STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495260	A. BUILDING _____ B. WING _____	C 10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAUFONT HEALTH AND REHABILITATION CENTER	200 HIOAKS ROAD RICHMOND, VA 23225

(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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10-3-17 through 10-5-17. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. 3 complaints were investigated during the survey. The census in this 120 certified bed facility was 101 at the time of the survey. The survey sample consisted of 18 current Resident reviews (Residents #1 through #13 and #18 through #22) and 7 closed record reviews (Residents #14 through #17, and #23 through #25).	F 000		
F 205 SS=D	NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR CFR(s): 483.15(d)(1)(i)-(iv)(2) (d) Notice of bed-hold policy and return- (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 (c)(5) of this section, permitting a	F 205		10/23/17

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

Electronically Signed | 10/18/2017

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F 205	Continued From page 1 resident to return; and (iv) The information specified in paragraph (c)(5) of this section. (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 (e)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed, for 1 resident (Resident #14) in the survey sample of 25 residents, to ensure an appropriate discharge. The facility staff failed to ensure that Resident #14 was provided written bed-hold information, during or after being transferred to the hospital. The Findings included: Resident #14 was a 70 year old who was admitted to the facility on 4/14/17 and discharged on 4/18/17. Resident #14's diagnoses included Congestive Heart Failure, Pulmonary Fibrosis, Dependence on Supplemental Oxygen, Chronic Embolism and Thrombosis of Unspecified Vein, Diabetes Mellitus Type 2, Dependence on Renal Dialysis, End Stage Renal Disease, Chronic Obstructive Pulmonary Disease, Hypertension, and Generalized Muscle Weakness. Resident #14 was his own responsible party.	F 205	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F 205 1. Resident # 14 has since been discharged from Center. 2. All residents with potential to Discharge per own request and are self-responsible party are at ris. 3. Administrator or Designee will educate discharge planning department , admissions department on policy and procedure related to scope of service , including documentation related to denial	

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F 205	Continued From page 2 The Minimum Data Set, which was a Five Day Assessment, with an Assessment Reference Date of 4/18/17, coded Resident #14 as being able to understand and be understood by others. Resident #14 was coded as not having any inappropriate physical, verbal, or other behavioral symptoms. In addition, he was coded as not exhibiting any rejection of care. On 10/4/17 a review was conducted of Resident #14's clinical record, revealing the following nurses note, "4/18/17 6:12 P.M. He told nurse about 15 minutes minutes before calling the ambulance that he didn't feel good. Said he was having pain in his stomach and chest. I assessed him, his vital signs were stable BP (Blood Pressure) 122/68, P (Pulse) 72, R (Respiration) 16, T (Temperature) 98.2 O 2 (Oxygen Saturation) 96%. In the process of calling the MD (medical doctor) when the EMTs (Emergency Medical Technicians arrived)". Resident #14 was transferred to the hospital. The nurse who wrote the note was the former Director of Nursing, and was not available for an interview. On 10/4/17 a review of facility documentation was conducted, revealing the following statement by the hospital discharge planner, "4/19/17. (Resident #14) came to the Emergency room by EMS 4/18/17 at 6:22 P.M. When attempts were made to contact (facility) regarding patient returning to their facility staff indicated they could not accept him back due to his behaviors. Staff indicated patient refused to go to dialysis earlier in the week and called 911 against their recommendations. This social worker spoke to (admission office) staff." On 10/5/17 at 9:30 A.M., an interview was	F 205	of admission to include: a. 24 hour Jumpstart IDT meeting and documentation including any behaviors that would prevent readmission to center. b. Need to initiate bed hold policy upon transfer to hospital. 4. Admissions director or designee will audit all Patients transferred from center to ensure bed hold policy is in place. 3 times a week x 3 weeks, weekly times 3 weeks, monthly times 2. Review quarterly in QA meeting B . Discharge Planning department will review IDT jumpstart meetings for compliance related to documentation on all new admissions, 3 times a week for 3 weeks, weekly times 3 weeks , monthly times 2 , then quarterly in QA meeting	

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F 205	Continued From page 3	F 205		

conducted with the Admissions Director (Employee D). When asked why Resident #14 had not been allowed to return to the facility after his hospitalization, the Admissions Director stated, "He was non-compliant with his care that's why we didn't let him back in." When asked if the Admissions Department makes the decision regarding residents being re-admitted to the facility after a hospital stay, the Admissions Director stated, "We discuss it with nursing staff, we talk about it in a meeting. I can't produce any evidence that we met about about him (Resident #14)."

On 10/5/17 at 10:00 A.M. an interview was conducted with the facility's Discharge Planner (Employee C). The Discharge Planner stated that her department staff had not met with Resident #14 during his stay, and that no discharge planning or social service assessments had been conducted. She stated that a Discharge Planner is supposed to meet with residents within 24 hours of their admission. She further stated that her department had not been consulted or made aware that Resident #14 would not be allowed to return to the facility.

On 10/5/17 a review was conducted of the facility's Discharge Planning policy (Effective Date 7/26/16) . It read, "Discharge planning staff will initiate discharge planning prior to admission and coordinate with the patient and responsible party and the interdisciplinary team throughout the patient's stay to ensure sufficient preparation as well as a safe and orderly discharge from the Center. Procedure: Confirm patient's expected discharge plans during Jumpstart meeting providing education of potential discharge planning and community based needs. Schedule

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F 205	Continued From page 4	F 205		

and conduct Discharge planning meetings with patient and/or responsible party. 48 hours prior to a scheduled discharge initiate discharge instructions, communicate to other designated departments-Nursing, Dietary, Physical Therapy, Speech Therapy, Occupational Therapy...Document specifics of arrangements in Discharge Planning notes as discharge plans are finalized."

On 10/5/17 a review was conducted of the facility's Notice of Transfer/Discharge policy (Effective Date 11/30/16) . It read, " 1. When the Center initiates a notice of transfer/discharge to a patient and/or responsible party the discharge planning staff will pursue timely and appropriate transfer/discharge notification as well as discharge planning initiatives to ensure a safe and orderly discharge from the Center.
Procedure: Verify the reason for the initiation of the Notice of Transfer/Discharge. Under federal and state law, a Notice of Transfer/Discharge can be initiated for the following reasons:
a. The patient's welfare and needs cannot be met in the Center;
b. The patient's health has improved and they no longer require the services provided by the Center;
c. The safety of individuals in the Center is endangered due to the clinical and/or behavioral status of the patient;
d. The health of individuals in the Center would be endangered;
e. The patient failed, after reasonable and appropriate notice, to pay for their stay at the Center; or
f. The Center ceases to operate.

2. Verify that the patient's medical record provides

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F 205	Continued From page 5	F 205		

supporting documentation by appropriate interdisciplinary disciplines related to reasons for discharge.

3. Verify that physician documentation includes:
a. The patient's welfare and needs cannot be met in the Center;
b. The patient's health has improved and they no longer require the service;
c. The health and safety of the patient, other patients, or staff is endangered due to the clinical and/or behavioral status of the patient.

4. Provide proper advance written notification of the transfer/discharge to the patient and family member/legal representative utilizing the Notice of Transfer/Discharge form."

Resident #14's Care Plan did not identify any behavioral issues or interventions. During his 4 day stay in the facility, he was not seen by the Social Services/Discharge Planning Department, or the Dietary Department. The facility's interdisciplinary team had not addressed discharge planning. Resident #14's physician had not documented any behavioral concerns, or addressed discharge planning. Resident #14's clinical record did not contain documentation of multidisciplinary assessments and interventions through care planning to address his needs, provide written notification prior to discharge, provide orientation prior to discharge, provide written bed-hold information, or permit him to return to the facility after a hospital stay.

On 10/5/17 at 12:00 Noon, the facility Administrator (Administration A), and Acting Director of Nursing (Administration B) were informed of the findings. No further information

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F 205	Continued From page 6 was received.	F 205		
F 206 SS=D	Complaint Deficiency POLICY TO PERMIT READMISSION BEYOND BED-HOLD CFR(s): 483.15(e)(1)(2) (e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. (e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5),	F 206		10/23/17

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F 206	Continued From page 7 the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed, for 1 resident (Resident #14) in the survey sample of 25 residents, to ensure an appropriate discharge. The facility staff failed to ensure that Resident #14 was permitted to return to the facility after a hospital stay. The Findings included: Resident #14 was a 70 year old who was admitted to the facility on 4/14/17 and discharged on 4/18/17. Resident #14's diagnoses included Congestive Heart Failure, Pulmonary Fibrosis, Dependence on Supplemental Oxygen, Chronic Embolism and Thrombosis of Unspecified Vein, Diabetes Mellitus Type 2, Dependence on Renal Dialysis, End Stage Renal Disease, Chronic Obstructive Pulmonary Disease, Hypertension, and Generalized Muscle Weakness. Resident #14 was his own responsible party. The Minimum Data Set, which was a Five Day Assessment, with an Assessment Reference Date of 4/18/17, coded Resident #14 as being able to understand and be understood by others. Resident #14 was coded as not having any	F 206	F 206 1. Resident # 14 has since been discharged from Center. 2. All residents with potential to Discharge per own request and are self-responsible party are at risk. 3. Center educator or Designee will educate Discharge planning department, Clinical Licensed, nurses , Physician and physician extender on appropriate documentation related to patient behaviors that may exclude them from readmission to the center . B. Administrator or designee will educate all members of IDT related to documentation through the care planning process including written notification prior to discharge, Bed hold policy. 4. Center Educator or Designee will audit all Patients transferred from center to ensure appropriate procedures have been followed, 3 times a week x 3 weeks, weekly times 3 weeks, monthly times 2. Review quarterly in QA meeting B . Center educator or designee will review 24 hour shift report to identify behavioral documentation DON or designee will review all patients transferred to hospital for potential	

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F 206	Continued From page 8 inappropriate physical, verbal, or other behavioral symptoms. In addition, he was coded as not exhibiting any rejection of care. On 10/4/17 a review was conducted of Resident #14's clinical record, revealing the following nurses note, "4/18/17 6:12 P.M. He told nurse about 15 minutes minutes before calling the ambulance that he didn't feel good. Said he was having pain in his stomach and chest. I assessed him, his vital signs were stable BP (Blood Pressure) 122/68, P (Pulse) 72, R (Respiration) 16, T (Temperature) 98.2 O 2 (Oxygen Saturation) 96%. In the process of calling the MD (medical doctor) when the EMTs (Emergency Medical Technicians arrived)." Resident #14 was transferred to the hospital. The nurse who wrote the note was the former Director of Nursing, and was not available for an interview. On 10/4/17 a review of facility documentation was conducted, revealing the following statement by the hospital discharge planner, "4/19/17. (Resident #14) came to the Emergency room by EMS 4/18/17 at 6:22 P.M. When attempts were made to contact (facility) regarding patient returning to their facility staff indicated they could not accept him back due to his behaviors. Staff indicated patient refused to go to dialysis earlier in the week and called 911 against their recommendations. This social worker spoke to (admission office) staff." On 10/5/17 at 9:30 A.M., an interview was conducted with the Admissions Director (Employee D). When asked why Resident #14 had not been allowed to return to the facility after his hospitalization, the Admissions Director stated, "He was non-compliant with his care that's	F 206	behaviors and related documentation that may affect readmission to center, 3 times a week for 3 weeks, weekly times 3 weeks, monthly times 2 , then quarterly in QA meeting	

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F 206	Continued From page 9	F 206		

why we didn't let him back in." When asked if the Admissions Department makes the decision regarding residents being re-admitted to the facility after a hospital stay, the Admissions Director stated, "We discuss it with nursing staff, we talk about it in a meeting. I can't produce any evidence that we met about about him (Resident #14)."

On 10/5/17 at 10:00 A.M. an interview was conducted with the facility's Discharge Planner (Employee C). The Discharge Planner stated that her department staff had not met with Resident #14 during his stay, and that no discharge planning or social service assessments had been conducted. She stated that a Discharge Planner is supposed to meet with residents within 24 hours of their admission. She further stated that her department had not been consulted or made aware that Resident #14 would not be allowed to return to the facility.

On 10/5/17 a review was conducted of the facility's Discharge Planning policy (Effective Date 7/26/16) . It read, "Discharge planning staff will initiate discharge planning prior to admission and coordinate with the patient and responsible party and the interdisciplinary team throughout the patient's stay to ensure sufficient preparation as well as a safe and orderly discharge from the Center. Procedure: Confirm patient's expected discharge plans during Jumpstart meeting providing education of potential discharge planning and community based needs. Schedule and conduct Discharge planning meetings with patient and/or responsible party. 48 hours prior to a scheduled discharge initiate discharge instructions, communicate to other designated departments-Nursing, Dietary, Physical Therapy,

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F 206	Continued From page 10 Speech Therapy, Occupational Therapy...Document specifics of arrangements in Discharge Planning notes as discharge plans are finalized." On 10/5/17 a review was conducted of the facility's Notice of Transfer/Discharge policy (Effective Date 11/30/16) . It read, " 1. When the Center initiates a notice of transfer/discharge to a patient and/or responsible party the discharge planning staff will pursue timely and appropriate transfer/discharge notification as well as discharge planning initiatives to ensure a safe and orderly discharge from the Center. Procedure: Verify the reason for the initiation of the Notice of Transfer/Discharge. Under federal and state law, a Notice of Transfer/Discharge can be initiated for the following reasons: a. The patient's welfare and needs cannot be met in the Center; b. The patient's health has improved and they no longer require the services provided by the Center; c. The safety of individuals in the Center is endangered due to the clinical and/or behavioral status of the patient; d. The health of individuals in the Center would be endangered; e. The patient failed, after reasonable and appropriate notice, to pay for their stay at the Center; or f. The Center ceases to operate. 2. Verify that the patient's medical record provides supporting documentation by appropriate interdisciplinary disciplines related to reasons for discharge. 3. Verify that physician documentation includes:	F 206		

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F 206	Continued From page 11 a. The patient's welfare and needs cannot be met in the Center; b. The patient's health has improved and they no longer require the service; c. The health and safety of the patient, other patients, or staff is endangered due to the clinical and/or behavioral status of the patient. 4. Provide proper advance written notification of the transfer/discharge to the patient and family member/legal representative utilizing the Notice of Transfer/Discharge form." Resident #14's Care Plan did not identify any behavioral issues or interventions. During his 4 day stay in the facility, he was not seen by the Social Services/Discharge Planning Department, or the Dietary Department. The facility's interdisciplinary team had not addressed discharge planning. Resident #14's physician had not documented any behavioral concerns, or addressed discharge planning. Resident #14's clinical record did not contain documentation of multidisciplinary assessments and interventions through care planning to address his needs, provide written notification prior to discharge, provide orientation prior to discharge, provide written bed-hold information, or permit him to return to the facility after a hospital stay. On 10/5/17 at 12:00 Noon, the facility Administrator (Administration A), and Acting Director of Nursing (Administration B) were informed of the findings. No further information was received.	F 206		
F 225	Complaint deficiency INVESTIGATE/REPORT	F 225		10/23/17

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F 225 SS=D	Continued From page 12 ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 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. (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	F 225		

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F 225	Continued From page 13 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 if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation review the facility staff failed to report an injury to the state agency in a timely manner for 1 resident (Resident #17) of 25 residents in the survey sample. Resident #17 was injured during a transfer on 7/18/17. The injury was not reported to the state agency until 7/20/17. The findings included:	F 225	F 225 1. Resident # 17 has since been discharged from center 2. All residents are at risk. 3. Nurse Consultant or Designee will educate all staff to include investigation /reporting all injuries within timely manner per state regulations . 4. The DON/designee will review all incident reports weekly x 3weeks and then monthly x 1 months to ensure injuries are reported as per state regulation. Review	

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Resident #17, a 76 year old, was admitted to the facility on 6/22/17. Her diagnoses included end stage renal disease, hypertension, asthma, depression, diabetes, reflux, multiple myeloma, and osteoporosis.

The most recent Minimum Data Set (MDS) assessment was an admission assessment with an assessment reference date of 6/29/17. She had a Brief Interview of Mental Status score of 15 indicating no cognitive impairment. She was coded to require extensive assistance with her activities of daily living, including two person assistance with transfers.

The nursing note dated 7/18/17 19:52 (7:52 PM) read "can transfer pt (patient) with lift both arms and heard pop noise. Pt (patient) c/o (complained of) left shoulder pain 10/10. stat x-ray done. results pending. Son Rp (responsible party) request send to (hospital) ER (emergency room) for Eval. Np (nurse practitioner) notified."

The findings of the x-ray report dated 7/18/17 20:28 (8:28PM) read "Since 12.10.2016, there is now a moderately deformed fracture of the neck of the left humerus with osteoporosis noted. The fracture is satisfactory position. Degree of healing is not yet determined. Clinical correlation is recommended. The appearance suggests a healing fracture."

The facility submitted a Facility Reported Incident (FRI) report to the state agency on 7/20/17 at 2:33 p.m. The injury was not reported within 24 hours.

The facility policy titled "Abuse/ Neglect/ Misappropriation/ Crime" was reviewed. The

in quarterly QA/ A meeting

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F 225	Continued From page 15 procedure section read "8. The Administrator and/ or his/her designee will immediately notify (within 24 hours of knowledge of an allegation) the Virginia Department of Health Office of Licensure and Certification by filing the initial Virginia Department of Health Facility Reported Incident Form." The issue was reviewed with the Administrator and corporate nurses on 10/5/17 at 12:05 p.m. When asked what the time period was for reporting an injury to the state agency, the corporate nurse stated within 24 hours. No further information was provided.	F 225		
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-	F 278		10/23/17

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F 278	Continued From page 16 (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and in the course of a complaint investigation, the facility staff failed for one Resident, Resident #16, in a survey sample of 25 residents, to ensure an accurate MDS assessment. Resident #16's MDS pressure ulcer was coded incorrectly and the resident's significant weight loss was not coded. The findings included: Resident #16 was admitted to the facility on 11/22/13. Diagnoses included high blood pressure,dementia, stroke, depression and anxiety. This resident was 101 years of age. Resident #16's most recent Minimum Data Set (MDS) assessment was a significant change in status assessment with an assessment reference date of 9/4/17. Resident #16 was coded as having both short and long term memory loss. The resident required total to extensive assistance with activities of daily living. The	F 278	F 278 1. Resident # 16 has since been discharged from center 2. A. All resident with pressure ulcers are at risk related to section M Coding B. All residents with Weight loss are at risk related to section K coding 3. Data Verification Analyst or designee will educate MDS staff on appropriate coding per state and federal regulations related to section M and Section K. 4. Data Verification Analyst or designee complete 100% audit of patients with acquired pressure areas to ensure appropriate coding then review 30% patients 3 times a week x 3 weeks , weekly times 3 weeks , monthly times 2 . Findings will be reviewed quarterly in QA meeting. b. Data Verification Analyst or designee will complete 100% audit of those patients with noted weight loss to ensure appropriate coding , audit 30%	

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F 278	Continued From page 17 resident was coded as having one stage 2 pressure ulcer with slough. There was no weight loss coded for this resident. Review of Resident #16's closed record revealed on 9/4/17, the resident had an ulcer coded as a stage 2 pressure ulcer with slough and necrotic (dead, devitalized tissue) in the wound bed. The wound was a Kennedy ulcer. www.kennedyterminalulcer.com describes the Kennedy ulcer as "A Kennedy Terminal Ulcer is a pressure ulcer some people develop as they are dying." NPUAP (National Pressure Ulcer Advisory Panel) describes a stage 2 ulcer as: "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 (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions)." Further review of the resident's closed record revealed on the weight tracking form that her weight had decreased from 157.7 pounds on 7/6/17 to 137.2 pounds on 8/3/17, greater than 10% weight loss in 30 days. The MDS was not coded for weight loss for this resident.	F 278	patients with noted weigh loss 3 times a week x 3 weeks , weekly times 3 weeks , monthly times 2 for appropriate coding . Findings will be reviewed quarterly in QA meeting.	

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F 278	Continued From page 18 On 10/4/17 at 11:20 AM, an interview was conducted with the MDS coordinator RN-registered nurse) A. She stated, "I didn't know what the wound bed looked like." On 10/4/17 at 11:50 AM, an interview was conducted with the Corporate RD (registered dietician). She stated, "Section K (weight section) is not accurate." On 10/4/17 at 12:00 PM, the Administrator, DON (director of nursing), and the Corporate RN, were notified of above findings.	F 278		
F 280 SS=E	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 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 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.	F 280		10/23/17

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F 280	Continued From page 19 (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. (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.	F 280		

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F 280	Continued From page 20 (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 staff interview, facility documentation review, and clinical record review, the facility staff failed to provide interdisciplinary care plan meetings, and to produce accurate and timely care plan revisions for 5 Residents (Resident's #12, 18, 22, 9, & #17) of the 25 residents in the survey sample. 1. For Resident #12, the facility staff failed to incorporate all disciplines in care planning, and waited a month to revise the care plan after each quarterly MDS (minimum data set) assessment was completed. 2. For Resident #18, the facility staff failed to incorporate all disciplines in care planning, and waited a month to revise the care plan after each quarterly MDS (minimum data set) assessment was completed.	F 280	F280 1. Resident # 12, Resident #18, Resident #22 , Resident #9 Care plans have been revised with IDT collaboration per regulation . Patient, Responsible party and MD have been made aware. B. Resident # 17 has since been discharged from center. 2. All Residents are at risk for deficient practice 3. Regional Consultant , Data Verification analyst or designee will educate all members of interdisciplinary team in timely development, review , updates , and importance of meeting to include participation of all members of the interdisciplinary team . 4. DON or Designee will complete audit of 30% IDT member Care plans to ensure compliance 3 times week for 3 weeks,	

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F 280	Continued From page 21 3. Resident #22's care plan was not revised by the IDT (interdisciplinary team). There was no documentation the care plan had been revised from 11/2/16 to 6/21/17. 4. Resident #9's care plan was not revised by the IDT (interdisciplinary team). 5. For Resident #17, the facility staff failed to ensure information regarding transfers was accurate. The findings included: For Residents #12, and #18, the care planning non-compliance with the federal regulation was essentially the same situation where care plans were not updated timely, and no Inter-disciplinary team was involved. This was repeated for all three Residents. 1. Resident #12, was admitted to the facility on 10-28-16. Diagnoses included; hypertension, diabetes, peripheral vascular disease, high cholesterol, hemiplegia, stroke, dysphagia, and major depressive disorder recurrent. Resident #12's most recent Minimum Data (MDS) assessment was a quarterly assessment with an assessment reference date of 7-20-17. The Resident was coded with no cognitive impairment and required extensive assistance with all activities of daily living. Resident #12's nursing progress notes were reviewed, and revealed that on numerous occasions in the last year, and most recently on 8-2-17 the discharge planner/social work representative, and a LPN (licensed practical	F 280	weekly times 3 weeks, monthly times 2 months then review quarterly in QA meeting. B. DON or designee will audit 30% of patient care plans 3 times a week for 3 weeks, weekly times 3 weeks, monthly times 2 months then quarterly in QA meeting to ensure appropriate development, update and review in place.	

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nurse) were the only 2 facility staff to attend the IDT "Inter-disciplinary team" care plan meeting. The 8-2-17 meeting occurred with Resident #12's family in attendance. None of the other disciplines were present to represent the dietary/nutrition department, the activities department, nor therapy department. Care plans must be inter-disciplinary, and revised and updated after each quarterly, significant change or full MDS assessment.

Review of the care plan revealed that from admission on 10-28-16, until the first full care plan was created through 11-25-16, the only changes, and revisions to the careplan interventions in the last year, were as follows:

1. Vital signs as ordered 2-3-17
2. Bathing showering provide sponge bath when a full bath or shower cannot be tolerated. Provide shower 2 times per week, and keep skin clean and dry. Use lotion on dry skin. 2-14-17
3. Honor preferences of leisure activities of watching TV, keeping up with sports, playing games, and attending church services 4-20-17

An interview with the 2 MDS coordinators was conducted on 10-5-17 at 10:00 a.m. They related that they do not attend care plan meetings, and that they get the information to produce MDS assessments from the clinical record, and they talk to staff nurses at times, when they have questions.

An interview with the Discharge planner/social work representative Employee (c) was conducted on 10-5-17 at 10:30 a.m. She was asked who attended care plan meetings, and she stated that it was usually just her and a nurse. When asked

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if she was aware that this should be an interdisciplinary meeting with all departments represented and in attendance that provide care to each resident, she stated she was not aware of that, and would change that.

Review of nursing progress notes revealed numerous situations requiring revisions to care planning, where none was completed. A sample of those are as follows:

9-14-17 doctor's note describing back pain, which had begun in July, continued through august (8-9-17) and up until this assessment. The Resident felt it was due to positioning in the wheel chair. No revision to the care plan was made.

5-26-17 Registered Pharmacist Medication Regimen Review stated to discontinue aspirin and to decrease the dosage of mirtazipine, a psychotropic drug. This was done by the doctor, but not care planned for changes in mood and behavior with the gradual dose reduction of the drug.

5-4-17 "TED" hose (compression hosiery for legs to increase blood return in those with poor peripheral circulation) was not added to the care plan for care.

On 10-4-17, and 10-5-17 at the end of day debrief, the Administrator and Director of Nursing were informed of the findings and the failure to provide interdisciplinary care plan meetings, and revisions to the care plan. The facility did not present any further information regarding the findings.

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2. Resident #18, was admitted to the facility on 2-10-17. Diagnoses included: hypertension, dementia with behaviors, high cholesterol, depression, anxiety, constipation, and recurrent urinary tract infections.

Resident #18's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 8-4-17. The Resident was coded with severe cognitive impairment and required limited to extensive assistance with all activities of daily living.

Resident #18's nursing progress notes were reviewed, and revealed that on numerous occasions in the last year, and most recently on 8-2-17 the discharge planner/social work representative, and an LPN (licensed practical nurse) were the only 2 facility staff to attend the IDT "Inter-disciplinary team" care plan meeting. The 8-2-17 meeting occurred with Resident #12's family in attendance. None of the other disciplines were present to represent the dietary/nutrition department, the activities department, nor therapy department. Care plans must be inter-disciplinary, and revised and updated after each quarterly, significant change or full MDS assessment.

Review of the care plan revealed that from admission on 2-10-17, until the first full care plan was created through 3-29-17, the only changes, and revisions to the careplan interventions in the last year, were as follows:

1. PT (physical therapy) evaluate and treat as ordered or PRN (as needed). Ordered 4-16-17
2. Monitor location. notify the nurse of wandering

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behavior and attempted diversional interventions. None were specified. Ordered 4-17-17
3. Pommel cushion for wheel chair. Ordered 4-18-17
4. Administer medications as ordered, Labs as ordered, Provide and serve supplements and diet as ordered. Monitor intake and record every meal. Ordered 4-25-17.

Constipation, and urinary tract infections were not care planned at all.

An interview with the 2 MDS coordinators was conducted on 10-5-17 at 10:00 a.m.. They related that they do not attend care plan meetings, and that they get the information to produce MDS assessments from the clinical record, and they talk to staff nurses at times, when they have questions.

An interview with the Discharge planner/social work representative Employee (c) was conducted on 10-5-17 at 10:30 a.m. She was asked who attended care plan meetings, and she stated that it was usually just her and a nurse. When asked if she was aware that this should be an interdisciplinary meeting with all departments represented and in attendance that provide care to each resident, she stated she was not aware of that, and would change that.

Review of nursing progress notes revealed numerous situations requiring revisions to care planning, where none was completed. a sample of those are as follows;

3-3-17 Resident refusing medications and care from staff, patient crying and yelling, ...attempting to get out of wheel chair, agitated about

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incontinent episode. Geriatric psychiatrist evaluations was discontinued 2-10-17, and no revision to the care plan was made.

3-27-17 urinary tract infection with antibiotics ordered, was not care planned.

4-28-17 The resident had an episode of constipation which was recurrent for this Resident, and was never care planned.

6-6-17 Behaviors again, and the Resident was not afforded care planning or psychiatric services added to the care plan for care.

On 10-4-17, and 10-5-17 at the end of day debrief, the Administrator and Director of Nursing were informed of the findings and the failure to provide interdisciplinary care plan meetings, and revisions to the care plan. The facility did not present any further information regarding the findings.

3. Resident #22's care plan was not revised by the IDT (interdisciplinary team). There was no documentation the care plan had been revised from 11/2/16 to 6/21/17.

Resident #22 was admitted to the facility on 4/7/17. Diagnoses included high blood pressure, Parkinson's Disease and depression.

Resident #22's most recent MDS (minimum data set) with an ARD (assessment reference date) of 9/1/17 was coded as a quarterly assessment. Resident #22 was coded as having no memory

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deficits and was able to make own daily life decisions. Resident #22 was also coded as standby to limited assistance of one staff member to perform activities of daily living such as toileting and hygiene.

Review of the clinical record revealed there was no care plan revision from 11/2/16 to 6/21/17 (February missed). In addition, there was no documentation the IDT (interdisciplinary team) was involved in the care planning process.

Review of the current care plan revealed the a revision date of 6/30/16. On 9/22/17, a care plan meeting note documented only the unit manager and the discharge planner were in attendance. There was no care plan meeting note in February, 2017.

On 10/5/17 at 10:40 AM, MDS coordinator RN (registered nurse) B stated, "We are not involved with the care plan meeting."

On 10/5/17 at 11:15 am, the discharge planner (Employee C) stated, "We have the Unit Manager or a nurse present, possibly rehab (rehabilitation) and dietary." She admitted there was no sign in sheet.

4. Resident #9's care plan was not revised by the IDT (interdisciplinary team).

Resident #9 was admitted to the facility on 8/5/17. Diagnoses included high blood pressure, Transient ischemic attack, polyneuropathy and anxiety.

Resident #9's most recent MDS (minimum data

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set) with an ARD (assessment reference date) of 8/12/17 was coded as an admission 5 day assessment. Resident #9 was coded as having no memory deficits and was able to make own daily life decisions. Resident #22 was also coded as extensive assistance of one to two staff members to perform activities of daily living such as toileting and hygiene.

Review of the clinical record notes did not have a note regarding an IDT care plan meeting for this resident. The care plan dated 8/16/17 did not include documentation or interventions for a comment on 8/17/17 to the MDS coordinator that he "would be better off dead."

On 10/5/17 at 11:15 AM, the discharge planner (Employee C) stated: "I usually do the IDT notes." None were presented.

On 10/5/17 at 12:00 PM, the Administrator, DON (director of nursing) and the Regional nurse consultant were notified of above findings.

5. For Resident #17, the facility staff failed to ensure information regarding transfers was accurate.

Resident #17, a 76 year old, was admitted to the facility on 6/22/17. Her diagnoses included end stage renal disease, hypertension, asthma, depression, diabetes, reflux, multiple myeloma, and osteoporosis.

The most recent Minimum Data Set (MDS) assessment was an admission assessment with

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F 280	Continued From page 29 an assessment reference date of 6/29/17. She had a Brief Interview of Mental Status score of 15 indicating no cognitive impairment. She was coded to require extensive assistance with her activities of daily living, including two person assistance with transfers. Resident #17's care plan for "self care performance deficit" was created on 6/22/17. Included was the intervention dated 7/17/17 that read "Transfer: The resident is able to complete with moderate assistance." On 10/5/17 at 12:05 p.m., it was reviewed with the corporate nurses that the MDS documented Resident #17 needed assistance from two persons for transfers. The corporate nurses were asked to define "moderate assistance" with regard to transfers. The corporate nurses thought this would be defined in the therapy notes, but did not provide further clarification. On 10/5/17 at 11:10 a.m., Certified Nursing Assistant B (CNA B) and Licensed Practical Nurse C (LPN C) explained that the information entered into a resident's care plan automatically populated in the the CNA kardex used by the CNAs as a reference to provide care (to include transfers). Resident #17's care plan did not accurately define the assistance required during transfers. The issue was reviewed with the Administrator and corporate nurses at the end of day meeting on 10/5/17.	F 280		
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		10/23/17

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F 281	Continued From page 30 CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed for one (Resident #19) of 25 residents in the survey sample, to follow professional standards of care for medication administration. The facility staff crushed the delayed release medication, Pantoprazole (Protonix). Pantoprazole is a proton pump inhibitor that decreases the amount of acid produced in the stomach and used for the treatment of GERD (gastroesophageal reflux disease). Delayed release (DR) medication should not be crushed unless ordered by the physician. The findings included: Resident #19 was admitted to the facility on 9/23/17 with the diagnoses of, but not limited to, muscle weakness, dysphagia (difficulty swallowing), and pleural effusion. Being Resident #19 was a new admission, a Minimum Data Set (MDS) assessment was not completed at the time of survey. On 10/4/17 at approximately 8:40 a.m. a medication pass observation was conducted with	F 281	F281 1. Resident #19 has since been discharged from center 2. All residents receiving Protonix are at risk for deficient practice 3. Center educator or designee will educate all Licensed staff on review of DO not Crush medication list. 4. DON or Designee will complete 100% audit of all residents receiving Protonix to ensure orders have instructions to not crush medication. Audit will be continued reviewing 30% patients on Protonix 3 times a week for 3 weeks , weekly times 3 weeks then monthly times 2 months to ensure appropriate practice . Results will be reviewed in QA meeting	

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Licensed Practical Nurse-A (LPN-A). LPN-A removed the following medications from the medication cart, crushed them, placed the crushed medications in applesauce, then administered them to Resident #1. They are as follows:

Aspirin 81 mg (milligrams) chewable tablet, Furosemide 20 mg tablet, multivitamin tablet, and pantoprazole DR 40 mg tablet. Resident #19 also received the dietary supplement liquid "Med Plus" 120 milliliters.

A review of Resident #19's clinical record revealed the medications administered were the current physician orders.

On 10/4/17 at 1:40 p.m. an interview was conducted with LPN-A. LPN-A was asked to remove the medication card (blisterpack) which contained the Protonix from the medication cart. Upon review of the blisterpack, LPN-A stated "Extended release." When asked what she shouldn't have done during the medication pass, LPN-A stated "Shouldn't have crushed it." When asked if there was a medication reference book that the nurses could use for reference, LPN-A stated it was at the desk.

The medication reference book available to the nurses was titled "DAVIS'S DRUG GUIDE for NURSES TWELFTH EDITION." Pages 990 and 991 of the reference book contained the following information:

"pantoprazole (the generic name for Protonix)...IMPLEMENTATION...PO: (by mouth) May be administered with or without food. Do not break, crush, or chew tablets."

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F 281	Continued From page 32 On 10/4/17 at 4:45 p.m., the Administrator and Director of Nursing were informed of LPN-A crushing the delayed release medication, Protonix. When asked what the facility's professional reference source was, the Administrator stated "Potter-Perry" was the professional reference. The medication administration policy and a list of medications that should not be crushed was requested. Review of facility provided policy titled "6.0 General Dose Preparation and Medication Administration" with a revision date of 01/01/13 included: "3. Dose Preparation: Facility should take all measures required by Facility policy and Applicable Law, including, but not limited to the following:... 3.8 Facility staff should crush oral medications only in accordance with Pharmacy guidelines as set forth in Appendix 16: Common Oral Dosage Forms that Should Not Be Crushed and/or Facility policy..." Administration instructions provided by accessdata.fda.gov included: "PROTONIX Delayed-Release Tablets should be swallowed whole, with or without food in the stomach..." No further information was provided by the facility staff.	F 281		
F 315 SS=D	NO CATHETER, PREVENT UTI, RESTORE BLADDER CFR(s): 483.25(e)(1)-(3) (e) Incontinence.	F 315		10/23/17

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F 315	Continued From page 33 (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. (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. (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, resident interview, staff interview and clinical record review, the facility staff failed to ensure appropriate care of an	F 315	F 315 1. Resident #20 has since been discharged from the center	

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F 315	Continued From page 34 indwelling catheter for one resident (Resident # 20) in a survey sample of 25 Residents. For Resident 20, the facility staff failed to ensure the indwelling catheter bag and tubing were anchored below the bladder. Findings included: Resident # 20 was a 58 year old female who was admitted to the facility on 9/22/2017. Resident #20's diagnoses included but were not limited to: Hypertension, Diabetes, congestive Heart Failure, Gastroesophageal Reflux Disease and Chronic Kidney Disease There was no Minimum Data Set (MDS) Assessment done because it was not yet due. Resident # 20 was documented as having no cognitive impairment. On 10/4/2017 at 1:20 PM, while returning to the facility, three surveyors observed two people standing near the front door of the facility. A female staff member was standing and talking with a female who had an opaque urinary drainage bag with urine visible in the tubing. The urinary catheter tubing was anchored above the bladder at the waist level. The Director of Nursing was in the lobby as the surveyors walked in. The Director of Nursing was asked if the person outside talking with the staff member was a resident in the facility. The Director of Nursing went outside, talked with the two people and told them the urinary drainage bag and tubing were too high. The Director of Nursing identified the staff member as a Physical Therapy Assistant and stated the other female was a resident. The resident was identified and placed in the sample	F 315	2. All residents with Foley Catheter are at risk for deficient practice 3. Center educator or designee will educate all Physical therapy staff on appropriate positioning of Foley catheter bag. 4. DON or Designee will review all patients using Foley catheters 3 times a week for 3 weeks, weekly times 3 weeks , monthly times 2 months for appropriate positioning . Findings will be reviewed in QA meeting.	

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F 315	Continued From page 35 as Resident # 20. During the end of day debriefing, the facility administrator, Director of Nursing and Corporate Nurses were informed of the observation. The Director of Nursing stated she observed the catheter bag and tubing were up too high when the surveyor asked her to identify the two individuals standing outside. The DON stated she used that incident as a teaching moment for the Physical Therapy staff member and also explained it to Resident # 20. On 10/4/2017 at 5:15 PM, an interview was conducted with LPTA (Licensed Physical Therapy Assistant) (Employee A) stated she had taken Resident # 20 outside to practice walking with a cane. The Director of Rehab (Employee B) was present during the interview. Employee B stated the facility staff should make sure the positioning of the urinary catheter bag and tubing are correct when working with residents. On 10/5/2017 at 8:45 AM, an interview was conducted with Resident # 20 who stated she was outside practicing walking with a cane with Physical Therapy when observed by the surveyors. Resident # 20 stated the clothes she had on did not have a place to attach the urinary drainage bag and tubing so "they just put it up by my waist while I was walking outside with my cane." Resident # 20 stated she was informed by the Director of Nursing that the bag and tubing were up too high and informed about why it should not be up high. Resident # 20 stated she had been given a leg bag and she was happy to be able to use that when outside.	F 315		

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F 315	Continued From page 36 Review of the Physicians Orders showed an order for the Foley Catheter. Review of the Facility policy on Indwelling Urinary Flow Catheter and Drainage Bag Changes Effective 2/1/2015 stated "Maintain the integrity of the closed system at al times. Properly secure catheter tubing." During the end of day debriefing on 10/5/2017, the facility Administrator, the Director of Nursing and Corporate Nurses (Admin C and Admin D) were informed of the findings. Admin C, Admin D and Director of Nursing stated the the urinary catheter bag and tubing should be anchored below the level of the bladder. On 10/5/2017 at 11:00 AM, Resident # 20 was observed walking outside with the LPTA (Employee A). Resident # 20 pointed to her left leg and told the surveyor " See, I have the leg bag on now." The tubing was positioned properly.	F 315		
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use	F 323		10/23/17

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F 323	Continued From page 37 appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation review the facility staff failed to ensure a safe transfer for 1 resident (Resident #17) of 25 residents in the survey sample. Resident #17's Minimum Data Set (MDS) documented that two persons were required to transfer the resident. On 7/18/17, one person transferred Resident #17 resulting in an injury. The finding included: Resident #17, a 76 year old, was admitted to the facility on 6/22/17. Her diagnoses included end stage renal disease, hypertension, asthma, depression, diabetes, reflux, multiple myeloma, and osteoporosis. The most recent MDS assessment was an admission assessment with an assessment reference date of 6/29/17. She had a Brief	F 323	F 323 1. Resident #17 has since been discharged from center. 2. All residents are at risk for deficient practice 3. Center educator or designee will inservice all staff in appropriate review of resident care plan to determine degree of assistance in ability to transfer positions. 4. DON or Designee will complete 100% audit of all residents care plan to ensure it reflects need for 2 person assist to transfer, will continue to audit 30% of residents 3 times a week for 3 weeks , weekly times 3 weeks , monthly times 2 months ,to ensure compliance in resident transfer. Findings will be reviewed in quarterly QA meeting.	

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F 323	Continued From page 38	F 323		

Interview of Mental Status score of 15 indicating no cognitive impairment. She was coded to require extensive assistance with her activities of daily living, including two person assistance with transfers.

The nursing note dated 7/18/17 19:52 read "can transfer pt (patient) with lift both arms and heard pop noise. Pt (patient) c/o (complained of) left shoulder pain 10/10. stat x-ray done. results pending. Son Rp (responsible party) request send to (hospital) ER (emergency room) for Eval. Np (nurse practitioner) notified."

Certified Nursing Assistant C (CNA C) transferred Resident #17. She was not available for interview. Her statement was documented during the investigation of the incident. CNA C's statement read, "While transferring resident to bed, I heard a pop noise in her shoulder. I asked the patient if she was okay and she said 'no my arm is broken, can you please get the nurse.' Shortly after I went to notify the nurse. I asked the patient if she transfers with one person and she said yes."

The findings of the x-ray report dated 7/18/17 20:28 read "Since 12.10.2016, there is now a moderately deformed fracture of the neck of the left humerus with osteoporosis noted. The fracture is satisfactory position. Degree of healing is not yet determined. Clinical correlation is recommended. The appearance suggests a healing fracture."

Resident #17's care plan for "self care performance deficit" was created on 6/22/17. Included was the intervention dated 7/17/17 that read "Transfer: The resident is able to complete

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F 323	Continued From page 39 with moderate assistance." On 10/5/17 at 12:05 p.m., it was reviewed with the corporate nurses that the MDS documented that Resident #17 needed assistance from two persons for transfers. The corporate nurses were asked to define "moderate assistance" with regard to transfers. The corporate nurses thought this would be defined in the therapy notes, but did not provide further clarification. On 10/5/17 at 11:10 a.m., Certified Nursing Assistant B (CNA B) was asked how she knew how many staff it took to transfer a resident. She stated that she would look in the kardex. CNA B and Licensed Practical Nurse C (LPN C) explained that the information entered into a resident's care plan automatically populated in the the CNA kardex. The issue was reviewed with the Administrator and corporate nurses on 10/5/17 at 12:05 p.m.	F 323		
F 334 SS=D	INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS CFR(s): 483.80(d)(1)(2) (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31	F 334		10/23/17

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annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and

(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and

(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-

(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;

(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and

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F 334	Continued From page 41 (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, facility documentation and clinical record review, the facility staff failed for one Resident, Resident #9, in a survey sample of 25 residents, to offer a pneumonia vaccine. Resident #9 did not have a pneumonia vaccine offered. The findings included: Resident #9 was admitted to the facility on 8/5/17. Diagnoses included pneumonia, high blood pressure, Transient ischemic attack, polyneuropathy and anxiety. Resident #9's most recent MDS (minimum data set) with an ARD (assessment reference date) of 8/12/17 was coded as an admission 5 day assessment. Resident #9 was coded as having no memory deficits and was able to make own daily life decisions. Resident #22 was also coded as extensive assistance of one to two staff members to perform activities of daily living such	F 334	F334 1. Resident # 9 Has received the Pneumonia vaccine 2. All residents are at risk for deficient practice 3. Center educator or designee will inservice all Licensed staff on need to review status of patient need for pneumonia vaccine and offer if requested. 4. DON or designee will complete 100% audit of all residents pneumonia vaccine status and offer if requested, will continue to audit all new residents 3 times a week for 3 weeks, weekly for 3 weeks then monthly times 2 months. Finding will be reviewed in Quarterly QA meeting.	

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F 334	Continued From page 42 as toileting and hygiene. The MDS had coded the pneumonia vaccine had "not been offered." On 10/4/17 at 10:30 AM, Resident #9 was sitting in his room in the wheelchair. When asked if he had received a pneumonia vaccine, Resident #9 stated: "no, but I would get one if they think I need it." Clinical record review documented no issues with shortness of breath, coughing or dyspnea. Review of the policy regarding pneumonia vaccines revealed: "Vaccination against pneumonia will be offered to Center patients as indicated." On 10/5/17 at 10:15 AM, the infection control nurse (RN-registered nurse) C stated, "It (vaccine) was not offered due to the diagnosis on admission. It should have had one by now." On 10/5/17 at 12:00 PM, the Administrator, DON (director of nursing) and the Regional nurse consultant were notified of above findings.	F 334		
F 428 SS=D	DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON CFR(s): 483.45(c)(1)(3)-(5) c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not	F 428		10/23/17

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limited to, drugs in the following categories:

(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic.

(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.

(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.

(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.

(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

(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

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F 428	Continued From page 44 to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review the facility staff failed to ensure pharmacy recommendations were acted upon timely by the physician for 4 Residents (Residents #12, 21, 11, and #4) of the 25 residents in the survey sample. . 1. For Resident #12 pharmacy recommendations had not been provided to the physician by the pharmacy or acted upon for 28 days. 2. For Resident #21 pharmacy recommendations had not been provided to the physician by the pharmacy or acted upon for 27 days. 3. For Resident # 11, Pharmacy Medication Review Recommendations written on 5/18/2017 were not signed by the physician until 6/22/2017. 4. For Resident #4, the facility staff failed to ensure a medication irregularity identified by the pharmacist was acted upon. -The findings included: 1. Resident #12, was admitted to the facility on 10-28-16. Diagnoses included; hypertension, diabetes, peripheral vascular disease, high cholesterol, hemiplegia, stroke, dysphagia, and major depressive disorder recurrent. Resident #12's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 7-20-17. The Resident was coded with no cognitive impairment and required extensive assistance with all	F 428	F 428 1. Resident # 12, Resident # 21, Resident #11. Pharmacy recommendations are complete and in compliance. Resident #4 Pharmacy recommendation has been completed and medication adjustment has been made. All responsible parties have been made aware of recommendations. 2. All residents with pharmacy recommendations are at risk for deficient practice. 3. Center educator or designee will educate Unit Managers in process related to completion of pharmacy recommendations by Physician , and subsequent review of all recommendations by medical director 4. DON or Designee will audit 30 % pharmacy recommendations 3 times a week for 3 weeks, weekly times 3 weeks , monthly times 2 months . Findings will be reviewed in Quarterly QA meeting	

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activities of daily living.

The pharmacy progress notes in Resident #12's clinical record documented that the pharmacist had made new medication recommendations on 5-26-17. The recommendations were located in the electronic clinical record, and included the following 2 recommendations;

1. Perform a gradual dose reduction (GDR) of Mirtazepine 30 mg (milligrams) at bedtime every night (psychotropic drug).

2. Reevaluate concomitant therapy of Aspirin with clopidogrel (both are anticoagulants and increase the likelihood of undesired hemorrhage or bleeding).

The Registered Pharmacy Consultant Reports were electronically signed by the pharmacist conducting the reviews. The forms were reviewed by surveyors, and revealed two areas to receive signatures. One for the Director of nursing (DON), and one for the attending physician, to denote the recommendations had been received and acted upon. The forms revealed that the Director of nursing (DON) had not signed the reports, and it was unknown by staff if she had received them, as she was no longer employed at the time of survey, and could not be interviewed. The physician had not seen or signed the 5-26-17 reports until 6-22-17 (28 days after the report was written). Both recommendations were accepted by the physician on 6-22-17. The Aspirin was discontinued, and the Mirtazipine was decreased by half, to 15 milligrams instead of 30.

Because of the 28 day lapse of report finally

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reaching the doctor, orders were not changed timely, and the Resident had received the blood thinning aspirin and higher dose of psychoactive drug mirtazepine for over 3 weeks longer than was necessary.

The facility policy was requested for Registered Pharmacy "Medication Regimen Review" (MRR) procedures, and it was delivered by the corporate RN. The policy stated that the facility "should alert the medical director where MRR's are not addressed by the attending physician".

The Corporate RN was asked why the Medical Director was not notified that the attending physician had not addressed the pharmacist recommendations timely. Her response was that the DON should have taken care of that, and the DON had been relieved of her duties 2 weeks prior to survey.

The physician progress notes were reviewed, and did not describe the changes in the orders, nor the pharmacist review.

On 10-4-17, and 10-5-17 at the end of day debrief, the Administrator, interim DON and corporate staff were notified of the issue. No further information was submitted by the facility.

2. For Resident #21 pharmacy recommendations had not been provided to the physician by the pharmacy or acted upon for 27 days.

Resident #21, was admitted to the facility on 11-23-16. Diagnoses included; hypertension, high cholesterol, anxiety, depression, osteoporosis, Gastro-esophageal reflux disease,

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scoliosis, and a history of falls.

Resident #21's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 6-27-17. The Resident was coded with mild cognitive impairment and required extensive assistance with all activities of daily living, with the exception of eating.

The pharmacy progress notes in Resident #12's clinical record documented that the pharmacist had made new medication recommendations on 5-26-17. The recommendations were located in the electronic clinical record, and included the following recommendation;

1. discontinue hydroxyzine due to anticholinergic effects and risk of increased confusion and falls.

The Registered Pharmacy Consultant Reports were electronically signed by the pharmacist conducting the reviews. The forms were reviewed by surveyors, and revealed two areas to receive signatures. One for the Director of nursing (DON), and one for the attending physician, to denote the recommendations had been received and acted upon. The forms revealed that the Director of nursing (DON) had not signed the reports, and it was unknown by staff if she had received them, as she was no longer employed at the time of survey, and could not be interviewed. The physician had not seen or signed the 5-26-17 reports until 6-21-17 (27 days after the report was written). the recommendation was not accepted by the physician on 6-21-17.

The facility policy was requested for Registered

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Pharmacy "Medication Regimen Review" (MRR) procedures, and it was delivered by the corporate RN. The policy stated that the facility "should alert the medical director where MRR's are not addressed by the attending physician".

The Corporate RN was asked why the Medical Director was not notified that the attending physician had not addressed the pharmacist recommendations timely. Her response was that the DON should have taken care of that, and the DON had been relieved of her duties 2 weeks prior to survey.

The physician progress notes were reviewed, and did not describe the rational for not changing the orders, however the MRR report stated "no change", and "stable" as the reason.

On 10-4-17, and 10-5-17 at the end of day debrief, the Administrator, interim DON and corporate staff were notified of the issue. No further information was submitted by the facility.

3. For Resident # 11, Pharmacy Medication Review Recommendations written on 5/18/2017 were not signed by the physician until 6/22/2017.

Resident #11 was a 52 year old male who was admitted to the facility on 2/12/2016. Resident #11's diagnoses included but were not limited to: Hypertension, Diabetes, Peripheral Vascular Disease, Pain, Contracture and Osteoarthritis.

The most recent Minimum Data Set (MDS) was an Quarterly Assessment with an Assessment Reference Date (ARD) of 8/14/2017. The MDS coded Resident #11 as having a Brief Interview of

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Mental Status score of 15, indicating no cognitive impairment. Resident # 11 required minimal assistance of supervision for Activities of Daily Living except required minimal assistance of one staff person for dressing, hygiene and toileting. Resident # 11 was coded as occasionally incontinent of bladder and always continent of bowel.

Review of Resident # 11's clinical record was conducted on 10/4/2017. Review of the Medication Regimen Reviews (MRR) revealed Pharmacist wrote two recommendations on 5/18/2017 that were not signed by the Physician until 6/22/2017.

On one form was written: "Metformin and glipizide were recently discontinued. Recommendation: Please consider clarifying if the resident is no longer to receive any medication for DM (Diabetes Mellitus). Last PN (Progress Note) on 5/4/17 that glipizide should be increased to 10 mg (milligrams) BID (twice a day)."
The form was signed on 6/22/17 by the physician with a statement that Resident # 11 "refuses TX (treatment for DM-"it's against my religion").

On the second form, the Pharmacist wrote: " receives a non-steroidal anti-inflammatory drug (NSAID), Ibuprofen, and is at risk for a cardiovascular event due to their diagnosis of Diabetes mellitus due to underlying condition with diabetic chronic kidney disease, Essential (primary) hypertension. Recommendation: Please evaluate the need for routine Ibuprofen therapy, perhaps considering a non-NSAID alternative such as acetaminophen (Tylenol). Rationale for Recommendation: The Food and Drug Administration (FDA) has released a public

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health advisory and required manufacturers to include a BOXED warning in their prescribing information describing the potential increased risk for serious cardiovascular thrombotic events, myocardial infarction, stroke, and GI (gastrointestinal) adverse reactions associated with long-term use of NSAIDS (excluding aspirin)."
This form was signed on 6/22/17 by the physician with a note "He's off IBU"

Review of the Physicians Progress Notes revealed progress notes written on 5/4/17 by the nurse practitioner and the next one was written on 6/14/17 by the nurse practitioner who changed the Ibuprofen to Tylenol on that date and for the diagnosis of Diabetes wrote "will not take any Rx (prescription)." The progress note was written 27 days after the recommendation from the Pharmacist.

On 10/4/2017 at 3:55 PM, an interview was conducted with the Facility Administrator who stated the pharmacist comes to the facility monthly to do medication regimen reviews, a copy of the recommendations is given to the Director of Nursing who would distribute them to the Unit Managers on each unit. The facility's previous Director of Nursing left the facility approximately two weeks prior to survey. The Administrator stated the Pharmacist will now give a copy of the recommendations to her.

During the end of day debriefing on 10/5/2017, the facility Administrator, the Director of Nursing and Corporate Nurses (Admin C and Admin D) were informed of the findings. Admin C stated the Physicians should review the Pharmacist

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Recommendations should review the monthly Medication Regimen Reviews Recommendations timely for each resident.

No further information was provided.

4. For Resident #4, the facility staff failed to ensure a medication irregularity identified by the pharmacist was acted upon.

Resident #4, a 94 year old, was admitted to the facility on 2/3/17. Her diagnoses included dementia, dysphagia, agitation, hypertension, reflux and depression.

The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 8/11/17. She was coded to have moderate cognitive impairment and required extensive assistance with her activities of daily living.

It was documented in the clinical record that the pharmacist completed the monthly medication review on Wednesday, 9/27/17. The pharmacist documented that an irregularity was noted. Information regarding the irregularity was not located in the clinical record. The corporate nurse was asked to locate the information.

On Thursday, 10/5/17 at 9:35 a.m., the corporate nurse stated that the facility had not yet received the irregularity report information from the the pharmacist. This was eight days after the original pharmacy note was written.

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F 428	Continued From page 52 The issue was reviewed with the Administrator and corporate nurses at the end of day meeting on 10/5/17.	F 428		