STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495416	A. BUILDING _____ B. WING	C 05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 5/16/17 through 5/18/17. One complaint was 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 44 certified bed facility was 42 at the time of the survey. The survey sample consisted of 13 current resident reviews (Residents #1 through #10, and Residents #14 through #16) and three closed record reviews (Residents #11 through #13).

F 225 SS=D 483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

483.12(a) The facility must-

(3) Not employ or otherwise engage individuals who-

(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;

(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or

(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

F 225

1.The facility followed up on all concerns for residents #15 and #16 listed during the state visit. This was accomplished on May 18, 2017. Going forward, any concerns logged with be reviewed for criteria that would qualify as state reportable under Virginia and federal regulations and reported in timeframes outlined in such regulations.

2. A 100% review of the concern and incident report log from April 1, 2017 through May 31, 2017 for any allegations of abuse that meet the criteria for reporting. This will be complete by June 30, 2017.

3. Staff will be educated on abuse prevention, policies and reporting. This will be complete by June 30, 2017

4. NHA or designee will monitor concern logs for any allegations of abuse and ensure reports are made per guidelines. Audits will be completed weekly for 3 months beginning in June 2017. Findings from these audits will be reported and reviewed at monthly QA/QI meeting.

6/30/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Director of Continuing Care	NHA	6/6/17

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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(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and

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if the alleged violation is verified appropriate corrective action must be taken.
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 report an allegation of abuse to the state agency (including to the State Survey Agency and adult protective seFVices where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for two of 16 residents in the suFVey sample, Residents #15 and #16.

1. The facility staff failed to report an allegation of abuse made by Resident #15 against facility staff on 4/11/17, to the state agency and to other officials in accordance with State law through established procedures.

2. The facility staff failed to report two allegations of abuse made by Resident #16 on 11/27/16 and 1/27/17 to the state agency and to other officials in accordance with State law through established procedures.

The findings include:

1. The facility staff failed to report an allegation of abuse made by Resident #15 against facility staff on 4/11/17, to the state agency and to other officials in accordance with State law through established procedures.

Resident #15 was admitted to the facility on 3/21/17 and readmitted on 4/4/17 with diagnoses including, but not limited to: history of a stroke;

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atrial fibrillation (1) and dementia. On the most recent MDS (minimum data set), an admission assessment with an assessment reference date of 4/11/17, he was coded as being severely cognitively impaired for making daily decisions. He was coded as usually understanding others, and as sometimes making himself understood for communication.

A review of the facility concern/complaint log revealed the following entry: "Name: [Resident #15]; Date complaint received: 4/11/17; Nature of Complaint: Abuse allegation; Disposition/Resolution Date: 4/14/17; Disposition/Resolution Action: staff education; family meeting; Notification Date: NA (not applicable); Notification Regulatory Office: NA; Logged by: [ASM (administrative staff member) #1, the administrator)]."

On 5/17/17 at 4:10p.m., ASM #1, the administrator, was interviewed regarding the concern/complaint log. He stated the social worker is now in charge of this process at the facility. He stated he had been employed at the facility for only a few weeks. He stated a concern/complaint can be made by anyone - resident, family, or staff- and the concerns now are funneled to the social worker. The social worker fills out a form and follows the procedure of notifying relevant staff members to investigate and follow up on the concern. ASM #1 stated once the concern is resolved; "we close the loop on the form and contact the person who expressed the concerns." At this time, ASM #1 was asked to provide all the information he had regarding the concern logged 4/11/17 for Resident #15. He returned with a file containing a document written by RN (registered nurse) #1,

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F 225	Continued From page 4 the MDS coordinator. The document was dated 4/19/17 and contained a written summary of Resident #15's allegation of abuse, her investigation, and a list of "pointers" for staff caring for Resident #15. On 5/17/17 at 4:20p.m., RN #1 was interviewed. When asked about the process to be followed when a resident alleges abuse, RN #1 stated: "It needs to be reported immediately to the administrator and director of nursing. The DON (director or nursing) may ask me to start an interview sometimes not. It depends. I have nursing management experience so I try to help out." When asked about the document she had written regarding Resident #15's allegation of abuse, RN #1 she stated: "Usually the manager on the unit takes the lead. But we don't have a manager on that unit right now." She stated one of the staff members reported that he had been having difficulty providing incontinence care to Resident #15, and that, when that staff member had been preparing to leave the resident's room, the resident indicated he had been mistreated. She stated she learned about the allegation during the morning huddle, and, in the absence of a manager, it fell to her to begin the investigative process. She stated she informed ASM (administrative staff member) #4, the corporate director of clinical operations, of the allegation, and she asked ASM #4 if she needed to follow up. RN #1 stated ASM #4, acting in the place of an administrator due to the facility not having an administrator at that time, asked her to begin the investigation. She stated she interviewed the resident, who could not verify that he had been mistreated. She stated she talked to the aide who had provided incontinence care, as well. She stated she could not find any evidence of any	F 225		

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abuse. RN #1 stated she also spoke to two other CNAs (certified nursing assistants) and a nurse to get their suggestions for taking care of Resident #15, "who was then, and remains, a very difficult resident to care for." RN #1 stated: "I did not feel it warranted the usual detail we usually document for an allegation of abuse. I took that executive privilege." She stated she let ASM #4 know of the results of her investigation.

On 5/17/17 at 4:45p.m., ASM #4, the corporate director of clinical operations and ASM #2, the director of nursing, were interviewed. ASM #4 stated her role is to "support this community for clinical concerns." ASM #4 stated that between the times the former administrator left and the new administrator arrived, "I was the supervisor in charge." When asked the process to be followed when a resident alleges mistreatment or abuse by a staff member, ASM #4 stated: "You interview and assess the resident, and investigate the concern. You notify the doctor and the RP (responsible party). You talk to anyone else involved, potential witnesses." She stated at this facility, the investigation usually starts with the manager in the area where the resident resides. When asked about reporting the abuse allegation to the state agency, ASM #4 stated: "We would report it to the state if it met the reporting guidelines." When asked what those guidelines are, ASM #4 stated: "I would have to get my papers and look." ASM #4 and ASM #2 were informed of the concern that this allegation of abuse was not reported immediately to the state agency, and other officials per state law and as required in the regulations.

On 5/17/17 at 5:20p.m., ASM #1, the administrator, was interviewed. He stated if a

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resident alleges abuse or mistreatment against a staff member, that staff member should be removed from the building and from the subsequent schedule until an investigation can be completed. He stated the resident should be interviewed, if possible. He stated all the "nursing partners" should also be interviewed. He stated the RP, physician, and IDT (interdisciplinary team) should be notified as welL ASM #1 stated: "We do our own internal investigation and follow the guidelines for reporting." When asked what these guidelines require, ASM #1 stated: "We report the allegation within 24 hours. We complete our investigation, and then we send a final report within five days." ASM #1 was asked if this allegation of abuse made by Resident #15 on 4/11/17 should have been reported to the state agency. ASM #1 stated: "Yes, absolutely."

A review of the facility policy "Abuse Prevention" revealed, in part, the following: "Investigation: The community will investigate all suspected or alleged incidents of resident abuse, mistreatment, neglect, exploitation, involuntary seclusion, and misappropriation of property. Reporting: The community will report incidents of abuse or alleged abuse per Federal, State, and local laws...The individual should notify the Administrator or designee as soon as possible within the timeframes listed above so that the facility can report the incident to the Secretary within the required timeframes. Upon receiving the report from the covered individual, the Administrator or designee assumes the responsibility for reporting the matter to the required authorities. The individual may also report the incident directly." A review of the facility policy "Abuse Reporting and Investigation" revealed, in part, the following: "[Name of

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corporation] is committed to providing an environment where residents' rights are protected and residents remain free from abuse, neglect, exploitation, and misappropriation of property. To this end, [name of corporation] has adopted a standard of zero tolerance of such incidents in our community, and will assure that all allegations of abuse, neglect, exploitation and misappropriation of resident property are reported or (sic) required by federal, state, and local laws, and investigated promptly. In addition, staff who work in our communities will be knowledgeable of [name of corporation] abuse prevention and investigation policies and protocols and state/local regulations...Upon receiving notice of an allegation covered in this policy, Executive Director, Nursing Home Administrator/Assistant Administrator or designee initiates an investigation and ensures notification of the appropriate State agencies of the allegation (as provided by law and within 24 hours). The Executive Director/Nursing Home Administrator must lead the community in cooperation with any state agency investigation as applicable...Aithough a resident may have cognitive impairment (mild or severe) allegations of abuse received from these residents should be taken seriously."

No further information was provided prior to exit.

(1) "Atrial fibrillation, or AF, is the most common type of arrhythmia. An arrhythmia is a problem with the rate or rhythm of the heartbeat. During an arrhythmia, the heart can beat too fast, too slow, or with an irregular rhythm.
AF occurs if rapid, disorganized electrical signals cause the heart's two upper chambers-called the atria)-to fibrillate. The term "fibrillate" means to

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contract very fast and irregularly.
In AF, blood pools in the atria. It isn't pumped completely into the heart's two lower chambers, called the ventricles. As a result, the heart's upper and lower chambers don't work together as they should.
People who have AF may not feel symptoms. However, even when AF isn't noticed, it can increase the risk of stroke. In some people, AF can cause chest pain or heart failure especially if the heart rhythm is very rapid". This information is taken from the website https://www. nhlbi.nih.gov/health/health-topics/topics/af.

2. The facility staff failed to report two allegations of abuse made by Resident #16 on 11/27/16 and 1/27/17 to the state agency and to other officials in accordance with State law through established procedures.

Resident #16 was admitted to the facility on 4/10/14 with diagnoses including, but not limited to: dementia, peripheral vascular disease, diabetes and anxiety. On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 3/1/17, Resident #16 was coded as being severely cognitively impaired for making daily decisions. He was coded as always being understood by others and as always understanding others for communication.

A review of the facility concern/complaint log revealed the following entries: "Name: [Resident #16); Date complaint received: 11/27/16; Nature

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of Complaint: Abuse, customer service; Disposition/Resolution Date: 11/28/16; Disposition/Resolution Action: interviews, different accounts; family meeting; Notification Date: NA (not applicable); Notification Regulatory Office: NA; Logged by: [ASM (administrative staff member) #1, the administrator)]. Name: [Resident #16]; Date complaint received: 1/27/17; Nature of Complaint: Abuse allegation; Disposition/Resolution Date: 1/30/17; Disposition/Resolution Action: SW (social worker) meeting; res (resident) wanted staff fired; Notification Date: NA (not applicable); Notification Regulatory Office: NA; Logged by: [ASM #1]."

On 5/17/17 at 4:10p.m., ASM #1, the administrator, was interviewed regarding the concern/complaint log. He stated the social worker is now in charge of this process at the facility. He stated he had been employed at the facility for only a few weeks. He stated a concern/complaint can be made by anyone - resident, family, or staff and the concerns now are funneled to the social worker. The social worker fills out a form and follows the procedure of notifying relevant staff members to investigate and follow up on the concern. ASM #1 stated once the concern is resolved; "we close the loop on the form and contact the person who expressed the concerns." At this time, ASM #1 was asked to provide all the information he had regarding the concerns logged for Resident #15. He returned with two files containing detailed notes regarding interviews with the resident and staff for both time frames listed in the concern/complaint log. The files contained no documents related to reporting to the state agency. ASM #1 stated: "The old administrator

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was in place when both of these allegations were made. I'm not sure what her process was."

On 5/17/17 at 4:45p.m., ASM #4, the corporate director of clinical operations and ASM #2, the director of nursing, were interviewed. ASM #4 stated her role is to "support this community for clinical concerns." She stated she was working in this capacity when both of these allegations occurred for Resident #16. She stated the former administrator was in charge of the investigation and reporting at these times. When asked about the process to be followed when a resident alleges mistreatment or abuse by a staff member, ASM #4 stated: "You interview and assess the resident, and investigate the concern. You notify the doctor and the RP (responsible party). You talk to anyone else involved, potential witnesses." She stated at this facility, the investigation usually tarts with the manager in the area where the resident resides. When asked about reporting the abuse allegation to the state agency, ASM #4 stated: "We would report it to the state if it met the reporting guidelines." When asked what those guidelines are, ASM #4 stated: "I would have to get my papers and look." ASM #4 and ASM #2 were informed of the concern that these allegations of abuse were not reported immediately to the state agency, and other officials per state law and as required in the regulations.

On 5/17/17 at 5:20p.m., ASM #1, the administrator, was interviewed. He stated if a resident alleges abuse or mistreatment against a staff member, that staff member should be removed from the building and from the subsequent schedule until an investigation can be

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F 225	Continued From page 11 completed. He stated the resident should be interviewed, if possible. He stated all the "nursing partners" should also be interviewed. He stated the RP, physician, and IDT (interdisciplinary team) should be notified as well. ASM #1 stated: "We do our own internal investigation and follow the guidelines for reporting." When asked what these guidelines require, he stated: "We report the allegation within 24 hours. We complete our investigation, and then we send a final report within five days." ASM #1 was asked if these two allegations of abuse made by Resident #16 should have been reported to the state agency. ASM #1 stated: "Yes, absolutely." No further information was provided prior to exit.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation	F 226		

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requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-

(c)(1)Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at§ 483.12.

(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property

(c)(3) Dementia management and resident abuse prevention.
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 and follow abuse policies and procedures for reporting allegations of abuse to the state agency(including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for two of 16 residents in the survey sample, Residents #15 and #16.

1. The facility staff failed to follow the facility abuse policy to report an allegation of abuse made by Resident #15 against facility staff on 4/11/17 to the state agency.

2. The facility staff failed to follow the facility abuse policy to report to the state agency two allegations of abuse made by Resident #16 on 11/27/16 and 1/27/17.

The findings include:

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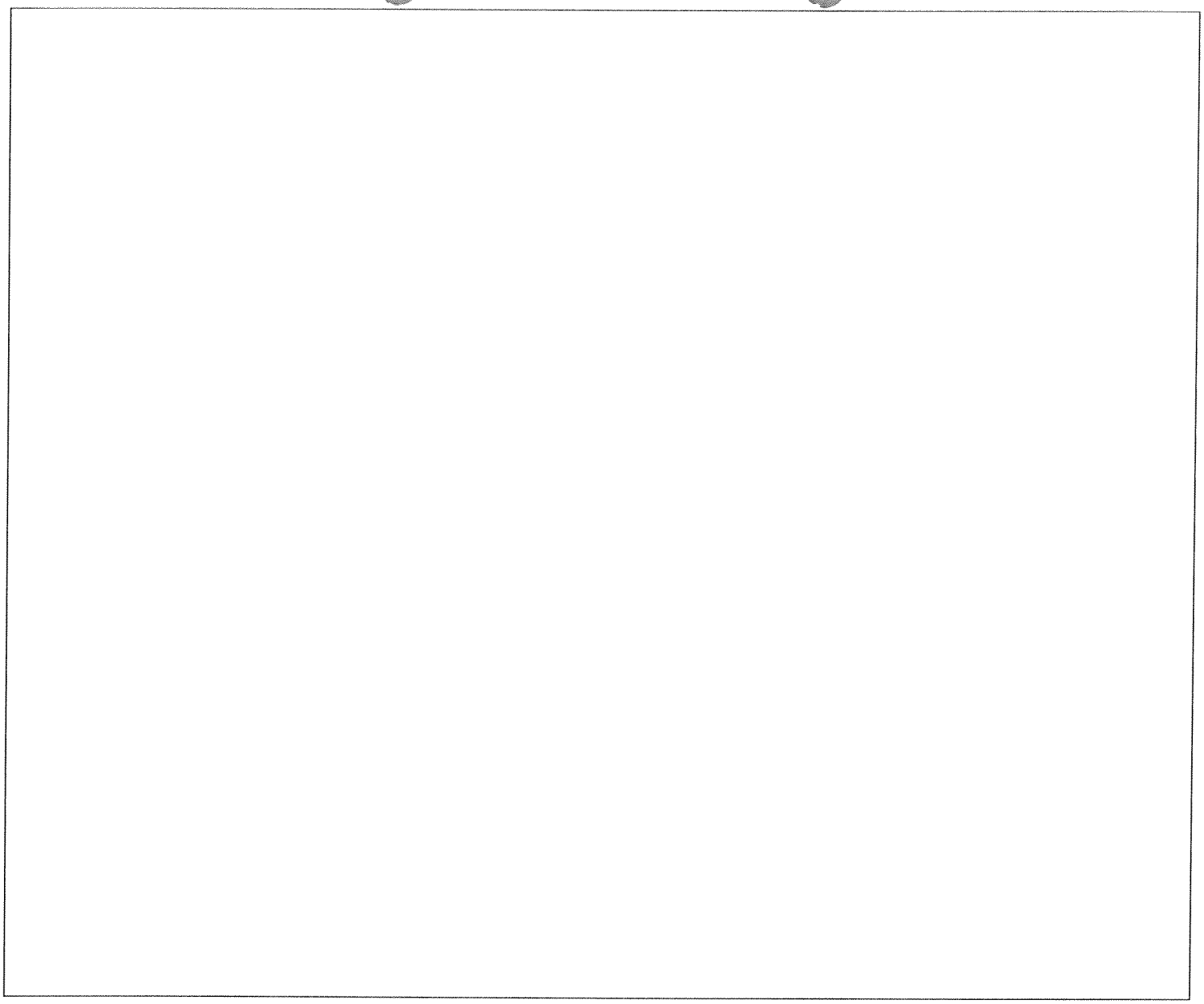
1.The facility followed up on all concerns for residents #15 and #16 listed during the state visit in accordance with our abuse policy. This was accomplished on May 18, 2017. A revised Erickson policy for abuse reporting was rolled out to the team in May 2017. Going forward, in accordance with our updated abuse policy, any concerns logged with be reviewed for criteria that would qualify as state reportable under Virginia and federal regulations and reported in timeframes outlined in such regulations.

2. A 100% review of the concern and incident report log from April 1, 2017 through May 31, 2017 for any allegations of abuse that meet the criteria for reporting per our abuse policy. This will be complete by June 30, 2017.

3. Staff will be educated on the newly revised Erickson abuse policy. This will be complete by June 30, 2017

4. The new Erickson abuse policy has been included into all new employee orientation. New employees will be trained on the policy prior to working on any care neighborhood. Annual and ongoing training will be completed by all staff in continuing care. The NHA or designee will review all training for new hires for three consecutive months beginning in June 2017. Findings from these audits will be reported and reviewed at monthly QA/QI meeting.

6/30/17



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
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1, The facility staff failed to follow the facility abuse policy to report an allegation of abuse made by Resident #15 against facility staff on 4/11/17 to the state agency.

Resident #15 was admitted to the facility on 3/21/17 and readmitted on 4/4/17 with diagnoses including, but not limited to: history of a stroke; atrial fibrillation (1) and dementia. On the most recent MDS (minimum data set), an admission assessment with an assessment reference date of 4/11/17, he was coded as being severely cognitively impaired for making daily decisions. He was coded as usually understanding others, and as sometimes making himself understood for communication.

A review of the facility concern/complaint log revealed the following entry: "Name: [Resident #15]; Date complaint received: 4/11/17; Nature of Complaint: Abuse allegation; Disposition/Resolution Date: 4/14/17; Disposition/Resolution Action: staff education; family meeting; Notification Date: NA (not applicable); Notification Regulatory Office: NA; Logged by: [ASM (administrative staff member) #1, the administrator)]."

On 5/17/17 at 4:10p.m., ASM #1 was interviewed regarding the concern/complaint log. He stated the social worker is now in charge of this process at the facility. He stated he had not been employed at the facility for only a few weeks. He stated a concern/complaint can be made by anyone - resident, family, or staff and the concerns now are funneled to the social worker. The social worker fills out a form and follows the procedure of notifying relevant staff members to

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investigate and follow up on the concern. He stated once the concern is resolved; "we close the loop on the form and contact the person who expressed the concerns." At this time, ASM #1 was asked to provide all the information he had regarding the concern logged 4/11/17 for Resident #15. He returned with a file containing a document written by RN (registered nurse) #1, the MDS coordinator. The document was dated 4/19/17 and contained a written summary of Resident #15's allegation of abuse, her investigation, and a list of "pointers" for staff caring for Resident #15.

On 5/17/17 at 4:20p.m., RN #1 was interviewed. When asked the process to be followed when a resident alleges abuse, she stated: "It needs to be reported immediately to the administrator and director of nursing. The DON (director or nursing) may ask me to start an interview- sometimes not. It depends. I have nursing management experience so I try to help out." When asked about the document she had written regarding Resident #15's allegation of abuse, she stated: "Usually the manager on the unit takes the lead. But we don't have a manager on that unit right now." She stated one of the staff members reported that he had been having difficulty providing incontinence care to Resident #15, and that, when that staff member had been preparing to leave the resident's room, the resident indicated he had been mistreated. She stated she learned about the allegation during the morning huddle, and, in the absence of a manager, it fell to her to begin the investigative process. She stated she informed ASM (administrative staff member) #4, the corporate director of clinical operations, of the allegation, and that she asked ASM #4 if she needed to

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follow up. She stated ASM #4, acting in the place of an administrator due to the facility not having an administrator at that time, asked her to begin the investigation. She stated she interviewed the resident, who could not verify that he had been mistreated. She stated she talked to the aide who had provided incontinence care, as welL She stated she could not find any evidence of any abuse. She stated she also spoke to two other CNAs (certified nursing assistants) and a nurse to get their suggestions for taking care of Resident #15, "who was then, and remains, a very difficult resident to care for." She stated: "I did not feel it warranted the usual detail we usually document for an allegation of abuse. I took that executive privilege." She stated she let ASM #4 know of the results of her investigation.

On 5/17/17 at 4:45p.m., ASM #4 and ASM #2, the director of nursing, were interviewed. ASM #4 stated her role is to "support this community for clinical concerns." She stated that between the times the former administrator left and the new administrator arrived, "I was the supervisor in charge." When asked the process to be followed when a resident alleges mistreatment or abuse by a staff member, she stated: "You interview and assess the resident, and investigate the concern. You notify the doctor and the RP (responsible party). You talk to anyone else involved, potential witnesses." She stated at this facility, the investigation usually starts with the manager in the area where the resident resides. When asked about reporting the abuse allegation to the state agency, she stated: "We would report it to the state if it met the reporting guidelines." When asked what those guidelines are, she stated: "I would have to get my papers and look." ASM #4 and ASM #2 were informed of the

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concern that this allegation of abuse was not reported immediately to the state agency, as required in the regulations.

On 5/17/17 at 5:20p.m., ASM #1 was interviewed. He stated if a resident alleges abuse or mistreatment against a staff member, that staff member should be removed from the building and from the subsequent schedule until an investigation can be completed. He stated the resident should be interviewed, if possible. He stated all the "nursing partners" should also be interviewed. He stated the RP, physician, and IOT (interdisciplinary team) should be notified as well. He stated: "We do our own internal investigation and follow the guidelines for reporting." When asked what these guidelines require, he stated: "We report the allegation within 24 hours. We complete our investigation, and then we send a final report within five days." ASM #1 was asked if this allegation of abuse made by Resident #15 on 4/11/17 should have been reported to the state agency. He stated: "Yes, absolutely."

A review of the facility policy "Abuse Prevention" revealed, in part, the following: "Investigation: The community will investigate all suspected or alleged incidents of resident abuse, mistreatment, neglect, exploitation, involuntary seclusion, and misappropriation of property. Reporting: The community will report incidents of abuse or alleged abuse per Federal, State, and local laws...The individual should notify the Administrator or designee as soon as possible within the timeframes listed above so that the facility can report the incident to the Secretary within the required timeframes. Upon receiving

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the report from the covered individual, the Administrator or designee assumes the responsibility for reporting the matter to the required authorities. The individual may also report the incident directly." A review of the facility policy "Abuse Reporting and Investigation" revealed, in part, the following: "[Name of corporation] is committed to providing an environment where residents' rights are protected and residents remain free from abuse, neglect, exploitation, and misappropriation of property. To this end, [name of corporation] has adopted a standard of zero tolerance of such incidents in our community, and will assure that all allegations of abuse, neglect, exploitation and misappropriation of resident property are reported or (sic) required by federal, state, and local laws, and investigated promptly. In addition, staff who work in our communities will be knowledgeable of [name of corporation] abuse prevention and investigation policies and protocols and state/local regulations...Upon receiving notice of an allegation covered in this policy, Executive Director, Nursing Home Administrator/Assistant Administrator or designee initiates an investigation and ensures notification of the appropriate State agencies of the allegation (as provided by law and within 24 hours). The Executive Director/Nursing Home Administrator must lead the community in cooperation with any state agency investigation as applicable...Although a resident may have cognitive impairment (mild or severe) allegations of abuse received from these residents should be taken seriously."

No further information was provided prior to exit.

(1) "Atrial fibrillation, or AF, is the most common

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type of arrhythmia. An arrhythmia is a problem with the rate or rhythm of the heartbeat. During an arrhythmia, the heart can beat too fast, too slow, or with an irregular rhythm.
AF occurs if rapid, disorganized electrical signals cause the heart's two upper chambers-called the atria)-to fibrillate. The term "fibrillate" means to contract very fast and irregularly.
In AF, blood pools in the atria. It isn't pumped completely into the heart's two lower chambers, called the ventricles. As a result, the heart's upper and lower chambers don't work together as they should.
People who have AF may not feel symptoms. However, even when AF isn't noticed, it can increase the risk of stroke. In some people, AF can cause chest pain or heart failure especially if the heart rhythm is very rapid". This information is taken from the website https://www.nhlbi.nih.gov/health/health-topics/topics/af.

2. The facility staff failed to follow the facility abuse policy to report to the state agency two allegations of abuse made by Resident #16 on 11/27/16 and 1/27/17.

Resident #16 was admitted to the facility on 4/10/14 with diagnoses including, but not limited to: dementia, peripheral vascular disease, diabetes and anxiety. On the most recent MDS (minimum data set), a quarterly assessment with the assessment reference date of 3/1/17, Resident #16 was coded as being severely cognitively impaired for making daily decisions. He was coded as always being understood by

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F 226	Continued From page 19 others and as always understanding others for communication. Resident #16 was admitted to the facility on 4/10/14 with diagnoses including, but not limited to: dementia, peripheral vascular disease, diabetes and anxiety. On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 3/1/17. Resident #16 was coded as being severely cognitively impaired for making daily decisions. He was coded as always being understood by others and as always understanding others for communication. A review of the facility concern/complaint log revealed the following entries: "Name: [Resident #16]; Date complaint received: 11/27/16; Nature of Complaint: Abuse, customer service; Disposition/Resolution Date: 11/28/16; Disposition/Resolution Action: interviews, different accounts; family meeting; Notification Date: NA (not applicable); Notification Regulatory Office: NA; Logged by: [ASM (administrative staff member) #1, the administrator)]. Name: [Resident #16]; Date complaint received: 1/27/17; Nature of Complaint: Abuse allegation; Disposition/Resolution Date: 1/30/17; Disposition/Resolution Action: SW (social worker) meeting; res (resident) wanted staff fired; Notification Date: NA (not applicable); Notification Regulatory Office: NA; Logged by: [ASM #1]." On 5/17/17 at 4:10p.m., ASM #1, the administrator, was interviewed regarding the concern/complaint log. He stated the social worker is now in charge of this process at the facility. He stated he had been employed at the	F 226		

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facility for only a few weeks. He stated a concern/complaint can be made by anyone- resident, family, or staff- and the concerns now are funneled to the social worker. The social worker fills out a form and follows the procedure of notifying relevant staff members to investigate and follow up on the concern. ASM #1 stated once the concern is resolved; "we close the loop on the form and contact the person who expressed the concerns." At this time, ASM #1 was asked to provide all the information he had regarding the concerns logged for Resident #15. He returned with two files containing detailed notes regarding interviews with the resident and staff for both time frames listed in the concern/complaint log. The files contained no documents related to reporting to the state agency. ASM #1 stated: 'The old administrator was in place when both of these allegations were made. I'm not sure what her process was."

On 5/17/17 at 4:45p.m., ASM #4, the corporate director of clinical operations and ASM #2, the director of nursing, were interviewed. ASM #4 stated her role is to "support this community for clinical concerns." She stated she was working in this capacity when both of these allegations occurred for Resident #16. She stated the former administrator was in charge of the investigation and reporting at these times. When asked about the process to be followed when a resident alleges mistreatment or abuse by a staff member, ASM #4 stated: "You interview and assess the resident, and investigate the concern. You notify the doctor and the RP (responsible party). You talk to anyone else involved, potential witnesses." She stated at this facility, the investigation usually tarts with the manager in the area where the resident resides. When asked about reporting

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the abuse allegation to the state agency, ASM #4 stated: "We would report it to the state if it met the reporting guidelines." When asked what those guidelines are, ASM #4 stated: "I would have to get my papers and look." ASM #4 and ASM #2 were informed of the concern that these allegations of abuse were not reported immediately to the state agency, and other officials per state law and as required in the regulations.

F 226

On 5/17/17 at 5:20p.m., ASM #1, the administrator, was interviewed. He stated if a resident alleges abuse or mistreatment against a staff member, that staff member should be removed from the building and from the subsequent schedule until an investigation can be completed. He stated the resident should be interviewed, if possible. He stated all the "nursing partners" should also be interviewed. He stated the RP, physician, and IOT (interdisciplinary team) should be notified as well. ASM #1 stated: "We do our own internal investigation and follow the guidelines for reporting." When asked what these guidelines require, he stated: "We report the allegation within 24 hours. We complete our investigation, and then we send a final report within five days." ASM #1 was asked if these two allegations of abuse made by Resident #16 should have been reported to the state agency. ASM #1 stated: "Yes, absolutely."

No further information was provided prior to exit.

F 279 SS=D 483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS

F 279

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483.20
(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.

483.21
(b) Comprehensive Care Plans

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its

F 279

1. A comprehensive care plan was developed based on the care area assessment triggers from the MDS assessment dated 3/8/17 for resident #6. This was completed as of May 25, 2017.

2. A review of admissions for the past 30 days will be completed by June 9, 2017 to ensure that a comprehensive care plan was initiated and the comprehensive care plan was developed based on the care area assessment triggers.

3. The SDC or designee will in service licensed nursing staff on the facility policy for the development of holistic/comprehensive care plans based on the care area assessment triggers. This will be completed by June 30, 2017.

4. ADON or designee will audit records of new admissions for initiation and completion of holistic/comprehensive care plans based on the care area assessment triggers. A random monthly audit will be completed for three months beginning in June 2017. Audit findings will be reviewed at the QA/QI committee for review and further direction as appropriate.

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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 and facility document review, it was determined that the facility staff failed to develop a comprehensive care plan for one of 16 residents in the survey sample, Resident #6.

The facility staff failed to develop a care plan for the Care Area Assessment (CAA) triggers of cognition, communication and psychoactive medication from the significant change MDS (Minimum Data Set) with an assessment reference date of 3/8/17.

The findings include:

Resident #6 was admitted to the facility on 9/17/15, and most recently readmitted on 3/1/17 with diagnoses including, but not limited to:

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arthritis, history of a stroke, cognitive communication deficit, and heart disease. On the most recent MDS, a significant change assessment with an assessment reference date of 3/8/17, she was coded as being moderately impaired for making daily decisions. She was coded as usually being understood by others, and as usually understanding others for communication.

A review of the above referenced 3/8/17 MDS assessment revealed that the CAA (care area assessment) in section V triggered cognition, communication and psychoactive medication as areas to be addressed in the comprehensive care plan. A "1" was placed in the box in column B, indicating that these areas were to be care planned. In an interview on 5/17/17 at 10:40 a.m., RN (registered nurse) #1, she stated that the "1" in column B indicated that these areas were to be care planned.

A review of the holistic/comprehensive assessment/care plan for Resident #6 dated 3/2/17 failed to reveal a care plan for cognition, communication, and psychoactive medication.

On 5/17/17 at 10:40 a.m., RN (registered nurse) #1, the MDS coordinator, was interviewed. She stated that when a resident is admitted to the facility, the admitting nurse is responsible for initiating a care plan as soon as possible. The unit managers are then responsible, under company policy, to upgrade to a comprehensive care plan within five to seven days of a resident's admission. Once the comprehensive assessment/MDS is done, the unit manager and RN #1 make sure that all CAA area triggers are covered in the care plan. She stated the facility

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does not have all unit managers in place currently, and it has fallen to her to make sure comprehensive care plans address all CAA triggers. RN #1 was asked to review Resident #6's comprehensive care plan for cognition, communication and psychoactive medication goals and interventions. Once she had reviewed the care plan, RN #1 stated: "I don't see it. It should have been done." She then provided the surveyor with a copy of the RAI (resident assessment instrument) manual section which addresses developing the care plan from CAAs. A review of this document revealed, in part, the following:

"Coding Instructions for V0200A, CAAs

·Facility staff are to use the RAI triggering mechanism to determine which care areas require review and additional assessment. The triggered care areas are checked in Column A "Care Area Triggered" in the CAAs section. For each triggered care area, use the CAA process and current standard of practice, evidence-based or expert-endorsed clinical guidelines and resources to conduct further assessment of the care area. Document relevant assessment information regarding the resident's status. Chapter 4 of this manual provides detailed instructions on the CAA process, care planning, and documentation.

·For each triggered care area, Column 8 "Care Planning Decision" is checked to indicate that a new care plan, care plan revision, or continuation of the current care plan is necessary to address the issue(s) identified in the assessment of that care area. The "Care Planning Decision" column must be completed within 7 days of completing the RAI, as indicated by the date in V0200C2, which is the date that the care planning decision(s) were completed and that the

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resident's care plan was completed."

On 5/17/17 at 5:10p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.

According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 278; "The nurse applies the nursing process to provide appropriate and effective nursing care. The process begins with an assessment or gathering and analysis of information about the client's health status. The nurse then makes clinical judgments about the client's response to health problems, defined as nursing diagnoses. Once the nurse defines appropriate nursing diagnoses, a plan of care is developed. The plan includes interventions individualized to each of the client's nursing diagnoses. The nurse performs all planned interventions in an effort to improve or maintain the client's health. After administering interventions, the nurse evaluates the client's response and whether the interventions were effective."

F 280 SS=D 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

483.10
(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:

(i) The right to participate in the planning process, including the right to identify individuals or roles to

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1. Care plan for resident # 1 dated 2/15/17 was updated to reflect the current status of the resident. (catheter, and pressure ulcer.)

2. A 100% audit of clinical records for residents with catheters and pressure ulcers was completed on June 9, 2017 to ensure accuracy.

3. The SDC or designee will in-service licensed nurses on the facility policy for maintaining an accurate and updated holistic/comprehensive care plan. This will be completed by June 30, 2017.

4. ADON or designee will audit care plans for accuracy of care plans related to catheters, MASD, and pressure ulcers. A random monthly audit will be completed for three months beginning in June 2017. Audit findings will be reviewed at the QA/QI committee for review and further direction as appropriate

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be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

(i) Developed within 7 days after completion of the comprehensive assessment.

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(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

This **REQUIREMENT** is not met as evidenced by:

Based on observation, 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 one of 16 residents in the survey sample, Resident #1.

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The facility staff failed to review and revise Resident #1's comprehensive care plan to include the presence of wounds and the use of a Foley catheter (1).

The findings include:

Resident #1 was admitted to the facility on 2/25/15 and most recently readmitted on 11/2/15 with diagnoses including, but not limited to: history of a hip fracture with surgical repair, dementia and high blood pressure. On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 3/21/17, Resident #1 was coded as being severely cognitively impaired for making daily decisions. She was coded as having a Foley catheter in place and as have no pressure ulcers (2).

On 5/17/17, Resident #1 was observed in bed receiving morning care from a CNA (certified nursing assistant). Resident #1 was observed to have a Foley catheter in place, draining clear, yellow urine.

A review of Resident #1's clinical record revealed a wound assessment (not pressure ulcer) dated 3/21/17 identifying the presence of moisture-associated skin damage (MASD) on 3/21/17. This area was documented as healed on 5/5/17.

A review of Resident #1's clinical record revealed a wound assessment dated 4/2/17 documenting the presence of Stage 2 pressure ulcer (3) on her buttocks measuring 1 X 1 X 0 centimeters. The wound assessment documented treatment including a wound cleanser and foam dressing

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every three days.

A review of Resident #1's clinical record revealed the following physician's order, dated and signed by the physician on 5/9/17: "Change Foley catheter 18 Fr. (French -indicating size of catheter).

A review of the physician's orders revealed the following orders:
- "4/7/17 Shear to sacrum and buttocks, apply a thin layer of house stock barrier cream (Zinc oxide) to groin and R (right) sacrum and buttocks daily and prn (as needed) with incontinence care. Discontinue previous wound care (orders by hospice nurse). Turn and reposition q 2 hrs (every two hours)."
- 4/19/17- Cleanse left sacrum stg (stage) 2 with dermal wound cleaner, apply thera honey (4), and cover with opti foam (foam dressing). Change q 3 days as needed if soiled."
These orders were all signed by the physician on 4/20/17.

A review of Resident #1's comprehensive/holistic care plan dated 2/15/17 failed to reveal evidence of information related to the Foley catheter, the **MASD,** and the pressure ulcer.

On 5/17/17 at 10:40 a.m., **RN** (registered nurse) #1, the **MDS** coordinator, was interviewed. She stated that unit managers and floor nurses are responsible for updating the care plans. She stated that changes made in between comprehensive annual reviews are usually made in handwriting. **RN** #1 stated: "We expect nurses on the neighborhoods or the unit managers will keep the care plans updated." She further explained that the facility does not have all unit

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managers in place currently, and that it has fallen to her to update the care plans. She stated that the staff discusses items for care plan updates during the morning meeting each day. When asked to review Resident #1's care plan for evidence of the Foley catheter and the wounds, she reviewed the care plan. She then stated there was no information related to the Foley catheter. She also stated the care plan did not specify the presence of the wounds or of a goal related to the wound care. RN #1 stated she would correct the care plan immediately.

On 5/17/17 at 5:10p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.

A review of the facility policy "Care/Service Plans" revealed, in part, the following: "Care/Service plan will be updated by hand in-between completion of the holistic assessments/care/service plans...All disciplines will document any updates/changes on care plan copy in guest/resident suite/apartment and review update with designated care associated. Documentation standards will be followed when documenting changes/updates."

No further information was provided prior to exit.

(1) "Foley catheter - a soft, plastic or rubber tube that is inserted into the bladder to drain the urine." This information is taken from the website http://www.nlm.nih.gov/medlineplus/ency/article/O 03981.htm

(2) The NPUAP defines a pressure ulcer as a " ..localized injury to the skin and/or underlying

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tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction." This information is taken from Pressure Ulcer Staging Revised by NPUAP. Copyright 2007. National Pressure Ulcer Advisory Panel. 8/3/2009 http://www.npuap.org.pr2.htm.

(3) "Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITO), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions)." This information is taken from the website <http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/>

(4) "Honey is a viscous, supersaturated sugar solution derived from nectar gathered and modified by the honeybee, Apis mellifera. Honey has been used since ancient times as a remedy in wound care. Evidence from animal studies and some trials has suggested that honey may accelerate wound healing." This information is taken from the website https://www.ncbi.nlm.nih.gov/pubmed/23450557

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Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care."

F 329 SS=D 483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

483.45(d) Unnecessary Drugs-General.
Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--

(1) In excessive dose (including duplicate drug therapy); or

(2) For excessive duration; or

(3) Without adequate monitoring; or

(4) Without adequate indications for its use; or

(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

F329

1. Seroquel was immediately discontinued for residents #4 and #8. This was completed on May 17, 2017.

2. A 100% audit of all clinical records for residents receiving antipsychotic medications was completed to ensure the presence of appropriate diagnosis and documentation of targeted behaviors. This was completed as of June 5, 2017.

3. The SDC or designee will educate the Medical providers and licensed nurses on the facility policy to ensure residents with antipsychotic medications have appropriate diagnosis and documentation. This will be completed by June 30, 2017.

4. DON or designee will audit clinical records of residents receiving antipsychotic medications for the presence of appropriate diagnosis and documentation. Audits will be completed monthly for 3 months beginning in June 2017. All findings from audits will be reported at our monthly QA/QI meeting for review and further direction as appropriate.

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(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.

483.45(e) Psychotropic Drugs.
Based on a comprehensive assessment of a resident, the facility must ensure that--

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

(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to ensure the drug regimen for two of 16 residents in the survey sample, Residents #4 and #8, was free from unnecessary drugs.

1 The facility staff failed to identify targeted behaviors and an appropriate diagnosis prior to the administration of Seroquel (1) to Resident #4.

2. The facility staff failed to identify targeted behaviors and an appropriate diagnosis prior to the administration of Seroquel to Resident #8.

The findings include:

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1. The facility staff failed to identify targeted behaviors and an appropriate diagnosis prior to the administration of Seroquel (1) to Resident #4.

Resident #4 was admitted to the facility on 1/13/16 and most recently readmitted on 5/12/17 with diagnoses including, but not limited to: urinary tract infection, fluid back-up in the kidneys, dementia with behaviors, and curvature of the spine. The resident had not been readmitted to the facility long enough for an MDS (minimum data set) to be completed. On the facility's Holistic Assessment dated 5/13/17, she was described as "oriented confused," and as requiring constant prompting, including cueing, repetition and reminders. She was described as being moderately independent for daily decision making. This document did not contain any reference to the resident receiving Seroquel.

A review of Resident #4's admission physician order sheet and plan of care, dated and signed by the physician on 5/12/17, revealed the following order: "Quetiapine (Seroquel) 50 mg (milligrams) po (by mouth) BID (twice a day) diagnosis depression."

A review of Resident #4's May 2017 MAR (medication administration record) revealed that she received the medication as ordered.

A review of the physician's admission progress note dated 5/12/17 failed to reveal any evidence of depression or of the resident's need for Seroquel.

A review of the nurses' notes for Resident #4 revealed no evidence of identified targeted behaviors for the administration of Seroquel.

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On 5/17/17 at 2:00p.m., LPN (licensed practical nurse) #2 was interviewed. She stated that the admission physician order sheet and plan of care was in her handwriting. When asked about Resident #4's Seroquel, LPN #2 stated: "She gets it twice a day." When asked why, LPN #2 stated: "For depression." When asked if Seroquel is an appropriate treatment for Seroquel, LPN #2 stated: "I thought it was." She stated the physician signed the orders, so the physician must have thought it was okay. When asked about targeted behaviors for the use of Seroquel for Resident #4, LPN #2 stated: "I don't know any specific behaviors. I just thought it was for her general depression."

The physician who signed the above-referenced orders did not return a call to the surveyor before exit.

On 5/17/17 at 2:35p.m., RN (registered nurse) #8 was interviewed. He was asked if depression is an indication for the use of Seroquel. RN #8 stated: "No, not really." When asked why Seroquel would be administered to a geriatric resident, RN #8 stated: "An example would be anxiety. It could be given for a relaxant." When asked if residents receiving Seroquel should have specific targeted behaviors documented for the administration of the medication, RN #8 stated: "No. We don't usually have that."

On 5/17/17 at 2:55p.m., ASM (administrative staff member) #3, a nurse practitioner, was interviewed. He was asked about the use of Seroquel in the facility's population. ASM #3 stated: "We try to avoid that. We would use it in extreme situations only. We would have psych

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(psychology) evaluate first." When asked if depression is an appropriate diagnosis for the use of Seroquel, ASM #3 stated: "In some situations, we use 30 milligrams of Seroquel for depression. In other situations, we use 15 milligrams as an appetite stimulant." When asked about the procedure to be followed if a resident comes from the hospital already on Seroquel, ASM #3 stated: "We look at the dosage. We do a chart review. We would be careful. It can increase somnolence. If it is higher than 30 milligrams, we would get a psych consult." When asked to look through Resident #4's chart to determine whether or not a psych consult had been ordered, or if Resident #4 had an appropriate diagnosis for the use of Seroquel, he checked the chart. ASM #3 then stated: "No. I don't see anything here about those things. We should have psych look at this. I don't even see she has depression."

On 5/17/17 at 5:10p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.

A review of the facility policy "Psychoactive Medications" revealed, in part, the following: "All psychoactive medication orders will contain supporting documentation to define specific goals of treatment. The minimum documentation required includes a specific diagnosis or condition, if known, OR of target symptoms or behaviors in the clinical record, and the documentation will be sufficient to demonstrate that said behaviors are: Violent or dangerous to self or others; or extremely disturbing to the resident or other staff; interfere significantly with care causing adverse outcomes...Residents who

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have not used antipsychotic drugs will not be given such drugs unless antipsychotic drug therapy is necessary to treat a specific condition...Delirium and behaviors associated with dementia and other cognitive disorders may require medications as part of a comprehensive treatment plan: which have been quantitatively and objectively documented; and which are persistent; and which are not caused by preventable reasons; and not amenable to redirection, changes in environment; and not felt to be due to other medications; and which are causing violent behavior that does not respond to other interventions; distressing hallucinations, delusions or paranoid ideation; abrupt or progressive worsening of condition in a resident with underlying dementia or mental illness...; depression with psychotic features, abrupt changes in behavior or cognition associated with an acute medical condition."

No further information was provided prior to exit.

(1)"Quetiapine tablets and extended-release (long-acting) tablets are used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). Quetiapine tablets and extended-release tablets are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). In addition, quetiapine tablets and extended-release tablets are used with other medications to prevent episodes of mania or depression in patients with

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bipolar disorder. Quetiapine extended-release tablets are also used along with other medications to treat depression. Quetiapine tablets may be used as part of a treatment program to treat bipolar disorder and schizophrenia in children and teenagers. Quetiapine is in a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain." This information is taken from the website https://www.nlm.nih.gov/medlineplus/druginfo/meds/a698019.html
Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. From the Federal Drug Administration website http://www.drugs.com/pro/seroquel.html.

2. The facility staff failed to identify targeted behaviors and an appropriate diagnosis prior to the administration of Seroquel to Resident #8.

Resident #8 was admitted to the facility on 4/27/17 with diagnoses including, but not limited to: left ankle fracture with surgical repair, dementia, and depression. On the most recent MDS (minimum data set), an admission assessment with an assessment reference date of 5/4/17, Resident #8 was coded as being severely impaired for making daily decisions. She was coded as having received an antipsychotic medication on all seven days of the look back period.

A review of Resident #8's clinical record revealed the following order, written and signed by the physician on 4/28/17: "Quetiapine (Seroquel) 50

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mg (milligram) tablet Give 25 mg po BID (twice a day) for depression."

A review of the nurses' progress notes for Resident #8 revealed no evidence of targeted behaviors demonstrating the need for SeroqueL

A review of the physician's progress notes dated 4/27/17, 5/1/17, and 5/9/17 revealed no mention of Seroquel, of the need for an antipsychotic, or of monitoring for its use.

On 5/17/17 at 2:35p.m., RN (registered nurse) #8 was interviewed. When asked if he had administered Seroquel to Resident #8, he stated that he had. When asked why the resident was receiving Seroquel, RN #8 stated: "The order says it's for depression. That's what it says." When asked if that is the reason Resident #8 was receiving the Seroquel, RN #8 stated: "No. She gets spasms. This is one of the first times I've worked with her. But it is being given as a relaxant." When asked if Resident #8 has any targeted behaviors for the use of Seroquel, RN #8 stated: "No. Just sometimes she gets spasms."

On 5/17/17 at 5:10p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.

No further information was provided prior to exit

F 371 483.60(i)(1)-(3) FOOD PROCURE, SS=E STORE/PREPARE/SERVE- SANITARY

(i)(1)- Procure food from sources approved or considered satisfactory by federal, state or local authorities.

F 329

F 371

1. The pot of soup that was open to air for potential contamination was discarded immediately.

2. Dining staff were educated on the proper food storage, preparing, and serving procedures. This will be completed by June 30, 2017.

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(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.

(i)(2)- Store, prepare, distribute and serve food in accordance with professional standards for food service safety.

(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, it was determined that the facility staff failed to store and prepare food in a sanitary manner.

A ten gallon pot of soup was observed in the walk-in refrigerator uncovered.

The findings include:

On 5/16/17 at approximately 8:50a.m., an observation of the kitchen was conducted with OSM (other staff member)# 2, a cook, and the following was observed: one ten gallon pot in the walk-in refrigerator with a tag identifying the contents as soup, "Today's Date" as 5/15/17, and

F 371 3. A random weekly audit will be completed by the dietary manager or designee for three months beginning in June 2017 for proper food storage.

4. All audit findings will be reported to the monthly QA/QI meeting.

6/30/17

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a "Use by Date" of 5/18/17. This pot was not covered and the contents were open to the air and potential contamination. OSM # 2 agreed that the pot was not covered. OSM # 2 then got a cart and transferred the pot to the cart. When OSM # 2 was asked what she was going to do with the pot of soup, OSM # 2 replied that she (OSM # 2) was going to put the pot into the steamer. At that moment OSM # 1, the dining supervisor, intervened and stated that the pot should have been covered and the soup would be discarded. At this time a facility policy was requested.

The following facility policy on "Storage" was provided by ASM (Administrative staff member)# 2, the director of nurses, on 5/16/17 at 5:30 p.m. Review of the facility policy revealed the following documentation: "Storage: PURPOSE: To establish standardized storage methods in order to ensure a safe, quality product is served to our Residents and employees ...PROCEDURE: 1. All food will be protected from contamination and spoilage ...5. Containers approved for food storage with tight-fitting covers will be used for all bulk foods ..."

During the end of day interview on 5/16/17 at 5:40 p.m. with ASM # 1, the administrator, and ASM # 2 this concern was reviewed.

No further information was provided prior to exit.

F 371

F 372 483.60(i)(4) DISPOSE GARBAGE & REFUSE
SS=F PROPERLY

F 372

(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by:

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Based on observation, and staff interview, it was determined that the facility staff failed to maintain the dumpsters in a sanitary manner.

The facility's trash dumpster was open. Used gloves and debris were observed on the ground around the dumpster.

The findings include:

During an observation of the dumpster area on 5/16/17 at 8:05a.m. with OSM (other staff member)# 1, the dining supervisor, the dumpster was observed. During the observation the left side door was open exposing the trash bags inside. On the ground in front of the dumpster and near the open door were used gloves (two). Also, a cigarette butt, straw paper, the plastic for a six pack of beverages, and twist ties for plastic bags. When asked who is responsible for the dumpster areas, OSM # 1 stated that housekeeping but added that the kitchen staff sweeps the area. At this time a facility policy was requested.

The following facility policy on "Waste Disposal" was provided by ASM (Administrative staff member)# 2, the director of nurses, on 5/16/17 at 5:30p.m. Review of the facility policy revealed the following documentation: "Waste Disposal: Policy: Waste is disposed of in a sanitary manner and in compliance with applicable federal, state, and local regulations. Procedure: 1. All waste is disposed of in leak-proof, non-absorbent containers with tight-fitting covers and all containers are kept clean. 2. Impermeable plastic liners are used inside all trash containers. 3. Trash container liners are secured, collected and deposited in the designated dumpster."

F 372

1. Trash and debris that was surrounding the dumpster was immediately cleaned up and disposed of properly.

2. Dining and Housekeeping staff were re-trained on the proper procedures in keeping the dumpster area sanitary. This will be completed by June 30, 2017.

3. The Housekeeping supervisor or designee will complete a random weekly audit for three months beginning in June 2017 to ensure the dumpster doors are closed when not in use and that the dumpster area is kept sanitary.

4. All audit findings will be reported to the monthly QA/QI meeting.

6/30/17

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During the end of day interview on 5/16/17 at 5:40 p.m. with ASM # 1, the administrator, and ASM # 2 this concern was reviewed.

No further information was provided prior to exit.

F 441 SS=F 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS

(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:

(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 (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

F 372

F441

1. The facility is unable to recreate the missing infection control logs from July- October 2016.

2. A 100% audit of all clinical records will be completed to ensure that residents with an infection or prescribed an antibiotic have a completed infection control surveillance assessment. This will be completed by June 30, 2017.

3. The SDC or designee will in service the licensed nurses on the facility policy for antibiotic management. This will be completed by June 30, 2017.

4. The ADON or designee will monitor the infection control & antibiotic stewardship report for accuracy and completion each week for one month and monthly for two months beginning in June 2017. All findings from audits will be reviewed at the monthly QA/QI meeting for review and further direction as appropriate.

6/30/17

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(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.

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

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

(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 that the facility staff failed to maintain a complete infection control program as evidenced by incomplete infection

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control tracking logs for July, August, September and October 2016.

The facility staff failed to record and track resident infection on the infection control tracking logs during July, August, September and October 2016.

The findings include:

On 5/16/17 at 7:30a.m., the survey team requested ASM (administrative staff member) #2, the director of nursing, to provide the team with infection control monthly logs dating back to the end of the previous year's survey.

ASM #1 provided the surveyor with logs listing infections by month, including resident names, room numbers, infection locations, cultures, organisms and resolved dates for all months since the previous survey except for July, August, September, and October 2016.

On 5/17/17 at 12:55 p.m., ASM #2 was interviewed. When asked about the missing infection control logs, she stated: "There has been a change in leadership. A big change, and there were some gaps. The infection control logs are one of those gaps. I'm sure they were done. I just can't locate them anywhere. When asked if she had completed the logs, she stated she had not. She stated she was not aware of anywhere the logs might be located that she had not already looked. When asked the purpose of completing the monthly logs, ASM #2 stated: "So we can track and trend the infections. We use that as a report in our QM (quality management) meetings."

F 441

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On 5/17/17 at 5:10p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.

A review of the facility policy "Infection Control Program," in effect at the time of the missing logs, revealed, in part, the following: "The purpose of the Infection Control Program is to establish and maintain practices in safeguarding a sanitary environment, thus preventing the spread of infection and disease among residents and personnei...The objectives of the program are as follows: Investigate, control, and prevent infections in the facility...follow established policy and maintain a system of surveillance and appropriate response for acquired infections...provide a system to monitor the appropriate use of antibiotics in the resident population for the treatment of infectious conditions."

No further information was provided prior to exit.

F 502 483.50(a)(1) ADMINISTRATION
SS=D

(a) Laboratory Services

(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.
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 obtain laboratory tests as ordered by the physician for one of 16 residents in the survey sample, Resident #10.

F 441

F502

1. Physician order for CBC and CMP dated 3/31 for resident # 10 was discontinued on May 17, 2017.

2. A 100 % review of physician lab orders for the past 30 days will be reviewed to assure completion. This will be completed by June 30, 2017.

3. The SDC or designee will in service licensed nurses on the facility policy for lab result management. This will be completed by June 30, 2017.

4. DON or designee will monitor compliance with the facility policy for lab result management weekly for one month and monthly for two months beginning in June 2017. All findings will be reviewed at the monthly QA/QI meeting for review and further direction as appropriate.

6/30/17

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The facility staff failed to obtain a CSC (complete blood count (1)) and CMP (complete metabolic panel (2)) blood test as ordered by the physician on 3/31/17 for Resident #10.

The findings include:

Resident #10 was admitted to the facility on 3/22/17 with diagnoses including high blood pressure and care following surgery. On the most recent MDS (minimum data set), a 30-day Medicare assessment with an assessment reference date of 4/17/17, Resident #10 was coded as having no cognitive impairment for making daily decisions.

A review of Resident #1O's clinical record revealed the following order, dated and signed by the physician on 3/31/17: "CSC, CMP."

Further review of the clinical record failed to reveal results of these tests.

On 5/17/17 at 5:10p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.

On 5/18/17 at 7:45a.m., RN (registered nurse) #7 was interviewed. He stated that once a physician writes or gives a verbal order for a laboratory test, the floor nurse enters the order into the electronic order system and writes down the tests and due date in the laboratory book on each hall. The contract lab company comes in to draw the blood. He stated the night shift nurses serve as the double check to make sure the lab test orders have been entered correctly into the

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electronic medical record and into the lab book on the unit.

On 5/18/18 at 8:30a.m., ASM #2 provided the surveyor with a copy of the contract laboratory (lab) company document indicating the blood was collected on 4/1/17 at 10:42 p.m. However, she stated that the contract lab company had no results for these tests. She also confirmed that there was no mention in Resident #10's nurses' notes that this test was performed.

A review of the facility policy "Lab Results Management" revealed, in part, the following: "A laboratory test will only be drawn after a Provider has written an order which includes the resident, name of the laboratory test, date of the draw as well as the reason for the lab test Nurse or designee enters the laboratory test and relevant information on the lab log in the front of the lab book. The nurse or designee will enter the lab requisition electronically into the Vendor's Lab System. Once entered, a copy of the lab requisition will be printed and placed in the Lab book. On the day of the lab draw, the lab phlebotomist or designee will draw the lab specimen. Prior to the phlebotomist leaving the building, a nurse or designee will reconcile the phlebotomist's manifest of labs drawn to the lab requisitions that required a specimen to be obtain (sic) so that the staff can confirm all required labs were drawn. Once the laboratory specimen is obtained and sent to the lab for processing, the laboratory completes the final result of the test. The laboratory sends the final result electronically where it will be visible in both the Provider's EMR (electronic medical record) and the Continuing Care EMR"

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No further information was provided prior to exit

(1) CBC- "This test measures number of red blood cells white blood cells total amount of hemoglobin and the fraction of the blood composed of red blood cells , and measures the number of different types of white blood cells." This information is taken from the website http://www.ncbi.nlm.nih.gov/pubmedhealth/PMHO 004108/

(2) "A comprehensive metabolic panel (Chem 14) is a group of blood tests. They provide an overall picture of your body's chemical balance and metabolism. Metabolism refers to all the physical and chemical processes in the body that use energy." This information is taken from the website https ://www. nlm.nih.gov/medlineplus/ency/article/ 003468.htm

According to Fundamentals of Nursing, 5th Edition, Lippincott Williams & Wilkins, 2007, Page 165: "Laboratory tests are always interpreted in relation to the client's underlying health problems and treatment modalities. These results can also identify actual or potential health problems....Sometimes, laboratory tests and diagnostic procedures are used to judge the effectiveness of nursing interventions or medical treatment."