent to (initials of hospital) ER (emergency room) per NP (nurse practitioner), (name of family member) emergency contact made aware."

The physician order dated, 5/21/18, documented, "Send to (initials of hospital) ER for Eval (evaluation)."

The "Nursing Home to Hospital Transfer Form" dated, 5/21/18, documented in part, "Vital signs: BP (blood pressure) - 230/114, HR (heart rate) - 110, Temp - 102.0...Resident is experiencing tachycardia, fever, hypertension, NP in to eval patient, request to send to (initials of hospital." There was no documentation evidencing that the resident and/or resident representative were provided a written copy of the reasons the resident was transferred to the hospital.

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On 8/15/18 at 12:16 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 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 8/15/18 at 1:12 p.m., an interview was conducted with OSM (other staff member) #1 (the assistant director of social services). OSM #1 stated she does not notify residents' representatives when residents are transferred to the hospital but she does fax a monthly list that contains the names of all resident discharges, including hospitalizations. OSM #1 stated this process was started when she began employment in April 2018.

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, RN (registered nurse) #2, the assistant director of nursing, LPN #1, a unit manager, and ASM #4, the Clinical Services Coordinator, were made aware of the above findings.

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.
8. The facility staff failed to provide written notification of the facility initiated transfer to Resident #65's resident representative for the facility initiated transfer to the hospital on 6/13/18.

Resident #65 was admitted to the facility on 5/18/18 and readmitted on 6/18/18 with diagnoses,

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that included but were not limited to: fracture of the left ankle, difficulty walking, irregular heartbeat and heart failure.

The most recent MDS (minimum data set), a 30 day assessment, with an ARD (assessment reference date) of 7/17/18 coded the resident as having a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact.

Review of the nurse's notes dated 6/13/17 at 7:27 p.m. documented, "Resident discharged from facility at 1715 (5:15 p.m.) for Direct admission to (name of hospital). Left via stretcher transport. Residents sister in facility and gathered belongings of resident."

On 8/15/18 at 12:16 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 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 8/15/18 at 1:12 p.m., an interview was conducted with OSM (other staff member) #1 (the assistant director of social services). OSM #1 stated she does not notify residents' representatives when residents are transferred to the hospital but she does fax a monthly list that contains the names of all resident discharges, including hospitalizations. OSM #1 stated this process was started when she began employment in April 2018.

On 8/15/18 at 5:55 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the

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F 623	Continued From page 49 director of nursing were made aware of the findings. No further information was provided prior to exit.	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	1. Corrective Action for those residents	9/26/18

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review, it was determined that the facility staff failed to evidence a written bed hold policy was provided within 24 hours of a facility-initiated transfer for six of 35 residents in the survey sample, Residents #13, #50, #75, #74, #63, and #40.

1. The facility staff failed to provide Resident #13's representative written notification of the bed hold policy when the resident was discharged to the hospital on 4/20/18.

2. The facility staff failed to provide Resident #50 and/or the resident's representative written notification of the bed hold policy when the resident was discharged to the hospital on 3/14/18.

3. The facility staff failed to evidence that a written bed hold notification was provided Resident #75's responsible party upon transfer of the resident to the hospital transfer on 6/19/18.

4. The facility staff failed to evidence that a written bed hold notification was provided to the responsible party upon Resident #74's transfer to the hospital transfer on 5/19/18.

5. The facility staff failed to evidence that a written bed hold notification was provided to the responsible party upon Resident #63's transfer to the hospital transfer on 7/1/18.

6. 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 Resident #40's transfer to the hospital on 5/21/18.

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found to be affected by the alleged deficient practice.
Immediate education with nursing leadership, the admissions team, and business office regarding sending written notification of bed hold policy to resident and/or resident representative(s), at time of acute transfer.

2. Corrective actions taken for residents with potential to be affected by alleged deficient practice.
Residents admitting into the facility have the potential to be affected. Audit compered on recent acute transfers to ensure written notification of bed hold policy was completed and addressed as necessary.

3. Systemic changes put into place to ensure the alleged deficient practice does not recur.
Education completed by the Director of Nursing to nursing leadership and the admission team regarding providing and documenting written bed hold policy to resident and/or resident representative.

4. Monitoring of corrective action to ensure the alleged deficient practice does not recur.
The Admission coordinator will complete audits of written notification of bed hold policy weekly x4 weeks and monthly x2 months to ensure written notification of bed hold policy was obtained and documented.

Plan of correction information and audits

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F 625	Continued From page 51 The findings include: 1. The facility staff failed to provide Resident #13's representative written notification of the bed hold policy when the resident was discharged to the hospital on 4/20/18. Resident #13 was admitted to the facility on 3/6/18. Resident #13's diagnoses included but were not limited to muscle weakness, high blood pressure and aftercare following joint replacement surgery. Resident #13's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/31/18, coded the resident's cognition as severely impaired. Review of Resident #13's clinical record revealed nurses note dated 4/20/18 that documented the resident was transferred to the hospital for a complaint of hip/pelvic pain and confirmation the resident had fallen in her son's presence. Further review of Resident #13's clinical record failed to reveal the facility staff provided written information regarding the bed hold policy to Resident #13''s representative. On 8/15/18 at 2:52 p.m., an interview was conducted with OSM (other staff member) #2 (the director of admissions and the person responsible for providing information regarding the bed hold policy to residents and their representatives). OSM #2 stated nurses send a notice of transfer form with residents when they are transferred to the hospital and she (OSM #2) calls residents' representatives and provides verbal information regarding the bed hold policy.	F 625	will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. Date if Compliance: 9/26/18	

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Review of the notice of transfer form that nurses send to the hospital failed to document information regarding the bed hold policy. OSM #2 confirmed written notice of the bed hold policy is not provided each time a resident is discharged to the hospital.

On 8/15/18 at 6:01 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 document titled, "Transfer or Discharge, Emergency" failed to document information regarding the bed hold policy.

No further information was presented prior to exit.

2. The facility staff failed to provide Resident #50 and/or the resident's representative written notification of the bed hold policy when the resident was discharged to the hospital on 3/14/18.

Resident #50 was admitted to the facility on 3/16/16. Resident #50's diagnoses included but were not limited to paralysis, muscle weakness and urinary retention. Resident #50's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 7/1/18, coded the resident as being cognitively intact.

Review of Resident #50's clinical record revealed a nurse's note dated 3/14/18 that documented the resident presented with bright red rectal bleeding and the resident was transferred to the hospital.

Further review of Resident #50's clinical record

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failed to reveal the facility staff provided written information regarding the bed hold policy to Resident #13 or the resident's representative.

On 8/15/18 at 2:52 p.m., an interview was conducted with OSM (other staff member) #2 (the director of admissions and the person responsible for providing information regarding the bed hold policy to residents and their representatives). OSM #2 stated nurses send a notice of transfer form with residents when they are transferred to the hospital and she (OSM #2) calls residents' representatives and provides verbal information regarding the bed hold policy. Review of the notice of transfer form that nurses send to the hospital failed to document information regarding the bed hold policy. OSM #2 confirmed written notice of the bed hold policy is not provided each time a resident is discharged to the hospital.

On 8/15/18 at 6:01 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

On 8/16/18 at 8:57 a.m., an interview was conducted with Resident #50. The resident stated he did not remember receiving written information regarding the bed hold policy when he was transferred to the hospital in March 2018.

No further information was presented prior to exit.

3. The facility staff failed to evidence that a written bed hold notification was provided Resident #75's responsible party upon transfer of the resident to the hospital transfer on 6/19/18.

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Resident #75 was admitted to the facility on 6/12/18 with the diagnoses of but not limited to sepsis, ataxia, Parkinson's disease, diabetes, pneumonia, glaucoma, and high blood pressure. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 7/2/18. The resident was coded as cognitively intact in ability to make daily life decisions.

A review of the clinical record revealed a nurse's note dated 6/19/18 at 8:03 p.m., which documented, "....Change in condition....patient seems to be sluggish and leaning more towards the left....(name of doctor) was notified....Interventions: ....transfer to hospital....(name of resident representative)....was notified on 6/19/18 at 8:00 p.m."

Further review of the clinical record failed to reveal any evidence that the resident representative was provided with written bed hold notification.

On 8/15/18 at 2:52 p.m., an interview was conducted with OSM (other staff member) #2 (the director of admissions and the person responsible for providing information regarding the bed hold policy to residents and their representatives). OSM #2 stated nurses send a notice of transfer form with residents when they are transferred to the hospital and she (OSM #2) calls residents' representatives and provides verbal information regarding the bed hold policy. Review of the notice of transfer form that nurses send to the hospital failed to document information regarding the bed hold policy. OSM #2 confirmed written notice of the bed hold policy is not provided each time a resident is discharged

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to the hospital.

On 8/15/18 at approximately 6:20 p.m., the Administrator, ASM (administrative staff member) #1 and Director of Nursing, ASM #2, were made aware of the findings. No further information was provided by the end of the survey.

4. The facility staff failed to evidence that a written bed hold notification was provided to the responsible party upon Resident #74's transfer to the hospital transfer on 5/19/18.

Resident #74 was admitted to the facility on 5/12/18 with the diagnoses of but not limited to hemiplegia, enterocolitis related to clostridium difficile, depression, diabetes, atrial fibrillation, pressure ulcer, rheumatoid arthritis, and chronic kidney disease. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 6/1/18. The resident was coded as being cognitively intact in ability to make daily life decisions.

A review of the clinical record revealed a nurse's note dated 5/19/18 at 10:49 a.m., which documented, "....dislodged rectal tube....NP (nurse practitioner) (name of NP) was notified on 5/19/2018 10:40 a.m. ...transfer to hospital.... (contact person) was notified on 5/19/2018 10:40 a.m."

Further review of the clinical record failed to reveal any evidence that the resident representative was provided with written bed hold notification.

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On 8/15/18 at 2:52 p.m., an interview was conducted with OSM (other staff member) #2 (the director of admissions and the person responsible for providing information regarding the bed hold policy to residents and their representatives). OSM #2 stated nurses send a notice of transfer form with residents when they are transferred to the hospital and she (OSM #2) calls residents' representatives and provides verbal information regarding the bed hold policy. Review of the notice of transfer form that nurses send to the hospital failed to document information regarding the bed hold policy. OSM #2 confirmed written notice of the bed hold policy is not provided each time a resident is discharged to the hospital.

On 8/15/18 at approximately 6:20 p.m., the Administrator, ASM (administrative staff member) #1 and Director of Nursing, ASM #2, were made aware of the findings. No further information was provided by the end of the survey.

5. The facility staff failed to evidence that a written bed hold notification was provided to the responsible party upon Resident #63's transfer to the hospital transfer on 7/1/18.

Resident #63 was admitted to the facility on 6/20/18 with the diagnoses of but not limited to traumatic hemorrhage of the cerebrum with loss of consciousness, dysphagia, traumatic subdural hemorrhage, deep vein thrombosis, seizures, atrial fibrillation, depression, osteoporosis, breast cancer and traumatic brain injury. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 7/11/18. The

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resident was coded as mildly cognitively impaired in ability to make daily life decisions.

A review of the clinical record revealed a nurse's note dated 7/1/18 at 10:28 a.m., that documented, "....Resident became unresponsive and foaming at the mouth, family today noted resident not at baseline, poor trunk control, Left sided facial droop, slurred speech, unable to hold food in mouth, L (left) arm flaccid....On call (physician) was notified on 07/01/2018 12:00 a.m. ....transfer to hospital....(name of resident representative) was notified on 07/01/2018 10:34 a.m. ...."

Further review of the clinical record failed to reveal any evidence that the resident representative was provided with written bed hold notification.

On 8/15/18 at 2:52 p.m., an interview was conducted with OSM (other staff member) #2 (the director of admissions and the person responsible for providing information regarding the bed hold policy to residents and their representatives). OSM #2 stated nurses send a notice of transfer form with residents when they are transferred to the hospital and she (OSM #2) calls residents' representatives and provides verbal information regarding the bed hold policy. Review of the notice of transfer form that nurses send to the hospital failed to document information regarding the bed hold policy. OSM #2 confirmed written notice of the bed hold policy is not provided each time a resident is discharged to the hospital.

On 8/15/18 at approximately 6:20 p.m., the Administrator, ASM (administrative staff member)

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#1 and Director of Nursing, ASM #2, were made aware of the findings. No further information was provided by the end of the survey.
6. 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 Resident #40's transfer to the hospital on 5/21/18.

Resident #40 was admitted to the facility on 3/11/18 with diagnoses that included but were not limited to: end stage renal 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), stroke, heart disease, high blood pressure, diabetes and depression.

The most recent MDS (minimum data set) assessment, a Medicare five day admission assessment, with an assessment reference date of 6/23/18, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating he was capable of making daily cognitive decisions. .

The nurse's note dated, 5/21/18 at 10:20 a.m. documented in part, "Change in condition noted related to resident has elevated temp (temperature) tachycardia (rapid heartbeat) and hypertension (high blood pressure). This change in condition started on 5/21/18. Since it started it has gotten worse." The nurse's note dated, 5/21/18 at 12:30 p.m. documented, "Sent to (initials of hospital) ER (emergency room) per NP (nurse practitioner), (name of family member) emergency contact made aware."

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The physician order dated, 5/21/18, documented, "Send to (initials of hospital) ER for Eval (evaluation)."

The "Nursing Home to Hospital Transfer Form" dated, 5/21/18, documented in part, "Vital signs: BP (blood pressure) - 230/114, HR (heart rate) - 110, Temp - 102.0...Resident is experiencing tachycardia, fever, hypertension, NP in to eval patient, request to send to (initials of hospital." There was no documentation evidencing that a written bed hold policy was given to the resident and/or resident representative.

On 8/15/18 at 2:52 p.m., an interview was conducted with OSM (other staff member) #2 (the director of admissions and the person responsible for providing information regarding the bed hold policy to residents and their representatives). OSM #2 stated nurses send a notice of transfer form with residents when they are transferred to the hospital and she (OSM #2) calls residents' representatives and provides verbal information regarding the bed hold policy. Review of the notice of transfer form that nurses send to the hospital failed to document information regarding the bed hold policy. OSM #2 confirmed written notice of the bed hold policy is not provided each time a resident is discharged to the hospital.

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, RN (registered nurse) #2, the assistant director of nursing, LPN #1, a unit manager, and ASM #4, the Clinical Services Coordinator, were made aware of the above findings.

No further information was provided prior to exit.

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F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §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	F 655		9/26/18

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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 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 observation, resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to ensure the baseline care plan was developed to meet all of the resident's immediate needs for one of 35 residents in the survey sample; Resident #250.

The facility staff failed to ensure the baseline care plan included immediate care needs for the care of a urinary catheter when the Resident #250 was admitted on 8/10/18.

The findings include:

Resident #250 was admitted to the facility on 8/10/18 for a respite care stay of approximately one week. The resident was admitted with the diagnoses of but not limited to chronic obstructive pulmonary disease, respiratory failure, atrial fibrillation, hepatitis C, C-spine disease status/post-cervical surgery failure, and high blood pressure. Due to the length of stay at the time of the survey, no MDS (Minimum Data Set)

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1. Corrective Action for those residents found to be affected by the alleged deficient practice.
Resident #250 has since discharged from the facility.

2. Corrective actions taken for residents with potential to be affected by alleged deficient practice.
Residents admitted into the facility have the potential to be affected. Director of Nursing completed audit on new admissions to ensure baseline care plans included residents immediate care needs and addressed as necessary.

3. Systemic changes put into place to ensure the alleged deficient practice does not recur.
Education completed by the Director of Nursing to licensed nursing personnel on ensuring resident immediate care needs are captured on the baseline care plan.

4. Monitoring of corrective action to ensure the alleged deficient practice does

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assessment had yet been completed. The nurse's evaluation note dated 8/10/18 at 3:36 p.m., documented that the resident was cognitively intact in ability to make daily life decisions; and that the resident was totally dependent on staff for activities of daily living.

On 8/14/18 at 12:29 p.m., and 2:15 p.m., and on 8/15/18 at approximately 8:15 a.m., observations were made of Resident #250. The resident was observed with a urinary catheter bag hanging on the side of the bed and the bag was noted to be pink-tinged inside. On 8/15/18 at 8:15 a.m., the resident stated he had had the catheter "for a while". On further interview, Resident #250 stated he had had it (catheter) before being admitted to the facility, when he was at home.

A review of the clinical record failed to reveal any physicians orders for the use and care of a urinary catheter.

A review of the nurse's evaluation note dated 8/10/18 at 3:36 p.m., documented, "No urinary catheter present."

Further review of the clinical record revealed hospice notes that were provided to the facility upon admission. There was a note dated 8/1/18, which documented, "Genitourinary...Patient requires a urinary catheter...." There was also a note dated 7/25/18, which documented, "....Genitourinary....External Catheter....Condom Cath...."

A review of the facility's certified nursing assistant (CNA) documentation record for the resident's bladder continence status revealed the facility's CNA's consistently coded the resident's bladder

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not recur.
Director of nursing will audit newly admitted residents charts 3x a week for 4 weeks and then monthly x2 to ensure immediate resident care needs are captured on the baseline care plan.

Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions.

Date if Compliance: 9/26/18

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status as "Continence Not Rated due to Condom Catheter (1)."

Review of the resident's baseline care plan failed to reveal any documentation for the use and care of a urinary catheter.

On 8/16/18 at 8:46 a.m., in an interview with CNA #2, who cared for Resident #250, she stated that he (Resident #250) had a condom catheter on and it had been in place the whole time he was in the facility.

On 8/16/18 at 8:31 a.m., in an interview with LPN #4 (Licensed Practical Nurse) who had written the above identified nurse's evaluation note at the time of admission, LPN #4 stated that, "He (Resident #250) had a condom cath (catheter) and it was used for transport." LPN #4 stated, "Hospice told me it was a condom cath for transport, that he didn't need a catheter and put it on him for transport." When LPN #4 was informed that staff had reported Resident #250 had the catheter the whole time he was in the facility, LPN #4 stated, "if he had it the whole time, there should have been orders for it and it should have been care planned." At this time, LPN #4 was shown the hospice notes dated 8/1/18 and 7/25/18, which documented Resident #250 had a catheter and that it was not just for transport. LPN #4 stated that is not what hospice told her on the phone prior to the resident's admission.

On 8/16/18 at 8:31 a.m., in an interview with LPN #3, the unit manager, she stated that the resident did not have a catheter. LPN #3 stated that if he came in with one, the staff should have called hospice or the doctor to clarify what to do with it.

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LPN #3 was notified of the above observations of Resident #250; and that the CNA staff stated the resident had the catheter the entire time he has been at the facility.

On 8/15/18 at 6:20 p.m., at the end of day meeting, the DON (Director of Nurses) (ASM #2 - Administrative Staff Member) stated she had reviewed the chart and the resident did not have a catheter because there were no orders, notes, or assessments about him having one. ASM #2 was notified at this time that two surveyors observed the catheter in place on multiple observations on two different days; and that the CNA staff stated the resident had the catheter the entire time he has been at the facility, while the nursing staff was unaware that the resident had a catheter at all.

On 8/16/18 at 9:20 a.m., in an interview with the ASM #2, the DON, she stated that, "the prior notes (hospice notes) were not reviewed. Obviously, he came in with one (a catheter). All forms of catheters should have assessments, notes, orders, and be care planned." ASM #2 stated that none of these items were present in the record.

On 8/16/18 at 10:11 a.m., in an interview with ASM #2, the DON, regarding the care of the catheter, ASM #2 stated there would be concerns for excoriation, skin concerns, leakage, placement, comfort, proper intake and output.

On 8/16/18 at 8:57 a.m., in an interview with ASM #3, the physician, he stated that there should have been orders for the use of the catheter and that it was unacceptable that there were not any.

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F 655	Continued From page 65 A review of the facility policy "Care Plans - Baseline" documented, "A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission." No further information was provided by the end of the survey. (1) Condom catheter an external urinary collection device that fits over the penis like a condom; used in the management of urinary incontinence. This information was obtained from the website: https://medical-dictionary.thefreedictionary.com/NIH+catheter	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656		9/26/18

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treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement the comprehensive care plan for one of 35 residents in the survey sample, Resident #65.

The facility staff failed to implement and follow the comprehensive care plan and physician's order to document Resident #65's daily weight.

The findings include:

Resident #65 was admitted to the facility on 5/18/18 and readmitted on 6/18/18 with diagnoses that included but were not limited to: fracture of the left ankle, difficulty walking,

1. Corrective Action for those residents found to be affected by the alleged deficient practice.
Resident #65's care plan was updated to reflect the most recent physician weight order.

2. Corrective actions taken for residents with potential to be affected by alleged deficient practice.
Residents admitting into the facility have the potential to be affected. Director of nursing completed an audit on residents with weight orders to ensure correct reflection on the care plans.

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irregular heartbeat and heart failure.

The most recent MDS (minimum data set), a 30 day assessment, with an ARD (assessment reference date) of 7/17/18 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact. The resident was coded as requiring assistance from one to two staff for activities of daily living except for eating which the resident could perform independently.

Review of the care plan initiated on 5/18/18 and revised on 5/30/18 documented, "Focus. Risk for altered nutrition status d/t (due to) ...cardiac dz (disease). Intervention/Tasks. Weights as ordered. "

Review of the August 2018 physician's orders documented, "WEIGHT QD (everyday) & RECORD IN (name of computer software) > (greater than) 3 LBS (pounds)/DAY/SYMPTOMATIC CALL MD [medical doctor]. >5LB/WK [week]/ SYMPTOMATIC."

Review of the July 2018 treatment administration record documented, "WEIGHT QD (everyday) & RECORD IN (name of computer software) > (greater than) 3 LBS (pounds)/DAY/SYMPTOMATIC CALL MD. >5LB /WK /SYMPTOMATIC." There was no documentation noted.

Review of the August 2018 weight summary record documented a weight on 8/4, 8/11 and 8/13/18.

Review of the August 2018 nurses' notes did not

F 656

3. Systemic changes put into place to ensure the alleged deficient practice does not recur.
Education completed by the Director of Nursing to licensed nursing personnel and the registered nursing assessment coordinator(s) on ensuring that the physician order is reflected on the care plan.

4. Monitoring of corrective action to ensure the alleged deficient practice does not recur.
Director of nursing will audit 5 resident care plans weekly x4 weeks, and 10 residents care plans monthly x2 to ensure correct reflection of physician orders are on the care plan.

Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions.

Date if Compliance: 9/26/18

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evidence documentation regarding the weights.

An interview was conducted on 8/15/18 at 12:40 p.m. with LPN (licensed practical nurse) #1. When asked why residents had care plans, LPN #1 stated, "A care plan is initiated to know what a resident needs." When asked if staff were expected to follow the care plan, LPN #1 stated, "Yes."

An interview was conducted on 8/15/18 at 3:42 p.m. with LPN (licensed practical nurse) #4, the resident's nurse. When asked who obtained the resident's weights, LPN #4 stated, "The CNAs (certified nursing assistants)." When asked how weights were documented, LPN #4 stated, "The CNAs can and the nurses can do it as well." When asked why Resident #65 was on daily weights, LPN #4 stated, "If I'm not mistaken he's on Lasix (1) and Spironolactone (2), they have to monitor his weight to make sure he's not gaining too much." LPN #4 was asked to review the physician's order and the weight summary form. LPN #4 stated, "We're not following the physician's orders." When asked why residents had care plans, LPN #4 stated, "So we can follow the physician orders and it tells us how we care for the patient." When asked if the staff were expected to follow the care plan, LPN #4 stated, "Yes

On 8/15/18 at 5:55 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

An interview was conducted on 8/16/18 at 9:52 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked why

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residents had care plans, ASM #2 stated, "To set a standard of care and intervention. Communication. We can discuss their goals and our goals. When asked who used the care plan, ASM #2 stated, "Everybody, nursing, CNAs (certified nursing assistants), dietary, therapy." When asked if staff were expected to follow the care plan, ASM #2 stated, "Yes."

Review of the facility's policy titled, "Weight Assessment and Intervention" did not address documenting weights.

Review of the facility's policy titled, "Care Plans, Comprehensive Person-Centered" documented, "Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation 1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.

No further information was provided prior to exit.

1. Lasix -- LASIX® (furosemide) is a potent diuretic, which, if given in excessive amounts, can lead to a profound diuresis with water and electrolyte depletion. Therefore, careful medical supervision is required and dose and dose schedule must be adjusted to the individual patient's needs. This information was obtained from:
https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=eadfe464-720b-4dcd-a0d8-45dba

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F 656	Continued From page 70 706bd33 2. Spironolactone -- Spironolactone is an aldosterone receptor antagonist and potassium-sparing diuretic widely used in the therapy of edema, particularly in patients with cirrhosis in which hyperaldosteronism appears to play a major role. Spironolactone has been linked to rare cases of clinically apparent drug induced liver disease. This information was obtained from: https://livertox.nlm.nih.gov/Spironolactone.htm	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §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.	F 657		9/26/18

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F 657	Continued From page 71 (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, 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 35 residents in the survey sample, Resident #32, and #61. 1. The facility staff failed to revise Resident #32's comprehensive care plan when his right knee immobilizer was no longer needed. 2. The facility staff failed to review and revise the comprehensive care plan for Resident #61, who has diabetes, who is non-compliant with her diet. The findings include: 1. Resident #32 was admitted to the facility on 3/22/18 with diagnoses that included but were not limited to hemiplegia (paralysis) affecting the right side of his body post stroke, muscle weakness, difficulty swallowing, and chronic kidney disease. Resident #32's most MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 6/14/18. Resident #32 was coded as being severely impaired in the ability to make daily decisions on the Staff Interview For Mental Status Exam. Resident #32 was coded as requiring extensive assistance from two plus persons with all ADLS (activities of daily living).	F 657	1. Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #32 care plan was updated to reflect the removal of the knee immobilizer and #61 care plan updated to reflect noncompliance with diabetic diet. 2. Corrective actions taken for residents with potential to be affected by alleged deficient practice. Residents admitting into the facility have the potential to be affected. Review completed by the Director of Nursing on progress notes and physician orders to ensure care plan revisions are completed as necessary. 3. Systemic changes put into place to ensure the alleged deficient practice does not recur. Education completed by the Director of Nursing to licensed nursing personnel and registered nurse assessment coordinators on revising care plans at the time of any changes. 4. Monitoring of corrective action to ensure the alleged deficient practice does not recur. Director of nursing will complete audits of 5 resident careplans 3x week x4 weeks and 10 resident careplans monthly x2	

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Review of Resident #32's comprehensive care plan dated 3/27/18, documented the following: "At risk for further falls due to impaired balance/poor coordination, spasticity of leg, limited functional ability s/p (status/post) CVA (cerebral vascular accident) (stroke), limited ability readjusting self, decrease cognition, side effect of medication, hx (history) of fall, seizure...Goal: Minimize risk for injury related to falls...Interventions: R (right) knee immobilizer to aid in decrease spasticity of leg." This intervention was added to his care plan on 3/27/18.

On 8/14/18 at 2:20 p.m., an observation was made of Resident #32. He was up in his wheelchair wearing a pair of shorts. He did not have an immobilizer to his right leg.

On 8/15/18 at 10:33 a.m., an observation was made of Resident #32. He was sleeping in bed. His right leg was bent. He did not have an immobilizer to his right leg.

On 8/15/18 at 12:15 p.m., an observation was made of Resident #32. He was up in his wheelchair with a visitor. He was wearing a pair of shorts. He did not have his right knee immobilizer to his right knee.

Review of Resident #32's therapy notes (physical therapy and occupational therapy) dated 3/23/18 through 4/9/18 failed to evidence his need for a right knee immobilizer.

Review of Resident #32 is August 2018 POS (physician order summary) failed to evidence an order for his right knee immobilizer.

On 8/15/18 at 1:39 p.m., an interview was

months for careplan revisions.

Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions.

Date if Compliance: 9/26/18

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conducted with CNA (Certified nursing assistant) #14, Resident #32's CNA. When asked how nursing aides are made aware of devices that need to be in place for residents such as splints etc., CNA #14 stated that the CNAs were normally educated by therapy. CNA #14 stated that all nursing aides had access to the care plan that documented interventions that needed to be implemented. When asked if Resident #32 needed a right knee immobilizer, CNA #14 stated that he had the immobilizer when he came into the building. CNA #14 stated that the resident did not need the immobilizer all the time. CNA #14 stated, "It's an as needed thing."

On 8/15/18 at 1:43 p.m., an interview was conducted with LPN (licensed practical nurse) #10, Resident #32's nurse. When asked who was responsible for ensuring splints, immobilizers etc. were in place, LPN #10 stated that the CNAs were responsible for putting on the devices, but the nurses were responsible for ensuring the devices were in place. LPN #10 stated an order should be active for all devices, alerting nursing staff to document on the TAR (treatment administration record) that the device is in place. LPN #10 stated all CNAs had access to the care plan to tell them what devices are needed for each resident. When asked if Resident #32 needed a right knee immobilizer, LPN #10 stated the resident did not have an order for one. LPN #10 stated she thought the resident's wife had taken it (immobilizer) from his room and that it was no longer needed. When asked the purpose of the care plan, LPN #10 stated that the purpose of the care plan was to serve as a guide for resident care. When asked when the care plan was updated, LPN #10 stated that the care plan was updated for new orders or any new changes.

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LPN #10 stated the unit managers were responsible for updating the care plan. When asked if it was important for the care plan to be accurate, LPN #10 stated, "Absolutely." When asked if the above intervention for a right knee immobilizer should be on Resident #32's comprehensive care plan, LPN #10 stated she would check with the unit manager to get rid of that intervention (the intervention for the immobilizer).

On 8/15/18 at 2:03 p.m., an interview was conducted with OSM (other staff member) #7, the Director of therapy who worked with Resident #32. OSM #7 stated Resident #32 was admitted to the facility with the right knee immobilizer. OSM #7 stated Resident #32 did not benefit from the right knee immobilizer because he was non-ambulatory. OSM #7 stated they did not use right knee immobilizer in therapy.

On 8/15/18 at 2:24 p.m., an interview was conducted with LPN #1, the unit manager. When asked who was responsible for updating the care plan, LPN #1 stated that all nurses could update the care plan. LPN #1 stated that the care plan was updated with falls, skin issues, new orders or any changes in condition. LPN #1 confirmed that Resident #32 did not need a right knee immobilizer. LPN #1 stated that it (immobilizer) should not have been on his care plan.

On 8/16/18 at 8:56 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and RN (registered nurse) #2 was made aware of the above concerns.

The facility policy titled, "Care Plans,

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Comprehensive Person Centered," documents in part, the following: "Assessments of Residents are ongoing and care plans are revised as information about the residents and the residents' conditions change."

2. The facility staff failed to review and revise the comprehensive care plan for Resident #61, who has diabetes, who is non-compliant with her diet.

Resident #61 was admitted to the facility on 6/27/18 with a readmission on 7/23/18 with diagnoses that included but were not limited to: fracture of the arm, infection in the joint, heart failure, diabetes, depression, high blood pressure 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 8/5/18, coded the resident as scoring a 12 on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make daily cognitive decisions. The resident was coded as requiring minimum to extensive assistance for all of her activities of daily living.

The comprehensive care plan dated, 6/28/18, documented in part, "Focus: Endocrine system related to diabetes." The "Interventions" documented in part, "Administer medications per physician orders. Report symptoms of hyperglycemia; excessive thirst/urination, hunger, weakness, nausea and vomiting or acetone breath. Report symptoms of hypoglycemia;

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weakness, pallor, diaphoresis, vision changes, changing consciousness." The care plan failed to evidence documentation of the resident's non-compliance with her diet.

A nurse's note dated, 8/9/18 at 5:27 p.m. documented in part, "Resident snacks frequently on cookies and fig newton's resulting in elevated BS (blood sugar)."

During an interview with LPN (licensed practical nurse) #6, on 8/15/18 at 12:59 p.m. LPN #6 stated, "The resident isn't compliant, she has a regular Pepsi in there now." When asked if her non-compliance should be care planned, LPN #6 stated, "Yes, absolutely."

An interview was conducted with LPN #3, the unit manager; on 8/15/18 at 1:16 p.m., this surveyor informed LPN #3 that the nurses on this floor, three nurses (LPN #6, LPN # 4 and LPN #12) all informed this surveyor on 8/15/18 at approximately 1:05 p.m. that Resident #61 was non-compliant with her diet. When asked if the resident's known non-compliant with her diet, should be care planned, LPN #3 stated, "Yes, it should be."

An interview was conducted with LPN #1, a unit manager, on 8/15/18 at 2:24 p.m. When asked who is responsible for updating the care plan, LPN #1 stated, "All of the nurse's." When asked what kind of things are updated on the care plans, LPN #1 stated any changes in the resident's condition, falls, infections, anything that affects their care. When asked if she would expect to see a diabetic's noncompliance with their diet on the care plan, LPN #1 stated, "Yes, it should be under the dietary care plan but it

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should also be under a behavior care plan for refusal."

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (2)

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, RN (registered nurse) #2, the assistant director of nursing, LPN #1, a unit manager, and ASM #4, the Clinical Services Coordinator, were made aware of the above findings.

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

F 658 SS=D — F 658 — 9/26/18

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,

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from two staff members with bed mobility and transfers; extensive assistance from one staff member with locomotion, dressing, toileting, personal hygiene, and bathing; and independent with meals.

Review of Resident #69's clinical record revealed that a cervical collar (used for the management of cervical spine injuries (1)) was placed status post cervical discectomy (Surgical operation of cervical spine (2)) while the resident was in the hospital. The following admission order was written on 7/9/18: " Cervical Collar x 6 weeks: May remove daily for skin check and hygiene."

Review of the July 2018 TAR revealed that facility staff were removing her collar two times a shift for skin checks.

Review of the August 2018 TAR revealed blanks (no signatures) from 8/1/18 until 8/14/18 (the day of residents discharge) indicating that skin checks were not performed.

Review of Resident #69's nursing notes dated 8/4/18, 8/7/18, 8/10/18, and 8/13/18 revealed that skin checks were performed and that no new skin areas were identified on the resident's neck and chin.

Review of Resident #69's weekly skin checks performed on 8/6/18 and 8/13/18 revealed no new skin areas identified on the Resident's neck and chin.

There was no evidence in the clinical record that Resident #69 developed a pressure ulcer to her chin.

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and completing skin note documentation, on ensuring pain medication orders match the physician order, and ensuring that residents with urinary assistive devices have catheter care orders as well as being on the careplan.

4. Monitoring of corrective action to ensure the alleged deficient practice does not recur.
Director of nursing will complete audits of 5 resident treatment administration records, careplans, and pain medication orders 3x week x4 weeks and 10 residents careplans monthly x2 months for careplan revisions.

Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions.

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On 8/10/18, the wound care nurse in part, documented the following note: "Resident has neck brace, no breakdown or redness noted.'

Review of Resident #69's skin integrity, care plan dated 7/9/18, documented the following intervention: "Remove cervical collar daily for skin checks and hygiene."

On 8/15/18 at 8:26 a.m., an interview was conducted with RN (registered nurse) #2, the ADON (assistant director of nursing). RN #2 was familiar with Resident #69. When asked about the care for a resident who has a cervical collar in place, RN #2 stated that the collar should be removed per physician's order to check the skin. RN #2 stated that the cervical collar was usually removed for hygiene. When asked if it should be documented anywhere that staff were removing the collar and checking the skin, RN #2 stated that it should be documented on the TAR. RN #2 confirmed that Resident #69's August 2018 TAR was blank. RN #2 stated nursing was checking Resident #69's skin daily and that they must have forgot to document. RN #2 stated that checking the skin for a resident with a cervical collar was also a professional standard and that her staff may have thought the order was an FYI (for your information) requiring no signature on the TAR. RN #2 confirmed again that it should have been documented on the TAR. RN #2 stated that Resident #69 did not develop a neck and/or chin wound while she was at the facility.

On 8/15/18 at 10:47 a.m., an interview was conducted with LPN (licensed practical nurse) #4, a nurse who frequently worked with Resident #69. LPN #4 confirmed that Resident #69 had a cervical collar. When asked the care provided to

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residents with a cervical collar, LPN #4 stated that the collar should be removed to do ADL (activities of daily living) care every morning. LPN #4 stated that she checked Resident #69's skin every day. LPN #4 stated that the skin was checked daily but was documented on her weekly skin sheets. When asked why the August 2018 TAR was blank for her daily skin checks, LPN #4 stated that she just didn't document on the TAR but that the skin checks may have been documented in her nursing notes. LPN #4 confirmed that she should have documented that daily skin checks were completed on the TAR. When asked why treatments completed were important to document, LPN #4 stated, "So we know that staff are doing it." LPN #4 stated that Resident #69 did not develop a wound to her neck or chin.

On 8/15/18 at 2:51 p.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). ASM #2 stated that nursing should be removing the cervical collar and checking skin per physician's order. ASM #2 confirmed that skin checks were not documented on the TAR for August. ASM #2 stated that if the skin checks were not in a nursing note then it should be documented on the TAR. When asked the importance of documenting that treatments were completed, ASM #2 stated, "To ensure that it is being done."

On 8/16/18 at 8:56 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and RN (registered nurse) #2 was made aware of the above concerns. ASM #2 stated that the facility followed their policies as a professional standard. A policy could not be provided regarding documentation.

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No further information was presented prior to exit.

The following quotation is found in Potter and Perry's Fundamentals of Nursing 6th edition (2005, p. 477): "Documentation is anything written or printed that is relied on as record or proof for authorized persons.
Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to the clients."

(1) This information was obtained from TheNational Insitutes of Health. https://www.ncbi.nlm.nih.gov/pubmed/12224182.

(2) This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3164061/.

2. The facility staff failed to clarify Resident #67's as needed physician's orders for pain medication.

Resident #67 was admitted to the facility on 12/9/15, with diagnoses that included but were not limited to: HIV (human immunodeficiency virus) disease (a disease that harms the immune system by destroying the white blood cells that fight infection, putting a patient at risk for serious infections and certain cancers), (1), high blood pressure, cirrhosis of the liver (a chronic condition which causes scar tissue to form in the liver,

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causing the liver to gets smaller and harder) (2), depression, schizoaffective disorder (a severe mental disorders that causes abnormal thinking and perceptions) (3), and diabetes with neuropathy (nerve pain) (4).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/10/18, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating she has no cognitive impairment for daily decision making. The resident was coded as requiring supervision of one staff member for bed mobility, transfers, dressing, eating, toileting, and personal hygiene. In Section N - Medications, the resident was coded as receiving opioids during the look back period.

The physician order dated, 6/21/18, documented, "Tramadol (an opioid used to treat moderate to moderately severe pain) (5) 50 mg (milligram): [Give] 0.5 tablet (25 mg) by mouth every 8 hours as needed for pain ...Acetaminophen (used to relieve mild to moderate pain) (6) 325 mg: [Give] 2 tablets by mouth every 8 hours as needed for pain." Neither order documented how to determine which pain medication to administer to the resident based on the resident's pain level.

The August 2018 MAR (medication administration record) documented the above physician orders. One 25 mg tablet of Tramadol was documented as having been administered on 8/1/18, 8/2/18, 8/7/18, 8/8/18, 8/10/18, 8/14/18, and 8/15/18. The time and pain level for each dosage recorded on the MAR could not be read and was illegible. The MAR failed to document that any as needed Tylenol was administered to Resident #67 during

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the same time period.

A review of the August 2018 nursing progress notes fails to document that any pain medication was administered to Resident #67.

The comprehensive care plan dated 12/17/18, with a most recent revision date of 2/8/18, documented in part, "Focus: At risk for pain." The "Interventions" documented in part, "Administered [sic] pain medication per physician orders."

An interview was conducted with LPN (licensed practical nurse) #9 on 8/16/18 at 11:23 a.m. When asked how it is determined which pain medication is given to a resident when the resident has multiple orders for as needed pain medications, LPN #9 stated, "We ask them the pain level or to number the pain they are having. LPN #9 was shown Resident #67's August 2018 MAR that documented both the as needed Acetaminophen order for pain relief, as well as the as needed order for Tramadol for pain relief. When asked how she determines which pain medication to give the resident, LPN #9 stated, "I ask them what pain medication they want and they tell me." When asked what she would do if the resident in pain was not cognitively intact, LPN #6 stated, "I would not be able to ask them." When asked who should make the determination of which pain medication should be given based on the resident's pain needs, LPN #9 stated, "The doctor. We need to ask the doctor to clarify which level of pain requires which pain medication."

An interview was conducted with LPN #1, unit manager, on 8/16/18 at 11:33 a.m. After

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reviewing the pain medication orders, LPN #1 stated, "These orders need clarification and parameters set by the doctor."

On 8/16/18 at 2:31 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the medical director, ASM #4, the clinical services coordinator, RN (registered nurse) #2, the assistant director of nursing, and LPN #1, the unit manager, were made aware of the above findings.

A review of the facility's policy, "Physician Orders: Obtaining and Transcribing" documented in part, "Medication orders should include the following information in the text of the order ...Parameters pertaining to administration."

A review of the facility's policy, "Pain-Clinical Protocol", documented in part, "2. The physician will order appropriate non-pharmalogic and medication interventions to address the individual's pain. 2.a. Pain medications should be selected based on pertinent treatment guidelines. Generally, and to the extent possible, an analgesic regiment should utilize the simplest regimen and lowest risk medications before using more problematic or higher risk approaches."

According to "Lippincott Manual Of Nursing Practice", Eighth Edition: by Lippincott Williams & Wilkins, pg. 87 read: "Nursing Alert: Unusual dosages or unfamiliar drugs should always be confirmed with the health care provider and pharmacist before administration." On pg. 15, the following is documented in part, "Inappropriate Orders: 2. Although you cannot automatically follow an order you think is unsafe, you cannot just ignore a medical order, either. b. .. Call the

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attending physician, discuss your concerns with him, obtain appropriate..orders. c. Notify all involved medical and nursing personnel.... d. Document clearly."

No further information was provided prior to exit.

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

2) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/patientinstructions/000290.htm

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

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

5) This information was obtained from the National Institutes of Health at https://medlineplus.gov/druginfo/meds/a695011.html

6) This information was obtained from the National Institutes of Health at https://medlineplus.gov/druginfo/meds/a681004.html

3. The facility staff failed to follow professional standards of practice to clarify /obtain orders for the use, care of a urinary catheter that was in

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place upon Resident #250's on 8/10/18.

Resident #250 was admitted to the facility on 8/10/18 for a respite care stay of approximately one week. The resident was admitted with the diagnoses of but not limited to chronic obstructive pulmonary disease, respiratory failure, atrial fibrillation, hepatitis C, C-spine disease status/post-cervical surgery failure, and high blood pressure. Due to the length of stay at the time of the survey, no MDS (Minimum Data Set) assessment had yet been completed. The nurse's evaluation note dated 8/10/18 at 3:36 p.m., documented that the resident was cognitively intact in ability to make daily life decisions; and that the resident was totally dependent on staff for activities of daily living.

On 8/14/18 at 12:29 p.m., and 2:15 p.m., and on 8/15/18 at approximately 8:15 a.m., observations were made of Resident #250. The resident was observed with a urinary catheter bag hanging on the side of the bed and the bag was noted to be pink-tinged inside. On 8/15/18 at 8:15 a.m., the resident stated he had had the catheter "for a while". On further interview, Resident #250 stated he had had it (catheter) before being admitted to the facility, when he was at home.

A review of the clinical record failed to reveal any physicians orders for the use and care of a urinary catheter.

A review of the nurse's evaluation note dated 8/10/18 at 3:36 p.m., documented, "No urinary catheter present."

Further review of the clinical record revealed hospice notes that were provided to the facility

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upon admission. There was a note dated 8/1/18, which documented, "Genitourinary...Patient requires a urinary catheter...." There was also a note dated 7/25/18, which documented, "....Genitourinary....External Catheter....Condom Cath...."

A review of the facility's certified nursing assistant (CNA) documentation record for the resident's bladder continence status revealed the facility's CNA's consistently coded the resident's bladder status as "Continence Not Rated due to Condom Catheter (1)."

Review of the resident's baseline care plan failed to reveal any documentation for the use and care of a urinary catheter.

On 8/16/18 at 8:46 a.m., in an interview with CNA #2, who cared for Resident #250, she stated that he had a condom catheter on and it had been in place the whole time he was in the facility.

On 8/16/18 at 8:31 a.m., in an interview with LPN #4 (Licensed Practical Nurse) who had written the above identified nurse's evaluation note at the time of admission, LPN #4 stated that, "He (Resident #250) had a condom cath (catheter) and it was used for transport." LPN #4 stated, "Hospice told me it was a condom cath for transport, that he didn't need a catheter and put it on him for transport." When LPN #4 was informed that staff had reported Resident #250 had the catheter the whole time he was in the facility, LPN #4 stated, "if he had it the whole time, there should have been orders for it and it should have been care planned." At this time, LPN #4 was shown the hospice notes dated 8/1/18 and 7/25/18, which documented Resident

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#250 had a catheter and that it was not just for transport. LPN #4 stated that is not what hospice told her on the phone prior to the resident's admission.

On 8/16/18 at 8:31 a.m., in an interview with LPN #3, the unit manager, she stated that the resident did not have a catheter. LPN #3 stated that if he came in with one, the staff should have called hospice or the doctor to clarify what to do with it. LPN #3 was notified of the above observations of Resident #250; and that the CNA staff stated the resident had the catheter the entire time he has been at the facility.

On 8/15/18 at 6:20 p.m., at the end of day meeting, the DON (Director of Nurses) (ASM #2 - Administrative Staff Member) stated she had reviewed the chart and the resident did not have a catheter because there were no orders, notes, or assessments about him having one. ASM #2 was notified at this time that two surveyors observed the catheter in place on multiple observations on two different days; and that the CNA staff stated the resident had the catheter the entire time he has been at the facility, while the nursing staff was unaware that the resident had a catheter at all.

On 8/16/18 at 9:20 a.m., in an interview with the ASM #2, the DON, she stated that, "the prior notes (hospice notes) were not reviewed. Obviously, he came in with one (a catheter). All forms of catheters should have assessments, notes, orders, and be care planned." ASM #2 stated that none of these items were present in the record.

On 8/16/18 at 10:11 a.m., in an interview with

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ASM #2, the DON, regarding the care of the catheter, ASM #2 stated there would be concerns for excoriation, skin concerns, leakage, placement, comfort, proper intake and output.

On 8/16/18 at 8:57 a.m., in an interview with ASM #3, the physician, he stated that there should have been orders for the use of the catheter and that it was unacceptable that there were not any.

On 8/15/18 at 2:51 p.m., ASM #2, the DON stated that the standard of practice the facility follows are the facility policies.

A review of the facility policy for "Catheter Care, Urinary" did not include any criteria for obtaining physician's orders for the use of a catheter, clarifying orders if a resident is admitted with a urinary catheter, care planning the use of the catheter, guidelines for the use of an external condom catheter and what concerns to observe for.

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

(1) Condom catheter an external urinary collection device that fits over the penis like a condom; used in the management of urinary incontinence. This information was obtained from the website: https://medical-dictionary.thefreedictionary.com/NIH+catheter

F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		9/26/18

§483.24(a)(2) A resident who is unable to carry

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out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide adl (activities of daily living) care for one of 35 residents in the survey sample, Resident #13.

The facility staff failed to remove facial hair from Resident #13's (a female resident) chin.

The findings include:

Resident #13 was admitted to the facility on 3/6/18. Resident #13's diagnoses included but were not limited to muscle weakness, high blood pressure and aftercare following joint replacement surgery. Resident #13's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/31/18, coded the resident's cognition as severely impaired. Section G coded Resident #13 as requiring extensive assistance of one staff with dressing, personal hygiene and bathing.

On 8/14/18 at 1:45 p.m., Resident #13 was observed in a wheelchair in the activities room. Multiple hairs (approximately 0.75 to 1 inch long) were observed on the resident's chin.

On 8/15/18 at 9:07 a.m., Resident #13 was observed sitting up in bed. Multiple hairs (approximately 0.75 to 1 inch long) were observed on the resident's chin.

F 677

1. Corrective Action for those residents found to be affected by the alleged deficient practice.
Resident #13s facial hair was immediately removed and refusal to shave added to residents careplan.

2. Corrective actions taken for residents with potential to be affected by alleged deficient practice.
Female residents admitting into the facility have the potential to be affected. Review completed by the director of nursing on female residents and shaved if necessary and if the resident is known to refuse grooming then the particular refusal was added to the careplan.

3. Systemic changes put into place to ensure the alleged deficient practice does not recur.
Education completed by the director of nursing to licensed nursing personnel on ensuring refusals of activities of daily living care and/or assistance of activities of daily living care is documented on the resident careplan and to certified nursing assistants on the grooming of residents, and completing refusal of grooming documentation.

4. Monitoring of corrective action to ensure the alleged deficient practice does not recur.

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Resident #13's comprehensive care plan initiated on 4/26/18 documented, "Resistive/noncompliant with treatment/care (refuses Adl care refuses showers, bed baths and weights at times)..." The care plan failed to document Resident #13 refused to have her chin hair removed. Review of nurses' notes for July and August 2018 failed to revealed documentation that Resident #13 refused to have her chin hair removed.

On 8/15/18 at 10:44 a.m., an interview was conducted with CNA (certified nursing assistant) #1 (a CNA who routinely cared for Resident #13). CNA #1 stated Resident #13 had not refused any care for her and she had not heard of the resident refusing care for other CNAs. CNA #1 was asked the facility process for ensuring female residents with facial hair are cared for. CNA #1 stated, "We have razors and shaving cream. We ask though do you mind if we do that." When asked if she had recently offered to shave Resident #13's face, CNA #1 stated, "No because she's always in a rush to BINGO. I don't think she would refuse me. It's just when she's set on doing something." When asked why she had not offered to shave Resident #13's face when assisting with routine ADL care, CNA #1 stated, "It probably just slipped my mind."

On 8/15/18 at 6:01 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

On 8/16/18 at 8:30 a.m., observation of Resident #13 revealed the resident's chin hairs were no longer present.

The facility document titled, "Shaving the

F 677

Director of nursing will complete audits of 5 female resident activities of daily living care to include facial grooming and careplans 3x week x4 weeks and 10 resident careplans monthly x2 months for careplan revisions.

Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions.

Date if Compliance:9/26/18

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F 677	Continued From page 93 Resident" documented, "The purpose of this procedure is to promote cleanliness and to provide skin care." The document noted the procedural steps for shaving a resident. No further information was presented prior to exit.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review it was determined, the facility staff failed to provide treatments and care in accordance with professional standard of practice and the comprehensive person-centered care plan for two of 35 residents in the survey sample, Resident #65 and Resident #61. 1. The facility staff failed to obtain Resident #65's daily weights as ordered by the physician. 2. The facility staff failed to follow the physician's orders for the notification of the physician, for blood sugars outside of the prescribed parameters, for Resident #61. The findings include:	F 684	1. Corrective Action for those residents found to be affected by the alleged deficient practice. Resident #65's daily weight was obtained and physician was notified of missing weights with new orders. Physician was notified of resident #61's recent blood sugar checks and noncompliance with diabetic diet with new orders obtained. 2. Corrective actions taken for residents with potential to be affected by alleged deficient practice. Residents admitting into the facility that have weight orders and/or blood sugar checks have the potential to be affected. Review completed by the director of	9/26/18

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1. Resident #65 was admitted to the facility on 5/18/18 and readmitted on 6/18/18 with diagnoses that included but were not limited to: fracture of the left ankle, difficulty walking, irregular heartbeat and heart failure.

The most recent MDS (minimum data set), a 30 day assessment, with an ARD (assessment reference date) of 7/17/18 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact. The resident was coded as requiring assistance from one to two staff for activities of daily living except for eating which the resident could perform independently.

Review of the care plan initiated on 5/18/18 and revised on 5/30/18 documented, "Focus. Cardiac disease. Intervention/Tasks. Obtain weights as indicated and report significant changes."

Review of the August 2018 physician's orders documented, "WEIGHT QD (everyday) & RECORD IN (name of computer software) > (greater than) 3 LBS (pounds)/DAY/SYMPTOMATIC CALL MD [medical doctor]. >5LB/WK [week]/ SYMPTOMATIC."

Review of the July 2018 treatment administration record documented, "WEIGHT QD (everyday) & RECORD IN (name of computer software) > (greater than) 3 LBS (pounds)/DAY/SYMPTOMATIC CALL MD. >5LB /WK /SYMPTOMATIC." There was no documentation noted.

Review of the August 2018 weight summary record documented a weight on 8/4, 8/11 and

F 684

nursing on residents with daily weight orders to ensure complete documentation and on residents with blood sugar checks to ensure parameter orders are being followed appropriately.

3. Systemic changes put into place to ensure the alleged deficient practice does not recur.
Education completed by the director of nursing to licensed nursing personnel on ensuring weights are obtained and documented in the resident record as well as the diabetic protocol to include notifying and documenting that the physician for blood sugar checks outside of specified parameters as ordered.

4. Monitoring of corrective action to ensure the alleged deficient practice does not recur.
Director of nursing will complete audits of residents on daily weights and blood sugar check logs 3x week x4 weeks and monthly x 2 for careplan revisions.

Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions.

Date if Compliance: 9/26/18

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8/13/18.

Review of the August 2018 nurses' notes did not evidence documentation regarding the weights.

An interview was conducted on 8/15/18 at 3:42 p.m. with LPN (licensed practical nurse) #4, the resident's nurse. When asked who obtained the resident's weights, LPN #4 stated, "The CNAs (certified nursing assistants)." When asked how weights were documented, LPN #4 stated, "The CNAs can and the nurses can do it as well." When asked why Resident #65 was on daily weights, LPN #4 stated, "If I'm not mistaken he's on Lasix (1) and Spironolactone (2), they have to monitor his weight to make sure he's not gaining too much." LPN #4 was asked to review the physician's order and the weight summary form. LPN #4 stated, "We're not following the physician's orders."

An interview was conducted on 8/16/18 at 7:33 a.m. with LPN #7, the resident's nurse. When asked who obtained the resident's weights, LPN #7 stated, "Generally the aide but we need to review them." When asked who documented Resident #65's weights, LPN #7 stated, "He gets his weight done on day shift."

On 8/15/18 at 5:55 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled, "Weight Assessment and Intervention" did not address documenting weights.

No further information was provided prior to exit.

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1. Lasix -- LASIX® (furosemide) is a potent diuretic which, if given in excessive amounts, can lead to a profound diuresis with water and electrolyte depletion. Therefore, careful medical supervision is required and dose and dose schedule must be adjusted to the individual patient's needs. This information was obtained from:
https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=eadfe464-720b-4dcd-a0d8-45dba706bd33

2. Spironolactone -- Spironolactone is an aldosterone receptor antagonist and potassium-sparing diuretic widely used in the therapy of edema, particularly in patients with cirrhosis in which hyperaldosteronism appears to play a major role. Spironolactone has been linked to rare cases of clinically apparent drug induced liver disease. This information was obtained from:
https://livertox.nlm.nih.gov/Spironolactone.htm
2. The facility staff failed to follow physician's orders for physician notification of Resident #61's blood sugars outside of the prescribed parameters.

Resident #61 was admitted to the facility on 6/27/18 with a readmission on 7/23/18 with diagnoses that included but were not limited to: fracture of the arm, infection in the joint, heart failure, diabetes, depression, high blood pressure 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).

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The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 8/5/18, coded the resident as scoring a 12 on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make daily cognitive decisions. The resident was coded as requiring minimum to extensive assistance for all of her activities of daily living.

The physician order dated, 6/27/18, documented, "Blood sugars AC (before meals) and at HS (at bedtime). Notify MD (medical doctor) for FSBS (finger stick blood sugar) less than 60 or greater than 350."

The blood sugar readings on 7/20/18 at 9:00 p.m. documented, "HI."

The physician order dated, 7/23/18, documented, "Blood sugars AC and at HS. Notify MD for FSBS less than 60 or greater than 350."

Resident #61's blood glucose monitoring sheet for August 2018 documented the resident's blood sugar readings on the following days as follows:
8/1/18 at 11:30 a.m. - 358
8/2/18 at 4:30 p.m. - 520
8/3/18 at 9:00 p.m. - 353
8/5/18 at 4:30 p.m. - 574
8/5/18 at 9:00 p.m. - 462
8/8/18 at 9:00 p.m. - 540
8/10/18 at 4:30 p.m. - 360
8/10/18 at 9:00 p.m. - 378
8/11/18 at 6:30 a.m. - 360
8/14/18 at 11:30 a.m. - 415
8/14/18 at 9:00 p.m. - 440

Review of the MARs (medication administration

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records), and nurse's note failed to evidence documentation the physician was notified of the above blood sugar reading per the physician orders.

The comprehensive care plan dated, 6/28/18, documented in part, "Focus: Endocrine system related to diabetes." The "Interventions" documented in part, "Administer medications per physician orders. Report symptoms of hyperglycemia; excessive thirst/urination, hunger, weakness, nausea and vomiting or acetone breath. Report symptoms of hypoglycemia; weakness, pallor, diaphoresis, vision changes, changing consciousness."

An interview was conducted with LPN (licensed practical nurse) #6 on 8/15/18 at 12:59 p.m. LPN #6 was asked what it means when the blood sugar machine reads "HI". LPN #6 stated, "I believe it means the blood sugar is over 600." The physician ordered parameters for notifying the physician were reviewed with LPN #6. When asked, what is expected of the nurse, if the resident's blood sugar is greater than 350, LPN #6 stated, "If it's greater than 350 you have to call the doctor and let him know. Then you follow his orders and write a SBAR (situation, background, assessment recommendation) note and notify the RP (responsible party)." When asked if the SBAR was the nurse's documentation, LPN #6 stated, "Yes, every time the blood sugar goes over 350 you are supposed to call the doctor." When asked how staff can tell if the doctor was called if there are no SBAR or nurse's notes, LPN #6 stated, "You don't." LPN #6 further stated, "The resident is non-compliant, she had regular Pepsi in there now." When asked if her non-compliance should be care planned and documented, LPN #6 stated,

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"Yes, absolutely."

An interview was conducted with administrative staff member (ASM) #3, the medical director, on 8/15/18 at 1:13 p.m. When asked why he or the other physicians order parameters to be notified for blood sugars, ASM #3 stated, "So we are reminded to make adjustments to their medications."

An interview was conducted with LPN #3, the unit manager, on 8/15/18 at 1:16 p.m. When asked what is expected of staff if a resident has parameters ordered for blood sugar readings, and a blood sugar reading is outside of the parameters, LPN #3 stated, "Normally the parameters are to notify for less than 60 and greater than 350. If the blood sugar is outside of those parameters the nurse is to contact the physician, write an SBAR, and follow the physician orders." When asked if there is no SBAR or nurse's note how do you know if staff called the doctor, LPN #6 stated, "We don't." LPN #6 was asked to review the blood sugars for Resident #61. When asked if staff not notifying the physician, is not following the physician's orders, LPN #6 stated, "Yes, they should follow the orders."

The facility policy, "Physician's Orders: Obtaining and Transcribing" documented in part, "Directives known as 'Physician's Orders' will be obtained to manage the medical condition and plan of care for each resident. Purpose: The purpose of this policy is to: ensure the medical condition and plan of care of the resident(s) is managed effectively under the guidance and direction of a licensed physician."

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F 684	Continued From page 100 In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients." Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, RN (registered nurse) #2, the assistant director of nursing, LPN #1, a unit manager, and ASM #4, the Clinical Services Coordinator, were made aware of the above findings. 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 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 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	F 686		8/29/18

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by:
Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide treatment and services to prevent the development of pressure ulcers for one of 35 residents in the survey sample, Resident #65.

Past noncompliance: no plan of correction required.

Resident #65 returned from an orthopedic office visit on 6/27/18 with a left CAM boot (1). The facility staff failed to clarify the physician's orders for care of the boot and failed to assess and monitor the skin of Resident #65's left lower leg; as a result, the resident developed a stage four pressure ulcer (2) to the left medial (inner) ankle and an unstageable (3) pressure ulcer to the left lateral (outer) ankle.

CAM boot: A CAM Walker is a walking boot that limits the movement of the ankle and or foot. (1)

Stage 4 Pressure Injury: Full-thickness skin and tissue loss
Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. (2)

Unstageable/Unclassified pressure ulcer: Full thickness skin or tissue loss - depth unknown: Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until

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enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV. Eschar is dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound. (3)

The findings include:

Resident #65 was admitted to the facility on 5/18/18 and readmitted on 6/18/18 with diagnoses that included but were not limited to: fracture of the left ankle, difficulty walking, irregular heartbeat and heart failure.

The most recent MDS (minimum data set), a 30 day assessment, with an ARD (assessment reference date) of 7/17/18 coded the resident as having a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact. The resident was coded as requiring assistance from one to two staff for activities of daily living except for eating which the resident could perform independently. Section M -- Skin Conditions documented that the resident was at risk for developing pressure ulcers. The resident was coded as having an in-facility acquired stage four pressure ulcer and an unstageable pressure ulcer. Section M1200 "Skin and Ulcer Treatments" coded a check mark beside "Pressure reducing device for chair. Pressure reducing device for bed. Pressure ulcer care. Application of nonsurgical dressing (with or without topical medications) other than to feet."

Review of the care plan initiated on 5/30/18

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documented, "Focus. At risk for alteration in skin integrity related to...splint/cast...Interventions/Tasks. Monitor LLE (left lower extremity) as ordered. Observe skin condition with ADL (activities of daily living) care daily; report abnormalities."

Review of the 5/18/18 Braden scale for predicting pressure sore risk scored the resident at 21 indicating the resident was at mild risk for pressure sore development.

The orthopedic office visit note dated 6/27/18 documented, "CAM Boot - Patient can pivot on until 7/11/18 and then can bear 50% WB (weight bearing) with crutches and boot." The instructions failed to document any information regarding removal of the boot for skin assessments.

Review of the July and August 2018 physician orders documented, "MONITOR CSM (circulation, sensation and movement) TO LT (left) FOOT."

The July and August 2018 treatment administration record documented, "MONITOR CSM TO LT FOOT." There was no documentation that the checks had been completed.

Review of the July 2018 treatment administration record documented that the nurses had completed a weekly skin check. There was no documentation that any skin issues were identified.

Review of the nurses' notes from 6/27/18 to 7/13/18 documented:
6/29/18 at 6:49 p.m. "Resident skin assessed by

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wound care nurse. Redness to sacrum, intact....Case (sic- cast) intact to lower leg. CMS present." There was no documentation that the staff assessed the resident's skin on the left lower leg.

7/6/18 at 2:08 p.m., "Resident skin assessed by wound care nurse...Case intact to lower leg. CSM present." There was no documentation that the staff assessed the resident's skin on the left lower leg.

The non-pressure skin condition record dated 7/2/18 and 7/9/18 documented, "Unable to assessed (sic) Resident refuse (sic) to remove boot." (Note: this document is not kept in the resident's record until wound has healed.)

Review of the nurse's notes on 7/2/ and 7/9/18 did not evidence documentation regarding the resident refusing to have the boot removed and what education was provided to the resident.

A nurse practitioner's note dated 6/29/18 at 10:06 a.m. documented, "CC (chief complaint): Displaced left bimalleolar (4) fracture, S/P (status post) ORIF (open reduction and internal fixation)...HPI (history of present illness) He is weight bearing on his left leg, walking boot in place."

A nurse's note dated 7/14/18 at 3:02 p.m. documented, "SITUATION: Change in condition noted related to wounds to left lower. This change in condition started on 07/14/2018. SKIN: Noted to have the following skin conditions present, round shaped, reddened periwound open areas, with a small amt (amount) of serous drainage to the left inner and outer ankle. Resident (Sic.) has

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been in a cast/hard boot since admission and would not allow his walking boot be removed until 7/14/18. Stating that it was an ortho (orthopedic) MD [medical doctor] order to leave on and not remove."

A wound care physician's note dated 7/16/18 documented, "Focused Wound Exam (Site 1). STAGE 4 PRESSURE WOUND OF THE LEFT, MEDIAL ANKLE. Wound Size (L [length] x W (width) x D (depth)] 1.4 x 2.1 x 0.1 cm (centimeters). Patient is an ortho [orthopedic] patient s/p ORIF [open reduction internal fixation] with a hard cast that was in place until 6/27. When this was DCed (discontinued), a non-removable boot was put in place. Per patient he was told that the boot was to be in place 24/7. He did not allow it to be removed until 7/13. Focused Wound Exam (Site 2) UNSTAGEABLE (DUE TO NECROSIS) OF THE LEFT, LATERAL ANKLE. Wound Size (L x W x D) 2.7 x 1.8 x No Measurable cm."

A nurse practitioner's note dated 7/16/18 at 11:00 p.m. documented, "Wound care to left ankle per wound care team."

An interview was conducted on 8/15/18 at 3:05 p.m. and 8/16/18 at 2:25 p.m. with Resident #65. When asked what happened to his leg, Resident #65 stated, "I complained to my sister because it was hurting and she opened it up. (Name of orthopedic doctor) wrote the instructions. He didn't mention how long to wear it. He told me he was putting a boot on me. The person in the prosthetic room told me I had to wear it 24/7. They wanted to take the boot off the first night and I told what they said at the VA (veteran's administration) hospital. I know now that wasn't

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right. They told me today the skin's growing some so the hardware (surgical instruments inserted to set the fracture) is covered." When asked if he had received any information from the staff regarding the boot the resident stated, "None." When asked how often staff had attempted to remove the boot, Resident #65 stated, "Two times and I refused." When asked what the staff said when he refused, Resident #65 stated, "Nothing."

An interview was conducted on 8/15/18 at 3:36 p.m. with LPN (licensed practical nurse) #4, the resident's nurse. When asked how staff knew how to care for a resident with a CAM boot, LPN #4 stated, "Usually ortho [orthopedic] sends us orders." When asked what staff did if there were no orders, LPN #4 stated they would call to get an order. When asked how staff cared for a resident with a boot, LPN #4 stated, "We check that the toes aren't discolored and circulation to the toes." When asked about Resident #65's boot care, LPN #4 stated, "I do remember he was supposed to have the boot on. You have to take that boot off q (every) shift to check that's there's no breakdown, you definitely have to do that. (Name of Resident #65) liked to sleep in that boot at night he was comfortable in that boot but yes that boot should have been taken off so that skin was checked." When asked if the boot had been removed, LPN #4 stated that the CNAs (certified nursing assistants) removed the boot when they did the resident's bath and they would check the skin. LPN #4 stated the CNAs would let the nurse know if there was any skin problem.

An interview was conducted on 8/15/18 at 4:06 p.m. with LPN #2, the resident's nurse. When asked how a resident's skin was assessed when

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they were wearing a CAM boot, LPN #2 stated, "First I check the toes to make sure it's not too tight. Check at the top (of the boot) for any pain or swelling. You have to have some hygiene to it, it just can't stay on." When asked how often the skin would be checked, LPN #2 stated, "It should be at least every shift, it can take a few minutes for skin breakdown to occur." When asked if she had completed a skin assessment on Resident #65's left lower leg, LPN #2 stated, "By the time I get to him he's in bed I don't know if he had a boot on. He wasn't complaining about anything so I didn't want to bother him. If I have someone who complains then I do more." When asked why she did not assess the resident's left lower leg skin, LPN #2 stated, "It never ran across my mind."

An interview was conducted on 8/15/18 at 4:18 p.m. with CNA #8. When asked how staff knew what to do for a resident, CNA #8 stated, "Before we leave off the unit to go home we are supposed to give report to the aide, or we get it from the nurse or we can get it from the kiosk (computer)." When asked what staff did if a resident had a boot on their leg, CNA #8 stated, "I would ask to be sure if we are allowed to take them off or not." When asked about Resident #65's boot, CNA #8 stated she wasn't that familiar with the resident.

An interview was conducted on 8/15/18 at 4:22 p.m. with RN (registered nurse) #1, the wound care nurse. When asked what her role was, RN #1 stated, "My main role is pressure areas and I assess the resident when they come into the facility. I'm the second check, I round with the wound doctor. I monitor wounds, I track them." When asked how skin was assessed when a resident had a CAM boot, RN #1 stated she didn't know, as she had not worked with a resident with

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a boot. When asked about Resident #65's skin assessment, RN #1 stated, "The resident refused to remove the boot. He told me the doctor told him not to take the boot off." When asked what she said to the resident when he refused the skin checks, RN #1 stated, "I said it's his right to refuse skin checks." When asked if that was documented, RN #1 stated it was. When asked if she had checked the resident's order for the boot, RN #1 didn't have an answer. A request was made for the documentation regarding the resident's refusal of care. No documentation was received.

An interview was conducted on 8/15/18 at 4:40 p.m. with RN #2, the assistant director of nursing. When asked the process when a resident came back from a doctor's appointment, RN #2 stated, "They usually come with orders." When asked what staff did if there were no orders, RN #2 stated, "I would prefer that they would follow up but there are a lot of times that there are no new orders." When asked if staff should have followed up with the orthopedic clinic after the resident's visit on 6/27/18, RN #2 stated, "Absolutely. They should have called and gotten orders from the doctor who applied it. They should have definitely been doing their checks and removing it and making sure he was doing well." When asked what staff did if a resident refused care, RN #2 stated, "I would either try to continue to evaluate it or get the physician to come in and get their feedback." When asked if that would be documented, RN #2 stated yes. When asked when was she made aware that the resident was refusing to have the boot removed, RN #2 stated, "The day the wound was found."

An interview was conducted on 8/15/18 at 4:52

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p.m. with ASM (administrative staff member) #3, the medical director. When asked when he was made aware of the resident's pressure ulcer, ASM #3 stated, "The day it was found." When asked what was the usual care for a resident in a CAM boot, ASM #3 stated it would be up to the orthopedic doctor. ASM #3 stated the resident was refusing to have the boot off. When asked if staff had asked him to talk to the resident about refusing to have the boot removed, ASM #3 stated they had not.

An interview was conducted on 8/15/18 at 5:17 p.m. with OSM (other staff member) #7, the director of rehabilitation. When asked what care was provided to a resident with a CAM boot, OSM #7 stated, "It depends on what ortho says." When asked to review the 6/27/18 orthopedic order, OSM #7 stated, "We would ask for clarification in that scenario."

An interview was conducted on 8/16/18 at 7:35 a.m. with LPN #8, the resident's nurse. When asked how the staff cared for a resident who had a CAM boot, LPN #8 stated, "We do skin care making sure you use soap and water." When asked if the boot would be opened, LPN #8 stated, "Yes." When asked if she had done that for Resident #65, LPN #8 stated, "I can't remember I do remember checking for circulation." When asked if she recalled if the resident refused care, LPN #8 could not remember. When asked what staff did if a resident returned from a doctor's appointment with a new boot and no orders, LPN #8 stated, "You'd have to follow up (with the physician)."

An interview was conducted on 8/16/18 at 8:40 a.m. with CNA #9. When asked what staff did if a

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resident had a boot on their leg, CNA #9 stated, "I would take the boot off, so you can wash the feet and check the skin, see if there are any new bruises or scratches." When asked if she had worked with Resident #65, CNA #9 stated she had. When asked if she had removed the resident's boot, CNA #9 stated, "I can't remember."

A telephone interview was conducted on 8/16/18 at 9:24 a.m. with RN #5, the orthopedic nurse practitioner. When asked what the usual care for a resident in a CAM boot was, RN #5 stated, "We definitely want it to be taken off for hygiene and definitely to do skin checks." When asked if an order would be sent with the resident, RN #5 stated, "It's basic care. We don't usually send an order. The whole point of a CAM boot is so skin checks can be done. That's why we didn't put him in a cast." When told that the resident stated the prosthetic staff member told him to wear the cast 24/7, RN #5 stated, "Our staff wouldn't say that. Our internal order sent to the prosthetic staff was for the boot to be on 24/7 except for bathing and skin checks."

The prosthetic staff were not available for interview.

An interview was conducted on 8/16/18 at 9:30 a.m. with LPN #3, the assistant unit manager. When asked what staff were to do if a resident returned from a physician visit without orders, LPN #3 stated, "Contact the doctor. We give then a consult sheet, they usually write their orders on it." When asked what the standard care for a resident with a CAM boot was, LPN #3 stated, "Remove it every shift. Do skin checks and hygiene."

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An interview was conducted on 8/16/18 at 9:52 a.m. with ASM #2, the director of nursing. When asked what staff should do if a resident came back from a doctor's visit without orders, ASM #2 stated, "My expectation is that the nurse is going to call and verify the treatment plan. When he came back he told us it was not to be removed but they should have done skin checks." When asked what staff should do if a resident refused skin assessments, ASM #2 stated, "We would notify the RP (responsible party) and the MD would be made aware." When asked if this would be documented, ASM #2 stated, "Yes it should be." When asked what occurred when they found the pressure ulcers, ASM #2 stated, "There were a lot of concerns. I asked when did the cast come off. We spoke to the nurses and they said they didn't have an order and I told them they should have done something." When asked what education the resident received regarding the risks of not having skin checks done, ASM #2 did not know. When asked what a skin assessment included, ASM #2 stated it was a head to toe assessment and that they documented by exception (meaning staff would only document if there was something abnormal found on the skin assessment)." When asked if the staff should have documented the resident's refusal to have the boot off, ASM #2 stated yes.

On 8/1618 at 10:15 a.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the concern of harm based on the staff failing to clarify the order for the CAM boot. That there was no evidence that the resident had been educated on the risks of not allowing the boot to be removed and that the nursing staff failed to attempt skin assessments

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on the resident's left lower leg even though they were able to articulate what should be done. ASM #1 and ASM #2 were encouraged to provide evidence that the facility had attempted to prevent the pressure ulcers. ASM #2 stated, "I'll get the shower sheets."

An interview was conducted on 8/16/18 at 10:40 a.m. with CNA #6, the resident's aide. When asked what staff looked for during resident care, CNA #6 stated, "During the bath we look for bruises, skin tears, redness and breakdown. When asked what staff did if they discovered a skin issue, CNA #6 stated, "Report it to the nurse." When asked what she did if a resident had a boot on their leg, CNA #6 stated, "We take it off and wash." When asked if she had checked the resident's skin under the boot, CNA #6, I gave him a shower probably two days before that (the discovery of the pressure ulcers)." When asked if that would be documented, CNA #6 stated, "Yes we have to put it in the kiosk." A review of the resident's activities report failed to evidence that the resident had a shower on or around 7/10/18. There was documentation that the resident refused a shower on 7/6/18. CNA #6 then stated, "When I get here he's always dressed and up and never thought to check the skin."

On 8/16/18 at 10:40 a.m., a request was made to ASM #1 for a copy of the facility's policy on splint care.

On 8/16/18 at 12:01 p.m., ASM #2 returned with the shower sheets. ASM #2 stated, "He refused them." Review of the shower sheets from 6/27/18 through 7/14/18 documented that the resident refused the shower on 6/27, 6/30, 7/7, 7/8, 7/11 and 7/14. On 7/3 and 7/4 "Not Applicable" was

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documented. ASM #2 stated, "I do have a PIP (performance improvement plan) in place. I recognized I had a problem with skin care and we started a PIP in June and then when this happened we restarted it."

The performance improvement plan documented:
"1) Cited residents -- (name of two residents);
2) Like residents- All resident have the potential to be affected;
3) Education to employees on the wound program to include skin assessments, skin documentation, turning and repositioning, and pressure relieving interventions:
4) Audits will be completed weekly x 4 then monthly x 1;
5) AD HOC QAPI (quality assurance and performance improvement);
6) Follow up and findings put through QAPI;
7) Compliance date: 8-6-18."

Employee Education Attendance Record included in the PIP documented that 13 staff received education on skin assessments and clarifying orders on 8/6/18.

On 8/16/18 at 2:00 p.m. RN #2, the assistant director of nursing stated they did not have a policy on splint care.

On 8/16/18 at 2:25 p.m. Resident "#65's wounds were observed. The left outer ankle wound was 2.5 by 1.7 cm and was covered with a a yellowish exudate. The left inner ankle wound was 1.1 by 0.2 by 0.1 cm and was clean and pink.

Review of the manufacturer's information documented, "Wearing Schedule: CAM Walker Boot should be worn according to physician's

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specified schedule. Make sure to check your skin every 2 to 3 hours a day."

Review of the facility's policy titled, "Prevention of Pressure Ulcers/Injuries" documented, "Purpose. The purpose of this procedure is to provide information regarding identification of pressure ulcer/injury risk factors and intervention for specific risk factors. Risk Assessment. 4. Inspect the skin on a daily basis when performing or assisting with personal care or ADLs. b. Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows...)."

Review of the facility's policy titled, "Physician Orders: Obtaining and Transmitting" documented, "Policy: Directives known as "Physician Orders" will be obtained to manage the medical condition and plan of care for each resident. Purpose: The purpose of this policy is to: ensure the medical condition and plan of care of the resident(s) is managed effectively under the guidance and direction of a licensed physician. Ensuring Safety/Reducing Risk: Process: 1. Contact physician to request or verify an order. 4. Clarify order if necessary and write/read back again if needed."

No further information was provided prior to exit.

1. CAM boot: A CAM Walker is a walking boot that limits the movement of the ankle and or foot. This information was obtained from: www.powelloandp.com

2. Stage 4 Pressure Injury: Full-thickness skin and tissue loss
Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon,

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GLENBURNIE REHAB & NURSING CENTER	1901 LIBBIE AVE RICHMOND, VA 23226

(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 686	Continued From page 115 ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. This information was obtained from: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ 3. Unstageable/Unclassified pressure ulcer: Full thickness skin or tissue loss - depth unknown: Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV. Eschar is dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound. This information was obtained from: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ 4. Bimalleolar fracture -- a fracture of the distal tibia and fibula in which the medial malleolus of the distal tibia and the lateral malleolus of the distal fibula are fractured. This information was obtained from: https://medical-dictionary.thefreedictionary.com/bimalleolar+fracture	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		9/26/18

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F 690	Continued From page 116 §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 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, resident interview, clinical record review, and facility	F 690	1. Corrective Action for those residents found to be affected by the alleged	

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F 690 Continued From page 117

document review, it was determined that the facility staff failed to ensure care and services were in place for the care needs of a urinary catheter that was in place upon admission for one of 35 residents in the survey sample; Resident #250.

The facility staff failed to ensure a physician order and orders for the care of Resident #250's urinary catheter, which was present upon the resident's admission to the facility on 8/10/18.

The findings include:

Resident #250 was admitted to the facility on 8/10/18 for a respite care stay of approximately one week. The resident was admitted with the diagnoses of but not limited to chronic obstructive pulmonary disease, respiratory failure, atrial fibrillation, hepatitis C, C-spine disease status/post-cervical surgery failure, and high blood pressure. Due to the length of stay at the time of the survey, no MDS (Minimum Data Set) assessment had yet been completed. The nurse's evaluation note dated 8/10/18 at 3:36 p.m., documented that the resident was cognitively intact in ability to make daily life decisions; and that the resident was totally dependent on staff for activities of daily living.

On 8/14/18 at 12:29 p.m., and 2:15 p.m., and on 8/15/18 at approximately 8:15 a.m., observations were made of Resident #250. The resident was observed with a urinary catheter bag hanging on the side of the bed and the bag was noted to be pink-tinged inside. On 8/15/18 at 8:15 a.m., the resident stated he had had the catheter "for a while". On further interview, Resident #250 stated he had had it (catheter) before being

F 690

deficient practice.
Resident #250 has since been discharged from the facility.

2. Corrective actions taken for residents with potential to be affected by alleged deficient practice.
Residents admitting into the facility with urinary assistive devices have the potential to be affected. Review completed by director of nursing on residents with urinary devices to ensure physician orders and catheter care orders are present in resident medical record.

3. Systemic changes put into place to ensure the alleged deficient practice does not recur.
Education completed by the director of nursing to licensed nursing personnel on ensuring that residents wit urinary devices have urinary catheter orders including catheter care orders and that the urinary catheter is on the careplan.

4. Monitoring of corrective action to ensure the alleged deficient practice does not recur.
Director of nursing will complete audits of residents with urinary catheter devices 3x week x 4 weeks and monthly x2 for careplan revisions.

Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions.

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F 690	Continued From page 118 admitted to the facility, when he was at home. A review of the clinical record failed to reveal any physicians orders for the use and care of a urinary catheter. A review of the nurse's evaluation note dated 8/10/18 at 3:36 p.m., documented, "No urinary catheter present." Further review of the clinical record revealed hospice notes that were provided to the facility upon admission. There was a note dated 8/1/18, which documented, "Genitourinary...Patient requires a urinary catheter...." There was also a note dated 7/25/18, which documented, "....Genitourinary....External Catheter....Condom Cath...." A review of the facility's certified nursing assistant (CNA) documentation record for the resident's bladder continence status revealed the facility's CNA's consistently coded the resident's bladder status as "Continence Not Rated due to Condom Catheter (1)." Review of the resident's baseline care plan failed to reveal any documentation for the use and care of a urinary catheter. On 8/16/18 at 8:46 a.m., in an interview with CNA #2, who cared for Resident #250, she stated that he (Resident #250) had a condom catheter on and it had been in place the whole time he was in the facility. On 8/16/18 at 8:31 a.m., in an interview with LPN #4 (Licensed Practical Nurse) who had written the above identified nurse's evaluation note at the	F 690	Date if Compliance: 9/26/18	

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F 690	Continued From page 119	F 690		

time of admission, LPN #4 stated that, "He (Resident #250) had a condom cath (catheter) and it was used for transport." LPN #4 stated, "Hospice told me it was a condom cath for transport, that he didn't need a catheter and put it on him for transport." When LPN #4 was informed that staff had reported Resident #250 had the catheter the whole time he was in the facility, LPN #4 stated, "if he had it the whole time, there should have been orders for it and it should have been care planned." At this time, LPN #4 was shown the hospice notes dated 8/1/18 and 7/25/18, which documented Resident #250 had a catheter and that it was not just for transport. LPN #4 stated that is not what hospice told her on the phone prior to the resident's admission.

On 8/16/18 at 8:31 a.m., in an interview with LPN #3, the unit manager, she stated that the resident did not have a catheter. LPN #3 stated that if he came in with one, the staff should have called hospice or the doctor to clarify what to do with it. LPN #3 was notified of the above observations of Resident #250; and that the CNA staff stated the resident had the catheter the entire time he has been at the facility.

On 8/15/18 at 6:20 p.m., at the end of day meeting, the DON (Director of Nurses) (ASM #2 - Administrative Staff Member) stated she had reviewed the chart and the resident did not have a catheter because there were no orders, notes, or assessments about him having one. ASM #2 was notified at this time that two surveyors observed the catheter in place on multiple observations on two different days; and that the CNA staff stated the resident had the catheter the entire time he has been at the facility, while the

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nursing staff was unaware that the resident had a catheter at all.

On 8/16/18 at 9:20 a.m., in an interview with the ASM #2, the DON, she stated that, "the prior notes (hospice notes) were not reviewed. Obviously, he came in with one (a catheter). All forms of catheters should have assessments, notes, orders, and be care planned." ASM #2 stated that none of these items were present in the record.

On 8/16/18 at 10:11 a.m., in an interview with ASM #2, the DON, regarding the care of the catheter, ASM #2 stated there would be concerns for excoriation, skin concerns, leakage, placement, comfort, proper intake and output.

On 8/16/18 at 8:57 a.m., in an interview with ASM #3, the physician, he stated that there should have been orders for the use of the catheter and that it was unacceptable that there were not any.

A review of the facility policy for "Catheter Care, Urinary" did not include any criteria for obtaining physician's orders for the use of a catheter, clarifying orders if a resident is admitted with a urinary catheter, care planning the use of the catheter, guidelines for the use of an external condom catheter and what concerns to observe for.

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

(1) Condom catheter an external urinary collection device that fits over the penis like a condom; used in the management of urinary incontinence. This information was obtained from

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F 690	Continued From page 121 the website: https://medical-dictionary.thefreedictionary.com/NIH+catheter	F 690		
F 695 SS=D	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 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, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide care and services for oxygen therapy for one of 35 residents in the survey sample, Resident #35. The facility staff failed to store a nebulizer mask in a sanitary manner for Resident #35. The findings include: Resident #35 was admitted to the facility on 12/1/17, with a most recent readmission date of 4/11/28, with diagnoses that included but were not limited to: Wernicke's encephalopathy (brain damage caused by a lack of vitamin B1 (thiamine) deficiency) (1), chronic retention of urine (the inability to empty the bladder completely) (2), difficulty swallowing, high blood pressure, cerebral infarction (stroke) (3), and	F 695	1. Corrective Action for those residents found to be affected by the alleged deficient practice. Residents #35's nebulizer mask was immediately placed into a storage bag. 2. Corrective actions taken for residents with potential to be affected by alleged deficient practice. Residents admitting into the facility who utilize a nebulizer face mask have the potential to be affected. Review completed by the director of nursing on residents who utilize nebulizer face mask to ensure that mask are stored in storage bags. 3. Systemic changes put into place to ensure the alleged deficient practice does not recur. Education completed by the director of	9/26/18

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chronic obstructive pulmonary disease (COPD is a common lung disease. Having COPD makes it hard to breathe) (4).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/15/18, coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score, indicating she has moderate cognitive impairment for daily decision making. The resident was coded as requiring extensive assistance of at least one staff member for bed mobility, transfers, dressing, and toileting. The resident was coded as requiring total assistance of at least one staff member for eating, bathing, and personal hygiene.

An observation was made on 8/15/18 at 8:40 a.m. of Resident #35's nebulizer (a small machine that turns liquid medicine into a mist that is breathed in through a connected mask) (5) mask un-bagged and sitting in the bedside table drawer. Resident #35 stated that the nurse put it in the drawer after her treatment. There was no storage bag for the mask observed in the drawer with the mask.

An observation was made on 8/15/18 at 11:42 a.m. of Resident #35's nebulizer mask un-bagged and sitting in the bedside table drawer.

On 08/15/18 at 4:25 p.m., LPN (licensed practical nurse) #1 was asked to observe Resident #35's nebulizer mask. LPN #1 confirmed that the mask was in a closed bedside drawer un-bagged. Upon this observation, LPN #1 stated "This [the nebulizer mask] should be in a storage bag." At that time, LPN #1 began looking through all of the

F 695

nursing to licensed nursing personnel to ensure that nebulizer mask are stored after completion of the nebulizer treatment.

4. Monitoring of corrective action to ensure the alleged deficient practice does not recur.
Director of nursing will complete audits of residents with nebulizer orders to ensure mask are stored 3x week x4 weeks and monthly x2.

Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions.

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bedside table drawers looking for the storage bag. After checking all of the drawers, LPN #1 located an empty storage bag in the drawer above the one with the un-bagged nebulizer mask. LPN #1 stated she would change the un-bagged mask immediately and would place the new mask in a new storage bag. When asked why the mask should be placed in a storage bag when not in use, she stated, "to keep the mask clean and decrease the potential risk for infection."

On 8/16/18 at 2:31 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the medical director, ASM #4, the clinical services coordinator, RN (registered nurse) #2, the assistant director of nursing, and LPN #1, the unit manager, were made aware of the above findings.

Review of the facility's policy titled, "Administering Medications through a Small Volume (Handheld) Nebulizer" documented in part, "The purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway ...29. When equipment [mask] is completely dry, store in a plastic bag with the resident's name and the date on it."

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

No further information was provided prior to exit.

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F 695	Continued From page 124 1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/000771.htm 2) This information was obtained from the National Institutes of Health at https://www.niddk.nih.gov/health-information/urologic-diseases/urinary-retention 3) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ischemicstroke.html 4) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/000091.htm 5) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/patientinstructions/000006.htm	F 695		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph	F 756		9/26/18

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F 756	Continued From page 125 (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. 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 policy for the monthly drug regimen with time frames for the different steps in the process in order to address recommendations from the pharmacist for five of 35 residents in the survey sample, Residents #61, #67, #12, #45, and #20. 1. The facility staff failed to develop and implement policies that addressed the time frames of the steps of the medication regimen review to guide staff on the process for acting on irregularities reported by the pharmacist for	F 756	1. Corrective Action for those residents found to be affected by the alleged deficient practice. The facility supporting pharmacy has supplied the policy regarding the allotted timeframe for the physician to address the monthly drug regimen review forms. 2. Corrective actions taken for residents with potential to be affected by alleged deficient practice. Residents admitting into the facility have the potential to affected. The facility has obtained the policy from the supporting	

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Resident #61.

2. The facility staff failed to develop and implement policies that addressed the time frames of the steps of the medication regimen review to guide staff on the process for acting on irregularities reported by the pharmacist for Resident #67.

3. The facility staff failed to develop and implement policies that addressed the time frames of the steps of the medication regimen review to guide staff on the process for acting on irregularities reported by the pharmacist for Resident #12.

4. The facility staff failed to develop and implement policies that addressed the time frames of the steps of the medication regimen review to guide staff on the process for acting on irregularities reported by the pharmacist for Resident #45.

5. The facility staff failed to develop and implement policies that addressed the time frames of the steps of the medication regimen review to guide staff on the process for acting on irregularities reported by the pharmacist for Resident #20.

The findings include:

1. The facility staff failed to develop and implement policies that addressed the time frames of the steps of the medication regimen review to guide staff on the process for acting on irregularities reported by the pharmacist for

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pharmacy regarding the physician timeframe for addressing pharmacy recommendations. The physicians will also ensure dates are included on the pharmacy recommendation forms going forward.

3. Systemic changes put into place to ensure the alleged deficient practice does not recur.
Education completed by the Medical Director to supporting physicians and nurse practitioners regarding the policy regarding the timeframe allotted for addressing the monthly medication regime reviews and ensuring dates are on every form going forward.

4. Monitoring of corrective action to ensure the alleged deficient practice does not recur.
Director of nursing will complete audits of monthly medication regime reviews monthly to ensure physicians are addressing the reviews in the allotted timeframe according to policy.

Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions.

Date if Compliance: 9/26/18

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Resident #61.

Resident #61 was admitted to the facility on 6/27/18 with a readmission on 7/23/18 with diagnoses that included but were not limited to: fracture of the arm, infection in the joint, heart failure, diabetes, depression, high blood pressure 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 8/5/18, coded the resident as scoring a 12 on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make daily cognitive decisions. The resident was coded as requiring minimum to extensive assistance for all of her activities of daily living.

The clinical record was reviewed for unnecessary psychotropic medications. There were no identified concerns with the use of the antidepressant medication the resident was receiving.

A review of the facility policy regarding medication regimen reviews and pharmacy recommendations revealed the following: Review of the facility's policy titled, "Medication Regimen Review" documented, "Policy Statement The Consultant Pharmacist shall review the medication regimen of each resident at least monthly. Policy Interpretation and Implementation 8. The Consultant Pharmacist will provide a written report to physicians for each resident with

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an identified irregularity. If the situation is serious enough to represent a risk to a person's life, health, or safety, the Consultant Pharmacist will contact the Physician directly to report the information to the Physician, and will document such contacts." The policy did not evidence documentation regarding the timeframe the physician must respond for non-urgent medication concerns.

The policy failed to include any documentation regarding the timeframe that a pharmacy recommendation is required to be provided to the physician and acted upon by the physician. The policy did not meet regulatory requirements of specifying those time frames.

An interview was conducted with administrative staff member (ASM) #3, the medical director, on 8/15/18 at 1:10 p.m. When asked how soon the recommendations from the pharmacy are acted upon, ASM #3 stated, "I'm reviewing all the medications and medication orders every 30 days. I do the recommendations at that time.

An interview was conducted with LPN (licensed practical nurse) #1, a unit manager, on 8/16/18 at 11:26 a.m. When asked about the process staff follows for the pharmacy recommendations, LPN #1 stated, "I review the recommendations and call the doctors, follow any orders they give me and transcribe those orders into the clinical record." When asked about timeframe to complete this, LPN #1 stated, "The DON (director of nursing) or ADON (assistant director of nursing) get them emailed from the pharmacy. They then distribute them to the unit managers. My process is to try to get them done in 14 days."

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An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 8/16/18 at 12:10 p.m. When asked the process for the monthly pharmacy recommendations, ASM #2 stated, "The pharmacist sends me the recommendations via email. I separate them by unit, they go in the doctor's books and then they go back to the unit manager after the doctor/nurse practitioner has signed them. After the nurse takes off the any orders, they are filed in the clinical record." When asked about the timeframe for getting them completed, ASM #2 stated, "We complete them in 30 day before the pharmacist comes in the next month. If they haven't been acted upon, the pharmacist will talk to me and put a second recommendation."

Administrative staff member (ASM) #1, the administrator, ASM #2, the director of nursing, RN (registered nurse) #2, the assistant director of nursing, LPN #1, a unit manager, and ASM #4, the Clinical Services Coordinator, were made aware of the above findings.

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. The facility staff failed to develop and implement policies that addressed the time frames of the steps of the medication regimen review to guide staff on the process for acting on irregularities reported by the pharmacist for Resident #67.

Resident #67 was admitted to the facility on 12/9/15, with diagnoses that included but were

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not limited to: HIV (human immunodeficiency virus) disease (a disease that harms the immune system by destroying the white blood cells that fight infection, putting a patient at risk for serious infections and certain cancers), (1), high blood pressure, cirrhosis of the liver (a chronic condition which causes scar tissue to form in the liver, causing the liver to gets smaller and harder) (2), depression, schizoaffective disorder (a severe mental disorders that causes abnormal thinking and perceptions) (3), and diabetes with neuropathy (nerve pain) (4).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/10/18, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating she has no cognitive impairment for daily decision making. In Section N - Medications, the resident was coded as receiving anti-psychotics during the look back period.

A review of Resident #67's clinical record documented communication between the MD (medical doctor) and pharmacist regarding Resident #67's medication regimen.

A review of the facility policy regarding medication regimen reviews and pharmacy recommendations failed to include any documentation regarding the time frames that a pharmacy recommendation is required to be provided to the physician and acted upon by the physician. The policy did not meet regulatory requirements of specifying those time frames.

An interview was conducted with administrative staff member (ASM) #3, the medical director, on

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8/15/18 at 1:10 p.m. When asked how soon the recommendations from the pharmacy are acted upon, ASM #3 stated, "I'm reviewing all the medications and medication orders every 30 days. I do the recommendations at that time.

An interview was conducted with LPN (licensed practical nurse) #1, a unit manager, on 8/16/18 at 11:26 a.m. When asked about the process staff follows for the pharmacy recommendations, LPN #1 stated, "I review the recommendations and call the doctors, follow any orders they give me and transcribe those orders into the clinical record." When asked about timeframe to complete this, LPN #1 stated, "The DON (director of nursing) or ADON (assistant director of nursing) get them emailed from the pharmacy. They then distribute them to the unit managers. My process is to try to get them done in 14 days."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 8/16/18 at 12:10 p.m. When asked the process for the monthly pharmacy recommendations, ASM #2 stated, "The pharmacist sends me the recommendations via email. I separate them by unit, they go in the doctor's books and then they go back to the unit manager after the doctor/nurse practitioner has signed them. After the nurse takes off the any orders, they are filed in the clinical record." When asked about the timeframe for getting them completed, ASM #2 stated, "We complete them in 30 day before the pharmacist comes in the next month. If they haven't been acted upon, the pharmacist will talk to me and put a second recommendation."

Administrative staff member (ASM) #1, the

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administrator, ASM #2, the director of nursing, RN (registered nurse) #2, the assistant director of nursing, LPN #1, a unit manager, and ASM #4, the Clinical Services Coordinator, were made aware of the above findings.

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

2) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/patientinstructions/000290.htm

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

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

3. The facility staff failed to develop and implement policies that addressed the time frames of the steps of the medication regimen review to guide staff on the process for acting on irregularities reported by the pharmacist for Resident #12.

Resident #12 was admitted to the facility on 6/11/13 and readmitted on 11/1/14 with diagnoses, which included but were not limited to: dementia, weakness, diabetes and falls. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 8/3/18 coded the resident as having being severely impaired cognitively. The resident was coded as receiving antidepressants,

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antianxiety and antipsychotic medications for seven of the seven day look back.

The clinical record was reviewed for unnecessary psychotropic medications. There were no identified concerns with the use of the antidepressant, antianxiety or antipsychotic medications the resident was receiving.

Review of the pharmacy recommendation dated 8/6/18 documented that the physician consider a reduction in the antidepressant and antianxiety medication. The physician responded on 8/24/18.

A review of the facility policy regarding medication regimen reviews and pharmacy recommendations failed to include any documentation regarding the time frames that a pharmacy recommendation is required to be provided to the physician and acted upon by the physician. The policy did not meet regulatory requirements of specifying those time frames.

An interview was conducted with administrative staff member (ASM) #3, the medical director, on 8/15/18 at 1:10 p.m. When asked how soon the recommendations from the pharmacy are acted upon, ASM #3 stated, "I'm reviewing all the medications and medication orders every 30 days. I do the recommendations at that time.

An interview was conducted with LPN (licensed practical nurse) #1, a unit manager, on 8/16/18 at 11:26 a.m. When asked the process for the pharmacy recommendations, LPN #1 stated, "I review the recommendations and call the doctors, follow any orders they give me and transcribe those orders into the clinical record." When asked what time frame these are completed, LPN #1

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stated, "The DON (director of nursing) or ADON (assistant director of nursing) gets them emailed from the pharmacy. They then distribute them to the unit managers. My process is to try to get them done in 14 days."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 8/16/18 at 12:10 p.m. When asked the process for the monthly pharmacy recommendations, ASM #2 stated, "The pharmacist sends me the recommendations via email. I separate them by unit. They go in the doctor's books and then they go back to the unit manager after the doctor/nurse practitioner has signed them. After the nurse takes off the any orders, they are filed in the clinical record." When asked how long you have to get them completed, ASM #2 stated, "We complete them in 30 day before the pharmacist comes in the next month. If they haven't been acted upon, the pharmacist will talk to me and put a second recommendation."

On 8/15/18 at 5:55 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

4. The facility staff failed to develop and implement policies that addressed the time frames of the steps of the medication regimen review to guide staff on the process for acting on irregularities reported by the pharmacist for Resident #45.

Resident #45 was admitted to the facility on 5/19/15 and readmitted on 7/11/17 with diagnoses

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that included but were not limited to: dementia, stroke, irregular heartbeat, depression and high blood pressure. The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 6/27/18 coded the resident as being severely impaired cognitively. The resident was coded as receiving an antipsychotic and antidepressant medication seven out of seven days in the look back period.

The clinical record was reviewed for unnecessary psychotropic medications. There were no identified concerns with the use of the antidepressant or antipsychotic medications the resident was receiving.

A review of the facility policy regarding medication regimen reviews and pharmacy recommendations failed to include any documentation regarding the time frames that a pharmacy recommendation is required to be provided to the physician and acted upon by the physician. The policy did not meet regulatory requirements of specifying those time frames.

An interview was conducted with administrative staff member (ASM) #3, the medical director, on 8/15/18 at 1:10 p.m. When asked how soon the recommendations from the pharmacy are acted upon, ASM #3 stated, "I'm reviewing all the medications and medication orders every 30 days. I do the recommendations at that time.

An interview was conducted with LPN (licensed practical nurse) #1, a unit manager, on 8/16/18 at 11:26 a.m. When asked the process for the pharmacy recommendations, LPN #1 stated, "I review the recommendations and call the doctors, follow any orders they give me and transcribe

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those orders into the clinical record." When asked what time frame these are completed, LPN #1 stated, "The DON (director of nursing) or ADON (assistant director of nursing) gets them emailed from the pharmacy. They then distribute them to the unit managers. My process is to try to get them done in 14 days."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 8/16/18 at 12:10 p.m. When asked the process for the monthly pharmacy recommendations, ASM #2 stated, "The pharmacist sends me the recommendations via email. I separate them by unit. They go in the doctor's books and then they go back to the unit manager after the doctor/nurse practitioner has signed them. After the nurse takes off the any orders, they are filed in the clinical record." When asked how long you have to get them completed, ASM #2 stated, "We complete them in 30 day before the pharmacist comes in the next month. If they haven't been acted upon, the pharmacist will talk to me and put a second recommendation."

On 8/15/18 at 5:55 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

5. The facility staff failed to develop and implement policies that addressed the time frames of the steps of the medication regimen review to guide staff on the process for acting on irregularities reported by the pharmacist for Resident #20.

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Resident #20 was admitted to the facility on 5/11/18 with diagnoses that included but were not limited to: high blood pressure, dementia with psychosis, irregular heart beat chronic brain syndrome (1). Review of the most recent MDS, an admission assessment, with an ARD of 5/18/18 coded the resident as being severely impaired cognitively. The resident was coded as receiving antipsychotic and antidepressant medications seven times in the seven-day look back period.

The clinical record was reviewed for unnecessary psychotropic medications. There were no identified concerns with the use of the antidepressant, antianxiety or antipsychotic medications the resident was receiving.

A review of the facility policy regarding medication regimen reviews and pharmacy recommendations failed to include any documentation regarding the time frames that a pharmacy recommendation is required to be provided to the physician and acted upon by the physician. The policy did not meet regulatory requirements of specifying those time frames.

An interview was conducted with administrative staff member (ASM) #3, the medical director, on 8/15/18 at 1:10 p.m. When asked how soon the recommendations from the pharmacy are acted upon, ASM #3 stated, "I'm reviewing all the medications and medication orders every 30 days. I do the recommendations at that time.

An interview was conducted with LPN (licensed practical nurse) #1, a unit manager, on 8/16/18 at 11:26 a.m. When asked the process for the pharmacy recommendations, LPN #1 stated, "I

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review the recommendations and call the doctors, follow any orders they give me and transcribe those orders into the clinical record." When asked what time frame these are completed, LPN #1 stated, "The DON (director of nursing) or ADON (assistant director of nursing) gets them emailed from the pharmacy. They then distribute them to the unit managers. My process is to try to get them done in 14 days."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 8/16/18 at 12:10 p.m. When asked the process for the monthly pharmacy recommendations, ASM #2 stated, "The pharmacist sends me the recommendations via email. I separate them by unit. They go in the doctor's books and then they go back to the unit manager after the doctor/nurse practitioner has signed them. After the nurse takes off the any orders, they are filed in the clinical record." When asked how long you have to get them completed, ASM #2 stated, "We complete them in 30 day before the pharmacist comes in the next month. If they haven't been acted upon, the pharmacist will talk to me and put a second recommendation."

On 8/15/18 at 5:55 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

1. Chronic brain syndrome -- A condition characterized by long-standing brain dysfunction or damage, usually of three months duration or longer. This information was obtained from: https://www.ncbi.nlm.nih.gov/medgen

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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 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 appropriately label and store medications in one of one medications room, the Linden medication room. The facility staff failed to label a bottle of liquid Ativan (1) with an open date and failed to discard the bottle after 90 days of opening.	F 761	1. Corrective Action for those residents found to be affected by the alleged deficient practice. The bottle of Ativan in the Linden unit medication room was immediately reordered and discarded. practice. Residents admitting into the facility have the potential to be affected. Review completed by director of nursing in both medication rooms and on both medication	9/26/18

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The findings include:

On 8/14/18 at 2:12 p.m., an observation of the medication room was conducted. An open bottle of Ativan was found with no open date. The directions on the label documented the following: "Discard opened bottle after 90 days." The dispense date documented on the bottle was "1/26/18." The expiration date on the bottle was "11/30/19."

On 8/14/18 at 2:13 p.m., an interview was conducted with LPN (licensed practical nurse) #10. When asked when the bottle of Ativan was opened, LPN #10 stated that she did not know. LPN #10 stated that the bottle should have been labeled with the open date, but that nursing went by the expiration date of the medication. LPN #10 stated that she would try to find the narcotic sheet for the Ativan.

Review of the narcotic log for the Ativan revealed that it was opened on 1/28/18.

On 8/15/18 at 3:00 p.m., an interview was conducted with OSM (other staff member) #9, the pharmacist. OSM #9 stated that Ativan should be discarded 90 days after opening.

Review of the manufacturer's instructions for the liquid Ativan documented in part, the following: "Discard opened bottle after 90 days."

On 8/16/18 at 8:56 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and RN (registered nurse) #2 was made aware of the above concerns.

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carts ensuring that all medications have dares and that the medications were not expired according to manufacturer's recommendations.

2. Corrective actions taken for residents with potential to be affected by alleged deficient

3. Systemic changes put into place to ensure the alleged deficient practice does not recur.
Education completed by the director of nursing to licensed nursing personnel on dating medications after opening and reading the expiration dates to ensure discarding.

4. Monitoring of corrective action to ensure the alleged deficient practice does not recur.
Director of nursing will complete audits of medication rooms and medication carts weekly x4 then monthly x2 for dating and expiration dates.

Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions.

Date if Compliance: 9/26/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 761	Continued From page 141 The facility policy tiled, "Storage of Medications" documents in part, the following: "The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed." This policy did not address labeling the medication with an open date. (1) Ativan is a benzodiazepine that works on the brain to relieve symptoms of anxiety. Ativan is a central nervous system depressant that slows down the central nervous system. This information was obtained from https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010988/?report=details.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §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	F 812		9/26/18

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F 812	Continued From page 142 by: Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to store and serve food in a sanitary manner. The findings include: On 8/14/18 at 11:11 a.m., the kitchen inspection was conducted with OSM #3 (Other Staff Member), the dietary manager. The following items were noted: In the dry storage area, several small flies resembling fruit flies were observed flying around. In the dry storage area, a 25 pound box of white chocolate chip morsels was observed opened. The bag was mostly full and not sealed. In the dry storage area, draped across the top of two storage racks was a spider web. The top plate of a stack of plates on the plate warmer, was a dirty with dried food debris on it. In an interview with OSM #3 on 8/14/18 at 11:23 a.m., he stated that these items should not have been like this. A review of the facility policy, "Food Receiving and Storage" documented, "5. Non-refrigerated foods, disposable dishware and napkins will be stored in a designated "dry storage" unit which is temperature and humidity controlled, free of insects and rodents and kept clean." On 8/15/18 at 6:20 p.m., at the end of day meeting, the Administrator (ASM #1 -	F 812	1. Corrective Action for those residents found to be affected by the alleged deficient practice. The box of white chocolate morsels was immediately discarded, the spider web was immediately removed, the dirty plate was immediately removed and washed, and the fruit that attracted the fruit flies was removed from the dry storage areas. 2. Corrective actions taken for residents with potential to be affected by alleged deficient practice. Review completed by director of culinary services to culinary services team o keeping kitchen area free of pests, cleanliness of dishes, and closure of food items. 3. Systemic changes put into place to ensure the alleged deficient practice does not recur. Education completed by the director of culinary services to culinary services team on keeping kitchen area free of pests, cleanliness of dishes, and closure of food items. 4. Monitoring of corrective action to ensure the alleged deficient practice does not recur. Director of culinary services will complete audits of dry storage areas to include closure of food items, cleanliness of dishes, and pests 3x week x 4 weeks and monthly x2. Plan of correction information and audits	

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F 812	Continued From page 143 Administrative Staff Member) and the Director of Nursing (ASM #2) were made aware of the findings. No further information was provided by the end of the survey.	F 812	will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions. Date if Compliance: 9/26/18	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance	F 842		9/26/18

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F 842	Continued From page 144 with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, it was determined that the facility staff failed to ensure a	F 842	1. Corrective Action for those residents found to be affected by the alleged deficient practice.	

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complete and accurate clinical record for one of 35 residents in the survey sample; Resident #250.

The facility staff failed to ensure a complete and accurate clinical record regarding the presence of a urinary catheter that was in place when Resident #250 was admitted to the facility on 8/10/18.

The findings include:

Resident #250 was admitted to the facility on 8/10/18 for a respite care stay of approximately one week. The resident was admitted with the diagnoses of but not limited to chronic obstructive pulmonary disease, respiratory failure, atrial fibrillation, hepatitis C, C-spine disease status/post-cervical surgery failure, and high blood pressure. Due to the length of stay at the time of the survey, no MDS (Minimum Data Set) assessment had yet been completed. The nurse's evaluation note dated 8/10/18 at 3:36 p.m., documented that the resident was cognitively intact in ability to make daily life decisions; and that the resident was totally dependent on staff for activities of daily living.

On 8/14/18 at 12:29 p.m., and 2:15 p.m., and on 8/15/18 at approximately 8:15 a.m., observations were made of Resident #250. The resident was observed with a urinary catheter bag hanging on the side of the bed and the bag was noted to be pink-tinged inside. On 8/15/18 at 8:15 a.m., the resident stated he had had the catheter "for a while". On further interview, Resident #250 stated he had had it (catheter) before being admitted to the facility, when he was at home.

Resident #250 has since been discharged from the facility.

2. Corrective actions taken for residents with potential to be affected by alleged deficient practice.
Residents admitting into the facility have the potential to be affected. Review completed by the director of nursing on baseline careplans to include use of urinary catheter devices, urinary catheter orders to include catheter care orders, and the clinical reimbursement coordinator on recent admissions for initial minimum data set assessment completion.

3. Systemic changes put into place to ensure the alleged deficient practice does not recur.
Education completed by the director of nursing to licensed nursing personnel on baseline careplans and urinary catheter orders to include catheter care orders.
Education completed by the clinical reimbursement coordinator on completing the initial minimum data set assessment on admission.

4. Monitoring of corrective action to ensure the alleged deficient practice does not recur.
Director of nursing will complete audits of baseline careplans and urinary catheter orders and documentation 3x week for 4 weeks and then monthly x2. Clinical reimbursement coordinator will complete initial minimum data set assessments 3x week x 4 weeks and then monthly x2.

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A review of the clinical record failed to reveal any physicians orders for the use and care of a urinary catheter.

A review of the nurse's evaluation note dated 8/10/18 at 3:36 p.m., documented, "No urinary catheter present."

Further review of the clinical record revealed hospice notes that were provided to the facility upon admission. There was a note dated 8/1/18, which documented, "Genitourinary...Patient requires a urinary catheter...." There was also a note dated 7/25/18, which documented, "....Genitourinary....External Catheter....Condom Cath...."

A review of the facility's certified nursing assistant (CNA) documentation record for the resident's bladder continence status revealed the facility's CNA's consistently coded the resident's bladder status as "Continence Not Rated due to Condom Catheter (1)."

Review of the resident's baseline care plan failed to reveal any documentation for the use and care of a urinary catheter.

On 8/16/18 at 8:46 a.m., in an interview with CNA #2, who cared for Resident #250, she stated that he had a condom catheter on and it had been in place the whole time he was in the facility.

On 8/16/18 at 8:31 a.m., in an interview with LPN #4 (Licensed Practical Nurse) who had written the above identified nurse's evaluation note at the time of admission, LPN #4 stated that, "He (Resident #250) had a condom cath (catheter)

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and it was used for transport." LPN #4 stated, "Hospice told me it was a condom cath for transport, that he didn't need a catheter and put it on him for transport." When LPN #4 was informed that staff had reported Resident #250 had the catheter the whole time he was in the facility, LPN #4 stated, "if he had it the whole time, there should have been orders for it and it should have been care planned." At this time, LPN #4 was shown the hospice notes dated 8/1/18 and 7/25/18, which documented Resident #250 had a catheter and that it was not just for transport. LPN #4 stated that is not what hospice told her on the phone prior to the resident's admission. However, she did not clarify catheter orders with the physician or hospice, and did not remove the catheter when the resident was admitted.

On 8/15/18 at 6:20 p.m., at the end of day meeting, the DON (Director of Nurses) (ASM #2 - Administrative Staff Member) stated she had reviewed the chart and the resident did not have a catheter because there were no orders, notes, or assessments about him having one. ASM #2 was notified at this time that two surveyors observed the catheter in place on multiple observations on two different days; and that the CNA staff stated the resident had the catheter the entire time he has been at the facility, while the nursing staff was unaware that the resident had a catheter at all.
On 8/16/18 at 9:20 a.m., in an interview with the ASM #2, the DON, she stated that, "the prior notes (hospice notes) were not reviewed. Obviously, he came in with one (a catheter). All forms of catheters should have assessments, notes, orders, and be care planned." ASM #2

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F 842	Continued From page 148 stated that none of these items were present in the record. No further information was provided by the end of the survey.	F 842		
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, 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;	F 880		9/26/18

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F 880	Continued From page 149 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined the facility staff failed to have a complete infection control program as evidenced by failure to have a complete	F 880	1. Corrective Action for those residents found to be affected by the alleged deficient practice. Legionella water plan has been completed	

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Legionella Water Management program, and failed to maintain infection control practices for one of 35 residents in the survey sample, Resident #35.

1. The facility staff did not have a complete Legionella Water Management program.

2. The facility staff failed to store a nebulizer mask in a sanitary manner for Resident #35.

The findings include:

At the end of the day meeting on 8/15/18 at 6:01 p.m. The administrator (administrative staff member - ASM #1), ASM #2, the director of nursing, ASM #4, the Clinical Services Coordinator and RN (registered nurse) #2, were asked to present the facility Legionella Water Management Program on the morning of 8/16/18.

Legionellosis (Legionnaires' disease and Pontiac fever) is an environment-related, acute respiratory infection caused by gram-negative, rod-shaped bacteria of the genus Legionella. Legionnaires' disease is more severe, has pneumonia as the predominant clinical finding, and is a potentially fatal illness. (1)

On 8/16/18 at approximately 10:30 a.m., ASM #1 presented a policy related to testing of the resident with symptoms of Legionella. The policy failed to evidence documentation of the Water Management Program.

An interview was conducted with ASM #1 on 8/16/18 at 10:47 a.m. When asked if the facility conducted a facility risk assessment to identify where Legionella and other opportunistic

F 880

and initiated. Resident #35 nebulizer mask was immediately put into a storage bag.

2. Corrective actions taken for residents with potential to be affected by alleged deficient practice.
Residents admitting into the facility have the potential to be affected. Review completed by the administrator to ensure all parts of the legionella water plan was implemented and in place. Review completed by the director of nursing to ensure nebulizer mask were stored in storage bags after usage.

3. Systemic changes put into place to ensure the alleged deficient practice does not recur.
Education completed by the director of nursing to licensed nursing personnel on ensuring nebulizer mask are put into storage bags after usage, and infection control practices. Education completed by the administrator to the director of maintenance on ensuring the legionella water program is in place.

4. Monitoring of corrective action to ensure the alleged deficient practice does not recur.
Director of nursing will complete audits of the storage of nebulizer mask 3x week x4 weeks and then monthly x2. The administrator will complete an audit of the legionella water program weekly x4 then monthly x2.

Plan of correction information and audits

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waterborne organisms could grow and spread in the facility water system, ASM #1 stated, "Not to my knowledge." When asked if the facility implemented a water management program that considers the standards for the heating, refrigeration and air conditioning engineers, ASM #1 stated, he didn't have anything. When asked if the facility had tested the water for Legionella at the facility, ASM #1 stated, "I'd have to check with the health department." ASM #1 further stated that when he was in orientation at the corporation headquarters, the maintenance director went out sick and the assistant resigned. When asked if the facility has a Legionella program, ASM #1 stated, "I guess we don't."

The facility policy, "Legionella Water Management Program" documented in part, "Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella. 1. As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team."

No further information was obtained prior to exit.

(1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3381417/

2. The facility staff failed to store Resident #35's nebulizer mask in a manner to prevent infection.

Resident #35 was admitted to the facility on 12/1/17, with a most recent readmission date of 4/11/28, with diagnoses that included but were not limited to: Wernicke's encephalopathy (brain

will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions.

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damage caused by a lack of vitamin B1 (thiamine) deficiency) (1), chronic retention of urine (the inability to empty the bladder completely) (2), difficulty swallowing, high blood pressure, cerebral infarction (stroke) (3), and chronic obstructive pulmonary disease (COPD is a common lung disease. Having COPD makes it hard to breathe) (4).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/15/18, coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score, indicating she has moderate cognitive impairment for daily decision making. The resident was coded as requiring extensive assistance of at least one staff member for bed mobility, transfers, dressing, and toileting. The resident was coded as requiring total assistance of at least one staff member for eating, bathing, and personal hygiene.

An observation was made on 8/15/18 at 8:40 a.m. of Resident #35's nebulizer (a small machine that turns liquid medicine into a mist that is breathed in through a connected mask) (5) mask un-bagged and sitting in the bedside table drawer. Resident #35 stated that the nurse put it in the drawer after her treatment. There was no storage bag for the mask observed in the drawer with the mask.

An observation was made on 8/15/18 at 11:42 a.m. of Resident #35's nebulizer mask un-bagged and sitting in the bedside table drawer.

On 08/15/18 at 4:25 p.m., LPN (licensed practical nurse) #1 was asked to observe Resident #35's

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F 880	Continued From page 153	F 880		

nebulizer mask. LPN #1 confirmed that the mask was in a closed bedside drawer un-bagged. Upon this observation, LPN #1 stated "This [the nebulizer mask] should be in a storage bag." At that time, LPN #1 began looking through all of the bedside table drawers looking for the storage bag. After checking all of the drawers, LPN #1 located an empty storage bag in the drawer above the one with the un-bagged nebulizer mask. LPN #1 stated she would change the un-bagged mask immediately and would place the new mask in a new storage bag. When asked why the mask should be placed in a storage bag when not in use, she stated, "to keep the mask clean and decrease the potential risk for infection."

On 8/16/18 at 2:31 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the medical director, ASM #4, the clinical services coordinator, RN (registered nurse) #2, the assistant director of nursing, and LPN #1, the unit manager, were made aware of the above findings.

Review of the facility's policy titled, "Administering Medications through a Small Volume (Handheld) Nebulizer" documented in part, "The purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway ...29. When equipment [mask] is completely dry, store in a plastic bag with the resident's name and the date on it."

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495391	A. BUILDING ______ B. WING ______	C 08/16/2018

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F 880	Continued From page 154 therapy equipment." 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/000771.htm 2) This information was obtained from the National Institutes of Health at https://www.niddk.nih.gov/health-information/urologic-diseases/urinary-retention 3) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ischemicstroke.html 4) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/000091.htm 5) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/patientinstructions/000006.htm	F 880		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. 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 ensure the kitchen area was free of pests and/or insects.	F 925	1. Corrective Action for those residents found to be affected by the alleged deficient practice. The spider web was immediately removed	9/26/18

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F 925 Continued From page 155

The findings include:

On 8/14/18 at 11:11 a.m., the kitchen inspection was conducted with OSM #3 (Other Staff Member), the dietary manager. The following items were noted:

In the dry storage area, several small flies resembling fruit flies were observed flying around.

In the dry storage area, draped across the top of two storage racks was a spider web.

In an interview with OSM #3 (Other Staff Member - the dietary manager) on 8/14/18 at 11:23 AM, he stated that these items should not have been like this.

A review of the pest control logs revealed the following:

The facility pest control company serviced the kitchen area on 7/27/18 and documented, "....Inspected /Treated Kitchen for Pest Activity...."

The facility pest control company serviced the kitchen area on 7/13/18 and documented, "...glueboard in kitchen....Kitchen, Common areas, Roach...."

The facility pest control company serviced the kitchen on 5/18/18 and documented, "Inspected and serviced in dry storage area for ants minor activity raining heavily outside may take more than one visit...."

The facility "Special Service Record" for pest

F 925

and the fruit that attracted the fruit flies was removed from the dry storage areas.

2. Corrective actions taken for residents with potential to be affected by alleged deficient practice.
Review completed by Director of culinary services on the dry storage area and the remaining fruit or fruit flies and to ensure that the kitchen area is free of pests.

3. Systemic changes put into place to ensure the alleged deficient practice does not recur.
Education completed by the director of culinary services to culinary services team on keeping kitchen area free of pest, and storage of fruit or discarding of fruit if fruit flies are found on the fruit.

4. Monitoring of corrective action to ensure the alleged deficient practice does not recur.
Director of culinary services will complete audits of dry storage area for pests 3x week x 4 weeks and monthly x2.

Plan of correction information and audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and any necessary additional interventions.

Date if Compliance: 9/26/18

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control, identified the following:

5/17/18 - "ants....Dry storage kitchen, all kitchen...."
5/2/18 - "ants....kitchen/office, dry storage...."
4/27/18 - "Ants.....Kitchen dry storage room"
3/29/18 - "nats {sic}/roaches....All kitchen areas: dry storage..."
3/5/18 - "nats {sic}....kitchen area...."
2/22/18 - "nats {sic}/bug zapper....kitchen area needs attention...."
2/15/18 - "nats {sic}....kitchen area still problem...."

On 8/16/18 at 9:47 a.m., in an interview with OSM #3, he stated that he had called the pest control company regarding the flies and spider web and that he was not able to identify what might have caused the flies to be back there. OSM #3 stated that maintenance does not do any spraying for insects because it has to be done by a licensed pest control. He stated that the pest control comes monthly or more often if needed.

A review of the facility policy, "Pest Control" documented, "Our facility shall maintain an effective pest control program."

On 8/15/18 at 6:20 p.m., at the end of day meeting, the Administrator (ASM #1 - Administrative Staff Member) and the Director of Nursing (ASM #2) were made aware of the findings. No further information was provided by the end of the survey.