To all surveyors:

The form is to be used for purposes of sending information back to your supervisor, after you approve or reject a Plan of Correction (POC). All of the LTC supervisors are using this form for consistency, so please discontinue use of other forms. Please, fill out all of the information as needed in the white boxes as applicable. This will assist the supervisors in determining if a revisit for the survey as required. If you have additional information, include it in the comments or in an email to your supervisor.

POC REVIEW/PAPER REVISIT FORM

Facility Name: [illegible]ng and Rehab	**Provider ID #:** 49-5362
Is this an [illegible] Date **within 45 days**? No NO	**Date of Admin's Signature:** 10/20/17
Survey: 9/29/17 [illegible] Licensure survey **45 days:** 11/1[illegible] [illegible]ned? **AOC:** 1[illegible] No	**Was this survey a 10 percenter? If so, enter entrance time: NO**
List below [illegible]s - OR - **Insert date on this line if AOC date is the same for all tags:**	
01. ALL	02.
[illegible]	04.
[illegible]	06.
[illegible]	08.
[illegible]	10.
11.	12.
13.	14.
Date of [illegible]	**Date of Facility Notification:**
[illegible]f [illegible]cable): 10/23/17	**Date Rejection letter/fax** (if applicable):
[illegible] [illegible]tion: 10/23/17	**Date of final Approval after rejection:**

[illegible] every single tag is wrong. All but F513 has an AOC of 11/14/17. The [illegible]7. F513 does not have an AOC date at all. It just says "5. Date of

10/24/17 TC to facility - Spoke to administrator will submit Corrected Copy ASAP.

[illegible] [illegible]veyor in hour [illegible] 1.00	**Review time** spent by supervisor in hour increments (e.g. 0.25, 0.5, etc.):

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 9/26/17 through 9/29/17. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety code survey/report will follow. The census in this 190 certified bed facility was 169 at the time of the survey. The survey sample consisted of 25 current resident reviews (Residents #1 through #23 and #31 through #32) and 7 closed record reviews (Residents #24 through #30).	F 000	RECEIVED OCT 20 2017 VDH/OLC	
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident, consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to	F 157	F157 1.Resident#2 suffered no adverse effects and did not require transfer to a higher level of care. A Physician order was obtained to discontinue Resident#2's order for Urinalysis. The Physician and responsible party were notified. Resident #15 suffered no adverse effects and did not require transfer to higher level of care. A physician order for Resident#15's Sputum culture to be discontinued was obtained by the Physician. The Physician and the responsible party received notification.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 10/20/17

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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F 157	Continued From page 1 commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document and clinical record review, it was determined that the facility staff failed to notify the physician of a change in status and treatment for two of 34 residents in the survey sample; Residents #2 and #15. 1. The facility staff failed to notify the physician when a urinalysis laboratory specimen was not obtained as ordered on 5/26/17 for Resident #2.	F 157	2. A quality review of current residents with physician orders for laboratory testing has been performed. Physician notification related to laboratory results is in present in the chart. 3. Licensed Nurses re-educated by DCS/Designee regarding following Physician orders on obtaining laboratory specimen and the process in following up with	

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F 157	Continued From page 2 2. The facility staff failed to notify the physician when a sputum culture and sensitivity was not obtained as ordered on 9/2/17 for Resident #15. The findings include: 1. The facility staff failed to notify the physician when a urinalysis laboratory specimen was not obtained as ordered on 5/26/17 for Resident #2. Resident #2 was admitted to the facility on 5/1/17 with diagnoses that included but were not limited to: HIV (human immunodeficiency virus), dementia, depression, difficulty swallowing and elevated cholesterol. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 8/8/17 coded Resident #2 as rarely or never being able to understand others or to be understood. The resident was coded as requiring assistance from staff for all activities of daily living. Review of the resident's comprehensive care plan developed on 5/6/17 did not address obtaining urine specimens. Review of Resident #2's physician orders dated on 5/26/17 documented, "Clean Catch U + A (urine and analysis) on 5/30/17." Review of the clinical record did not evidence documentation of the urine specimen results. A request was made on 9/27/17 at 1:45 p.m. of ASM (administrative staff member) #1, the administrator/executive director, for a copy of the urine specimen results.	F 157	laboratory results including Physician and RP notification. DCS/Designee during Morning Clinical Meeting to conduct quality monitoring of physician laboratory orders, contacting the Physician and RP notification daily x4, weeklyx4 and then monthly, PRN and as indicated.	

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An interview was conducted on 9/28/17 at 10:58 a.m. with ASM #2, the director of nursing/clinical services. ASM #2 stated, "I don't have the lab (laboratory specimen) which is why the order was discontinued." (The staff obtained an order to discontinue the urine specimen order on 9/27/17.) When asked when staff notified the physician if they were not able to follow an order, ASM #2 stated, "It probably depends on what the physician wants. I would say a day."

An interview was conducted on 9/28/17 at 12:25 p.m. with LPN (licensed practical nurse) #3. When asked when staff notified a physician if they were not able to follow an order, LPN #3 stated, "Within a day." When asked when the physician was notified if staff could not obtain a urine specimen, LPN #3 stated, "It was an order. I would notify the doctor and notify the next shift."

Review of the facility's policy titled, "Laboratory, Diagnostic and X-Ray" did not evidence documentation regarding notifying the physician if staff were not able to obtain a laboratory specimen.

No further information was provided prior to exit.

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

4.DCS/Designee to conduct quality monitoring regarding physician notification with documentation in the medical record as indicated. Findings to be communicated to the QAPI committee monthly and as indicated. Quality monitoring schedules modified based on findings

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is responsible for directing the medical treatment of a patient.

2. The facility staff failed to notify the physician when a sputum culture and sensitivity was not obtained as ordered on 9/2/17 for Resident #15.

Resident #15 was admitted to the facility on 10/3/16 with diagnoses that included but were not limited to: seizures; schizophrenia; kidney disease, diabetes, high blood pressure and stroke. The most recent MDS, a quarterly assessment, with an ARD of 7/7/17 coded the resident as having scored a 13 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of Resident #15's care plan initiated on 10/13/16 and revised on 7/26/17 did not evidence documentation related to obtaining sputum specimens.

Review of the physician's orders dated 9/2/17 documented, "Obtain sputum c+s (culture and sensitivity) on Tuesday (9/5/17)."

Review of the clinical record did not evidence documentation of the sputum specimen results. A request was made on 9/27/17 at 1:45 p.m. of ASM (Administrative Staff Member) #1, the administrator/executive director, for a copy of the sputum specimen results.

An interview was conducted on 9/28/17 at 10:58 a.m. with ASM #2, the director of nursing/clinical

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services. ASM #2 stated, "I don't have the lab (laboratory specimen) which is why the order was discontinued." (The staff obtained an order to discontinue the sputum specimen on 9/27/17.) When asked when staff notified the physician if they were not able to follow an order, ASM #2 stated, "It probably depends on what the physician wants. I would say a day."

An interview was conducted on 9/28/17 at 12:25 p.m. with LPN (licensed practical nurse) #3. When asked when staff notified a physician if they were not able to follow an order, LPN #3 stated, "Within a day." When asked when the physician was notified if staff could not obtain a sputum specimen for culture and sensitivity as ordered by the physician, LPN #3 stated, "It was an order. I would notify the doctor and notify the next shift."

No further information was provided prior to exit.

F 157

F 166 SS=D 483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES

(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The

F 166

F166

1. Resident #3's grievance on 1/25/17 has been resolved.
2. The administrator met with Resident council to inquire about any unresolved grievances. All grievances are up to date and have been resolved.

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grievance policy must include:

(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;

(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately

3. The administrator and or designee re-educated staff on the Grievance Process to ensure compliance is attained and maintained regarding resolving grievances.
4. The administrator and or designee to conduct Quality monitoring of the grievance log Quality monitoring to be conducted 3X a week per week for 4 weeks to ensure compliance and then 1X a week per month and then quarterly thereafter. Quality monitoring schedule to be modified based on findings of quality reviews. The

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reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;

(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and

(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.

This REQUIREMENT is not met as evidenced by:

Based on staff interview, facility document review, clinical record review and in the course of complaint investigation, it was determined that facility staff failed to resolve a reported grievance for one of 34 residents in the survey sample, Resident #3.

results of the Quality monitoring to be reviewed at the monthly quality assurance performance Improvement (QAPI) meetings for review, analysis and further recommendations.

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The facility staff failed to resolve Resident #3's grievance reported to the social worker by the responsible party (RP) about a missing laundry basket full of dirty clothes in January of 2017.

The findings include:

Resident #3 was admitted to the facility on 6/20/14 with diagnoses that included but were not limited to: schizophrenia, Alzheimer's Disease, enlarged thyroid, depression and glaucoma. Resident #3's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 8/24/17. Resident #3 was coded as being severely impaired in cognitive function scoring 04 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #3 was coded as requiring supervision only with transfers, ambulation, locomotion, and eating; minimal assistance with one staff member with dressing, and personal hygiene; and extensive assistance with one staff member with bathing.

Review of the January 2017 grievance logs revealed, Resident #3's son (responsible party) had voiced a grievance on 1/25/17 about Resident #3's missing clothes. The following was documented, "1/25/17 Resident (Resident #3) is missing her laundry basket with her dirty clothes in it. Resolution: The facility does the resident's laundry-Grievance still pending with Laundry Director."

Further review of the grievance logs failed to document the outcome of Resident #3's grievance from 1/25/17.

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Review of Resident #3's clinical record failed to reveal any notes about a missing laundry basket.

On 9/27/17 at 2:42 p.m., an interview was conducted with OSM (Other staff member) #7, the social worker. OSM #7 was asked about the process followed by staff when a resident or family member reports a grievance to a staff member. OSM #7 stated, "Whoever takes the concern, will take it to social services and then we will create a grievance form." OSM #7 stated after the grievance form is completed, she will take the concern to administration. OSM #7 stated if the grievance is regarding missing clothing, administration will have staff look for the articles of clothing in laundry or throughout the facility. OSM #7 stated if the facility cannot locate the missing clothing, the facility will reimburse the resident/family and then fill out a Petty Cash Reimbursement form. When asked if the resident or family member is always reimbursed in cash, OSM #7 stated that they will call the resident or family and ask if they would rather be reimbursed in cash or have the item (s) replaced. When asked if she was familiar with the above grievance filed on 1/25/17 from Resident #3's RP, OSM #7 stated she was not. OSM #7 stated another social worker worked at the facility during that time. OSM #7 stated sometime in June of 2017, Resident #3's son had placed copies of receipts in her box and requested that he be reimbursed for missing clothing. OSM #7 stated she had the laundry director look for the clothes that were supposedly missing. OSM #7 stated the facility reimbursed Resident #3's RP when the clothes were unable to be located. When asked if the missing clothes reported in June 2017, were the same clothes that were missing back in

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January, OSM #7 stated she was not sure. OSM #7 stated she would try to find the soft file for the grievance back in January to see what was done to resolve the concern. When asked if the laundry director was available, OSM #7 stated the previous laundry director would be familiar with above concern and he was no longer employed with the facility.

On 9/27/17 at 3:08 p.m., an interview was conducted with OSM (other staff member) #11, a laundry aide who had worked at the facility for a few years. When asked how she is made aware that a resident is missing an article of clothing, OSM #11 stated that administration will tell her boss (the laundry director) about the missing item and then her boss will tell her. OSM #11 stated that she will then search for the item (s). OSM #11 could not recall Resident #3's missing laundry basket full of dirty clothes. OSM #11 stated she was never made aware of it.

On 9/27/17 at 4:00 p.m., an interview was conducted with OSM #13, the director of housekeeping and laundry. He could not recall the above grievance. OSM #13 stated that he was not the laundry director at that time.

On 9/27/17 at 5:43 p.m., further interview was conducted with OSM #7. OSM #7 stated she could not find any information regarding Resident #3's grievance on 1/25/17. OSM #7 stated she was not sure how the grievance was resolved. OSM #7 had also presented a copy of the receipts Resident #3's RP had placed in her box in June of 2017. A petty cash reimbursement request was attached to the receipts. The following was documented: "Date of Request: 6/19/17, Replacement receipts attached:

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Yes-Resident's son, (Name of son) stated that resident is missing these items. Missing clothes -pants, stretch pants, socks. Amount reimbursement requested: $135.95." OSM #7 also presented a copy of an email from Resident #3's RP confirming he had received the reimbursement for clothes. The following was documented, "I (name of RP) POA (power of attorney) received $135.00 cash in regards to (Name of Resident #3) reimbursement for clothing missing."

On 9/27/17 at 6:00 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator/executive director. When asked about the process followed if a resident or family member reports a concern, ASM #1 stated a grievance or concern can be reported to any staff member and that staff member should then fill out a grievance concern form. ASM #1 stated the form is given to administration and then administration will try to resolve the concern. When asked about the process followed if the concern is regarding missing clothing, ASM #1 stated she will try to investigate the concern for missing clothing within 14 days. ASM #1 stated if the clothing cannot be located, she will reimburse the family or resident. When asked if she could recall Resident #3's RP's (responsible party) concern for a missing laundry basket full of dirty clothes back in January of 2017, ASM #1 stated she was not sure. ASM #1 stated she would look to see what was done to resolve that concern.

On 9/28/17 at 5:15 p.m., ASM #1 stated she could not find any documentation showing the grievance filed on 1/25/17 was resolved. ASM #1 was made aware of the above concerns,

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	495362	A. BUILOING _____ B. WING _____	C 09/29/2017

NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETION DATE
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Facility policy titled, "Complaint/Grievance" documents in part, the following: "Purpose: To support each resident's right to voice grievances; resulting in a follow-up and resolution while keeping the resident apprised of it progress toward resolution. Process: An employee receiving a complaint/grievance from a resident, family member and/or visitor shall initiate a Complaint/Grievance Form or electronic equivalent. - Complaint/Grievance forms will be available 24 hours per day 7 days a week in an unsecured common area. - Accommodations will be made to ensure residents have the opportunity regardless of their physical abilities or limitations. Original grievance forms are then submitted to the Grievance Officer/designee for further action. The Grievance Officer/designee shall act on the grievance and begin follow-up of the concern or submit it to the appropriate department director for follow-up. The grievance follow-up should be completed in a reasonable time frame; this should not exceed 14 days. The findings of the grievance shall be recorded on the Complaint /Grievance form or electronic equivalent. Once the follow up is complete, the results should be forwarded to the Executive Director for review and filing. The executive director/designee will log complaints/grievances in Monthly Grievance Log or electronic equivalent. The individual voicing the grievance shall receive follow up communication with the resolution, a copy of the grievance resolution will be provided to the resident upon request."

No further information was presented prior to exit.

COMPLAINT DEFICIENCY

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F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE	F 167		

(g)(10) The resident has the right to-

(i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and

(g)(11) The facility must--

(i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.

(ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and

(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

(iv) The facility shall not make available identifying information about complainants or residents.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, it was determined that facility staff failed to ensure the plan of correction from the last standard survey was in the survey results binder.

The facility staff failed to ensure the plan of correction from the last standard survey dated 10/6/2016 was in the survey results binder.

F 167

1. The Plan of correction from the last Standard Survey (2016) is posted in the Survey Results Binder and Binder is clearly marked for easy identification.
2. Residents through Resident Meeting have been notified of Survey Results Binder location.
3. The Administrator and or designee re-educated the current Interdisciplinary Team on Survey Results Binder requirement to ensure compliance with requirement to post Plans of Corrections in Survey Binder for Including Plans of corrections in Survey Results Binder.

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The findings include:

On 9/28/17 at 5:30 p.m., observation of the survey results binder was conducted. The binder contained surveys from the past two years. The POC (plan of correction) from the last standard survey conducted 10/6/16, could not be found in the binder.

On 9/28/17 at 7:40 a.m., the POC from the last standard survey was requested from ASM (administrative staff member) #2, the DON (Director of Nursing)/clinical services. ASM #2 stated that the POC should be in survey results binder. ASM #2 checked the binder, could not find the POC, and stated she would go try to find the POC.

On 9/28/17 at 8:00 a.m., ASM #1, (the executive director/administrator) stated, "You got me. Corporate keeps asking for a copy of the 2567, I must have put the wrong one back in the binder." ASM #1 stated she was responsible for maintaining the survey results binder.

On 9/28/17 at 8:00 a.m., ASM #1 and ASM #2 were made aware of the above concerns. No further information was presented prior to exit.

F 221 SS=D 483.10(e)(1), 483.12(a)(2) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS

§483.10(e) Respect and Dignity.

The resident has a right to be treated with respect and dignity, including:
§483.10(e)(1) The right to be free from any

F 167

4. The Administrator and or designee to conduct Quality Monitoring of Survey Results Binder for including Plans of Corrections. Quality Monitoring to be conducted 3X a week per week for 4 weeks to ensure compliance and then 1X a week per month and then quarterly thereafter. Quality Monitoring Schedule to be modified based on the findings of the Quality Reviews. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis and further recommendations.
5. November 14, 2017

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F 221	Continued From page 15 physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). 42 CFR §483.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. (a) The facility must- (1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to ensure a resident was free from a physical restraint for one of 34 residents in the survey sample, Resident #1. Resident #1 was inappropriately restrained to a wheelchair without an evaluation or monitoring on 2/10/17.	F 221	Past noncompliance: no plan of correction required.	

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The findings include:

Resident #1 was admitted to the facility on 3/28/16. Resident #1's diagnoses included but were not limited to: repeated falls, dementia and blindness. Resident #1's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 8/4/17, coded the resident's cognitive skills for daily decision making as severely impaired. Section G coded Resident #1 as being totally dependent of one staff with transfers, locomotion, dressing, eating and personal hygiene.

Review of Resident #1's clinical record failed to reveal any assessments regarding physical restraints. Resident #1's comprehensive care plan initiated on 8/29/16 documented the resident presented with behaviors such as playing with feces, attempting to stand/transfer without assistance and combative behaviors. The care plan failed to document information regarding a physical restraint.

A nurse's note dated 2/10/17 documented, "Rn (registered nurse) observed resident secured to wheelchair with blanket. Blanket immediately removed. Resident alert and confused, lungs clear, abdomen soft and nontender. Resident with old scabs to the L (left) forearm and left hand...No observable s/sx (signs or symptoms) bruising or distress. MD (medical doctor)/RP (responsible party) made aware of incident. Law enforcement notified. Resident will continue to be monitored."

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A FRI (facility reported incident) submitted to the Virginia Department of Health Office of Licensure and Certification on 2/10/17 documented, "Report date: 2/10/2017. Incident date: 2/10/2017. Incident type: (an 'X' beside) Allegation of abuse/mistreat. Describe incident, including location, and action taken: The Director of Clinical Services was called to the secured unit this morning by a CNA (certified nursing assistant) and she observed the said resident (Resident #1) sitting in his wheelchair with the ties of a blanket fastened to the back of the wheelchair. The Director of Clinical Services immediately released the ties and assessed the resident and found him to be in no acute distress, no bruises or skin changes noted. The Director of Clinical Services immediately suspended the CNAs and the Nurse attending to (name of Resident #1). The Resident was assessed by the Medical Director of the facility and found to be in no acute distress and no observable bruising or skin issues noted. Social Services has assessed (name of Resident #1) and he is at baseline and he appears to have suffered no distress from this incident. We will continue to monitor the resident for adverse affects (sic) as we complete a full investigation. A final report will be completed within 5 working days and sent to your office..."

The final report submitted to the Office of Licensure and Certification on 2/16/17 documented, "This is a follow up to an initial Facility Reported Incident filing submitted to your office on February 10, 2017 involving resident (name of Resident #1). (Name of Resident #1) is a 66 y/o (year old) resident with the following diagnoses: Hypertension (high blood pressure), Repeated Falls, Dementia with behavioral disturbances. He has been assessed to be

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cognitively impaired with a BIMS (brief interview for mental status) score of 0. On February 10, 2017, the Director of Clinical Services was called to the secured unit by a CNA and she observed (name of Resident #1) with the ties of a blanket fastened to the back of his wheelchair. The Director of Clinical Services immediately released the ties and assessed the resident and found him to be in no acute distress, no bruises or skin changes noted. The Director of Clinical Services immediately suspended the CNAs and the Nurse attending to (name of Resident #1). The resident was assessed by the Medical Director of the facility and found to be in no acute distress and no observable bruising or skin issues noted. Social Services has assessed (name of Resident #1) and he appears to have suffered no distress from this incident. CNA (name) was suspended, CNA, (name) was suspended. CNA, (name) was suspended and LPN (licensed practical nurse) (name) was suspended pending investigation. The Town of Ashland Police Department was contacted and Patrol Officer (name) responded with report number (number). Interviews with Staff were conducted to reveal that (name) is the CNA that cared for (name of Resident #1) and fastened the ties of the blanket to (name of Resident #1's) wheelchair. Based on the evidence above, the allegation was substantiated and (name of CNA) has been terminated. (Name of CNA) has also been reported to the board of Nursing. The center will continue to monitor (name of Resident #1) related to this incident and intervene accordingly. If you have any questions or concerns, please don't hesitate to contact me."

Multiple observations of Resident #1 were conducted during the survey. A one on one sitter was with the resident during each observation.

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No concerns regarding a physical restraint were identified.

On 9/27/17 at 11:05 a.m. an interview was conducted with CNA (certified nursing assistant) #9, an employee working on Resident #1's unit on 2/10/17. CNA #9 stated on 2/10/17 she noticed Resident #1 was not moving and was tied up. CNA #9 stated she got another CNA who got the director of clinical services while she (CNA #9) stayed with Resident #1. CNA #9 stated she untied the restraint a little while waiting for the director of clinical services. When asked to describe how Resident #1 was tied up, CNA #9 stated the resident was in a wheelchair. CNA #9 stated the front of a sheet was covering the resident's lap and the back of the sheet was rolled up and tied around the resident and the back of the wheelchair.

Attempts to contact the other staff working on Resident #1's unit on 2/10/17 were conducted during the survey. The staff were not available for interview.

On 9/27/17 at 5:37 p.m. an interview was conducted with ASM (administrative staff member) #2 (the director of nursing/clinical services). ASM #2 stated on the morning of 2/10/17 a CNA called her to come to Resident #1's unit. ASM #2 stated when she got to the unit Resident #1 was sitting upright in a wheelchair and she inquired what was going on. ASM #2 stated Resident #1 had a blanket around his waist and the staff motioned for her to look at the back of the wheelchair. ASM #2 stated Resident #1 was tied to the wheelchair. ASM #2 stated she released the resident, completed a full body assessment, a pain assessment and started an

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investigation. ASM #2 stated she called the administrator to the unit, called the police, notified the Office of Licensure and Certification, and notified the resident's physician and responsible party. ASM #2 stated no one admitted to securing a blanket around Resident #1 but based on the investigation she identified the CNA that was more than likely responsible, terminated the CNA and reported the CNA to the department of health professions. ASM #2 stated she also completed a full abuse in-service with staff.

On 9/27/17 at approximately 6:00 p.m. ASM #1 (the executive director/administrator) and ASM #2 were made aware of the above concern.

The facility policy titled, "Physical Restraints" documented, "Residents have the right to considerate and respectful care at all times and under all circumstances, with recognition of their personal dignity and safety in the least restrictive manner. As needed, the interdisciplinary team will evaluate the resident for the potential need for physical restraint. The restraint must be the least restrictive means available. If a resident is identified by the interdisciplinary team and/or a discipline as requiring further intervention due to safety concerns, alternative methods will be attempted before restraint application will be considered..."

A restraint four-point plan of correction dated 2/10/17 documented, "1. A resident was physically restrained to his wheelchair with a blanket by a staff member. The resident was immediately released and assessed by Nursing Staff. MD/RP (medical doctor/responsible party) and the authorities were immediately notified. Notification was sent to APS (adult protective

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services) Ombudsman and an investigation was started. 2. Residents that reside in this facility have the potential to be physically restrained. All residents in the facility were checked and no residents were found to be physically restrained. 3. Staff members to be educated on (name of corporation's) policy and procedure around restraints, resident abuse and dealing with behaviors. Employees have been instructed that at no time under any circumstances are residents to be secured to equipment unless indicated by a medical doctor. The DCS (director of clinical services) or designee will conduct audits 5X (times) a week X 2 weeks and then 1X week X 1 month to ensure compliance. Staff will be in-serviced on resident abuse monthly. 4. Findings of audits to be discussed during QAPI (quality assurance performance improvement) X 2 months alson (sic) with root cause analysis assessments as needed. Compliance date: 2/13/2017." Credible evidence regarding the plan was reviewed and the facility was found to be in compliance during the survey.

No further information was provided prior to exit.

COMPLAINT DEFICIENCY

PAST NON-COMPLIANCE

F 223 SS=D 483.12(a)(1) FREE FROM ABUSE/INVOLUNTARY SECLUSION — F 223

483.12
The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and

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any physical or chemical restraint not required to treat the resident's symptoms.

483.12(a) The facility must-
(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to ensure a resident was free from abuse for one of 34 residents in the survey sample, Resident #1.

Resident #1 was inappropriately restrained to a wheelchair without an evaluation or monitoring on 2/10/17.

The findings include:

Resident #1 was admitted to the facility on 3/28/16. Resident #1's diagnoses included but were not limited to: repeated falls, dementia and blindness. Resident #1's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 8/4/17, coded the resident's cognitive skills for daily decision making as severely impaired. Section G coded Resident #1 as being totally dependent of one staff with transfers, locomotion, dressing, eating and personal hygiene.

Review of Resident #1's clinical record failed to reveal any assessments regarding physical restraints. Resident #1's comprehensive care

Past noncompliance: no plan of correction required.

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plan initiated on 8/29/16 documented the resident presented with behaviors such as playing with feces, attempting to stand/transfer without assistance and combative behaviors. The care plan failed to document information regarding a physical restraint.

A nurse's note dated 2/10/17 documented, "Rn (registered nurse) observed resident secured to wheelchair with blanket. Blanket immediately removed. Resident alert and confused, lungs clear, abdomen soft and nontender. Resident with old scabs to the L (left) forearm and left hand...No observable s/sx (signs or symptoms) bruising or distress. MD (medical doctor)/RP (responsible party) made aware of incident. Law enforcement notified. Resident will continue to be monitored."

A FRI (facility reported incident) submitted to the Virginia Department of Health Office of Licensure and Certification on 2/10/17 documented, "Report date: 2/10/2017. Incident date: 2/10/2017. Incident type: (an 'X' beside) Allegation of abuse/mistreat. Describe incident, including location, and action taken: The Director of Clinical Services was called to the secured unit this morning by a CNA (certified nursing assistant) and she observed the said resident (Resident #1) sitting in his wheelchair with the ties of a blanket fastened to the back of the wheelchair. The Director of Clinical Services immediately released the ties and assessed the resident and found him to be in no acute distress, no bruises or skin changes noted. The Director of Clinical Services immediately suspended the CNAs and the Nurse attending to (name of Resident #1). The Resident was assessed by the Medical Director of the facility and found to be in no acute distress

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and no observable bruising or skin issues noted. Social Services has assessed (name of Resident #1) and he is at baseline and he appears to have suffered no distress from this incident. We will continue to monitor the resident for adverse affects (sic) as we complete a full investigation. A final report will be completed within 5 working days and sent to your office..."

The final report submitted to the Office of Licensure and Certification on 2/16/17 documented, "This is a follow up to an initial Facility Reported Incident filing submitted to your office on February 10, 2017 involving resident (name of Resident #1). (Name of Resident #1) is a 66 y/o (year old) resident with the following diagnoses: Hypertension (high blood pressure), Repeated Falls, Dementia with behavioral disturbances. He has been assessed to be cognitively impaired with a BIMS (brief interview for mental status) score of 0. On February 10, 2017, the Director of Clinical Services was called to the secured unit by a CNA and she observed (name of Resident #1) with the ties of a blanket fastened to the back of his wheelchair. The Director of Clinical Services immediately released the ties and assessed the resident and found him to be in no acute distress, no bruises or skin changes noted. The Director of Clinical Services immediately suspended the CNAs and the Nurse attending to (name of Resident #1). The resident was assessed by the Medical Director of the facility and found to be in no acute distress and no observable bruising or skin issues noted. Social Services has assessed (name of Resident #1) and he appears to have suffered no distress from this incident. CNA (name) was suspended, CNA, (name) was suspended. CNA, (name) was suspended and LPN (licensed practical nurse)

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(name) was suspended pending investigation. The Town of Ashland Police Department was contacted and Patrol Officer (name) responded with report number (number). Interviews with Staff were conducted to reveal that (name) is the CNA that cared for (name of Resident #1) and fastened the ties of the blanket to (name of Resident #1's) wheelchair. Based on the evidence above, the allegation was substantiated and (name of CNA) has been terminated. (Name of CNA) has also been reported to the board of Nursing. The center will continue to monitor (name of Resident #1) related to this incident and intervene accordingly. If you have any questions or concerns, please don't hesitate to contact me."

Multiple observations of Resident #1 were conducted during the survey. A one on one sitter was with the resident during each observation. No concerns regarding a physical restraint were identified.

On 9/27/17 at 11:05 a.m. an interview was conducted with CNA (certified nursing assistant) #9, an employee working on Resident #1's unit on 2/10/17. CNA #9 stated on 2/10/17 she noticed Resident #1 was not moving and was tied up. CNA #9 stated she got another CNA who got the director of clinical services while she (CNA #9) stayed with Resident #1. CNA #9 stated she untied the restraint a little while waiting for the director of clinical services. When asked to describe how Resident #1 was tied up, CNA #9 stated the resident was in a wheelchair. CNA #9 stated the front of a sheet was covering the resident's lap and the back of the sheet was rolled up and tied around the resident and the back of the wheelchair.

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Attempts to contact the other staff working on Resident #1's unit on 2/10/17 were conducted during the survey. The staff were not available for interview.

On 9/27/17 at 5:37 p.m. an interview was conducted with ASM (administrative staff member) #2 (the director of nursing/clinical services). ASM #2 stated on the morning of 2/10/17 a CNA called her to come to Resident #1's unit. ASM #2 stated when she got to the unit Resident #1 was sitting upright in a wheelchair and she inquired what was going on. ASM #2 stated Resident #1 had a blanket around his waist and the staff motioned for her to look at the back of the wheelchair. ASM #2 stated Resident #1 was tied to the wheelchair. ASM #2 stated she released the resident, completed a full body assessment, a pain assessment and started an investigation. ASM #2 stated she called the administrator to the unit, called the police, notified the Office of Licensure and Certification, and notified the resident's physician and responsible party. ASM #2 stated no one admitted to securing a blanket around Resident #1 but based on the investigation she identified the CNA that was more than likely responsible, terminated the CNA and reported the CNA to the department of health professions. ASM #2 stated she also completed a full abuse in-service with staff.

On 9/27/17 at approximately 6:00 p.m. ASM #1 (the executive director/administrator) and ASM #2 were made aware of the above concern.

The facility policy titled, "Resident Abuse" documented, "It is inherent in the nature and dignity of each resident at The Company that he/she be afforded basic human rights, including

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the right to be free from abuse, neglect, mistreatment, exploitation and/or misappropriation of property. The management of the facility recognizes these rights and hereby establishes the following statements, policies, and procedures to protect these rights and to establish a disciplinary policy, which results in the fair and timely treatment of occurrences of resident abuse. Employees of The Company are charged with a continuing obligation to treat residents so they are free from abuse, neglect, mistreatment, and/or misappropriation of property..."

A restraint four-point plan of correction dated 2/10/17 documented, "1. A resident was physically restrained to his wheelchair with a blanket by a staff member. The resident was immediately released and assessed by Nursing Staff. MD/RP (medical doctor/responsible party) and the authorities were immediately notified. Notification was sent to APS (adult protective services) Ombudsman and an investigation was started. 2. Residents that reside in this facility have the potential to be physically restrained. All residents in the facility were checked and no residents were found to be physically restrained. 3. Staff members to be educated on (name of corporation's) policy and procedure around restraints, resident abuse and dealing with behaviors. Employees have been instructed that at no time under any circumstances are residents to be secured to equipment unless indicated by a medical doctor. The DCS (director of clinical services) or designee will conduct audits 5X (times) a week X 2 weeks and then 1X week X 1 month to ensure compliance. Staff will be in-serviced on resident abuse monthly. 4. Findings of audits to be discussed during QAPI

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F 223	Continued From page 28 (quality assurance performance improvement) X 2 months alson (sic) with root cause analysis assessments as needed. Compliance date: 2/13/2017." Credible evidence regarding the plan was reviewed and the facility was found to be in compliance during the survey. No further information was provided prior to exit. COMPLAINT DEFICIENCY PAST NON-COMPLIANCE	F 223		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that facility staff failed to ensure access to call bells in resident bathrooms for two of 14 resident bathrooms on the Hanover station unit. The bathrooms for rooms 300 and 301, had a metal pull string to the call bell system that measured 4 inches in length and was not accessible from the toilet or floor for resident use if desired/needed.	F 246	F246 1. The call bells for bathrooms 300 and 301 in Hanover Station have been replaced with PVC String that measures 55 inches from the metal pull station to the floor that is accessible from the toilet or floor for resident use if desired or needed.	

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F 246	Continued From page 29 The findings include: On 9/26/17 at 1:15 p.m., observation of the bathrooms for room 300 and 301 was conducted on the Hanover Station unit. The metal pull string to the call bell system measured 4 inches in length. The call bells did not have a long nylon string attached to the metal string, like the other bathrooms on the unit. The call bell system was next to the toilet but was barely accessible. The call bell system was also placed four feet above the floor and not accessible from the floor. On 9/27/17 at 8:30 a.m., an interview was conducted with OSM (other staff member) #12, the maintenance director. When asked how long the call bell string should be, OSM #12 stated, "These call bells are missing the nylon string." OSM #12 stated that the call bell string needs to be almost to the floor so that if a resident falls, they are able to reach it from the floor. When asked if a resident would be able to reach the metal pull string from the floor, OSM #12 stated, "No." OSM #12 stated that he was not aware that these bathrooms were missing the nylon string to the call bell. OSM #12 stated that he would attach a nylon string right away. On 9/28/17 at 5:00 p.m., ASM (administrative staff member) #1, the administrator/executive director and ASM #2, the DON (Director of Nursing)/clinical services, were made aware of the above concerns. The facility policy titled, "Call Bell System-Inoperable," did not address the above concerns. No further information was obtained prior to exit.	F 246	2. Call bell cords in bathrooms have been re-evaluated for call bell cords being accessible from the floor or toilet. Call bells have been reviewed by the Maintenance Director and or Designee and all residents have call bell access in their bathroom. 3. The Administrator and or designee re-educated current facility staff on bathroom call bell cords being assessable to ensure compliance with requirement.	

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F 248 SS=E	Continued From page 30 483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review, it was determined that facility staff failed to provide person-centered activities for two of 34 residents in the survey sample, Residents #12 and #15. 1. The facility staff failed to provide person-centered, individualized activities as per Resident #12's preferences documented on the significant change MDS (minimum data set) assessment with an ARD (assessment reference date) of 4/10/17. 2. The facility staff failed to provide activities as per Resident #15's preferences as documented on the admission MDS (minimum data set) with an ARD (assessment reference date) of 10/10/16 and in the social worker's notes of 12/19/16.	F 248 F 248	4. The Administrator and or designee to conduct Quality Monitoring of bathroom Call Bell cords for accessibility. Quality monitoring to be conducted 3X a week per week for 4 weeks to ensure compliance and then 1X a week per month and then Quarterly thereafter. Quality monitoring schedule to be modified based on findings of Quality Reviews. The results of the Quality Reviews. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis and further recommendations. 5. November 14, 2017	

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The findings include:

1. The facility staff failed to provide person centered, individualized activities as per Resident #12's preferences documented on the significant change MDS assessment with an ARD of 4/10/17.

Resident #12 was admitted to the facility on 8/12/15 with diagnoses that included but were not limited to enlarged prostate; heart failure, muscle weakness, hypothyroidism, dementia, and COPD (chronic obstructive pulmonary disease). Resident #12's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/11/17. Resident #12 was coded as being severely impaired in cognitive function scoring 03 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #12 was coded as requiring total dependence on one staff member with dressing, locomotion on the unit, eating, and bathing; and extensive assistance from one staff member with personal hygiene.

Review of Resident #12's significant change MDS assessment with an ARD of 4/10/17, documented under Section F "Preferences for Customary Routine and Activities," that is was "Very Important" for Resident #12 to listen to music, be around animals such as pets, keep up with the news, do things with groups of people, and to go outside to get fresh air when the weather is good. Further review of Section F revealed that it was "Somewhat Important" for Resident #12 to participate in religious services or practices.

Resident #12 was observed lying in his bed in his room on the following dates and times: 9/26/17 at

1. Resident #12 and 15's have been re-assessed and have been provided person centered activities. The MDS, Care Plan and Social Work note has been updated.

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4:00 p.m. and 5:15 p.m., 9/27/17 at 7:38 a.m., 10:05 a.m., 11:30 a.m., 12:20 p.m., 12:45 p.m., and 2:15 p.m.

Review of Resident #12's activity care plan dated 8/19/17 documented the following: "Focus: Resident is on 1:1 program for activities. Goal: Resident will be visited by activity assistant 2-3x (times) per week. Interventions: Encourage OOR (out of room) and independent activities congruent with resident abilities and interests. Evaluate time awake and observe gestures, expressions, and verbal responses and actions. Provide conversation and reality orientation during visits."

Review of Resident #12's activity note dated 8/19/17 documented the following: "Annual-Resident is now on 1:1 program with activity dept. (department). Resident spends a lot of time in his room and is thereby visited 2-3 x per week by activity staff. Resident is provided hydration, reality orientation, and conversation. Resident will be visited 2-3 x (times) per week by activities."

On 9/27/17 at 5:00 p.m., an interview was conducted with OSM (other staff member) #2, the activities director. OSM #2 stated that she had been the activity director for a month and a half at the facility. When asked the purpose of completing the activity MDS assessment and creating an activity care plan for each resident, OSM #2 stated that the goal was to get an idea of what each resident wanted to do. When asked what 1:1 activities meant on the care plan, OSM #2 stated that one to one activities were for those residents who do not like to leave the room or who are cognitively impaired and cannot

2. Current residents have been re-evaluated by the Activities Director and are offered person-centered activities. Updated Activity preferences have been reviewed by the Administrator and all residents have been re-assessed and provided person-centered activities. The MDS, Care Plan and Social Work notes have been updated.

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F 248	Continued From page 33	F 248	3. The Administrator and or designee re-educated the Activity staff on Person- Centered Activities to ensure compliance with person-centered activities. The Administrator and or designee re-educated MDS, Activity Staff and Social Work staff on care planning process, MDS process and Social Work notes policy by October 19, 2017.	

participate in group activities. When asked what type of activities Resident #12 liked to do, OSM #2 stated that she was not familiar with every resident but her assistants knew their residents well. Resident 12's activity logs were requested.

On 9/27/17 at approximately 5:10 p.m., OSM #2 presented Resident #12's activity logs.

Review of Resident #12's "Record of One-To-One Activities" for August and September 2017 documented the following:

"Date: 8-3, Description of activity: Lunch. Resident's Reaction/Response: Alert. Time Spent 20 m (minutes).
Date: 8-5, Description of activity: TV, check in. Resident's Reaction/Response: Waking up, excited. Time Spent: 5 (m).
Date: 8-9, Description of activity: Lunch. Resident's Reaction/Response: Alert, ready to eat. Time Spent: 15 (m).
Date: 8-18, Description of activity: TV, Movie, Talking. Resident's Reaction/Response: relaxed, alert. Time Spent 10 (m).
Date: 8-22, Description of activity: ADL (activities of daily living)/help. Resident's Reaction/Response: calm, appreciative. Time Spent: 10 (m).
Date: 8-29, Description of activity: check in, talking. Resident's Reaction/Response: Happy, ok. Time Spent: 5 (m).
Date: 9-5, Description of activity: lunch, TV. Resident's Response: Hungry. Time Spent: 15 (m).
Date: 9-8, Description of activity: ADL care. Resident's Response: Thankful. Time Spent: 10 (m)."

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F 248	Continued From page 34 Activity documentation after 9/8/17 could not be located. On 9/27/17 at 5:10 p.m., further interview was conducted with OSM #2. When asked if lunch was considered an activity, OSM #2 stated that if her assistant goes in to assist with lunch and socialize with the resident, then she would consider lunch an activity. When asked if she considered ADL care an activity, OSM #2 stated that ADL care should not be considered an activity and that staff should always be assisting with ADL care. When asked if she considered the television as an activity, OSM #2 stated that if her staff are watching the television with him and also socializing with Resident #12, then she would consider television an activity. When asked why Resident #12's activities stop at 9/8/17, OSM #2 stated that she was wondering the same thing. OSM #2 stated that she doesn't always check behind her assistants to ensure that they are documenting each visit with the residents. When asked if her activity assistants are also CNAs who work the floor, OSM #2 stated, "No." When OSM #2 was asked if Resident #12's care plan provided a good picture of his likes and dislikes and was resident centered, OSM #2 stated Resident #12's care plan was generic and you wouldn't be able to tell what Resident #12 liked to do by looking at his care plan. OSM #2 stated that she was in the process of re-doing activity care plans to make them individualized. When asked if Resident #12 ever got out of bed to attend activities, OSM #2 stated that she was not sure. When asked who was responsible for ensuring a resident was able to attend an activity of choice, OSM #2 stated, "We are responsible for telling nursing that we would like a resident to get to an activity. We	F 248	4. The Administrator and or designee to conduct Quality Monitoring of Person-Centered care activities, care plan process, MDS process and Social Work notes. Quality Monitoring to be conducted 3X a week per week for 4 weeks to ensure compliance and then 1X a week per	

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can't get them out of bed."

On 9/28/17 at 5:15 p.m., ASM (administrative staff member) #1, the executive director/administrator, and ASM #2, the DON (Director of Nursing)/clinical services, were made aware of the above concerns.

The facility policy titled, "Participation in Activities" documents in part, the following: "Residents have the right to attend and participate in activities of their choice. A daily record of resident activity involvement both independently and in group settings will be maintained in the Director of Therapeutic Recreational Services' office. Procedure: Residents are encouraged to attend and participate in activities of their choosing. However, residents will not be required to attend or participate in any activity program against their wishes...The facility to the extent as possible, will accommodate an individual's needs, adaptive equipment, and choices both inside and outside the facility, expect when the health and safety of the individual or other resident would be endangered. A record of the resident's involvement will be maintained in the Director of Therapeutic Recreational Services' office. The form should be completed as follows:
a. Daily activity record form is set up for each month.
b. Extra lines are available for any other additional programs or leisure pursuits.
c. Utilize the participation key to describe the residents degree of participation in the activity.
d. These sheets are for activity staff in assisting with quarterly documentation. Three months worth should be kept in the Director of Director of Therapeutic Recreational Services' office."

month and then quarterly thereafter. Quality Monitoring schedule to be modified based on findings of Quality reviews. The results of the Quality Monitoring to be reviewed at the Monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis and further recommendations.

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No further information was presented prior to exit.

2. The facility staff failed to provide activities as per Resident #15's preferences as documented on the admission MDS (minimum data set) with an ARD (assessment reference date) of 10/10/16 and in the social worker's notes of 12/19/16.

Resident #15 was admitted to the facility on 10/3/16 with diagnoses that included but were not limited to: seizures, schizophrenia, kidney disease, diabetes, high blood pressure and stroke.

The most recent MDS, a quarterly assessment, with an ARD of 7/7/17 coded the resident as having scored a 13 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the annual MDS assessment with an ARD of 10/10/16 in the activities section coded listening to music and participating in religious practices as being very important to Resident #15.

Review of the social worker's note dated 12/19/16 documented, "The resident continues to require assistance with her activities of daily living. The resident prefers to lie in her bed and does not like to get out of bed with the exception of going to appointments outside of the facility. The resident does not watch much television, but enjoys listening to the radio; especially gospel music. The resident has several gospel compact discs

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by gospel artists such as (names of artists) etc. The resident has made a request that those particular artists play continuously on her cd player."

Review of the resident's care plan initiated on 10/13/16 and revised on 4/5/17 documented, "Focus. The resident is independent for activities, cognitive stimulation, social interaction r/t (related to) Resident wishes not to participate. Interventions. Music."

An observation was made on 9/26/17 at 4:45 p.m. of Resident #15. The resident was lying in bed awake and calling out. There was no music or television on in the room.

An observation was made on 9/27/17 at 11:55 a.m. of Resident #15. The resident was lying in bed awake. There was no music or television on in the room.

An observation was made on 9/27/17 at 12:20 p.m. of Resident #15. The resident was lying in bed. Staff were in with the resident. There was no music or television on in the room.

An interview was conducted on 9/27/17 at 2:45 p.m. with OSM (other staff member) #7, the director of social services. When asked about resident's preferences for activities, OSM #7 stated, "Well, during out care plan meeting we should discuss it (activity preferences)." When asked to review the social worker's note of 12/19/16 regarding Resident #15's request to have the gospel music playing at all times and if that would be on the care plan, OSM #7 stated, "Yes, I should care plan that." When asked to review Resident #15's activities care plan

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regarding the resident's request, OSM #7 stated, "I'm not seeing it on the care plan."

An interview was conducted on 9/27/17 at 4:40 p.m. with OSM #1, the activities co-director. When asked the role of activities, OSM #1 stated, "We are looking to enhance quality of life, keeping them (the residents) oriented, making them feel comfortable. Keep them active." When asked how resident's activity preferences were obtained, OSM #1 stated, "We have an MDS list that scores them (the preferences) from one to five. We put it in the comprehensive care plan and I follow it."

A review of the activities log for 9/1/17 through 9/26/17 for Resident #15 documented that the television and music were on every day. There was no documentation that the resident had gospel music played or that the resident was offered to participate in religious services.

An interview was conducted on 9/27/17 at 4:50 p.m. with OSM #2, the director of activities. When asked the goal of activities for residents, OSM #2 stated, "To get an idea first of all for what they want to do." When asked to review Resident #15's September 2017 activity log, OSM #2 stated that someone was not really paying any attention to it and that the care plan for the resident's activities were "somewhat generic." When asked if it was important that residents received activities that were important to them, OSM #2 stated it was.

Review of the facility's policy titled, "Participation in Activities" documented, "Policy: Residents have the right to attend and participate in activities of their choice. Procedure: 4. The facility, to the

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F 248	Continued From page 39 extent possible, will accommodate an individual's needs..." On 9/28/17 at 7:28 a.m. ASM (administrative staff member) #1, the administrator/executive director,was made aware of the findings. No further information was provided prior to exit.	F 248	F252 1. In room 300 the drawer has been replaced in the cabinet used to contain the resident's clothes. The toilet paper rack to hold toilet paper was replaced in bathroom 300. In room 301a the handle to the upper drawer of the bedside end table was replaced. In room 301b the two large gouges behind the base of the bed were repaired. The toilet paper rack in 301's bathroom was replaced. The ceiling tiles for bathroom 302 and room 304 (shared bathroom) ceiling tiles were replaced. The baseboard in room 308b were repaired and replaced. The toilet paper holder was replaced in bathroom	
F 252 SS=E	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by:	F 252		

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Based on observation, staff interview, and facility document review, it was determined that facility staff failed to maintain a clean, comfortable and homelike environment for 6 of 16 resident rooms on the Hanover Station unit, 4 of 14 resident bathrooms on the Hanover Station unit, and 1 of 3 shower rooms, unit one.

1. The facility staff failed to maintain the Hanover Station unit in a clean homelike manner as follows:
In room 300, a drawer was missing from the cabinet used to contain the residents' clothes. The bathroom for room 300 was missing a toilet paper rack to hold toilet paper.
In room 301 (A-bed (the first bed), the handle to the upper drawer of the bedside end table was broken; and for B-bed (the second bed), two large gouges were observed behind the base of the bed. The bathroom for room 301 was missing a toilet paper rack to hold toilet paper.
The bathroom for room 302 and Room 304 (shared bathroom), was observed to have a ceiling tile that was buckling with a brown water stain on the tile.
In room 308 (B-bed (the second bed), the baseboard to the wall was pulled back exposing dry wall and old glue behind the second bed. The bathroom for room 308 and room 306 (shared bathroom) was missing a toilet paper rack to hold toilet paper; and the call bell cord appeared to be brown in color.
In room 311, the window was observed to have missing blinds.
In room 310, a drawer appeared to be broken from the cabinet used to contain the residents' clothes; the blinds were observed to be broken; and the bedside end table to the second (B) bed, was missing a knob on the second (bottom)

308 and room 306 (shared bathroom) and the call bell cord was replaced. The window blind was replaced in room 311. In room 310 the drawer was replaced in the cabinet used to contain the residents clothes and the blinds were replaced and the bedside table end table to B bed's know was replaced on the second bottom drawer in room 310. The ceiling tile was replaced near the bathroom door on the outside of the bathroom in room 330. The dried up brown feces in room 310b behind the bed was cleaned and disinfected. The dirty gloves and towels in the sink in shower room on unit 1 were removed.

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drawer.
For room 330 (private room), a water stain was observed on a ceiling tile near the bathroom door on the outside of the bathroom.

2. Dried up brown feces like substance was observed on the wall behind the headboard of the second bed (B-bed) in room 301 on the Hanover Station unit.

3. The unit one shower room was observed with dirty gloves and towels in the sink.

The findings include:

1. The facility staff failed to maintain the Hanover Station unit in a clean homelike manner.

On 9/26/17 at 1:15 p.m., observation of the Hanover Station (dementia) unit was observed. Room 300 was the first room observed. In room 300 a drawer was missing from the cabinet used to hold the resident's clothes. The bathroom for room 300 had marks on the wall from where the toilet paper rack used to be. There was no toilet paper rack in the bathroom. There was no toilet paper in the bathroom.

Room 301 was the second room to be observed. The end table next to the first bed had a broken handle on the top drawer. Two large gouges were observed behind the second bed. The first gouge measured approximately 18 inches long and the second gouge measured approximately 15 inches long. The bathroom to room 301 was missing the center piece to the toilet paper rack to hold the toilet paper roll. There was no toilet paper in the bathroom.

2. Night stands, drawers used to contain residents clothing, toilet paper racks, handle to drawers, large gouges in walls, ceiling tiles, baseboards, call bell cords, blinds, dried up feces, shower rooms have been reviewed by the Administrator and all have been replaced, repaired or cleaned.
3. The Administrator and or designee re-educated current staff on

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On 9/26/17 at 1:22 p.m., observation of the bathroom between room 302 and 304 was conducted. The bathroom was observed to have a ceiling tile that was buckling with a brown water stain on the tile.

On 9/26/17 at 1:25 p.m., observation of room 308 was conducted. The baseboard to the wall was observed pulled back exposing dry wall and old glue on the dry wall behind the second bed. The baseboard that was pulled back was kept in place by the bedside end table. The bathroom for room 308 that was shared with room 306 was missing a toilet paper rack. The nylon string attached to the call bell was covered with a brown substance.

On 9/26/17 at 1:27 p.m., observation of room 311 was conducted. The blinds to the window had sections where slats were missing.

On 9/26/17 at 1:28 p.m., an observation of room 310 was conducted. A cabinet drawer used to contain the residents' clothes appeared to be broken. A gap was observed in the cabinet where the drawer should have been sitting. The residents' window blind was observed with missing and broken off slats. The bedside table next to the second bed was observed with a hole next to the knob.

On 9/26/17 at 1:32 p.m., an observation was made of Room 330. A water stain was observed on a ceiling tile near the bathroom door on the outside of the bathroom.

On 9/27/17 at 8:30 a.m., a walk through was conducted with OSM (other staff member) #12, the maintenance director. When asked how

maintaining a Homelike Environment to ensure regulation is attained and maintained.

4. The Administrator and or designee to conduct random observations of the toilet paper racks to hold toilet paper, drawer knobs, handle to drawers, large gouges in rooms, ceiling tiles, baseboard, call bell cords with brown spots, window blinds, dried up feces on the wall, dirty gloves and towels in the shower room in the

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often maintenance walked the building to see if resident rooms, bathrooms etc. needed repairs, OSM #12 stated that he walks the building all the time, but it also depended on what nursing reported needed fixing to him. OSM #12 stated that if something needed to be fixed on the unit, nursing staff would log this information into the maintenance book on a repair requisition form. OSM #12 stated that the Hanover Station unit needed constant maintenance. OSM #12 stated that maintenance repairs sometimes get pushed back due to their current renovations on unit one and in the main dining room. OSM #12 stated that he also does weekly audits of the building but that it was difficult to see every room. OSM #12 stated that if he sees anything during the audits that need to be replaced, he will put this information on "homework" sheets and try to make repairs as soon as possible.

Room 300 was observed with OSM #12. When asked about the residents' cabinet drawer, OSM #12 stated that he has been trying to get a company in to replace all cabinets. OSM #12 stated that he had put in a request in with corporate for new furniture but he accidentally tried ordering from an un-approved company. OSM #12 stated the process for ordering furniture was placed on hold due to that reason. OSM #12 stated that the process for being approved for new furniture was also placed on hold because the company had facilities in Florida that needed repairs from the recent hurricane. OSM #12 stated that the cabinets in room 300 were from 1988 and that he could not find parts for them. OSM #12 was then taken into the bathroom of room 300. When asked if he could tell what was missing, OSM #12 stated, "The toilet paper holder. That might of went missing yesterday. I

sink. Quality monitoring to be conducted 3X a week per week for 4 weeks to ensure compliance and then 1X a week per month and then quarterly thereafter. Quality monitoring schedule to be modified based on findings of quality reviews. The results of the quality monitoring to be reviewed at the monthly quality assurance performance improvement (QAPI) meetings for review, analysis and further recommendations.

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wasn't aware of it."

Room 301was observed with OSM #12. The gouges behind the second bed were patched up with spackle. OSM #12 stated that he made rounds yesterday afternoon and went room to room to see what needed repair. OSM #12 stated, "I made a quick list." When asked for a copy of his list, OSM #12 stated, "I didn't write this one down. I fixed it on the fly." When asked if he looked at the resident's bathrooms' yesterday, OSM #12 stated that he did not look at the bathrooms. This writer took OSM #12 into the bathroom for room 301. OSM #12 confirmed that the center piece for the toilet paper rack was missing. OSM #12 stated that the residents on the Hanover Station unit always take the center piece from the toilet paper rack and lose them. OSM #12 stated that he is always replacing the toilet paper holders. OSM #12 stated that he was not aware of the missing toilet paper rack in room 301. OSM #12 stated that he was also not aware of the water stain on the ceiling tile of the bathroom shared by room 302 and 304.

On 9/27/17 at 8:15 a.m., room 308 was observed with OSM #12. The baseboard to the bottom of the wall behind the second bed was put back into place. OSM #12 confirmed that he had seen the baseboard of the wall folded up and had fixed it. OSM #12 stated that he was not sure how long the baseboard was folded back but he was not made aware of it until he made rounds yesterday. OSM #12 was then taken into the bathroom of room 308. When asked what color the nylon string attached to the call bell should be, OSM #12 stated, "white." When asked what he noticed about the nylon string, OSM #12 stated that the cord was brown and needed to be replaced. OSM

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On 9/27/17 at approximately 1:00 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator/executive director. ASM #1 stated that she made the OLC (Office of Licensure and Certification) aware that renovations were going on at this time and the facility may be a mess. A copy of the letter was requested.

Review of the letter sent to the OLC about the renovations documented the following: "I wanted to inform you of renovations that will begin here at (Name of facility) on tomorrow September 20, 2017. The construction crew will be removing the wallpaper and repairing a portion of the sheetrock and repainting the main dining room. The wallpaper in the Lobby will be taken down and painted. On our Unit 1, the wallpaper and the carpet will be removed from the walls and will be repainted. In addition, we are replacing all of the handrails in the center-we will be replacing them in small sections."

The above letter did not mention the above concerns.

On 9/28/17 at 5:15 p.m., ASM (administrative staff member) #1, the administrator/executive director, and ASM #2, the DON (Director of Nursing)/clinical services, were made aware of the above concerns.

No further information was presented prior to exit. A policy could not be provided.

2. Dried up brown feces like substance was observed on the wall behind the headboard of the

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second bed (B-bed) in room 301 on the Hanover Station unit.

On 9/26/17 at 1:20 p.m., observation of room 301 was conducted. Two large gouges were observed behind the second bed. While measuring the gouges in the wall; this writer noticed a foul odor and dried up brown feces like substance stuck to the wall behind the headboard of the bed.

On 9/26/17 at 3:00 p.m., a second observation was made of room 301. Dried up brown-feces like substance remained stuck to the wall behind the headboard of the bed.

On 9/26/17 at 4:10 p.m., an interview was conducted with CNA (certified nursing assistant) #12. When asked how often CNAs made rounds on the resident's rooms, CNA #12 stated, "Every 2 hours." When asked what Resident #12 looks for on her rounds, CNA #12 stated that she checks on the residents and looks at the cleanliness of the rooms. When asked when the last time she went into room 301, CNA #12 stated she was in room 301 at approximately 3:30 p.m. When asked if she noticed anything unusual in the room, CNA #12 stated, "No." CNA #12 followed this writer into room 301. When asked what she noticed behind the head board of the second bed, CNA #12 stated, "That looks like BM (bowel movement). It looks very old and dry." When asked why feces on the wall is a concern, CNA #12 stated that feces on the wall was unsanitary. CNA #12 then took a paper towel and removed the feces from the wall. CNA #12 alerted a housekeeper that was across the hall to disinfect the area.

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On 9/26/17 at 4:33 p.m., an interview was conducted with OSM (other staff member) # 13, the housekeeping director. When asked how often housekeeping made rounds in resident rooms on the dementia unit, OSM #13 stated that housekeeping rounded on resident rooms at least four times a day on the dementia unit. OSM #13 stated that he tries to round at least every hour. When asked what he checked while rounding, OSM #13 stated that he checked rooms, floors, and bathrooms for cleanliness. OSM #13 also stated that each room received a deep cleaning on certain days of the weeks. When asked if rounding and deep cleaning included checking behind and under the beds, OSM #13 stated that sometimes he will check behind the beds and he always checks underneath the beds. A copy of the deep cleaning schedule was requested.

On 9/26/17 at approximately 6 p.m., the deep cleaning schedule was presented. Room 301 received a deep cleaning on 9/1/17.

On 9/28/17 at 5:15 p.m., ASM (administrative staff member) #1, the executive director/administrator and ASM #2, the DON (Director of Nursing)/clinical services, were made aware of the above concerns. No further information was presented prior to exit.

3. The unit one shower room was observed with dirty gloves and towels in the sink.

On 9/26/17 at 4:05 p.m., observation of the shower rooms was conducted. On 9/16/17 at 4:10 p.m., the Wing One shower room was observed. Dirty towels and used gloves was observed in the sink of the shower room.

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On 9/26/17 at 4:10 p.m., an interview was conducted with CNA (certified nursing assistant) #13. When asked when the shower rooms were cleaned, CNA #13 stated that the nursing aides were supposed to clean the shower rooms after each resident use. CNA #13 stated that nursing aides will wipe down the shower chairs and place dirty linens and towels in a trash bag to be taken to the dirty linen barrel. CNA #13 stated that trash should also be bagged separately and taken to the trash bin immediately after a shower. When asked if it was ever ok to leave trash and linen in the sink of the shower rooms, CNA #13 stated that it was not. When asked if she could tell this writer what was in the sink of the shower room, CNA #13 stated, "Something that shouldn't be." CNA #13 immediately placed on gloves and discarded the dirty towels and gloves from the sink. When asked when the last time the shower room was used, CNA #13 stated that it must have been that morning. CNA #13 stated that she had arrived to the facility at 3 p.m. for evening shift.

On 9/28/17 at 5:15 p.m., ASM (administrative staff member) #1, the executive director/administrator and ASM #2, the DON (Director of Nursing)/clinical services, were made aware of the above concerns.

The facility policy titled, "Handling of soiled linen" documents in part, the following: "Policy: To promote and encourage the concept that all soiled linen is considered contaminated...Procedure: Do not sort or pre-rinse soiled linen in the resident areas. Perform hand hygiene, Don Gloves, Place dirty linen into bad (carefully, not to touch outside of bag), remove gloves, perform hand hygiene,

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F 252	Continued From page 50 secure plastic bag, place bag in designated barrel in hallway or soiled utility room. Perform hand hygiene."	F 252		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 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).	F 279	F279 1. The comprehensive care plan for vision which triggered in section V. on the CAA (care area assessment) of the admission MDS (minimum data set) with an ARD (assessment reference date) of 5/8/17 has been developed for resident #2. The care plan for resident #9 has been updated for vision which triggered in section V on the CAA summary of the 4/26/17 admission/5-day MDS (minimum data set) assessment.	

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

(iv)In consultation with the resident and the resident's representative (s)-

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to develop a comprehensive care plan for two of 34 residents in the survey sample, Residents #2 and #9.

1. The facility staff failed to develop Resident #2's comprehensive care plan for vision which triggered in section V. on the CAA (care area assessment) of the admission MDS (minimum data set) with an ARD (assessment reference date) of 5/8/17.

2. MDS has reviewed most recent compressive MDS assessments for current residents and ensured CAA's that triggered are care planned appropriately.
3. The Administrator and or Regional MDS Consultant re-educated the MDS staff on compressive MDS assessments and Comprehensive care plans to ensure compliance is attained and maintained.
4. The Administrator and or designee to conduct quality monitoring of the completed MDS for 30 days to comprehensive MDS assessments for all current residents and all CAA's that triggered are all care planned

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2. The facility staff failed to care plan Resident #9 for Vision, which triggered in section V on the CAA summary of the 4/26/17 Admission/5-day MDS (minimum data set) assessment.

The findings include:

1. The facility staff failed to develop Resident #2's comprehensive care plan for vision which triggered in section V. on the CAA (care area assessment) of the admission MDS (minimum data set) with an ARD (assessment reference date) of 5/8/17.

Resident #2 was admitted to the facility on 5/1/17 with diagnoses that included but were not limited to: HIV (human immunodeficiency virus), dementia, depression, difficulty swallowing and elevated cholesterol. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 8/8/17 coded the resident as rarely or never being able to understand others or to be understood. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the admission MDS with an ARD of 5/8/17 coded the resident as having impaired vision. The resident triggered for a care plan to be developed on the CAA in section V if the assessment. Review of the CAA documented that a vision care plan would be developed.

Review of Resident #2's care plan initiated on 5/6/17 did not evidence a vision plan of care.

An interview was conducted on 9/28/17 at 9:15

appropriately. Quality monitoring to be conducted 3X a week per week for 4 weeks to ensure compliance and then 1X a week per month and then quarterly thereafter. Quality monitoring schedule to be modified based on findings of quality reviews. The results of the quality monitoring to be reviewed at the monthly quality assurance performance improvement (QAPI) meetings for review, analysis and further recommendations.

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a.m. with LPN (licensed practical nurse) #1, the MDS coordinator. When asked the purpose of the care plan, LPN #1 stated, "Basically to map out how the whole team cares for that resident." When asked the process staff followed if an area was triggered on the CAA of the MDS assessment, LPN #1 stated, "If the CAA triggers that's a cue to you to put it on the care plan." LPN #1 was asked to review Resident #2's CAA from the 5/8/17 admission MDS assessment and the care plan for a vision plan of care. LPN #1 stated, "There isn't one (vision plan of care)." When asked if there should be a vision plan of care, LPN #1 stated, "Yes." When asked what reference the MDS staff followed to complete an MDS assessment, LPN #1 stated, "The RAI (resident assessment instrument)."

On 9/28/17 at 10:57 a.m. ASM (administrative staff member) #2, the director of nursing/clinical services was made aware of the findings.

Review of the facility's policy titled, "Plans of Care" documented, "The facility will develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

No further information was provided prior to exit.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs,

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and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (1)

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

2. The facility staff failed to care plan Resident #9 for Vision, which triggered in section V on the CAA summary of the 4/26/17 Admission/5-day MDS (minimum data set) assessment.

Resident #9 was admitted to the facility on 4/19/17 with the diagnoses of but not limited to: altered mental status, dementia, delusional disorder, borderline personality disorder, depression, anxiety, chronic kidney disease, stroke, and cataracts. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 7/27/17. Resident #9 was coded as being moderately impaired in ability to make daily life decisions, scoring a 9 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring extensive assistance for bathing; supervision for hygiene, eating and ambulation; as independent for transfers; and as continent of bowel and bladder.

A review of the clinical record revealed the admission MDS assessment with an ARD of 4/26/17.
In Section V - Care Area Assessment (CAA) Summary, the resident was triggered in Column A

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F 279	Continued From page 55 (Care Area Triggered) and was to be care planned as evidence by an "X" in Column B (Care Planning Decision) for the areas of: 02. Cognitive Loss/Dementia, 03. Visual Function, 05. ADL Functional/Rehabilitation Potential, 07. Psychosocial Well-Being; and 12. Nutritional Status. A review of the care plan failed to reveal any evidence the area of "03. Visual Function", as being care planned. Resident #9 had a diagnosis of cataracts. On 9/28/17 at 8:55 a.m., in an interview with LPN #1 (Licensed Practical Nurse, the MDS nurse) she stated that if it is triggered, then it should be care planned unless it was specifically documented that it would not be. LPN #1 stated she did not know if the cataracts for Resident #9 were causing her any impairment but that it was a potential for them to become visually significant. When asked about a facility policy for care planning from the CAA triggers, LPN #1 stated the facility uses the RAI manual (Resident - Assessment Instrument). On 9/28/17 at 5:20 p.m., the Administrator was made aware of the findings. No further information was provided by the end of the survey.	F 279		
F 280 SS=E	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:	F 280		

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(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.

(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-

1. Resident #11's care plan has been updated with altercations from October 2016 through March 2017. The care plan for resident #15 has been updated to include the resident's individual activity preferences. Resident #12's care plan for eye infection has been resolved. Resident #10's care plan was updated related to the fall that occurred on April 20, 2017.
2. MDS has reviewed care plans for altercations in the past 12 months for all current residents and

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F 280	Continued From page 57 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to review and revise the plan of care for four of 34 residents in the survey sample, Residents #11, #15, #12 and #10.	F 280	updated as indicated. Activity staff has re-assessed current residents activity preferences and those preferences have been added to current care plans. Infections that have resolved have been resolved on the current residents care plans. Falls that have occurred in the past 12 months to have interventions documented on care plan of current residents.	

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1. The facility staff failed to review and revise Resident #11's care plan following multiple resident to resident altercations from October 2016 through March 2017.

2. The facility staff failed to update Resident #15's activities plan of care to include the resident's individual activity preferences.

3. The facility staff failed to resolve Resident #12's care plan for an eye infection, after the resident's eye infection had cleared on 6/11/17.

4. The facility staff failed to review and revise Resident #10's comprehensive care plan following a witnessed fall that occurred in April 20, 2017.

The findings include:

1. The facility staff failed to review and revise Resident #11's care plan following multiple resident to resident altercations from October 2016 through March 2017.

Resident #11 was admitted to the facility on 9/9/15. Resident #11's diagnoses included but were not limited to: Huntington's disease (1), history of falling and difficulty swallowing. Resident #11's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 8/22/17, coded the resident's cognitive skills for daily decision making as severely impaired.

Review of Resident #11's clinical record and facility reported incidence reports submitted to the

3. The Administrator and or designee has re-educated the MDS on care planning altercations, care planning infections and care planning falls. The Administrator and or designee has re-educated the Activity staff on updating care plans to include the residents individual activity preferences.
4. The Administrator and or designee to conduct quality monitoring of care plans. Quality monitoring to be conducted 3X a week per week for 4 weeks to ensure compliance and then 1X a week per month and then quarterly thereafter. Quality monitoring

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Virginia Department of Health Office of Licensure and Certification revealed the following resident to resident altercations involving Resident #11:

- 10/17/16: Resident #11 was ambulating in the hallway and pushed another resident down to the floor. Resident #11 was placed on one on one supervision and monitored. The other resident was assessed and treated.
-2/4/17: Resident #11 was observed lying in another resident's bed. The other resident was sitting on the floor with blood dripping from over top of her eye. Resident #11 was placed on one on one supervision and monitored. The other resident was assessed and treated.
-3/21/17: Resident #11 was ambulating in the hallway swinging his arms back and forth. The resident inadvertently struck another resident who fell to the floor (and sustained no injury). Another resident struck Resident #11 in the face causing multiple scratches. Resident #11 was assessed, treated and placed on one on one supervision indefinitely.

Review of Resident #11's care plan initiated on 10/25/16 failed to reveal the care plan was reviewed or revised for each of the above incidents.

On 9/27/17 at 2:54 p.m. an interview was conducted with OSM (other staff member) #7 (the social services director). OSM #7 was asked if residents' care plans should be updated after resident to resident altercations. OSM #7 stated, "They should be for both (residents)." OSM #7 stated the social services department and MDS department was responsible for updating residents' care plans after resident to resident altercations.

schedule to be modified based on findings of quality reviews. The results of the quality monitoring to be reviewed at the monthly quality assurance performance improvement (QAPI) meetings for review, analysis and further recommendations.

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On 9/27/17 at 5:13 p.m. ASM (administrative staff member) #1 (the executive director/administrator) presented an action plan for care plans not being updated in a timely manner. The resolution column was blank. ASM #1 stated the action plan was ongoing.

On 9/27/17 at approximately 5:30 p.m. an interview was conducted with LPN (licensed practical nurse) #1 (the MDS coordinator). LPN #1 confirmed Resident #11's care plan was not updated after each of the above incidents. LPN #1 stated a regional employee recently identified issues with residents' care plans not being updated in a timely manner. LPN #1 stated there was a current plan of correction and care plans were still being audited.

On 9/27/17 at 6:10 p.m. ASM #1, ASM #2 (the director of nursing/clinical services) and ASM #3 (the regional director of clinical services) were made aware of the above concern.

The facility policy titled, "Plans of Care" documented, "The Comprehensive plan of care is reviewed and updated at least quarterly, and as needed, by the interdisciplinary team and revisions are made by the interdisciplinary team to ensure needs are addressed and that the plan is oriented toward attaining or maintaining the highest practicable physical, mental and psychosocial well-being..."

No further information was presented prior to exit.

(1) "Huntington's disease (HD) is an inherited disease that causes certain nerve cells in the brain to waste away. People are born with the

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defective gene, but symptoms usually don't appear until middle age. Early symptoms of HD may include uncontrolled movements, clumsiness, and balance problems. Later, HD can take away the ability to walk, talk, and swallow. Some people stop recognizing family members. Others are aware of their environment and are able to express emotions." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=huntingtons+disease&_ga=2.104416073.876861010.1506957357-139120270.1477942321

2. The facility staff failed to update Resident #15's activities plan of care to include the resident's individual activity preferences.

Resident #15 was admitted to the facility on 10/3/16 with diagnoses that included but were not limited to: seizures, schizophrenia, kidney disease, diabetes, high blood pressure and stroke. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 7/7/17 coded Resident #15 as having scored a 13 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the annual MDS assessment with an ARD of 10/10/16 coded listening to music and participating in religious practices as being very important to Resident #15.

Review of the social worker's note dated 12/19/16

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documented, "The resident continues to require assistance with her activities of daily living. The resident prefers to lie in her bed and does not like to get out of bed with the exception of going to appointments outside of the facility. The resident does not watch much television, but enjoys listening to the radio; especially gospel music. The resident has several gospel compact discs by gospel artists such as (names of artists) etc. The resident has made a request that those particular artists play continuously on her cd player."

Review of the resident's care plan initiated on 10/13/16 and revised on 4/5/17 documented, "Focus. The resident is independent for activities, cognitive stimulation, social interaction r/t (related to) Resident wishes not to participate. Interventions. Music."

An observation was made on 9/26/17 at 4:45 p.m. of Resident #15. The resident was lying in bed awake and calling out. There was no music or television on in the room.

An observation was made on 9/27/17 at 11:55 a.m. of Resident #15. The resident was lying in bed awake. There was no music or television on in the room.

An observation was made on 9/27/17 at 12:20 p.m. of Resident #15. The resident was lying in bed. Staff were in with the resident. There was no music or television on in the room.

An interview was conducted on 9/27/17 at 2:45 p.m. with OSM (other staff member) #7, the director of social services. When asked about residents' preferences for activities, OSM #7

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stated, "Well, during out care plan meeting we should discuss it (activity preferences)."

An interview was conducted on 9/27/17 at 4:40 p.m. with OSM #1, the activities co-director. When asked the role of activities, OSM #1 stated, "We are looking to enhance quality of life, keeping them (the residents) oriented, making them feel comfortable. Keep them active." When asked how resident's activity preferences were obtained, OSM #1 stated, "We have an MDS list that scores them (the preferences) from one to five. We put it in the comprehensive care plan and I follow it." When asked if the care plan would include the resident's activities preferences, OSM #1 stated, "Yes ma'am."

A review of the activities log for 9/1/17 through 9/26/17 for Resident #15 documented that the television and music were on every day. There was no documentation that the resident was offered to participate in religious services.

An interview was conducted on 9/27/17 at 4:50 p.m. with OSM #2, the director of activities. When asked the goal of activities for residents, OSM #2 stated, "To get an idea first of all for what they want to do." When asked to review Resident #15's September 2017 activity log, OSM #2 stated that someone was not really paying any attention to it and that the care plan for the resident's activities were "somewhat generic." When asked if it was important that residents received activities that were important to them, OSM #2 stated it was. When asked if Resident #15's resident's specific preferences were care planned, OSM #2 stated that it should be.

On 9/28/17 at 7:28 a.m. ASM (administrative staff

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member) #1, the administrator/executive director, was made aware of the findings.

An interview was conducted on 9/28/17 at 11:50 a.m. with LPN (licensed practical nurse) #1, the MDS coordinator. When asked why residents had care plans, LPN #1 stated, "To make sure their needs and care were done and their preferences are abided by." When asked to review Resident #15's annual MDS and the activities plan of care, LPN #1 stated, "I did not see that her preferences were documented on."

No further information was provided prior to exit.

3. The facility staff failed to resolve Resident #12's care plan for an eye infection, after the resident's eye infection had cleared on 6/11/17.

Resident #12 was admitted to the facility on 8/12/15 with diagnoses that included but were not limited to: enlarged prostate, heart failure, muscle weakness, hypothyroidism, dementia, and COPD (chronic obstructive pulmonary disease).
Resident #12's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/11/17. Resident #12 was coded as being severely impaired in cognitive function scoring 03 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #12 was coded as requiring total dependence on one staff member with dressing, locomotion on the unit, eating, and bathing; and extensive assistance from one staff member with personal hygiene.

Review of Resident #12's current care plan revealed the following focus area initiated on

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6/2/17: "Focus: The resident has an eye infection r/t (related to) AEB (as evidence by)- drainage, Eye. Goal: Resident infection will resolve by 6/17/17. Interventions: Antibiotics as ordered by the physician. Encourage mobility. Monitor infection (redness, drainage, fever, erythema (reddening of skin) etc.)"

Review of Resident #12's POS (physician order sheet) dated 8/23/17, failed to reveal an order for antibiotics related to an eye infection.

Resident #12's June 2017 POS and MAR (medication administration record) could not be located in his thinned record.

Review of Resident #12's June 2017 nursing notes failed to document when the eye infection had healed or resolved.

Review of the facility's infection control log revealed that Resident #12 had conjunctivitis on 6/4/17. This infection was documented as resolved on 6/11/17.

On 9/27/17 at 11:05 a.m., an interview was conducted with LPN (licensed practical nurse) #10, Resident #12's nurse. When asked who was responsible for reviewing and revising the care plan, LPN #10 stated that the MDS nurses were responsible. When asked if that included resolving items from the care plan, LPN #10 stated, "Yes." When asked if Resident #12 continued to have an eye infection, LPN #10 stated that Resident #12 did not have an eye infection. When LPN #10 was shown Resident #12's care plan for his eye infection, LPN #10 stated, "That should have been discontinued." When asked the purpose of the care plan, LPN

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#10 stated that the purpose of the care plan was to serve as a guide for providing care.

On 9/27/17 at 11:56 a.m., an interview was conducted with LPN #1, the MDS nurse. When asked who was responsible for updating care plans, LPN #1 stated that the whole interdisciplinary team was responsible for updating the care plans. When asked if Resident #12 continued to have an eye infection, LPN #1 stated that she would have to find out. When LPN #1 was shown Resident #12's eye infection care plan, LPN #1 stated, "It probably should have been resolved."

On 9/27/17 at approximately 12:15 p.m., further interview was conducted with LPN #10. LPN #10 stated, "There is no medication on the MAR (medication administration record) actively treating an eye infection. The care plan should be resolved."

On 9/28/17 at 5:15 p.m., ASM (administrative staff member) #1, the administrator/executive director and ASM #2, the DON (Director of Nursing)/clinical services, were made aware of the above concern.

No further information was presented prior to exit.

4. The facility staff failed to review and revise Resident #10's comprehensive care plan following a witnessed fall that occurred on April 20, 2017.

Resident #10 was admitted to the facility on 5/2/13 with a readmission date of 9/14/14 with diagnoses that included, but were not limited to,

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dementia, difficulty swallowing, convulsions, depression and psychosis.

Resident #10's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/6/17, coded Resident #10 as being unable to complete the BIMS (brief interview for mental status). The staff assessment of Resident #10's cognitive status was coded as a "3" (three) out of a possible score of 15, on the BIMS exam, indicating that Resident #10 was severely cognitively impaired with daily decision making. Resident #10 was also coded as requiring extensive assistance of one to two staff members for all activities of daily living and as rarely understanding or understood when communicating with others.

A review of Resident #10's progress notes revealed, in part, the following documentation; "4/20/17 1p (1:00 p.m.) Resident had fallen from on (sic) matt (sic) & (and) was witnessed. 0 (no) apparent injuries noted. No facial grimacing noted. Resident rested (sic) in bed the rest of shift quietly (sic). RP (responsible party) called."

A review of Resident #10's comprehensive care plan did not reveal any documentation concerning the 4/20/17 fall.

On 9/27/17 at 3:45 p.m. an interview was conducted with LPN (licensed practical nurse) #3, a floor nurse. LPN #3 was asked who was responsible for reviewing comprehensive care plans following an incident. LPN #3 stated that was the responsibility of the DON (director of nursing) and / or the unit manager.

On 9/28/17 at 7:30 a.m. ASM (administrative staff

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member) #1, the executive director/administrator, was made aware of the above findings. A policy regarding comprehensive care plans was requested at this time.

On 9/28/17 at 8:45 a.m. an interview was conducted with LPN #4, a floor nurse. LPN #4 was asked who was responsible for reviewing and revising the comprehensive care plan following an incident. LPN #4 stated, "I'm not sure."

On 9/28/17 at 9:15 a.m. an interview was conducted with LPN #1, the MDS coordinator. LPN #1 was asked who was responsible in the facility for reviewing and revising the comprehensive care plans. LPN #1 stated that the IDT (interdisciplinary team) reviewed and revised the care plans. LPN #1 further stated, "An interim 21-day care plan is completed on admission and then each section is completed by the assigned discipline. Ongoing the IDT will review and revise care plans at quarterly care plan meetings and whenever there is a change such as new medications, changes in condition, falls and or other incidents. We would look at a need for new interventions and adjust the care plan accordingly. We also look at all new orders and incidents in morning meeting and address those items on the care plan at that time." When asked specifically about falls, LPN #1 stated that the care plan would be reviewed following each fall to determine whether or not new interventions are necessary." LPN #1 was asked to review Resident #10's comprehensive care plan and to state whether or not his care plan was reviewed and revised following the April 20,2017 fall. LPN #1 stated she would get back to this writer.

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F 280	Continued From page 69 On 9/28/17 at 10:30 a.m., an interview was conducted with ASM #2, the director of nursing/clinical services. ASM #2 was asked when a care plan was to be reviewed and revised. ASM #2 stated that the care plan was reviewed at each care plan meeting and with any incidents. ASM #2 was asked who was responsible for reviewing and revising the care plans, ASM #2 stated, "The MDS staff and nursing can assist." On 9/28/17 at 11:20 a.m., LPN #1 returned to this writer and stated that Resident #10's fall was not reviewed or revised on his care plan. No further information was presented prior to the end of the survey process.	F 280		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to follow professional standards of practice for two of 34 residents in the survey sample, Residents #12 and #2. 1. The facility staff documented Resident #12's	F 281	F281 1. Resident#12 has left hand palm protector applied as ordered and application is documented. A treatment error report has been	

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F 281	Continued From page 70 left hand palm protector was in place when it was not applied on 7/27/17. 2. The facility staff failed to clarify a 9/13/17 physician's order for a T-spot (1) laboratory specimen for Resident #2. The findings include: 1. The facility staff documented Resident #12's left hand palm protector was in place when it was not applied on 7/27/17. Resident #12 was admitted to the facility on 8/12/15 with diagnoses that included but were not limited to: enlarged prostate, heart failure, muscle weakness, hypothyroidism, dementia, and COPD (chronic obstructive pulmonary disease). Resident #12's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/11/17. Resident #12 was coded as being severely impaired in cognitive function scoring 03 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #12 was coded as requiring total dependence on one staff member with dressing, locomotion on the unit, eating, and bathing; and extensive assistance from one staff member with personal hygiene. On 9/26/17 at 5:15 p.m., an observation was made of Resident #12. He was lying in bed with his hands at his side. The fingers to his left hand appeared to be slightly contracted. His right hand was under the covers and was not visible. He was not wearing a palm protector to his left hand. On 9/27/17 at 7:38 a.m., an observation was	F 281	generated for Resident#12 not having left hand palm protector applied but documented. LPN#10 has been counseled on not following Physician orders and educated on following physician orders as indicated. Resident#2 laboratory request for a T-SPOT" has been obtained and documented in the chart accordingly. Resident #12 currently resides in the facility and has no s/s of any adverse effects. Resident #2 currently resides in the facility and has no s/s of any adverse effects.	

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F 281	Continued From page 71 made of Resident #12. He was lying in bed with his hands at his side. The fingers to his left and right hands appeared to be slightly contracted. He was not wearing a splint or palm protector to his bilateral hands. On 9/27/17 at 10:05 a.m., an observation was made of Resident #12. He was lying in bed with his hands at his side. The fingers to his left and right hands appeared to be slightly contracted. He was not wearing a splint or palm protector to his bilateral hands. On 9/27/17 at 12:35 p.m., an observation was made of Resident #12. He was lying in bed with his hands at his side. The fingers to his left hand appeared to be slightly contracted. His right hand was under the covers and was not visible. He was not wearing a palm protector to his left hand. On 9/27/17 at 2:15 p.m., an observation was made of Resident #12. He was lying in bed with his hands at his side. The fingers to his left hand appeared to be slightly contracted. His right hand was under the covers and was not visible. He was not wearing a palm protector to his left hand. On 9/28/17 at 10:30 a.m., an observation was made of Resident #12. He was not wearing his left hand palm guard or his right hand splint. Review of Resident #12's clinical record revealed the following occupational therapy note dated 8/22/16: " Long term goals: Pt (patient) will tolerate wearing right hand splint for up to 8 hours to prevent development of further contractures. Pt will tolerate wearing left dyna-splint (type of splint) with modifications (sic) or up to 8 hours per day."	F 281	2. A quality review of current residents with Physician orders for hand splints/palms protectors has been performed. A quality review of _____ current resident with physician orders for laboratory testing has been performed. Physician notification related to laboratory results is in present in the chart.	

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F 281	Continued From page 72 Further review of the occupational therapy notes revealed that Resident #12 was discharged from OT services on 8/31/16 with orders for the bilateral splints. The following was documented: "staff have been in-serviced in donning/doffing of splint and splints have been turned over to staff. Pt is tolerating bilateral hand splints for up to 8 hours per day to prevent skin breakdown and contractures. No further OT (occupational) services are indicated at this time." Review of Resident #12's POS (physician order sheet) signed by the physician on 8/28/17, documented the following orders: "Right hand splints on during the day, check skin once removed. Left hand palm protector on at all times. May remove for hygiene, skin checks, check placement every shift." Review of Resident #12's "Impaired skin integrity" care plan dated 8/31/16, documented the following interventions: "Left hand palm protector as ordered. Right hand splint as ordered." These interventions were initiated on 2/2/17. Review of Resident #12's September 2017 TAR (treatment administration record) revealed blanks (no signatures) under the following treatment: "Right hand splints on during the day check skin once removed." Further review of the September 2017 TAR revealed initials or signatures on 9/26/17 for 3-11 shift and 9/27/17 for 7-3 and 3-11 shifts indicating that the left hand splint was in place. On 9/28/17 11:05 a.m., an interview was conducted with LPN (licensed practical nurse)	F 281	3.Licensed Nurses re-educated by DCS/Designee regarding following Physician orders on obtaining laboratory specimen and the process in following up with laboratory results including Physician and RP notification. Licensed Nurses re-educated by DCS/Designee regarding following Physician orders on application of hand splints and palm protectors.DCS/Designee during Morning Clinical Meeting to conduct quality monitoring of physician laboratory orders and application of hand splints and palm protectors dailyx4 weeks, weeklyx4 and then monthly, PRN and as indicated.	

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#10, Resident #12's nurse. When asked if Resident #12 was supposed to have a splint to his right hand and a palm protector to his left hand, LPN #10 looked at his physician's orders and stated that he was supposed to have splints in place. When asked if they were in place, LPN #10 stated that she was not sure.

When asked what initials meant on the TAR, LPN #10 stated that initials meant that a treatment was completed. When asked why there were blanks (no signatures) for the right hand splint on Resident #12's September TAR, LPN #10 stated, "That is supposed to just be an FYI." When asked if it was her initials documented on 9/27/17 for 7-3 and 3-11 shift documenting that Resident #12's left palm protector was in place, LPN #10 stated, "yes." When asked if his palm protector was in place on 9/27/17, LPN #10 stated, "No. I probably should have circled my initials." LPN #10 stated that circled initials indicated that the treatment was not done.

On 9/28/17 at 5:15 p.m., ASM (administrative staff member) #1, the administrator/executive director and ASM #2, the DON (Director of Nursing)/clinical services, were made aware of the above concern.

The facility policy titled, "Clinical/Medical Records" documented in part, the following: "Clinical Records are maintained in accordance with professional practice standards to provide complete and accurate information on each resident for continuity of care."
2. The facility staff failed to clarify a 9/13/17 physician's order for a T-spot (1) laboratory specimen for Resident #2.

4.Findings to be communicated to the QAPI committee monthly and as indicated. Quality monitoring schedules modified based on findings
5.November 14, 2017

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	495362	A. BUILOING _____ B. WING _____	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CDOE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOED BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETION OATE
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Resident #2 was admitted to the facility on 5/1/17 with diagnoses that included but were not limited to: HIV (human immunodeficiency virus (2)), dementia, depression, difficulty swallowing and elevated cholesterol. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 8/8/17 coded the resident as having both short and long term memory problems and as severely impaired cognitively. Resident #2 was coded as rarely or never being able to understand others or to be understood. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the resident's care plan did not specifically address obtaining laboratory specimens.

Review of the infectious disease consult dated 9/13/17 documented, "Check T-spot."

Review of the clinical record did not evidence documentation of the T-spot laboratory (lab) results.

Review of the nurse's notes dated 9/14/17 at 4:30 a.m. documented, "Lab @ (at) facility unable to obtain blood draw due to type of order. Tech unable to identify type of blood draw from order she called her supervisor who also does not know what type of lab needed. questions what is a "T-SPOT" needs clarification note left on 24 hr (hour) report to call MD (medical doctor)."

Further review of the clinical record did not evidence documentation that the laboratory test had been clarified with the physician.

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F 281	Continued From page 75	F 281		

An interview was conducted on 9/28/17 at 10:58 a.m., with ASM (administrative staff member) #2, the director of nursing/clinical services. ASM #2 was asked when an order would be clarified. ASM #2 stated, "It probably depends on what the physician wants. I would say a day." ASM #2 was made aware of the findings at that time.

An interview was conducted on 9/28/17 at 12:25 p.m., with LPN (licensed practical nurse) #3. When asked what staff did if they did not understand a doctor's order, LPN #3 stated, "Call the doctor." When asked what was a reasonable amount of time to call the physician, LPN #3 stated, "Within a day."

Review of the facility's policy on laboratory testing did not evidence documentation regarding clarifying a physician's laboratory specimen order.

No further information was provided prior to exit.

1. T-spot -- For the detection of effector t cells that respond to stimulation by mycobacterium tuberculosis antigens esat-6 and cfp-10 and indicated for use as an aid in the diagnosis of M. Tuberculosis infection in conjunction with risk assessment, radiography and other medical diagnostic evaluations. This information was obtained from: https://accessgudid.nlm.nih.gov/devices/15051716000046

2. HIV stands for human immunodeficiency virus, which is the virus that causes HIV infection. The abbreviation "HIV" can refer to the virus or to HIV infection. HIV is the virus that causes HIV infection. AIDS is the most advanced stage of HIV infection.

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ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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F 281	Continued From page 76 HIV is spread through contact with the blood, semen, pre-seminal fluid, rectal fluids, vaginal fluids, or breast milk of a person with HIV. In the United States, HIV is spread mainly by having anal or vaginal sex or sharing drug injection equipment with a person who has HIV. Antiretroviral therapy (ART) is the use of HIV medicines to treat HIV infection. People on ART take a combination of HIV medicines (called an HIV regimen) every day. ART can't cure HIV infection, but it can help people with HIV live longer, healthier lives. HIV medicines can also reduce the risk of transmission of HIV. This information was obtained from the website: https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/19/45/hiv-aids--the-basics	F 281		
F 282 SS=E	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to follow the written plan of care for six of 34 residents in the survey sample, Residents #12, #15, #23, #2, #6, and #7. 1a. The facility staff failed to apply Resident #12's	F 282	F282 1. Resident#12 has left hand palm protector applied as ordered and application is documented. A treatment error report has been generated for Resident#12 not having left hand palm protector applied but documented.	

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F 282	Continued From page 77 left hand palm protector and right hand splint per the physician orders and written plan of care. b. The facility staff failed to follow the written plan of care to attempt non-pharmacological interventions prior to the administration of Ativan to Resident #12 on multiple occasions in July. 2. a. The facility staff failed to follow Resident #15's written plan of care for obtaining blood pressures as ordered by the physician and per the comprehensive plan of care. b. The facility staff failed to follow Resident #15's written plan of care to monitor the resident's blood glucose before meals and at bedtime per the physician's order and comprehensive care plan. 3. The facility staff failed to follow Resident #23's written plan of care to obtain blood glucose levels before each meal per the physician's orders and comprehensive care plan. 4. The facility staff failed to follow Resident #2's comprehensive care plan to provide the HIVHIV-(human immunodeficiency virus (2)) medication Triumeq (1) to Resident #2 and failed to follow the 6/23/17 infectious disease doctor's order to continue the Triumeq. 5. The facility staff failed to follow Resident # 6's comprehensive care plan in regards to medications. 6. The facility staff failed to follow Resident # 7's care plan in regards to medications.	F 282	LPN#10 has been counseled on not following Physician orders and educated on following physician orders as indicated. The facility has added non-pharmacological intervention has been added to Resident#12's profile. Resident#15's blood pressures are being obtained as per Physician order and documented in the medical record. Resident#15's blood glucose is being obtained and	

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F 282	Continued From page 78	F 282		

The findings include:

1a. The facility staff failed to apply Resident #12's left hand palm protector and right hand splint per the physician orders and written plan of care.

Resident #12 was admitted to the facility on 8/12/15 with diagnoses that included but were not limited to: enlarged prostate, heart failure, muscle weakness, hypothyroidism, dementia, and COPD (chronic obstructive pulmonary disease). Resident #12's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/11/17. Resident #12 was coded as being severely impaired in cognitive function scoring 03 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #12 was coded as requiring total dependence on one staff member with dressing, locomotion on the unit, eating, and bathing; and extensive assistance from one staff member with personal hygiene.

On 9/26/17 at 5:15 p.m., an observation was made of Resident #12. He was lying in bed with his hands at his side. The fingers to his left hand appeared to be slightly contracted. His right hand was under the covers and was not visible. He was not wearing a palm protector to his left hand.

On 9/27/17 at 7:38 a.m., an observation was made of Resident #12. He was lying in bed with his hands at his side. The fingers to his left and right hands appeared to be slightly contracted. He was not wearing a splint or palm protector to his bilateral hands.

On 9/27/17 at 10:05 a.m., an observation was made of Resident #12. He was lying in bed with

documented in the medical record as per Physicians order.Resident#23 blood glucose is being obtained and documented in the medical record as per Physician order.Resident#2 is currently receiving all prescribed HIV medications as indicated by Physician order. Resident#6 is currently receiving all prescribed medications as indicated by Physician order.

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his hands at his side. The fingers to his left and right hands appeared to be slightly contracted. He was not wearing a splint or palm protector to his bilateral hands.

On 9/27/17 at 12:35 p.m., an observation was made of Resident #12. He was lying in bed with his hands at his side. The fingers to his left hand appeared to be slightly contracted. His right hand was under the covers and was not visible. He was not wearing a palm protector to his left hand.

On 9/27/17 at 2:15 p.m., an observation was made of Resident #12. He was lying in bed with his hands at his side. The fingers to his left hand appeared to be slightly contracted. His right hand was under the covers and was not visible. He was not wearing a palm protector to his left hand.

On 9/28/17 at 10:30 a.m., an observation was made of Resident #12. He was not wearing his left hand palm guard or his right hand splint.

Review of Resident #12's POS (physician order sheet) signed by the physician on 8/28/17, documented the following orders: "Right hand splints on during the day, check skin once removed. Left hand palm protector on at all times. May remove for hygiene, skin checks, check placement every shift."

Review of Resident #12's "Impaired skin integrity" care plan dated 8/31/16, documented the following interventions: "Left hand palm protector as ordered. Right hand splint as ordered." These interventions were initiated on 2/2/17.

Resident #12's most recent "Nursing Tech Information Kardex" documented the following:

Resident#6 is blood glucose is being obtained and documented in the medical record as per Physician order.Resident#7 is currently receiving all prescribed medications as indicated by Physician order. Resident#7 blood glucose is being obtained and documented in the medical record as per Physician order. Resident#12 currently resides in the facility and has no s/s of adverse effects. Resident#15

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"Splint: R (right) hand/palm protectors." The Kardex failed to mention Resident #12's palm protector to his left hand.

Review of Resident #12's September 2017 TAR (treatment administration record) revealed blanks (no signatures) under the following treatment: "Right hand splints on during the day check skin once removed."

Further review of the September 2017 TAR revealed initials or signatures on 9/26/17 for 3-11 shift and 9/27/17 for 7-3 and 3-11 shifts indicating that the left hand splint was in place.

On 9/28/17 11:05 a.m., an interview was conducted with LPN (licensed practical nurse) #10, Resident #12's nurse. When asked the purpose of the care plan, LPN #10 stated that the purpose of the care plan was to serve as a guide for providing care on each resident. When asked who had access to the care plan, LPN #12 stated that nurses such as the MDS nurse, floor nurses, DON (director of nursing) and unit manager had access to the care plan. When asked if CNAs had access to the care plan, LPN #10 stated that CNAs used a nursing Kardex that was updated with changes. When asked if Resident #12 was supposed to have a splint to his right hand and a palm protector to his left hand, LPN #10 stated that he was supposed to have splints in place. When asked if they were in place, LPN #10 stated that she was not sure. When asked what initials meant on the TAR, LPN #10 stated that initials meant that a treatment was completed. When asked why there were blanks (no signatures) for the right hand splint on Resident #12's September TAR, LPN #10 stated, "That is supposed to just be an FYI." When asked if it

currently resides in the facility and has no s/s of adverse effects. Resident#23 currently resides in the facility and has no s/s of adverse effects. Resident#2 currently resides in the facility and has no s/s of adverse effects. Resident#6 currently resides in the facility and has no s/s of adverse effects. Resident#7 currently resides in the facility and has no s/s of adverse effects.

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was her initials documented on 9/27/17 for 7-3 and 3-11 shift documenting that Resident #12's left palm protector was in place, LPN #10 stated, "yes." When asked if his palm guard was in place on 9/27/17, LPN #10 stated, "No. I probably should have circled my initials." When asked who was responsible for putting on splints, and palm protectors; LPN #10 stated that the CNAs put on the splints and the nurses have to ensure that the splints are in place. LPN #10 was asked to review Resident #12's Kardex with this surveyor. LPN #10 showed this writer Resident #12's Kardex. When asked how CNA's would know to put a palm protector to Resident #12's left hand if it is not documented on the Kardex, LPN #10 stated that CNA's would get that information in a verbal report. At this time LPN #10 accompanied this surveyor to Resident #12's room. LPN #10 confirmed that Resident #12's splint and palm protector were not in place.

On 9/28/17 at 11:33 a.m., an interview was conducted with CNA (certified nursing assistant) #4, Resident #12's CNA. When asked how CNAs would know what to put into place for skin preventive measures etc., CNA #4 stated that she would get report from the nurses or other CNAs. When asked if she had a reference to use that documented resident needs, CNA #4 stated, "If there is, I don't know where it is."

On 9/28/17 at 5:15 p.m., ASM (administrative staff member) #1, the administrator/executive director and ASM #2, the DON (Director of Nursing)/clinical services were made aware of the above concerns.

The facility policy titled, "Plans of Care" documents in part the following, "Direct staff

2.A quality review of current residents with Physician orders for hand splints/palms protectors has been performed. A quality review of current residents with orders for Antipsychotic medications has been performed. A quality review of residents with orders for blood pressure and blood glucose monitoring has been performed. A quality review of residents with orders for HIV medications has been performed. A quality review of residents with orders for prescribed

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should be aware, understand and follow their Resident's Plan of Care. If unable to implement any part of the plan, notify the Clinical Nurse or Care Planning Coordinator, so that documentation to support his (sic) can be provided and plan of care changed if necessary."

No further information was presented prior to exit.

b. The facility staff failed to follow the written plan of care to attempt non-pharmacological interventions prior to the administration of Ativan to Resident #12 on multiple occasions in July.

Review of Resident #12's clinical record revealed that he was admitted under hospice services on 3/29/17 and the following order was written: "Ativan 2 MG (milligrams)/ML (milliliter) give 0.25 mg q (every) 4 hours prn (as needed) anxiety."

Review of Resident #12's "Psychoactive medication Use" care plan dated 9/08/16, documented the following intervention: "Anti-Anxiety-Non-drug interventions." This intervention was initiated on 4/4/17.

Review of Resident #12's July 2017 MAR (medication administration record) revealed that Resident #12 received Ativan 0.25 mg on 7/5/17, 7/15/17, and 7/28/17. There was no evidence in the clinical record that non-pharmacological interventions were attempted prior to the administration of Ativan.

Further review of the MAR dated 7/2017, documented the following under "Nurse's Medication Notes: "Date: 7/5. Drug/Strength Dose: Ativan 0.25. Reason: aggitated (sic)."

performed. Follow up based on findings.

3.Licensed Nurses re-educated by DCS/Designee regarding following Physician orders regarding wound care implementation and treatment. Licensed Nurses re-educated by DCS/Designee regarding following Physician orders on documenting on Treatment Administration Record (TAR). DCS/Designee during Morning Clinical Meeting to conduct quality monitoring of skin assessments and TARs daily 4 weeks, weekly x4 and then monthly, PRN and as indicated.

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Behaviors that required Ativan to be administered on 7/15/17 and 7/28/17 could not be found on the July 2017 MAR or in the July 2017 nursing notes.

On 9/28/17 at 11:05 a.m., an interview was conducted with LPN (licensed practical nurse) #10, Resident #12's nurse. LPN #10 was asked about the process followed prior to administering a prn (as needed) anti-anxiety medication. LPN #10 stated that she would observe the resident and their behaviors, try to calm them down by redirection and distraction before administering medication. LPN #10 stated that if non-pharmacological interventions are ineffective, she would administer the prn anti-anxiety medication. When asked if she would always attempt non-pharmacological interventions, LPN #10 stated that she would. When asked if non-pharmacological interventions attempted are documented, LPN #10 stated that non-pharmacological interventions should be documented on a behavior sheet or nursing note. When asked how she would know if a nurse attempted non-pharmacological interventions prior to administering Ativan if it is not documented, LPN #10 stated, "You wouldn't." When asked if Resident #12's care plan was followed if non-pharmacological interventions were not attempted prior to administering prn Ativan, LPN #10 stated that if non-pharmacological (interventions) were not attempted then the care plan was not followed.

A July 2017 behavior sheet for Resident #12 could not be found in the clinical record.

On 9/29/17 at 5:15 p.m., ASM (administrative staff member) #1, the administrator/executive director, and ASM #2, the DON (Director of

4.DCS/Designee to conduct quality monitoring regarding physician notification with documentation in the medical record as indicated. Findings to be communicated to the QAPI committee monthly and as indicated. Quality monitoring schedules modified based on findings
5.November 14, 2017

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Nursing)/clinical services, were made aware of the above findings.

No further information was presented prior to exit.

[1] Ativan-used to treat anxiety disorders. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010988/?report=details.

2. a. The facility staff failed to follow Resident #15's written plan of care for obtaining blood pressures as ordered by the physician and per the comprehensive plan of care.

Resident #15 was admitted to the facility on 10/3/16 with diagnoses that included but were not limited to: seizures, schizophrenia, kidney disease, diabetes, high blood pressure and stroke. The most recent MDS, a quarterly assessment, with an ARD of 7/7/17 coded the resident as having scored a 13 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of Resident #15's comprehensive care plan initiated on 10/4/16 and revised on 10/19/16 documented, "Focus. The resident has potential for alteration in perfusion r/t (related to) HTN (high blood pressure), Diabetes...Interventions. Vital signs as ordered and prn (as needed)."

Review of the physician's order dated 9/21/17 documented, "Monitor BP (blood pressure) 2 x (times) a week (goal < 140/90) Sunday +

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F 282	Continued From page 85 Thursday." Review of Resident #15's MAR (medication administration record) documented, "Monitor blood pressure 2x a week (goal <140/90) Sunday + Thursday." 9/24/17 had a box around it indicating the blood pressure was to be obtained on that day. There was no blood pressure or nurse's initials in the box. Review of the nurse's notes for 9/24/17 did not evidence documentation of the resident's blood pressure. An interview was conducted on 9/28/17 at 12:15 p.m. with LPN (licensed practical nurse) #3, the resident's nurse. When asked why the residents had care plans, LPN #3 stated, "To make sure we're following protocol and things the patient needs from the beginning to the end." When asked why staff followed the care plan, LPN #3 stated, "Because it's what's best for the resident." When asked to review Resident #15's MAR for the 9/24/17 blood pressure, LPN #3 stated, "I can't speak to that." When asked if the blood pressure would be documented anywhere else, LPN #3 stated, "No, it's only on the MAR." When asked what the empty box on 9/24/17 meant, LPN #3 stated, "It wasn't done." On 9/28/17 at 5:00 p.m. ASM (administrative staff member) #1, the administrator/executive director, and ASM #2, the director of nursing/clinical services, were made aware of the findings. Review of the facility's policy titled, "Plans of Care" documented, "Direct care staff should be aware, understand and follow their Resident's Plan of Care...."	F 282		

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No further information was provided prior to exit.

b. The facility staff failed to follow Resident #15's written plan of care to monitor the resident's blood glucose before meals and at bedtime per the physician's order and comprehensive care plan.

Review of the care plan initiated on 10/4/16 and revised on 10/19/16 documented, "Focus. The Resident is at Risk for Metabolic Complications r/t (related to) Diabetes....Interventions. Blood-Glucose levels as ordered."

Review of the physician's orders for September 2017 documented, "CHECK BLOOD SUGAR BEFORE MEALS AND AT BEDTIME FOR DM (diabetes mellitus)."

Review of the September 2017 MAR documented, "CHECK BLOOD SUGAR BEFORE MEALS AND AT BEDTIME FOR DM. 05/30/17." Further review of the MAR revealed that the blood sugar was not checked on 11 occasions out of 72 opportunities.

An interview was conducted on 9/28/17 at 12:15 p.m. with LPN (licensed practical nurse) #3, the resident's nurse. When asked why the residents had care plans, LPN #3 stated, "To make sure we're following protocol and things the patient needs from the beginning to the end." When asked why staff followed the care plan, LPN #3 stated, "Because it's what's best for the resident." When asked to review Resident #15's MAR for the physician ordered blood sugars, LPN #3 stated, "I can't speak to these." When asked if the

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blood sugars would be documented anywhere else in the resident's chart, LPN #3 stated, No. It's on the MAR." When asked what the blank spaces meant, LPN #3 stated, "It wasn't done." When asked why it was important to obtain the resident's blood sugar, LPN #3 stated, "To make sure that they're not having a hypoglycemic (low blood sugar) episode. Especially so we know if we should hold it (the insulin)."

A telephone interview was conducted on 9/28/17 at 3:30 p.m. with LPN #13, the resident's nurse. When asked what the blank space on the MAR meant, LPN #13 stated, "It usually means it wasn't done."

On 9/28/17 at 5:00 p.m. ASM (administrative staff member) #1 and ASM #2 were made aware of the findings.

No further information was provided prior to exit.

3. The facility staff failed to follow Resident #23's written plan of care to obtain blood glucose levels before each meal per the physician's orders and comprehensive care plan.

Resident #23 was admitted to the facility on 5/18/15 with diagnoses that included but were not limited to: diabetes, high blood pressure, anemia and shortness of breath. Review of the most recent MDS, a quarterly assessment, with an ARD of 7/12/17 coded the resident as having scored a 12 out of 15 on the brief interview for mental status indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring set up assistance from staff except for dressing and

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bathing in which the resident was coded as requiring the assistance of one staff member.

Review of Resident #23's comprehensive care plan initiated on 2/15/17 and revised on 3/8/17 documented, "Focus. The Resident is at Risk for Metabolic Complications r/t Diabetes. Interventions. Blood Glucose levels as ordered."

Review of the September 2017 physician's orders documented, "CHECK BLOOD SUGAR BEFORE MEALS DAILY." The order date was 2/26/27.

Review of the September 2017 MAR documented, "CHECK BLOOD SUGAR BEFORE MEALS DAILY." Further review of the MAR revealed that the resident did not have a blood glucose checks completed before meals as ordered on eight occasions out of 82 opportunities.

An interview was conducted on 9/28/17 at 12:15 p.m. with LPN (licensed practical nurse) #3, the resident's nurse. When asked why the residents had care plans, LPN #3 stated, "To make sure we're following protocol and things the patient needs from the beginning to the end." When asked why staff followed the care plan, LPN #3 stated, "Because it's what's best for the resident." When asked to review Resident #23's MAR for the blood sugars, LPN #3 stated, "I can't speak to these." When asked if the blood sugars would be documented anywhere else in the resident's chart, LPN #3 stated, No. It's on the MAR." When asked what the blank spaces meant, LPN #3 stated, "It wasn't done." When asked why it was important to obtain the resident's blood sugar, LPN #3 stated, "To make sure that they're not having a hypoglycemic (low blood sugar) episode.

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Especially so we know if we should hold it (the insulin)."

A telephone interview was conducted on 9/28/17 at 3:30 p.m. with LPN #13, the resident's nurse. When asked what the blank space on the MAR meant, LPN #13 stated, "It usually means it wasn't done."

On 9/28/17 at 5:00 p.m. ASM #1 and ASM #2 were made aware of the findings.

No further information was provided prior to exit.

4. The facility staff failed to follow Resident #2's comprehensive care plan to provide the HIV (human immunodeficiency virus (2)) medication Triumeq (1) to Resident #2 and failed to follow the 6/23/17 infectious disease doctor's order to continue the Triumeq.

Resident #2 was admitted to the facility on 5/1/17 with diagnoses that included but were not limited to: HIV, dementia, depression, difficulty swallowing and elevated cholesterol. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 8/8/17 coded the resident as having both short and long term memory problems and as severely impaired cognitively. Resident #2 was coded as rarely or never being able to understand others or to be understood. The resident was coded as requiring assistance from staff for all activities of daily living. The resident was coded as having HIV.

Review of Resident #2's care plan initiated on 5/12/17 documented, "Focus. The resident has

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an infection r/t (related to) medical dx (diagnosis) of HIV. Interventions. Provide medications as ordered."

Review of the 6/23/17 infectious disease doctor's note documented in part, "In brief, this is a 65-year-old African American woman with HIV - probable HIV associated dementia.... Per the family, she is eating very little and is losing weight, medication adherence has been confirmed. Prescriptions & Documented Meds (medications) by Hx (history): abacavir/dolutegravir/lamivudine (Triumeq) (Hx [history]): PO (by mouth) daily...Assessment/Plan: 2. continue Triumeq." A handwritten note documented, "Transferred to telephone order 6/23/17 8 pm."

Review of the resident's 6/23/17 telephone orders did not evidence documentation regarding the Triumeq.

Review of the June 2017 MAR (medication administration record) did not evidence documentation regarding the Triumeq.

Review of the July and August 2017 MARs did not evidence documentation regarding the Triumeq.

An interview was conducted on 9/27/17 at 3:05 p.m. with the resident's daughter. When asked about the resident's history, the daughter stated that sometime in 2014 or 2015 her mother had gone to an HIV clinic in New York. She was diagnosed with HIV and was started on medications. The daughter stated she and her sister brought the mother to Virginia to get her closer to home and that the New York facility had

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given them a supply of her HIV medications for the trip. The daughter stated that she told the facility that the resident was on the HIV medication and that she needed her medications. The daughter stated she had brought the medication (Triumeq) to the facility and that the medication had been given to her mother.

An interview was conducted on 9/28/17 at 12:15 p.m. with LPN (licensed practical nurse) #3. When asked why the residents had care plans, LPN #3 stated, "To make sure we're following protocol and things the patient needs from the beginning to the end." When asked why staff followed the care plan, LPN #3 stated, "Because it's what's best for the resident." When asked to review Resident #2's MAR for documentation of the medication Triumeq, LPN #3 stated, "I can't speak to these." When asked if the medication administration would be documented anywhere else in the resident's chart, LPN #3 stated, No. It's on the MAR." When asked what the blank spaces meant, LPN #3 stated, "It wasn't done."

On 9/28/17 at 5:00 p.m. ASM #1, the administrator/executive director, and ASM #2, the director of nursing/clinical services, were made aware of the findings.

No further information was provided prior to exit.

Complaint deficiency

1. Triumeq contains abacavir, an HIV medicine. People who take abacavir-containing products, including Triumeq, may have a serious allergic reaction (hypersensitivity reaction) that can cause death. This information was obtained from: https://aidsinfo.nih.gov/drugs/534/triumeq/0/patie

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2. HIV stands for human immunodeficiency virus, which is the virus that causes HIV infection. The abbreviation "HIV" can refer to the virus or to HIV infection. HIV is the virus that causes HIV infection. AIDS is the most advanced stage of HIV infection.
HIV is spread through contact with the blood, semen, pre-seminal fluid, rectal fluids, vaginal fluids, or breast milk of a person with HIV. In the United States, HIV is spread mainly by having anal or vaginal sex or sharing drug injection equipment with a person who has HIV.
Antiretroviral therapy (ART) is the use of HIV medicines to treat HIV infection. People on ART take a combination of HIV medicines (called an HIV regimen) every day.
ART can't cure HIV infection, but it can help people with HIV live longer, healthier lives. HIV medicines can also reduce the risk of transmission of HIV. This information was obtained from the website: https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/19/45/hiv-aids--the-basics
5. The facility staff failed to follow Resident # 6's comprehensive care plan in regards to medications.

Resident # 6 was admitted to the facility on 7/14/11 and was most recently readmitted on 9/7/17 with diagnoses that included but were not limited to: cancer, anemia, coronary artery disease, gastroesophageal reflux disease, diabetes, seizure disorder, cerebral palsy (1), congestive heart failure. stroke, depression, and end stage renal disease.

Resident # 6's most recent MDS (minimum data

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set) assessment, an Annual Assessment, with an ARD (assessment reference date) of 8/5/17 coded Resident # 6 as understood by others and as able to understand others. Resident # 6 was coded as being cognitively impaired making daily decisions, scoring 4 out of 15 on the BIMS (brief interview for mental status).

Review of Resident #6's comprehensive care plan revealed the following documentation:

"Focus: *Psychoactive Medication Use Anti-Depressant medication for DX (diagnosis) of Major Depressive disorder date initiated: 8/9/16" under "Interventions...*Medication as ordered (see MAR) date initiated: 8/9/16."

"Focus: *The Resident is at Risk for Metabolic Complications r/t (related to) Diabetes Type II, Other disease processes: ESRD (end stage renal disease) with hemodialysis ..." under "Interventions ... *Blood Glucose levels as ordered ...Date Initiated 8/11/16 ..."

"Focus: *The Resident has decreased cardiac output and potential for alteration in perfusion r/t HTN (high blood pressure) * Diabetes...*Renal Disease... initiated 8/9/16 and revised 8/17/16" Under "Interventions... *Medications as ordered. Date Initiated 8/9/16 ..."

Review of Resident #6's physician orders revealed the following documentation:

Dated 3/20/17: "LEXAPRO (2) 20MG (milligram) TABLET TAKE 1 TABLET BY MOUTH EVERY DAY." This order was signed by the physician on 7/1/17 and 8/2/17.

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"CHECK FASTING BLOOD SUGAR EVERY DAY @ AT 6:30 AM AND 4:30 PM." This order was signed by the physician on 7/1/17 and 8/2/17.

Dated 7/30/16: "DIOVAN (3)160 MG TABLET TAKE 1 TABLET BY MOUTH DAILY." This order was signed by the physician on 7/1/17 and 8/2/17.

Dated 1/24/17: "RENA-VITE (4) 0.8MG TABLET TAKE 1 TABLET BY MOUTH EVERY DAY." This order was signed by the physician on 7/1/17 and 8/2/17.

Dated 7/30/16: "NORVASC (5) 10 MG TAKE 1 TABLET BY MOUTH DAILY." This order was signed by the physician on 7/1/17 and 8/2/17.

Dated 5/15/17: "RENENLA (6) 800MG TABLETS GIVE ½ TABLET (400 MG) BY MOUTH THREE TIMES DAILY." This order was signed by the physician on 7/1/17 and 8/2/17.

Review of the MAR (medication administration record) for July and August 2017 revealed the following:

For July:
- Lexapro was not given at 9:00 a.m. one time out of 31 opportunities.
- Check fasting blood sugar at 6:30 a.m. was not done two times out of 31 opportunities.
- Check fasting blood sugar at 4:30 p.m. was not done one time out of 31 opportunities.
- Rena-Vite was not given at 9:00 a.m. one time out of 31 opportunities.

For August:
- Lexapro was not given at 9:00 a.m. five times out of 31 opportunities.

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- Renvela not given at 7:30 a.m. four times out of 10 opportunities.
- Renvela not given at 11:30 a.m. five times out of 10 opportunities.
- Renvela not given at 4:30 a.m. two times out of 10 opportunities.
- Norvasc was not given at 9:00 a.m. four times out of 31 opportunities.
- Diovan not given at 9:00 a.m. four times out of 31 opportunities.

During an interview on 9/28/17 at 1:55 p.m. with LPN (licensed practical nurse) # 5, LPN # 5 was asked the purpose of the care plan. LPN # 5 stated that it was her understanding that the care plan was where staff would go to get information on how to care for the resident to include diet, medications, and therapy. The care plan is used by all nurses. The CNAs (certified nurse's assistants) use the Kardex for information to care for the residents.

During an interview on 9/28/17 at 4:50 p.m. with ASM (administrative staff member) # 1, the administrator/executive director, and ASM # 2, the director of nurses/clinical services, this concern was shared.

No further information was provided prior to exit.

References:

(1) Cerebral palsy refers to a group of neurological disorders that appear in infancy or early childhood and permanently affect body movement and muscle coordination Cerebral palsy (CP) is caused by damage to or

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abnormalities inside the developing brain that disrupt the brain's ability to control movement and maintain posture and balance. The term cerebralrefers to the brain; palsy refers to the loss or impairment of motor function. This information was obtained from the website: https://www.ninds.nih.gov/Disorders/Patient-Caregiver-Education/Hope-Through-Research/Cerebral-Palsy-Hope-Through-Research#3104_2

(2) LEXAPRO -- Escitalopram is used to treat depression and generalized anxiety disorder (GAD). It is an antidepressant that belongs to a group of medicines known as selective serotonin reuptake inhibitors (SSRIs). These medicines work by increasing the activity of the chemical serotonin in the brain.
This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010165/?report=details

(3) DIOVAN -- Valsartan and hydrochlorothiazide combination is used alone or with other medicines to treat high blood pressure (hypertension). This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012601/?report=details

(4) RENA-VITE -- Supplies your body with vitamin B and vitamin C. You might need extra vitamins because of an illness or other medicines that you are using. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012655/

(5) NORVASC -- Amlodipine is used alone or together with other medicines to treat angina

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(chest pain) and high blood pressure (hypertension). This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008948/?report=details

(6) RENENLA -- Lowers the amount of phosphorus in blood of patients receiving kidney dialysis.
This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012110/?report=details

6. The facility staff failed to follow Resident # 7's care plan in regards to medications.

Resident # 7 was admitted to the facility on 3/28/13 and most recently on 3/10/17 with diagnoses that included but were not limited to: diabetes, dementia, hypertension, bipolar disorder, chronic obstructive pulmonary disease, atrial fibrillation, glaucoma, and irritable bowel syndrome.

Resident # 7's most recent MDS (minimum data set) assessment, a Quarterly Assessment, with an ARD (assessment reference date) of 8/5/17 coded Resident # 7 as understood by others and as able to understand others. Resident # 7 was coded as being cognitively intact for making daily decisions, scoring 15 out of 15 on the BIMS (brief interview for mental status).

Review of Resident #7's comprehensive care plan revealed the following documentation:

"Focus: *Potential fluid imbalance r/t (related to)

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medication side effects. Date Initiated: 3/16/17." Under "Interventions * Administer medications as ordered ...Date Initiated: 3/16/17 ..."

"Focus: *The Resident is at Risk for Metabolic Complications r/t Diabetes. Date Initiated: 3/27/17 ..." Under "Interventions: *Blood Glucose levels as ordered. Date Initiated 3/27/17 ..."

Review of physician orders revealed the following documentation:

Dated 3/10/17: "LASIX (1) 40 MG TAKE 1 TABLET BY MOUTH EVERY DAY ..." This order was signed by the physician on 7/1/17 and 8/2/17.

Dated 3/16/17: "HUMALOG (2) KWIKPEN - 100/ML (milliliter) INSULIN PEN INJECT SUBCUTANEOUSLY PER SLIDING SCALE THREE TIMES DAILY IF BLOOD SUGAR IS 152-200 = 2 UNITS, 201-250=4 UNITS, 251-300=6 UNITS, 301-350=8 UNITS, 351-400=10 UNITS, 401-450=12 UNITS, GREATER THAN 450=14 UNITS AND REPEAT BLOOD SUGAR IN 2 HOURS AND FOLLOW SLIDING SCALE COVERAGE, IF REPEAT BLOOD SUGAR IN 2 HOURS AND STILL OVER 450, FOLLOW SLIDING SCALE AND CALL MD [medical doctor]" This order was signed by the physician on 7/1/17 and 8/2/17.

Review of Resident #7's MAR (medication administration record) for July and August 2017, revealed the following:

For July 2017:
- Sliding Scale Insulin blood sugar not checked at 11:30 a.m. three times out of 31 opportunities.
- Sliding Scale Insulin blood sugar not checked

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at 4:30 p.m. one time out of 31 opportunities.

For August 2017:
- Lasix was not given one time out of 31 opportunities.
- Sliding Scale Insulin blood sugar not checked at 11:30 a.m. one time out of 31 opportunities.
- Sliding Scale Insulin blood sugar not covered with insulin at 11:30 a.m. one time out of 9 opportunities.
- Sliding Scale Insulin blood sugar not checked at 4:30 p.m. two times out of 31 opportunities.
- Sliding Scale Insulin blood sugar not covered with insulin at 4:30 p.m. five times out of 12 opportunities.

During an interview on 9/28/17 at 1:55 p.m. with LPN (licensed practical nurse) # 5, LPN # 5 was asked what the purpose of the care plan. LPN # 5 stated that it was her understanding that the care plan was where staff would go to get information on how to care for the resident to include diet, medications, and therapy. The care plan is used by all nurses. The CNAs (certified nurse's assistants) use the Kardex for information to care for the residents.

During an interview on 9/28/17 at 4:50 p.m. with ASM (administrative staff member) # 1, the administrator/executive director, and ASM # 2, the director of nurses/clinical services, this concern was shared.

Review of the facility policy: "Plans of Care" under "Procedure ...Direct care staff should be aware, understand and follow their Resident's Plan of Care..."

No further information was provided prior to exit.

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References:

(1) LASIX - furosemide tablet Furosemide belongs to a group of medicines called loop diuretics (also known as water pills). Furosemide is given to help treat fluid retention (edema) and swelling that is caused by congestive heart failure, liver disease, kidney disease, or other medical conditions. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010414/?report=details

(2) Humalog® [insulin lispro injection, USP (rDNA origin)] Insulin lispro is a fast-acting type of insulin. Insulin is one of many hormones that the body turn the food we eat into energy. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010736/ helps

F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309	F309 1. Resident#2 is currently receiving prescribed HIV medications as per Physician order. Resident#15's blood glucose is being obtained and documented in the medical record as per Physicians order. Resident#23 blood glucose is being obtained and documented in the medical record as per Physician order. Resident#17 is receiving prescribed pain medication as per Physician's order.

483.24 Quality of life
Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive

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assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:

(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, family interview, facility document review and clinical record review it was determined that the facility staff failed to provide the necessary care and services and treatment to maintain the highest level of physical well-being for ten of 34 residents in the survey sample, Residents #2, #15, #23, #17, #32, #6, #7, #16, #12 and #10.

1. The facility staff failed to follow the infectious disease physician's 6/23/17 order to continue Resident #2 on Triumeq (1) resulting in a delay of treatment of the resident's HIV (human immunodeficiency virus (2)) infection. The resident was ordered HIV medication on 9/13/17.

2. a. The facility staff failed to obtain Resident

Resident#32's pain and anxiety medication is being administered as per Physician order. Resident#6's prescribed medications and treatments are being administered as per Physician order. Resident#7 prescribed medications and treatments as per being administered as per MD order. Resident#16's order for notification to the Physician for

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#15's blood pressure twice a week, as ordered by the physician on 9/21/17.

2. b. The facility staff failed to check Resident #15's blood sugar before meals and at bedtime, per the 6/13/17 and 7/27/17 physician's orders.

3. The facility staff failed to follow Resident #23's physician's order date 2/26/17, to check Resident #15's blood glucose before meals.

4. The facility staff failed to administer Resident #17's pain medication per physician's order on multiple dates in September 2017.

5. The facility staff failed to administer Resident #32's pain and anxiety medications per physician's order on 7/30/17.

6. The facility staff failed to administer medications and treatments to Resident # 6 as ordered by the physician.

7. The facility staff failed to administer medications and treatments to Resident # 7 as ordered by the physician.

8. The facility staff failed to obtain oxygen saturation levels in order to notify the physician if levels dropped below 90 % for Resident #16.

9. a. The facility staff failed to follow physician's orders and apply a left hand palm protector and a right hand splint to Resident #12's hands.

9b. The facility staff failed to attempt non-pharmacological pain interventions prior to the administration of Morphine [1] to Resident #12; failed to assess pain location and intensity

saturation levels below 90% has been discontinued by the Physician. Resident #12 has left hand palm protector applied as ordered and application is documented. The facility has added non-pharmacological intervention has been added to Resident#12's profile. The Physician has discontinued the order to elevate Resident#16 lower legs with two pillows while in bed and seated in chair.

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prior to the administration of Morphine and failed to document the effectiveness of Morphine after it was administered to the resident.

10. The facility staff failed to follow a physician order to keep Resident #10's bilateral lower legs elevated on two pillows when in bed and seated in a chair.

The findings include:

1. The facility staff failed to follow the infectious-disease physician's 6/23/17 order to continue Resident #2 on Triumeq (1) resulting in a delay of treatment of the resident's HIV (human immunodeficiency virus (2)) infection. The resident was ordered HIV medication on 9/13/17.

Resident #2 was admitted to the facility on 5/1/17 with diagnoses that included but were not limited to: HIV, dementia, depression, difficulty - swallowing and elevated cholesterol. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 8/8/17 coded the resident as having both short and long term memory problems and as severely impaired cognitively. Resident #2 was coded as rarely or never being able to understand others or to be understood. The resident was coded as requiring assistance from staff for all activities of daily living. The resident was coded as having HIV.

Review of Resident #2's care plan initiated on 5/12/17 documented, "Focus. The resident has an infection r/t (related to) medical dx (diagnosis) of HIV. Interventions. Provide medications as ordered."

Resident#2 currently resides in the facility and has no s/s of adverse effects. Resident#15 currently resides in the facility and has no s/s adverse effects. Resident#23 currently resides in the facility and has no s/s adverse effects. Resident#17 currently resides in the facility and has no s/s adverse effects. Resident#32 currently resides in the facility has no s/s of adverse effects. Resident#32

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Review of the nurse's note dated 5/2/17 at 2:00 p.m. documented, "Currently awaiting meds (medications) to arrive, resident is on a medication called Truimeq 600 (mg)-50 (mg)-300 mg the medication was called in by pharmacy to be @ (at) the cost of $2827 and insurance would not cover medication and the facility would have to fort (sic) the bill, pharmacy advise (sic) not to fill prescription until (nurse) (writer) speak to family and MD (medical doctor) to see if their (sic) an equivenlant (sic) med (medication) that can be order (sic) the insurance will cover. MD (name of physician) notifies (sic) of situation and asked to prescribed (sic) something else, MD instructed to call pharmacy (sic) ask for equivenalt (sic), pharmotish (sic) stated theirs (sic) is not a medication that is Generic for medication and that some-thing totally different would have to be ordered. MD (name of physician) notified once more and made aware of pharmacy answer to question, MD decided to D/C particular medication and refer resident to infectious control center ASAP (as soon as possible), order has been given to unit clerk to set up. Awaiting appoint (appointmenl) Resident RP (responsible party) daughter has been called and made aware of d/cing (discontinuing) of medication."

Review of the physician's history and physical dated 5/2/17 documented, "History of Present Illness: The patient is a 65-year-old female with history of dementia, HIV, who is admitted here for rehabilitation. She came with orders for antiretroviral, Triumeq, for HIV from the other facility with no records regarding HIV, who has ordered it, what are the CD4 (HIV) counts (4). Here [at the facility], the insurance is not covering it [medication]. I was asked to review and

is currently resides in the facility and has no s/s of adverse effects. Resident#6 currently resides in the facility and has no s/s of adverse effects. Resident#7 currently resides in the facility and has no s/s of adverse effects. Resident#12 currently resides in the facility and has no s/s adverse effects. Resident#16 currently resides in the facility and has no s/s adverse effects.

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address. The patient is demented. Cannot give any history. We called the patient's daughter or RP (responsible party), and she said she has not been started on this medicine. She has not seen any HIV doctor before. Assessment and Plan: 1. History of human immunodeficiency virus. Recommendations: 1. We will discontinue the Triumeq and refer to HIV Clinic at (name of hospital) for further recommendations."

Review of a physician's order dated 5/13/17 documented, "Start Triumeq 600-50-300 tablet (supplied by daughter) Give 1 tablet po (by mouth) daily. Dx (diagnosis) HIV *8-day supply received*."

Review of the physician order dated 5/28/17 documented, "D/C (discontinue) Triumeq 600-50-300 after 8-day supply given. Pt (patient) to f/u (follow up) with (name of hospital HIV clinic)."

Review of Resident #2's May 2017 medication administration record documented, "Triumeq 600-50-300 Give 1 tablet by mouth daily (8-day supply) Dx HIV." The medication was documented as being given from 5/14/17 through 5/22/17.

Review of the 6/23/17 infectious disease doctor's note documented in part, "In brief, this is a 65-year-old African American woman with HIV - probable HIV associated dementia.... Per the family, she is eating very little and is losing weight, medication adherence has been confirmed. Prescriptions & Documented Meds (medications) by Hx (history): abacavir/dolutegravir/lamivudine (Triumeq) (Hx): PO (by mouth) daily...Assessment/Plan: 2.

2.A quality review of current residents with Physician orders for hand splints/palms protectors has been performed. A quality review of current residents with orders for Antipsychotic medications has been performed. A quality review of residents with orders for oxygen saturation and blood glucose monitoring has been performed. A quality review of residents with orders for blood pressure monitoring has been performed. A quality review of residents with

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continue Triumeq." A handwritten note documented, "Transferred to telephone order 6/23/17 8 pm."

Review of Resident #2's 6/23/17 telephone orders did not evidence documentation regarding the Triumeq.

Review of Resident #2's June 2017 MAR (medication administration record) did not evidence documentation regarding the Triumeq.

Review of the July and August 2017 MARs did not evidence documentation regarding the Triumeq.

Review of the infectious disease doctor's orders dated 9/1/17 documented, "Plan is to start Raltegravir (2) + Descovy (3) (...if prior authorization required for Descovy, then use Truvad...avoid further Rx [treatment] delays)."

Review of the September 2017 MAR (medication administration record) documented, "Descovy 200-25mg (milligrams) 1 tab (tablet) PO (by mouth) Daily. Isentress 400 mg 1 tab PO BID (twice a day)." The start date was documented as being 9/13/17.

An interview was conducted on 9/27/17 at 2:30 p.m. with OSM (other staff member) #7, the director of social services. OSM #7 was asked who assisted residents with obtaining medications that the insurance company did not cover. OSM #7 stated. "The business office handles that piece of it."

An interview was conducted on 9/27/17 at 3:05 p.m. with Resident #2's daughter. When asked

orders for HIV medications has been performed. A quality review of residents with orders for prescribed medications has been performed. A quality review of treatment orders has been performed.

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F 309	Continued From page 107	F 309	2. Licensed Nurses re-educated by DCS/Designee regarding following Physician orders on application of hand splints and palm protectors, following Physician orders regarding medication administration and documentation, following Physician orders on blood glucose monitoring and documentation, following Physician orders on blood pressure monitoring and documenting, obtaining oxygen saturation and documenting, and attempting non-pharmacological interventions and pain management. .	

about the resident's history, the daughter stated that sometime in 2014 or 2015 her mother had gone to an HIV clinic in New York. She was diagnoses with HIV and was started on medications. The daughter stated she and her sister brought the mother to Virginia to get her closer to home and the New York facility had given them a supply of her HIV medications for the trip. The daughter stated she told the facility the resident (Resident #2) was on the HIV medication and that she needed her medications. The daughter stated that she had brought the medication (Triumeq) to the facility and the medication had been given to her mother.

An interview was conducted on 9/28/17 at 8:10 a.m. with LPN (licensed practical nurse) #6, the unit manager. When asked if staff followed the orders from a consultant, LPN #6 stated, "When they bring the consult back we order anything they order." When asked why Resident #2 wasn't put on the Triumeq as ordered by the infectious disease doctor on 6/23/17, LPN #6 stated, "She wasn't on it." When asked to review the 6/23/17 infectious disease doctor's orders, LPN #6 stated, "I didn't see this. She (LPN #13) never showed me this because I would have followed up. I would have called (name of hospital)."

On 9/28/17 at 1:15 p.m. an interview was conducted with OSM (other staff member) #6, the business office manager. OSM #6 was asked about the process staff follows if insurance does not cover a resident's medication. OSM #6 stated, "If there is insurance there is a way to get it covered. We want to get that medication." When asked what he knew about Resident #2, OSM #6 stated, "She should have been given meds (medications) based on the hospital orders

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and what the doctor ordered." When asked if the business office staff was asked to assist in getting Resident #2's medications, OSM #6 stated they were not.

On 9/28/17 at 2:40 p.m. a message was left with a secretary for the infectious disease doctor. The doctor did not return the call.

An interview was conducted on 9/28/17 at 3:15 p.m. with LPN #13, the nurse who took off Resident #2's 6/23/17 infectious disease doctor's orders. When asked about the process staff followed when a resident returned from a consult with orders, LPN #13 stated, "Usually that information and any orders need to be put on a telephone order." When asked if she remembered Resident #2, LPN #13 stated she did. When asked why she did not enter the Triumeq order that the infectious disease doctor had written, LPN #13 stated she thought the infectious disease doctor wanted to wait until all of the resident's laboratory work was completed but she wasn't sure. When asked if that information would be documented, LPN #13 stated it should be.

Review of the physician's orders for 6/23/17 did not evidence documentation regarding holding the medication.

Review of the nurse's note dated 6/23/17 at 8:00 p.m. did not evidence documentation regarding holding the Triumeq.

Review of the nurse's note dated 6/28/17 documented, "Labs ordered from Infectious disease arrived. (Name of staff person at the hospital) ordered. Unable to obtain fax #. Will

DCS/Designee during Morning Clinical Meeting to conduct quality monitoring daily x4 weeks, weekly x4 weeks and then monthly, PRN and as indicated.

4.Findings to be communicated to the QAPI committee monthly and as indicated. Quality monitoring schedules modified based on findings

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pass on in report."

An interview was conducted on 9/28/17 at 3:55 p.m. with ASM (administrative staff member) #2, the director of nursing/clinical services. When asked why the Triumeq had not been started after the infectious disease doctor ordered it, ASM #2 stated, "So, (name of ASM #5, the physician) discontinued it so we couldn't give it." When asked to review the 6/23/17 infectious disease doctor's orders, ASM #2 stated, "Well we didn't have an order for it." When asked what would staff be expected to do, ASM #2 stated they should get a clarification of the order. ASM #2 was made aware of the findings at that time.

An interview was conducted on 9/28/17 at 4:05 p.m. with ASM #5, the resident's doctor. When asked about Resident #2's Triumeq, ASM #5 stated, "That medication was not covered by the insurance. The nurses tell me the drugs that insurance isn't covering." When asked if that was the reason he discontinued the Triumeq, ASM #5 stated, "I wasn't sure she had HIV. The family didn't know anything. She wasn't on any medication." When asked why he order the Triumeq on 5/12/17, ASM #5 did not have an answer. ASM #5 stated, "I wanted her seen by ID (infectious disease) doctors first." When asked if he followed the recommendations of the infectious disease doctors, ASM #5 stated, "Yeah, whatever the ID (infectious disease) clinic says should be what is done." When asked why the Triumeq was not started on 6/23/17 as ordered by the infectious disease doctor, ASM #5 stated, "They wanted the labs (laboratory specimens) drawn before they started it and they were going to send in their own lab people." When informed the laboratory specimens had been drawn on

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6/28/17, ASM #5 didn't reply. When asked if the resident had any negative consequence to not receiving treatment for her HIV until 9/13/17; ASM #5 stated, "No. She has been diagnosed with progressive dementia. It's not reversible but the medications may slow it."

On 9/28/17 at 5:00 p.m. ASM #1, the administrator/executive director, and ASM #2, the director of nursing/clinical services, were made aware of the findings.

Review of the facility's policy titled, "Physician/Prescriber Authorization and Communication of Orders to Pharmacy" documented, "12. Facility should follow the following procedures with respect to verbal orders. 12.1 Facility's licensed nurses should contact the residents Physician/Prescriber when there is a change in condition that may require a new medication or a renewal of an existing order."

No further information was provided prior to exit.

Complaint deficiency

1. Triumeq contains abacavir, an HIV medicine. People who take abacavir-containing products, including Triumeq, may have a serious allergic reaction (hypersensitivity reaction) that can cause death. This information was obtained from: https://aidsinfo.nih.gov/drugs/534/triumeq/0/patient

2. Raltegravir is a prescription medicine approved by the U.S. Food and Drug Administration (FDA) for the treatment of HIV infection in adults and children 4 weeks of age and older. Raltegravir is

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always used in combination with other HIV medicines This information was obtained from: https://aidsinfo.nih.gov/drugs/420/raltegravir/0/patient

3. Descovy is a prescription medicine approved by the U.S. Food and Drug Administration (FDA) for the treatment of HIV infection in adults and children 12 years of age and older who weigh at least 77 pounds (35 kilograms). Descovy is always used in combination with other HIV medicines. This information was obtained from: https://aidsinfo.nih.gov/drugs/560/descovy/0/patient

4. CD4 Count: A laboratory test that measures the number of CD4 T lymphocytes (CD4 cells) in a sample of blood. In people with HIV, the CD4 count is the most important laboratory indicator of immune function and the strongest predictor of HIV progression. The CD4 count is one of the factors used to determine when to start antiretroviral therapy (ART). This information was obtained from the website: https://aidsinfo.nih.gov/understanding-hiv-aids/glossary/822/cd4-count

2. a. The facility staff failed to obtain Resident #15's blood pressure twice a week, as ordered by the physician on 9/21/17.

Resident #15 was admitted to the facility on 10/3/16 with diagnoses that included but were not limited to: seizures, schizophrenia, kidney disease, diabetes, high blood pressure and stroke. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 7/7/17 coded

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Resident #15 as having scored a 13 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. Resident #15 was coded as requiring assistance from staff for all activities of daily living.

Review of Resident #15's care plan initiated on 10/4/16 and revised on 10/19/16 documented, "Focus. The resident has potential for alteration in perfusion r/t (related to) HTN (high blood pressure), Diabetes...Interventions. Vital signs as ordered and prn (as needed)."

Review of the physician's order dated 9/21/17 documented, "Monitor BP (blood pressure) 2 x (times) a week (goal < 140/90) Sunday + Thursday."

Review of Resident #15's MAR (medication administration record) documented, "Monitor blood pressure 2x a week (goal <140/90) Sunday + Thursday." 9/24/17 had a box around it indicating the blood pressure was to be obtained on that day. There was no blood pressure or nurse's initials documented in the box.

Review of the nurse's notes for 9/24/17 did not evidence documentation of the resident's blood pressure.

An interview was conducted on 9/28/17 at 12:15 p.m. with LPN (licensed practical nurse) #3, the resident's nurse. When asked to review Resident #15's MAR for the 9/24/17 blood pressure, LPN #3 stated, "I can't speak to that." When asked if the blood pressure would be documented anywhere else, LPN #3 stated, "No, it's only on the MAR." When asked what the empty box on

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9/24/17 meant, LPN #3 stated, "It wasn't done."

On 9/28/17 at 5:00 p.m. ASM (administrative staff member) #1, the administrator/executive director, and ASM #2, the director of nursing/clinical services, were made aware of the findings.

No further information was provided prior to exit.

2. b. The facility staff failed to check Resident #15's blood sugar before meals and at bedtime, per the 6/13/17 and 7/27/17 physician's orders.

Review of the care plan initiated on 10/4/16 and revised on 10/19/16 documented, "Focus. The Resident is at Risk for Metabolic Complications r/t (related to) Diabetes....Interventions. Blood Glucose levels as ordered."

Review of the physician's orders for September 2017 documented, "CHECK BLOOD SUGAR BEFORE MEALS AND AT BEDTIME FOR DM (diabetes mellitus)."

Review of Resident #15's September 2017 MAR documented, "CHECK BLOOD SUGAR BEFORE MEALS AND AT BEDTIME FOR DM. 05/30/17." Further review of the MAR revealed that the blood sugar was not checked on 11 occasions out of 72 opportunities.

An interview was conducted on 9/28/17 at 12:15 p.m. with LPN (licensed practical nurse) #3, the resident's nurse. When asked to review Resident #15's MAR for the physician ordered blood sugars, LPN #3 stated, "I can't speak to these." When asked if the blood sugars would be

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documented anywhere else in the resident's chart, LPN #3 stated, No. It's on the MAR." When asked what the blank spaces meant, LPN #3 stated, "It wasn't done." When asked why it was important to obtain the resident's blood sugar, LPN #3 stated, "To make sure that they're not having a hypoglycemic (low blood sugar) episode. Especially so we know if we should hold it (the insulin)."

A telephone interview was conducted on 9/28/17 at 3:30 p.m. with LPN #13. When asked what the blank space on the MAR meant, LPN #13 stated, "It usually means it wasn't done."

On 9/28/17 at 5:00 p.m. ASM #1, the administrator/executive director, and ASM #2, the director of nursing/clinical services, were made aware of the findings.

No further information was provided prior to exit.

3. The facility staff failed to follow Resident #23's physician's order date 2/26/17, to check Resident #15's blood glucose before meals.

Resident #23 was admitted to the facility on 5/18/15 with diagnoses that included but were not limited to: diabetes, high blood pressure, anemia and shortness of breath. Review of the most recent MDS, a quarterly assessment, with an ARD of 7/12/17 coded the resident as having scored a 12 out of 15 on the brief interview for mental status indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring set up assistance from staff except for dressing and bathing in which the resident was coded as

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requiring the assistance of one staff member.

Review of Resident #23's care plan initiated on 2/15/17 and revised on 3/8/17 documented, "Focus. The Resident is at Risk for Metabolic Complications r/t Diabetes. Interventions. Blood Glucose levels as ordered."

Review of Resident #23's September 2017 physician's orders documented, "CHECK BLOOD SUGAR BEFORE MEALS DAILY." The order date was 2/26/27.

Review of Resident #23's September 2017 MAR documented, "CHECK BLOOD SUGAR BEFORE MEALS DAILY." Further review of the MAR revealed that the resident did not have a blood glucoses done on eight occasions out of 82 opportunities.

An interview was conducted on 9/28/17 at 12:15 p.m. with LPN (licensed practical nurse) #3, the resident's nurse. When asked to review Resident #23's MAR for the blood sugars, LPN #3 stated, "I can't speak to these." When asked if the blood sugars would be documented anywhere else in the resident's chart, LPN #3 stated, No. It's on the MAR." When asked what the blank spaces meant, LPN #3 stated, "It wasn't done." When asked why it was important to obtain the resident's blood sugar, LPN #3 stated, "To make sure that they're not having a hypoglycemic (low blood sugar) episode. Especially so we know if we should hold it (the insulin)."

A telephone interview was conducted on 9/28/17 at 3:30 p.m. with LPN #13, the resident's nurse. When asked what the blank space on the MAR meant, LPN #13 stated, "It usually means it

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wasn't done."

On 9/28/17 at 5:00 p.m. ASM #1, the administrator/executive director, and ASM #2, the director of nursing/clinical services, were made aware of the findings.

No further information was provided prior to exit.

4. The facility staff failed to administer Resident #17's pain medication per physician's order on multiple dates in September 2017.

Resident #17 was admitted to the facility on 1/28/17. Resident #17's diagnoses included but were not limited to: fractured vertebrae, diabetes and heart failure. Resident #17's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/7/17, coded the resident as being cognitively intact. Section J documented Resident #17 reported no pain during the five-day look back period.

On 9/27/17 at 2:00 p.m. during a group interview, Resident #17 voiced concern that he was not getting his pain medication like he was supposed to.

Review of Resident #17's clinical record revealed a physician's order dated 7/20/17 for Lyrica 75 mg (milligrams) by mouth every eight hours. Resident #17's September 2017 MAR (medication administration record) documented the Lyrica was scheduled for 6:00 a.m., 2:00 p.m. and 10:00 p.m.

Review of Resident #17's Lyrica controlled

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medication utilization record for 8/28/17 through 9/28/17 revealed the medication was not administered to the resident on the following dates/times:
-9/1/17 at 6:00 a.m.
-9/6/17 at 6:00 a.m.
-9/7/17 at 10:00 p.m.
-9/9/17 at 2:00 p.m.
-9/11/17 time unknown (one pill was signed as being administered at 6:00 a.m. and another pill was signed as being administered on the same day but the time was not documented).

Further review of the above Lyrica controlled medication utilization record revealed the medication was available on the above dates and times as evidenced by the previous and latter doses being administered.

Further review of Resident #17's clinical record (including the back of the MAR, nurses' notes and a leave of absence form) failed to reveal the resident was out of the facility or refused the medication on the above dates/times.

Resident #17's comprehensive care plan initiated on 2/10/17 documented, "The resident has alteration in pain/comfort r/t (related to) Disease process...Interventions: Administer analgesia as per orders and prior to treatments or care prn (as needed) ..."

On 9/28/17 at 11:05 a.m. an interview was conducted with LPN (licensed practical nurse) #6. LPN #6 was asked what should be done if a resident has a physician's order for Lyrica every eight hours. LPN #6 stated, "You have to assess the pain, you might be ODing (overdosing) them." LPN #6 was asked when the medication should

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be given if it is ordered scheduled every eight hours. LPN #6 stated the medication should be given at 6:00 a.m., 2:00 p.m. and 10:00 p.m. LPN #6 stated each Lyrica pill administered must be documented and counted (in the controlled medication utilization record) and each shift the medication listed on the controlled medication utilization record is counted so there are no discrepancies. Resident #17's controlled medication utilization record was reviewed with LPN #6. LPN #6 stated, "He might have refused. He's kind of difficult." LPN #6 stated the resident also went out of the facility a lot. When asked where medication refusal and the resident's absence was documented, LPN #6 stated this information should be documented on the back of the MAR. Resident #17's September 2017 MAR and September 2017 nurse's notes were reviewed with LPN #6. LPN #6 was asked if it looked like the medication was not administered to Resident #17 on the above dates, LPN #6 stated, "Exactly."

On 9/29/17 at 9:45 a.m. ASM (administrative staff member) #1 (the executive director/administrator) and ASM #2 (the director of nursing/clinical services) were made aware of the above concern.

The facility policy titled, "Pain Management Guidelines" documented, "POLICY: The center strives to improve patient/resident comfort and minimize pain in order to help a resident attain or maintain his or her highest practicable level of well-being. PURPOSE: To ensure residents receive the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management..."

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No further information was presented prior to exit.

5. The facility staff failed to administer Resident #32's pain and anxiety medications per physician's order on 7/30/17.

Resident #32 was admitted to the facility on 5/26/17. Resident #32's diagnoses included but were not limited to: anxiety disorder, disease of the spinal cord and osteomyelitis (1). Resident #32's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/12/17, coded the resident as being cognitively intact. Section J documented Resident #32 received scheduled and as needed pain medication during the five-day look back period and reported frequent pain rated as a seven on a scale from zero to ten.

Review of Resident #32's clinical record revealed a physician's order dated 5/26/17 for OxyContin (2) 30 mg (milligrams) by mouth every eight hours. Resident #32's July 2017 MAR (medication administration record) documented the medication was scheduled for 6:00 a.m., 2:00 p.m. and 10:00 p.m. OxyContin 30 mg was initialed and circled (indicating the medication was not administered) on 7/30/17 at 2:00 p.m. and 10:00 p.m. (note- the resident may have been in the hospital when the 10:00 p.m. dose was due).
Review of Resident #32's OxyContin controlled medication utilization record (a record of documentation that accounts for each pill) for 7/20/17 through 7/30/17 revealed the last pill in that supply of OxyContin was administered at

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6:00 a.m. on 7/30/17. Per the next OxyContin controlled medication utilization record, the next dose of OxyContin administered to Resident #32 was on 7/31/17 at 6:00 a.m.

A physician's order dated 5/26/17 documented an order for Xanax (3) 0.5 milligrams by mouth every six hours. Resident #32's July 2017 MAR documented the medication was scheduled for 6:00 a.m., 12:00 p.m., 6:00 p.m. and 12:00 a.m. Xanax 0.5 mg was initialed and circled on 7/30/17 at 6:00 a.m., 12:00 p.m., 6:00 p.m. and 12:00 a.m. The back of the MAR documented, "7/30/17 12mn (12:00 a.m.) (initials) Xanax 0.5mg PO (by mouth) Rx (Pharmacy) called need hard script. 7/30/17 6am (initials) 0.5mg PO need hard script."
Review of Resident #32's Xanax controlled medication utilization record for 7/22/17 through 7/29/17 revealed the last pill in that supply of Xanax was administered on 7/29/17 at 6:00 p.m. Per the next Xanax controlled medication utilization record, the next dose of Xanax administered to Resident #32 was on 7/30/17 at 12:00 p.m.

A nurse's note dated 7/30/17 documented, "Resident alert & verbal oriented X (times) 3. Resident upset PRN (as needed) and 1 of scheduled medications are awaiting doctor approval. Resident became verbally abusive and stated he was going to punch Dr. (name) in the face when he see (sic) him. Writer offered other medication alternative and resident refused. Writer called on call doctor and he said 'no' he was not going to sign any hard scripts. Resident refused wound care X 2 at 10 am & 1:15 pm... Called pharmacy to see if writer can pull medications out stat box and was told that he

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needed hard scripts. Spoke with (name). Resident stated since he don't (sic) have any pain medications he wants to go to hospital. Director of Nursing aware."

The EMS (emergency medical services) patient report dated 7/30/17 documented, "Time call received: 1541 (3:41 p.m.) ...Chief ComplainI: BACK PAIN- ON PAIN MGT (management) PROTOCOL. FACILITY OUT OF OXY (OxyContin)..." The hospital records dated 7/30/17 documented, "52 year paraplegic male presents to the ED (emergency department) c/o. (complaint of) pain at his R (right) ischial area, rated 10/10, since today. Pt (Patient) reports that his nursing home ran out of his Rx (prescription) OxyContin and Xanax, which has happened multiple times in the past, and he has not had any meds (medications) today..." Further review of the hospital records revealed Resident #32 was administered Oxycodone 30 mg Xanax 0.5 mg in the hospital.

A nurse's note dated 7/31/17 documented, "Resident return (sic) from Hospital. Nurse called from Hospital, stated she gave him OxyContin. Resident was medicaled with his scheduled med (medication) upon return. Xanax and OxyContin in from pharmacy at 8:20 pm. Resident is resting in bed with no s/s (signs or symptoms) of withdrawal. No sweats. No distress noted."

Resident #32's comprehensive care plan initiated on 6/7/17 documented, "The resident has alteration in pain/comfort r/t (related to) Right Ischium surgical wound. Chronic back pain, disease of the spinal cord. Major depression...Interventions: Anticipate the resident's need for pain relief and respond to any

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complaint of pain..."

On 9/28/17 at 11:50 a.m. an interview was conducted with Resident #32. Resident #32 acknowledged there were times when his medications were not available.

On 9/28/17 at 3:50 p.m. an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 was asked the facility process for ensuring medication availability. LPN #5 stated when a week's worth of the supply of medication is left, she obtains a hard prescription from the physician and faxes the prescription to the pharmacy. LPN #5 stated Resident #32 takes a lot of medication. LPN #5 stated sometimes the nurses may not pay attention when the medication supply gets low and don't realize the time it takes for the pharmacy to deliver medication. LPN #5 stated sometimes the insurance will decline allowing the pharmacy to send the medication if it's ordered too early.

On 9/28/17 at 4:20 p.m. an interview was conducted with ASM (administrative staff member) #5 (Resident #32's physician). ASM #5 was made aware Resident #32's scheduled OxyContin was not available for administration on 7/30/17 because the facility staff needed a hard prescription. ASM #5 stated, "The guy is drug seeking. He wants his breakthrough medication to get his kick." ASM #5 stated if this situation occurred on a weekend and a hard prescription was needed then the physician could not call in the medication (due to controlled substance laws). When asked if a hard prescription could be faxed to the pharmacy on a weekend, ASM #5 stated, "Where are you going to fax it from?" ASM #5 stated he and the facility staff take care

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of hard prescriptions on Thursdays and Fridays, and this situation rarely occurs. ASM #5 stated, "What can I do?" ASM #5 was read the portion of the 7/30/17 nurse's note that documented the on-call physician stated he would not sign a hard prescription. ASM #5 stated, "Yeah, so this was a weekend."

On 9/28/17 at 4:25 p.m. an interview was conducted with LPN #6. LPN #6 stated medications that are signed and circled on the MAR indicate the medications were not administered. LPN #6 stated an explanation should be documented on the back of the MAR.

On 9/28/17 at 4:30 p.m. another interview was conducted with Resident #32. The resident was reluctant to talk. Resident #32 was asked if he felt comfortable describing how he feels when he doesn't receive his medication. Resident #32 stated he was in a car accident when he was 18 years old, has had eight back surgeries, multiple leg surgeries and degenerative joint disease. Resident #32 stated he feels pain 24 hours a day and he immediately tanks when he doesn't receive his pain medication. When asked to explain what that meant, Resident #32 stated "It feels like hot barbed wire running up the length of my leg. Just spinning in there." Resident #32 stated he also experiences symptoms of withdrawal including hot and cold sweats, shaking and the loss of bowel/bladder function. Resident #32 stated feeling the pain on top of these symptoms is horrifying. Resident #32 was made aware his clinical record had been reviewed and this surveyor saw that he also had a physician's order for as needed Oxycodone (4). Resident #32 was asked why he wasn't willing to accept the as needed Oxycodone when the OxyContin

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was not available. The resident stated it was pointless to take the short acting Oxycodone without the long acting OxyContin because it didn't help.

On 9/28/17 at 5:05 p.m. an interview was conducted with ASM #2 (the director of nursing/clinical services). ASM #2 was asked the facility process for ensuring medication availability. ASM #2 stated that process has changed and narcotic medications require a hard prescription from the physician. ASM #2 stated as nurses approach running out of a resident's narcotic medication, nurses should contact the doctor to collaborate and let him know they are getting low on a medication and need a prescription. ASM #2 was asked what should occur if a resident runs out of a narcotic medication. ASM #2 stated the nurses should follow up with the doctor or the on-call doctor to see if they can administer another medication because most residents have PRN (as needed) orders for other medications. ASM #2 was asked if the physician could come to the facility on a Sunday to write a hard prescription and fax the prescription to the pharmacy. ASM #2 stated, "Yes."

On 9/29/17 at 9:45 a.m. ASM (administrative staff member) #1 (the executive director/administrator) and ASM #2 were made aware of the above concern.

No further information was presented prior to exit.

(1) Osteomyelitis is a bone infection. This information was obtained from the website: https://kidshealth.org/en/teens/osteomyelitis.html

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(2) "OxyContin Tablets are a controlled-release oral formulation of oxycodone hydrochloride indicated for the management of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time..." This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=15783

(3) Xanax is used to treat anxiety. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a684001.html

(4) Oxycodone is used to treat moderate to severe pain. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011537/

6. The facility staff failed to administer medications and treatments to Resident # 6 as ordered by the physician.

Resident # 6 was admitted to the facility on 7/14/11 and most recently on 9/7/17 with diagnoses that included but were not limited to: cancer, anemia, coronary artery disease, gastroesophageal reflux disease, diabetes, seizure disorder, cerebral palsy (1), congestive heart failure. stroke, depression, and end stage renal disease.

Resident # 6's most recent MDS (minimum data set) assessment, an Annual Assessment, with an ARD (assessment reference date) of 8/5/17 coded Resident # 6 as understood by others and as able to understand others. Resident # 6 was

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coded as being cognitively impaired for making daily decisions, scoring 4 out of 15 on the BIMS (brief interview for mental status).

Review of the physician orders revealed the following documentation:

Dated 7/30/16: "REGLAN (2) 5MG (milligram) TAKE 1 TABLET BY MOUTH BEFORE BREAKFAST, LUNCH, DINNER." This order was signed by the physician on 7/1/17 and 8/2/17.

Dated 7/30/16: "LIPITOR (3) 10MG TABLET TAKE 1 TABLET BY MOUTH NIGHTLY." This order was signed by the physician on 7/1/17 and 8/2/17.

Dated 7/30/16: "DIOVAN (4)160 MG TABLET TAKE 1 TABLET BY MOUTH DAILY." This order was signed by the physician on 7/1/17 and 8/2/17.

Dated 3/20/17: "LEXAPRO (5) 20MG TABLET TAKE 1 TABLET BY MOUTH EVERY DAY." This order was signed by the physician on 7/1/17 and 8/2/17.

Dated 1/24/17: "RENA-VITE (6) 0.8MG TABLET TAKE 1 TABLET BY MOUTH EVERY DAY." This order was signed by the physician on 7/1/17 and 8/2/17.

Dated 7/30/16: "BRILINTA (7) 90MG TABLET TAKE 1 TABLET BY MOUTH TWICE DAILY." This order was signed by the physician on 7/1/17 and 8/2/17.

Dated 7/30/16: "SYNTHROID (8) 200MCG TAKE 1 TABLET BY MOUTH BEFORE BREAKFAST." This order was signed by the physician on 7/1/17

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Dated 7/30/16: "NORVASC (9) 10 MG TAKE 1 TABLET BY MOUTH DAILY." This order was signed by the physician on 7/1/17 and 8/2/17.

Dated 7/30/16: "XALATAN (10) 0.005% DROPS ADMINISTER 1 DROP TO BOTH EYES NIGHTLY." This order was signed by the physician on 7/1/17 and 8/2/17.

Dated 7/30/16: "KEPPRA (11) 100MG TAKE 1 TABLET BY MOUTH DAILY." This order was signed by the physician on 7/1/17 and 8/2/17.

Dated 3/20/17: "PROTONIX (12) 40MG TABLET TAKE 1 TABLET BY MOUTH EVERY DAY." This order was signed by the physician on 7/1/17 and 8/2/17.

Dated 7/30/16: "ASPIRIN 81 MG TAKE 1 TABLET BY MOUTH DAILY." This order was signed by the physician on 7/1/17 and 8/2/17.

Dated 7/30/16: "COLACE (12) 100MG TAKE 1 CAPSULE BY MOUTH DAILY." This order was signed by the physician on 7/1/17 and 8/2/17.

Dated 5/15/17: "RENENLA (13) 800MG TABLET GIVE ½ TABLET (400 MG) BY MOUTH THREE TIMES DAILY." This order was signed by the physician on 7/1/17 and 8/2/17.

"CHECK FASTING BLOOD SUGAR EVERY DAY @ AT 6:30 AM AND 4:30 PM." This order was signed by the physician on 7/1/17 and 8/2/17.

Review of the MAR (medication administration record) for Resident # 6 revealed lack of

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documentation for the following:

For July 2017:
Reglan was not given at 6:30 a.m. seven times out of 31 opportunities.
Reglan was not given at 10:00 a.m. three times out of 31 opportunities.
Reglan was not given at 3:00 p.m. seven times out of 31 opportunities.
Lipitor was not given at 9:00 p.m. one time out of 31 opportunities.
Lexapro was not given at 9:00 a.m. one time out of 31 opportunities.
Rena-Vite was not given at 9:00 a.m. one time out of 31 opportunities.
Brilinta was not given at 5:00 a.m. one time out of 31 opportunities.
Check fasting blood sugar at 6:30 a.m. was not done two times out of 31 opportunities.
Check fasting blood sugar at 4:30 p.m. was not done one time out of 31 opportunities.

For August 2017:
Synthroid was not given three times out of 31 opportunities.
Reglan was not given at 6:30 a.m. two times out of 31 opportunities.
Reglan was not given at 10:00 a.m. six times out of 31 opportunities.
Reglan was not given at 3:00 p.m. four times out of 31 opportunities.
Norvasc was not given at 9:00 a.m. four times out of 31 opportunities.
Aspirin not given at 9:00 a.m. four times out of 31 opportunities.
Colace not given at 9:00 a.m. four times out of 31 opportunities.
Keppra not given at 9:00 a.m. four times out of 31 opportunities.

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Diovan not given at 9:00 a.m. four times out of 31 opportunities.
Renvela not given at 7:30 a.m. four times out of 10 opportunities.
Renvela not given at 11:30 a.m. five times out of 10 opportunities.
Renvela not given at 4:30 a.m. two times out of 10 opportunities.
Lipitor was not given at 9:00 p.m. four times out of 31 opportunities.
Xalatan was not given at 9:00 p.m. five times out of 31 opportunities.
Lexapro was not given at 9:00 a.m. five times out of 31 opportunities.
Protonix was not given at 9:00 a.m. four times out of 31 opportunities.
Rena-Vite was not given at 9:00 a.m. two times out of 31 opportunities.
Brilinta was not given at 9:00 a.m. four times out of 31 opportunities.
Brilinta was not given at 5:00 a.m. four times out of 31 opportunities.
Check fasting blood sugar at 4:30 p.m. was not done nine times out of 31 opportunities.

Nurses notes for July and August 2017 were reviewed and no notation as to why the medications were not given could be found.

During an interview on 9/28/17 at 8:40 a.m. with LPN (licensed practical nurse) # 10, LPN # 10 was asked what it meant if there were blocks on the MAR that had no initials inside. LPN # 10 stated that technically it meant that staff did not do it - "Not documented not done."

During an interview on 9/28/17 at 8:50 a.m. with LPN # 9, LPN # 9 was asked what it meant if there were blocks on the MAR that had no initials

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inside. LPN # 9 stated that staff might have forgotten to sign but if it is not signed then it is not done - staff has to document.

During an interview on 9/28/17 at 10:47 a.m. with ASM (administrative staff member) # 2, the director of nurses/clinical services, this concern was shared. ASM # 2 was asked what blanks on the MARs meant. ASM # 2 stated that if it is not documented it is not given. At this time ASM # 2 was asked to identify the nurses' initials so those nurses could be interviewed. A request for the facility policy on following physician orders was requested at this time.

During an interview on 9/28/17 at 1:20 p.m. with LPN # 6, a unit manager, LPN # 6 was asked what it meant if there were blocks on the MAR that had no initials inside. LPN # 6 stated if there is a hole in the MAR then the medication was not given. LPN # 6 identified three of the nurses that were missing initials on the MARs in question: all were interviewed.

During an interview on 9/28/17 at 1:30 p.m. with LPN # 7, LPN # 7 stated that if there is a blank then no medication was given.

During an interview on 9/28/17 at 3:30 p.m. with LPN # 8, LPN # 8 stated that if there are blanks it means that the medication was not given.

During an interview on 9/28/17 at 4:50 p.m. with ASM # 1, the administrator/executive director and ASM # 2, the director of nurses/clinical services, this concern was again shared.

Review of the policy that was presented did not address the concern of this citation.

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No further information was presented prior to exit.

References:

(1) Cerebral palsy-- a group of disorders that affect a person's ability to move and to maintain balance and posture. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html.

(2) REGLAN -- Metoclopramide is an oral prokinetic and antiemetic agent used in the therapy of gastroesophageal reflux disease, gastroparesis and severe or chemotherapy induced nausea.
This information was obtained from the website: https://livertox.nlm.nih.gov/Metoclopramide.htm

(3) LIPITOR -- Atorvastatin is used together with a proper diet to lower cholesterol and triglyceride (fats) levels in the blood. This medicine may help prevent medical problems (e.g., chest pain, heart attack, or stroke) that are caused by fats clogging the blood vessels.
This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009143/?report=details

(4) DIOVAN -- Valsartan and hydrochlorothiazide combination is used alone or with other medicines to treat high blood pressure (hypertension). This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012601/?report=details

(5) LEXAPRO -- Escitalopram is used to treat

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depression and generalized anxiety disorder (GAD). It is an antidepressant that belongs to a group of medicines known as selective serotonin reuptake inhibitors (SSRIs). These medicines work by increasing the activity of the chemical serotonin in the brain.
This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010165/?report=details

(6) RENA-VITE -- Supplies your body with vitamin B and vitamin C. You might need extra vitamins because of an illness or other medicines that you are using. This information was obtained from the website:
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012655/

(7) BRILINTA (Ticagrelor) is an oral antiplatelet drug that is used with low dose aspirin to decrease the risk of myocardial infarction and stroke in patients with acute coronary syndromes. This information was obtained from the website: https://livertox.nlm.nih.gov/Ticagrelor.htm

(8) SYNTHROID -- Levothyroxine is used to treat hypothyroidism, a condition where the thyroid gland does not produce enough thyroid hormone. Levothyroxine is also used to help decrease the size of enlarged thyroid glands (also called a goiter) and to treat thyroid cancer.
This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010926/?report=details

(9) NORVASC -- Amlodipine is used alone or together with other medicines to treat angina (chest pain) and high blood pressure (hypertension). This information was obtained

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from the website:
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008948/?report=details

(10) XALATAN -- Latanoprost is used to treat certain kinds of glaucoma. It is also used to treat a condition called hypertension of the eye. Latanoprost appears to work by increasing the outflow of fluid from the eye. This lowers the pressure in the eye. This information was obtained from the website:
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010869/?report=details

(11) KEPPRA -- Levetiracetam is used to help control certain types of seizures in the treatment of epilepsy. This information was obtained from the website:
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010898/?report=details

(12) COLACE -- Stool softener -- relieves occasional constipation (irregularity). This information was obtained from the website:
https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=124986

(13) RENENLA -- Lowers the amount of phosphorus in blood of patients receiving kidney dialysis.
This information was obtained from the website:
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012110/?report=details

7. The facility staff failed to administer medications and treatments to Resident # 7 as ordered by the physician.

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Resident # 7 was admitted to the facility on 3/28/13 and most recently on 3/10/17 with diagnoses that included but were not limited to: diabetes, dementia, hypertension, bipolar disorder, chronic obstructive pulmonary disease, atrial fibrillation, glaucoma, and irritable bowel syndrome.

Resident # 7's most recent MDS (minimum data set) assessment, a Quarterly Assessment, with an ARD (assessment reference date) of 8/5/17 coded Resident # 7 as understood by others and as able to understand others. Resident # 7 was coded as being cognitively intact for making daily decisions, scoring 15 out of 15 on the BIMS (brief interview for mental status).

Review of the physician orders revealed the following documentation:

Dated 3/16/17: "HUMALOG (1) KWIKPEN 100/ML (milliliter) INSULIN PEN INJECT SUBCUTANEOUSLY PER SLIDING SCALE THREE TIMES DAILY IF BLOOD SUGAR IS 152-200 = 2 UNITS, 201-250=4 UNITS, 251-300=6 UNITS, 301-350=8 UNITS, 351-400=10 UNITS, 401-450=12 UNITS, GREATER THAN 450=14 UNITS AND REPEAT BLOOD SUGAR IN 2 HOURS AND FOLLOW SLIDING SCALE COVERAGE, IF REPEAT BLOOD SUGAR IN 2 HOURS AND STILL OVER 450, FOLLOW SLIDING SCALE AND CALL MD." This order was signed by the physician on 7/1/17 and 8/2/17."

Dated 3/10/17: "IPRATROPIUM-ALBUTEROL-- (2)... INHALE 1 UNIT DOSE VIA NEBULIZER THREE TIMES DAILY..." This order was signed

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by the physician on 7/1/17 and 8/2/17.

Dated 3/10/17: "LANTUS (3)...INJECT 30 UNITS SUBCUTANEOUSLY EVERY EVENING ..." This order was signed by the physician on 7/1/17 and 8/2/17.

Dated 3/10/17: "LASIX (4) 40 MG (milligram) TAKE 1 TABLET BY MOUTH EVERY DAY ..." This order was signed by the physician on 7/1/17 and 8/2/17.

Dated 4/26/17: "DEPAKOTE (5) 500 MG TAKE 1 TABLET BY MOUTH EVERY EVENING." This order was signed by the physician on 7/1/17 and 8/2/17.

Review of the MAR (medication administration record) for Resident # 7 revealed lack of documentation for the following:

For July 2017:
Sliding Scale Insulin blood sugar not checked at 11:30 a.m. three times out of 31 opportunities.
Sliding Scale Insulin blood sugar not checked at 4:30 p.m. one time out of 31 opportunities.
Ipratropium-Albuterol not given at 9:00 a.m. one time out of 31 opportunities.
Ipratropium-Albuterol not given at 1:00 p.m. two times out of 31 opportunities.
Ipratropium-Albuterol not given at 5:00 p.m. two times out of 31 opportunities.

For August 2017:
Sliding Scale Insulin blood sugar not checked at 11:30 a.m. one time out of 31 opportunities.
Sliding Scale Insulin blood sugar not covered with insulin at 11:30 a.m. one time out of 9

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opportunities.
Sliding Scale Insulin blood sugar not checked at 4:30 p.m. two times out of 31 opportunities.
Sliding Scale Insulin blood sugar not covered with insulin at 4:30 p.m. five times out of 12 opportunities.
Lantus not given two times out of 31 opportunities.
Ipratropium-Albuterol not given at 1:00 p.m. one time out of 31 opportunities.
Ipratropium-Albuterol not given at 5:00 p.m. two times out of 31 opportunities.
Lasix was not given one time out of 31 opportunities.
Depakote was not given one time out of 31 opportunities.

Nurses notes for July and August 2017 were reviewed and no notation as to why the medications and treatments were not given could be found.

During an interview on 9/28/17 at 8:40 a.m. with LPN (licensed practical nurse) # 10, LPN # 10 was asked what it meant if there were blocks on the MAR that had no initials inside. LPN # 10 stated that technically it meant it was not done - "Not documented not done."

During an interview on 9/28/17 at 8:50 a.m. with LPN # 9, LPN # 9 was asked what it meant if there were blocks on the MAR that had no initials inside. LPN # 9 stated that staff might have forgotten to sign but if it is not signed then it is not done - staff have to document.

During an interview on 9/28/17 at 10:47 a.m. with ASM (administrative staff member) # 2, the

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director of nurses/clinical services, this concern was shared. ASM # 2 was asked what blanks on the MARs meant: ASM # 2 stated that if it is not documented it is not given. At this time ASM # 2 was asked to identify the nurses' initials so those nurses could be interviewed. A request for the facility policy on following physician orders was requested at this time.

During an interview on 9/28/17 at 1:20 p.m. with LPN # 6, a unit manager, LPN # 6 was asked what it meant if there were blocks on the MAR that had no initials inside. LPN # 6 stated if there is a hole in the MAR then the medication was not given. LPN # 6 identified three of the nurses that were missing initials on the MARs in question: all were interviewed.

During an interview on 9/28/17 at 1:30 p.m. with LPN # 7, LPN # 7 stated that if there is a blank then no medication was given.

During an interview on 9/28/17 at 3:30 p.m. with LPN # 8, LPN # 8 stated that if there are blanks it means that the medication was not given.

During an interview on 9/28/17 at 4:50 p.m. with ASM # 1, the administrator/executive director, and ASM # 2, the director of nurses/clinical services, this concern was again shared.

Review of the policy that was presented did not address the concern of this citation.

No further information was presented prior to exit.

References:

(1) Humalog® [insulin lispro injection, USP (rDNA

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origin)] Insulin lispro is a fast-acting type of insulin. Insulin is one of many hormones that the body turn the food we eat into energy. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010736/ helps

(2) IPRATROPIUM-ALBUTEROL Ipratropium and albuterol combination is used to help control the symptoms of lung diseases, such as asthma, chronic bronchitis, and emphysema. It is also used to treat air flow blockage and prevent the worsening of chronic obstructive pulmonary disease (COPD) in patients who need another medicine. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010776/?report=details

(3) LANTUS(Insulin glargine) is a long-acting type of insulin that works slowly, over about 24 hours. Insulin is one of many hormones that help the body turn the food we eat into energy. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010731/?report=details

(4) LASIX - furosemide tablet Furosemide belongs to a group of medicines called loop diuretics (also known as water pills). Furosemide is given to help treat fluid retention (edema) and swelling that is caused by congestive heart failure, liver disease, kidney disease, or other medical conditions. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH--T0010414/?report=details

(5) DEPAKOTE --Valproic acid is used to treat

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certain types of seizures (epilepsy). This medicine is an anticonvulsant that works in the brain tissue to stop seizures. Valproic acid is also used to treat the manic phase of bipolar disorder (manic-depressive illness), and helps prevent migraine headaches. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012594/?report=details

8. The facility staff failed to obtain oxygen saturation levels in order to notify the physician if levels dropped below 90 % for Resident #16.

Resident #16 was admitted to the facility on 7/13/17 with diagnoses that included but were not limited to: stroke, muscle spasms of the back, COPD (chronic obstructive pulmonary disease) (general term for chronic nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (1)), BPH (benign prostatic hypertrophy) (Benign prostatic hyperplasia-also called BPH-is a condition in men in which the prostate gland is enlarged and not cancerous. Benign prostatic hyperplasia is also called benign prostatic hypertrophy or benign prostatic obstruction (2)), restless leg syndrome, and high blood pressure.

The most recent MDS (minimum data set), an admission assessment, with an assessment reference date of 7/25/17, coded Resident #16 as being cognitively intact to make daily decisions. The resident was coded as requiring supervision to extensive assistance of one staff member for all of his activities of daily living. In Section O - Special Treatments, Procedures and Programs, the resident was not coded as having a CPAP* or any respiratory equipment.

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* C-PAP, Continuous Positive Airway Pressure, is a machine used to assist people who are diagnosed with sleep apnea. A C-Pap machine increased air pressure in the throat so that the airway does not collapse when you breathe in. (3).

Review of the clinical record revealed a physician order dated 7/27/17, which documented, "O2 (oxygen) @ (at) 2 L/MIN (liters per minute) via nasal cannula for comfort; notify MD (medical doctor) if O2* drop under 90%."
*Pulse oximetry is a noninvasive monitoring technique used to estimate the measurement of arterial oxygen saturation (SaO2,) of hemoglobin. (4).

Review of Resident #16's MARS (medication administration records) for September 2017 documented in part, "O2 @ 2 L/MIN via nasal cannula for comfort; notify MD if O2* drop under 90%." The nurses signed with their initials but there was no documentation of the O2 saturation levels. Further review of the clinical record failed to evidence documentation of the resident's O2 saturation levels.

The comprehensive care plan dated 7/26/17 documented, in part, "Focus: The resident has the potential for an ineffective breathing pattern r/t (related to) GERD (gastroesophageal reflux disease), COPD, hx (history) of smoking and dyspnea (difficulty breathing)." The "Interventions" documented, in part, "Oxygen as ordered." Resident #16's care plan, further documented, in part: "Focus: The resident has the potential for alteration in perfusion r/t COPD, arrhythmias, hypertension (high blood pressure)." The

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"Interventions" documented in part, "Monitor for S/S (signs and symptoms) of decreased cardiac output including changes in pulse, weakness, dizziness, shortness of breath, edema, lethargy, syncope. Notify physician of any change in lung sounds or increasing edema. Vital signs as ordered and prn (as needed)."

An interview was conducted with LPN (licensed practical nurse) #16 on 9/27/17 at 3:40 p.m. The above physician order was reviewed with her. When asked if the resident's oxygen saturation levels (O2 sats) should be checked per the order, LPN #16 stated, "I'll have to research that and get back with you."

On 9/27/17 at 3:55 p.m. LPN #16 stated to this surveyor that the facility was in the process of getting an order to discontinue Resident #16's prn (as needed) oxygen." When asked if the oxygen and the O2 Sats, were a current order, LPN #16 stated, "Yes, it is." When asked if the O2 saturations should be documented, LPN #16 stated, "Yes, Ma'am."

On 9/27/17 at 4:32 p.m. an interview was conducted with administrative staff member (ASM) #2, the director of nursing/clinical services. ASM #2 was asked to review the above physician order. When asked if O2 sats should be documented, ASM #2 stated, "They should be documented if he was going to use the oxygen." The above MAR was reviewed with ASM #2. When asked if the boxes were signed as if oxygen was administered, should there not be O2 saturation levels documented, ASM #2 stated, "We are in the process of changing that order."

The executive director/administrator, (ASM #1),

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ASM #2, the director of nursing/clinical services and ASM #4 the regional director of clinical services, were made aware of the above findings on 9/27/17 at 5:23 p.m.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition; Rothenberg and Chapman; page 124.
(2) BPH This information was obtained from the following website: https://www.niddk.nih.gov/health-information/urologic-diseases/prostate-problems/prostate-enlargement-benign-prostatic-hyperplasia.
(3) This information was obtained from the following website: www.webmd.com/sleep-disorders/sleep-apnea.
(4) Grap MJ. Pulse oximetry. In: AACN Protocols for Practice: Technology Series. Aliso Viejo, Ca: American Association of Critical-Care Nurses; 1996.

9a. The facility staff failed to follow physician's orders and apply a left hand palm protector and a right hand splint to Resident #12's hands.

Resident #12 was admitted to the facility on 8/12/15 with diagnoses that included but were not limited to: enlarged prostate, heart failure, muscle weakness, hypothyroidism, dementia, and COPD (chronic obstructive pulmonary disease). Resident #12's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/11/17. Resident #12 was coded as being severely impaired in cognitive function scoring 03 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #12 was coded as requiring total dependence on one staff member with dressing,

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locomotion on the unit, eating, and bathing; and extensive assistance from one staff member with personal hygiene.

On 9/26/17 at 5:15 p.m., an observation was made of Resident #12. He was lying in bed with his hands at his side. The fingers to his left hand appeared to be slightly contracted. His right hand was under the covers and was not visible. He was not wearing a palm protector to his left hand.

On 9/27/17 at 7:38 a.m., an observation was made of Resident #12. He was lying in bed with his hands at his side. The fingers to his left and right hands appeared to be slightly contracted. He was not wearing a splint or palm protector to his bilateral hands.

On 9/27/17 at 10:05 a.m., an observation was made of Resident #12. He was lying in bed with his hands at his side. The fingers to his left and right hands appeared to be slightly contracted. He was not wearing a splint or palm protector to his bilateral hands.

On 9/27/17 at 12:35 p.m., an observation was made of Resident #12. He was lying in bed with his hands at his side. The fingers to his left hand appeared to be slightly contracted. His right hand was under the covers and was not visible. He was not wearing a palm protector to his left hand.

On 9/27/17 at 2:15 p.m., an observation was made of Resident #12. He was lying in bed with his hands at his side. The fingers to his left hand appeared to be slightly contracted. His right hand was under the covers and was not visible. He was not wearing a palm protector to his left hand.

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On 9/28/17 at 10:30 a.m., an observation was made of Resident #12. He was not wearing his left hand palm guard or his right hand splint.

Review of Resident #12's POS (physician order sheet) signed by the physician on 8/28/17, documented the following orders: "Right hand splints on during the day, check skin once removed. Left hand palm protector on at all times. May remove for hygiene, skin checks, check placement every shift."

Review of Resident #12's "Impaired skin integrity" care plan dated 8/31/16, documented the following interventions: "Left hand palm protector as ordered. Right hand splint as ordered." These interventions were initiated on 2/2/17.

Resident #12's most recent "Nursing Tech Information Kardex" documented the following: "Splint: R (right) hand/palm protectors." The Kardex failed to mention Resident #12's palm protector to his left hand.

Review of Resident #12's September 2017 TAR (treatment administration record) revealed blanks (no signatures) under the following treatment: "Right hand splints on during the day check skin once removed."

Further review of the September 2017 TAR revealed initials or signatures on 9/26/17 for 3-11 shift and 9/27/17 for 7-3 and 3-11 shifts indicating that the left hand splint was in place.

On 9/28/17 11:05 a.m., an interview was conducted with LPN (licensed practical nurse) #10, Resident #12's nurse. When asked if Resident #12 was supposed to have a splint to

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his right hand and a palm protector to his left hand, LPN #10 looked at his physician's orders and stated that he was supposed to have splints in place. When asked if they were in place, LPN #10 stated that she was not sure.

When asked what initials meant on the TAR, LPN #10 stated that initials meant that a treatment was completed. When asked why there were blanks (no signatures) for the right hand splint on Resident #12's September TAR, LPN #10 stated, "That is supposed to just be an FYI." When asked if it was her initials documented on 9/27/17 for 7-3 and 3-11 shift documenting that Resident #12's left palm protector was in place, LPN #10 stated, "yes." When asked if his palm protector was in place on 9/27/17, LPN #10 stated, "No. I probably should have circled my initials."

When asked who was responsible for putting on splints, and palm protectors; LPN #10 stated the CNAs put on the splints and the nurses have to ensure the splints are in place. LPN #10 was asked to review Resident #12's Kardex with this surveyor. LPN #10 showed this writer Resident #12's Kardex. When asked how CNA's would know to put a palm protector to Resident #12's left hand if it is not documented on the Kardex, LPN #10 stated that CNA's would get that information in a verbal report. At this time LPN #10 accompanied this surveyor to Resident #12's room. LPN #10 confirmed that Resident #12's splint and palm protector were not in place.

On 9/28/17 at 11:33 a.m., an interview was conducted with CNA (certified nursing assistant) #4, Resident #12's CNA. When asked how CNAs would know what to put into place for skin preventive measures etc., CNA #4 stated that she

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would get report from the nurses or other CNAs. When asked if she had a reference to use that documented resident needs, CNA #4 stated, "If there is, I don't know where it is."

On 9/28/17 at 5:15 p.m., ASM (administrative staff member) #1, the administrator/executive director and ASM #2, the DON (Director of Nursing)/clinical services were made aware of the above concerns.

A policy could not be provided.

9b. The facility staff failed to attempt non-pharmacological pain interventions prior to the administration of Morphine [1] to Resident #12; failed to assess pain location and intensity prior to the administration of Morphine and failed to document the effectiveness of Morphine after it was administered to the resident.

Review of Resident #12's POS (physician order sheet) dated 8/28/17, documented the following orders: "Morphine Sulfate 20 MG/1ML (milligram/ milliliters) Solution, 0.25 ml (milliliters) by mouth/under tongue every 2 hours as needed for pain/SOB (shortness of breath).
Code status: D.N.R. (DO NOT RESUSCITATE) Comfort Care."

Review of Resident #12's September, August and July 2017 MARS (medication administration record) revealed that Resident #12 received Morphine 20 MG on 7/7/17 at 6 p.m., 7/10/17 at 5 p.m., 7/15/17, at 10 p.m., 7/24/17 at 10:00 a.m. and 5 p.m., and 7/30/17 at 6 p.m.

Further review of the July 2017 MAR failed to

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reveal non-pharmacological pain interventions attempted prior to the administration of Morphine, assessments documenting location and intensity of pain prior to the administration of Morphine and follow up pain assessments after the administration of Morphine.

Review of the July 2017 nursing notes failed to reveal documentation of non-pharmacological interventions attempted prior to the administration of Morphine to Resident #12 on the above dates, assessments documenting location and intensity of pain prior to the administration of Morphine on the above dates and follow up pain assessments after the administration of Morphine.

Further review of the July 2017 nursing notes revealed a note dated 7/15/17 that documented the following: "Resident given Morphine 0.25 ml and Ativan [2] 0.25 ml pain of 6/10 (6 out of 10)..."

The above note did not document non-pharmacological interventions attempted prior to the administration of Morphine, the location of pain, and a follow up pain assessment to determine the effectiveness of the medications.

On 9/27/17 at 11:05 a.m. an interview was conducted with LPN (licensed practical nurse) #10, Resident #12's nurse. When asked about the process followed prior to administering prn (as needed) pain medication, LPN #10 stated that she would first find out the resident's pain level, location of pain and attempt non-pharmacological interventions prior to administering pain medication. LPN #10 stated that if non-pharmacological interventions are not effective, she would administer the pain medication and do a follow up pain assessment.

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LPN #10 stated that the pain assessment prior to the administration of pain medication, non-pharmacological (interventions) attempted or offered and the follow up pain assessment should be documented in a nursing note or on a pain flow sheet. When asked if she would attempt non-pharmacological interventions for a resident on hospice, LPN #10 stated that she would. LPN #10 could not determine if pain evaluations were completed for Resident #12 prior to and after the administration of Morphine on the dates documented above. LPN #10 could not determine if non-pharmacological interventions were attempted prior to the administration of Morphine on the dates documented above.

On 9/27/17 at 12:20 p.m., an interview was attempted with Resident #12. He could not understand the questions that were asked.

On 9/28/17 at 5:15 p.m., ASM (administrative staff member) #1, the executive director/administrator and ASM #2, the DON (Director of Nursing)/clinical services were made aware of the above concerns.

The facility policy titled, "Pain management Guideline" documents in part, the following: "Purpose: To ensure residents receive the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. Process: Identification: Evaluate patient/residents upon admission/re-admission, quarterly, with a change in condition, or with a new onset of pain. Pain evaluation: Identify if a resident is experiencing pain using resident's self-report of pain (utilizing a 0-10 scale) or for those patient/residents who

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cannot self-report, use the non-verbal clinical indicators. The pain flow record or electronic equivalent to be maintained in the Medication Administration Record (MAR). Treatment: Develop patient centered interventions (pharmacologic and non-pharmacologic) to manage pain. Document interventions on the care plan. Monitoring: Monitor and document the patient/resident's response to interventions. Evaluate the effectiveness of the interventions and progress toward goals. Discuss new interventions and goals with the resident and/or family/resident representative. Update the care plan as indicated."

[1] Morphine is a narcotic pain reliever used to alleviate moderate to severe pain. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0001216/.
[2] Ativan-used to treat anxiety disorders. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010988/?report=details.

10. The facility staff failed to follow a physician order to keep Resident #10's bilateral lower legs elevated on two pillows when in bed and seated in a chair.

Resident #10 was admitted to the facility on 5/2/13 with a readmission date of 9/14/14 with diagnoses that included, but were not limited to: dementia, difficulty swallowing, convulsions, depression and psychosis.

Resident #10's most recent MDS (minimum data

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set), a quarterly assessment with an ARD (assessment reference date) of 7/6/17, coded Resident #10 as being unable to complete the BIMS (brief interview for mental status). The staff assessment of Resident #10's cognitive status was coded as a "3" (three) indicating that Resident #10 was severely cognitively impaired with daily decision making. Resident #10 was also coded as requiring extensive assistance of one to two staff members for all activities of daily living and as rarely understanding or being understood when communicating with others.

Resident #10 was observed lying in his bed with his legs flat on the bed and without pillows under his legs as ordered on the following dates and times; 9/26/17 at 1:00 p.m. and 4:40 p.m., 9/27/17 at 8:05 a.m., 8:36 a.m., 8:47 a.m. and 10:44 a.m., and on 9/28/17 at 8:40 a.m.

Resident #10 was observed seated in a tilt-in-space wheelchair on 9/27/17 at 11:45 a.m., 1:20 p.m. and 3:40 p.m.

A review of Resident #10's physician orders revealed the following order dated 6/8/17, "Order clarification: Elevate lower extremities two (sic) pillow height while in bed or seated."

A review of Resident #10's physician order summary dated 8/31/17 revealed, in part, the following documentation; "8/3/17: ELEVATE LOWER EXTREMITIES TWO PILLOW HIGHT (sic) WHILE IN BED OR SEATED." Signed by the physician on 8/31/17.

A review of Resident #10's TAR (treatment administration record) dated 9/1/17 - 9/30/17 revealed, in part, the following documentation;

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"8/3/17 ELEVATE LOWER EXTREMITIES TWO PILLOW HIGHT (sic) WHILE IN BED OR SEATED. FYI (for your information).

A review of Resident #10's progress notes revealed, in part, the following documentation; "Order clarification: Elevate lower extremities two pillow height while in bed or seated."

On 9/27/17 at 3:40 p.m. an interview was conducted with CNA (certified nursing assistant) #11, a nursing aide working with Resident #10. CNA #11 was asked to state how she would know what was on a resident's care plan so she would know how to care for a resident. CNA #11 stated care plan items were placed on the kardex (a communication tool) so they could refer to that for special needs. CNA #11 was asked what special needs Resident #10 had in regards to his daily care. CNA #11 stated she would have to refer to the kardex. CNA #11 reviewed the kardex and stated Resident #10 was dependent on care and wore "hipsters" hip protectors worn on either side of his hips. CNA #11 was asked if there was any direction to elevate Resident #10's lower extremities on two pillows when in bed and when seated. CNA #11 stated there was not. At this time CNA #11 and this writer went into Resident #10's room and confirmed that Resident #10's lower extremities were not elevated on two pillows and there were no extra pillows on his bed or in his room. There was one pillow observed under Resident #10's head.

On 9/27/17 at 3:45 p.m., an interview was conducted with LPN (licensed practical nurse) #3, a floor nurse working with Resident #10. LPN #3 was asked if she was aware of a physician order to elevate Resident #10's lower extremities on

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two pillows while lying in bed or seated. LPN #3 stated she was not. At this time Resident #10's physician orders were reviewed with LPN #3 and LPN #3 then stated she would "take care of it."

On 9/28/17 at 7:30 a.m., ASM (administrative staff member) #1, the executive director/administrator, was made aware of these findings. A policy was requested regarding following physician orders.

On 9/28/17 at 8:40 a.m. Resident #10 was observed lying in his bed with his lower legs flat on the bed. Resident #10's legs were not elevated on two pillows and there were no pillows observed to be on the bed other than one pillow behind the resident's head.

On 9/28/17 at 10:15 LPN #3 was asked to state what should happen when a physician wrote an order. LPN #3 stated, "It should be completed as ordered." LPN #3 was asked whether or not the order to elevate Resident #10's legs had been followed as ordered. LPN #3 stated, "No and I am not sure why."

A review of the facility document titled "Physician Orders" did not reveal any documentation regarding following the physician orders.

No further information was provided prior to the end of the survey process.

In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419 "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm

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F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide treatment and services to prevent and promote healing of a pressure ulcer for one of 34 residents in the survey sample, Resident #4. The facility staff failed to provide treatment to Resident #4's pressure sores on several occasions in June and for six consecutive days in July 2017. The facility staff failed notify the wound care nurse of Resident #4's pressure ulcers until 7/6/17, at which time the wound was assessed and documented as two wounds. The wound on the right buttock/ischium was identified	F 314		

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and documented as a stage III pressure ulcer and the wound on the left hip was identified and documented as an unstageable pressure ulcer.

The findings include:

Resident #4, a 47 years old was admitted to the facility on 7/20/15 with a readmission on 10/30/15 with diagnoses that included, but were not limited to: schizophrenia (a group of mental disorders characterized by gross distortions of reality, withdrawal from social contacts and disturbances of thought, language, perception and emotional response (1)), paraplegia, edema, suicide attempt, traumatic brain injury, high blood pressure and drug overdose.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date (ARD) of 8/28/17, coded the resident as being cognitively intact to make daily decisions. Resident #4 was coded as requiring extensive assistance for most of his activities of daily living. In Section M - Skin Conditions, the resident was coded as having one stage III pressure ulcer and one Stage IV pressure ulcer. The dimensions of the unhealed Stage III or Stage IV pressure ulcer were documented as: 5.5 cm (centimeters) in length, 8.6 cm in width, and 5.4 cm in depth. It was coded as: "eschar - black, brown or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin".

A quarterly assessment MDS assessment, with an ARD of 7/5/17, was reviewed and did not code Resident #4 in Section M as having any pressure

2.A quality review of current residents with pressure ulcers has been performed. A quality review of TAR's of current residents has been performed. A quality review of skin of current residents in the facility has been performed. Follow up based on findings.

3.Licensed Nurses re-educated by DCS/Designee regarding following Physician orders regarding wound care implementation and treatment. Licensed Nurses re-educated by DCS/Designee regarding following Physician orders on documenting on Treatment Administration Record

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ulcers.

The "Braden Scale for Predicting Pressure Sore Risk" dated, 1/26/17, 4/9/17 and 8/22/17, documented the Resident #4's score as a "17." A score of 17 indicates the resident is "at risk" for developing pressure ulcers.

Resident #4's "Skin Observation Form" completed by the CNAs (certified nursing assistants) and signed by a nurse, dated 6/1/17, 6/5/17, and 6/15/17 documented, "No new areas." The form contained a diagram of the body. Nothing was documented on the drawing of the body. The "Skin Observation Form" dated, 6/19/17, documented, "Resident stated old cut has reopened from his sliding board." The diagram of a body on the form documented a circle around the right lower buttock and documented, "bleeding." The "Skin Observation Form" dated, 6/22/17 documented, "Open are underneath cheek." An "X" was documented on the diagram of the body on the form, under the buttock cheek. The "Skin Observation Form" dated 6/29/17 documented a check mark next to, "Open area." A circle was documented on the forms body diagram below the right buttock and written next to it was: "Open, bleeding sore." The "Skin Observation Form" dated 7/2/17, documented a check mark next to "open area." Also written on the form was "Open Area/ bleeding." A circle was drawn around the lower part of the buttock on the right side on the forms body diagram. The "Skin Observation Form" dated 7/6/17 did not have any documentation other that a check mark next to "bed bath." There was no signature of a nurse.

The "Weekly Skin Integrity Review" sheets were

(TAR). DCS/Designee during Morning Clinical Meeting to conduct quality monitoring of skin assessments and TARs daily 4 weeks, weekly x4 and then monthly, PRN and as indicated.

4.DCS/Designee to conduct quality monitoring regarding physician notification with documentation in the medical record as indicated. Findings to be communicated to the QAPI committee monthly and as indicated. Quality monitoring schedules modified based on findings

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reviewed. These are completed by the nurse assigned to the resident. The form documented, "Indicate site(s) with an "X." The following was documented:
"Weekly Skin Integrity Review" - 6/12/17 - An X was placed next to "Open area." Handwritten on document, "TX (treatment) in place." There were no marks on the diagram of the body.

"Weekly Skin Integrity Review" - 6/19/17 - An X was placed next to "Open area." Handwritten on document, "TX (treatment) in place." A circle was documented over the right buttock on the body diagram.

"Weekly Skin Integrity Review" - 6/26/17 - An X was placed next to "Open area." Handwritten n document, "TX (treatment) in place." There were no marks on the diagram of the body.

"Weekly Skin Integrity Review" - 6/30/17 - An X was placed next to "Open area." Handwritten on document, "TX (treatment) in place." There were no marks on the diagram of the body.

"Weekly Skin Integrity Review" - 7/3/17 - An X was placed next to "Open area." Handwritten n document, "TX (treatment) in place." There was a circle documented under the left buttock on the body diagram.

"Weekly Skin Integrity Review" - 7/6/17 - An X was placed next to "Open area." Handwritten on document, "TX (treatment) in place." There were no marks on the diagram of the body.

"Weekly Skin Integrity Review" - 7/10/17 - An X was placed next to "Open area." Handwritten on the document was the following: "TX (treatment)

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in place." There was a circle documented under the left buttock on the body diagram.

"Weekly Skin Integrity Review" - 7/17/17 - An X was placed next to "Open area." Handwritten on document was the following: "TX (treatment) in place." There was a circle documented under the left buttock on the body diagram.

"Weekly Skin Integrity Review" - 7/24/17 - An X was placed next to "Open area." Handwritten on the document was the following: "TX (treatment) in place." There was an X over the sacral/lower back on the body diagram.

"Weekly Skin Integrity Review" - 7/31/17 - An X was placed next to "Open area." Handwritten on document was the following: "TX (treatment) in place." There was a circle documented under both left and right buttocks on the body diagram.

"Weekly Skin Integrity Review" - 8/7/17 - An X was placed next to "Open area." An X was placed next to "previously identified." Handwritten on the document was the following: there were two circles documented under the left and right buttocks. This is the first documentation that there were two pressure areas on the Weekly Skin Integrity Review.

A review of the nurse's notes did not evidence any nurse's notes from 6/12/17 until 7/17/17 by the floor nurses.

The wound care nurse documented on 7/6/17, no time documented, "Resident has open area under R (right) & (and) L (left) buttocks/right buttocks/ischium measures 3.0 x 2.0 x 0.1 cm (centimeters). The left buttock/hip measures 2.9 x

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2.0 x 0.1 cm. Granulation tissue and skin noted to areas. New treatment orders put in place. RP (responsible party) & MD (medical doctor) made aware of areas & treatment in place. Resident encouraged not to sit for long period of time in w/c (wheelchair) and take rest periods from sitting in w/c."

The "Pressure Ulcer Records" dated 7/6/17, documented, "Left buttock/hip: Stage: Unstageable; Measurements (cm): L (length) 2.9 X W (width) 2.0 X D (depth) 0.1." There was nothing documented under the tissue type, wound edges, drainage, or periwound area. The form was signed by the wound care nurse.

An Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. (2)

The "Pressure Ulcer Records" dated 7/6/17, documented, "Right Buttock/ischium: Stage: 3; measurements (cm) L 3.0 x W 2.0 X D 0.1. There was nothing documented under tissue type, wound edges, drainage or periwound area. The form was signed by the wound care nurse.

A Stage 3 Pressure Injury: Full-thickness skin loss
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present.

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Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. (3)

The Wound Care Physician notes dated, 7/24/17, documented in part, "Left Hip Unstageable (Due to necrosis). Wound Size: 5.7 x 6.8 x 0.1. Thick adherent devitalized necrotic tissue: 100%. Pressure Wound of the Right Ischium: 5.3 x 4.2 x 0.1. Granulation: 80%; Skin: 20%.

The physician order dated, 7/6/17, documented, "Cleanse L & R buttock with NS (normal saline, apply alginate* & cover with dry dressing QD (every day) and PRN (as needed)."

*Alginate is a biomaterial that has found numerous applications in biomedical science and engineering due to its favorable properties, including biocompatibility and ease of gelation. Alginate hydrogels have been particularly attractive in wound healing, drug delivery, and tissue engineering applications to date, as these gels retain structural similarity to the extracellular matrices in tissues and can be manipulated to play several critical roles. (4)

The July 2017 TAR (Treatment administration record) documented in part, "Cleanse L & R buttock with NS, apply alginate & cover with dry dressing QD and PRN." The July TAR did not document any other treatments to the pressure areas prior to 7/6/17. A request was made to the administrative team, on 9/27/17 at approximately

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1:20 p.m., for Resident #4's June 2017 TAR.

The comprehensive care plan dated, 8/5/16 and last revised on 7/20/17, documented in part, "The resident has the potential for further impairment of skin integrity r/t (related to) incontinence, AEB (as evidenced by) history of pressure ulcer." The "Interventions" documented in part, "Administer treatments as ordered and monitor or effectiveness. Assess/record/monitor wound healing weekly. Measure length, width and depth where possible. Assist resident with turning and positioning PRN. Follow physician order for preventative treatment. If resident refuses treatment, attempt to determine why and try alternate methods to gain compliance. If resident refuses treatment/interventions, wait and try again. Inform the resident/family/caregivers of any new area of skin breakdown. Monitor changes in skin status; appearance, color, wound healing, s/sx (signs and symptoms) of infection wound size and or stage. Monitor dressing (freq [frequently]) to ensure it is intact and adhering. Report loose dressing to nurse. Notify nurse of any new areas of skin breakdown; redness, blisters, bruises, discoloration noted during bath or daily care. Notify physician for change in condition. Weekly skin checks." The comprehensive care plan dated, 7/6/17, documented in part, ""The resident has impaired skin integrity @ (at) bilateral buttocks r/t (related to) impaired mobility." The "Interventions" documented in part, "Administer treatments as ordered and monitor for effectiveness. Assess/record. Monitor wound healing weekly. Measure length, width and depth where possible. assist resident with turning and positioning q (every) 2 hours and PRN. Braden scale quarterly. Monitor changes in skin status;

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appearance, color, wound healing, s/sx (signs/symptoms) of infection, wound size and/or stage. Notify nurse of any new areas of skin breakdown; redness, blisters, bruises, discoloration noted during bath or daily care. Therapy screen PRN (as needed). Weekly skin checks."

An interview was conducted with LPN (licensed practical nurse) #4, the wound care nurse, on 9/27/17 at 3:05 p.m. When asked when she was first made aware of the wounds on Resident #4's buttocks, LPN #4 stated, "I'm not sure but I documented the day in the nurse's notes." When asked if she had any pressure ulcer tracking records, LPN #4 stated that she did and went off to obtain them. LPN #4 returned at 3:10 p.m. with pressure ulcer records for Resident #4. When asked to describe the resident's wounds when she first observed on 7/6/17 and documented on them in the record, LPN #4 stated, "The one wound, the left hip wound was unstageable, it was dark and crusty looking. The right buttock/ischium wound was a stage III wound." When asked who staged the wounds, LPN #4 stated that she had staged the wounds. When asked what she did when she was made aware of the wounds, LPN #4 stated, "I called ([Administrative staff member - ASM] #3, the wound doctor), and described the wounds to him, he agreed with my staging and gave me orders to put in place for the resident. He (ASM #3) wasn't here a lot in July due to illness and vacations." When asked what was in place prior to her being made aware of the wounds on 7/6/17, LPN #4 stated, "I'd have to go look and see."

On 9/28/17 at 8:15 a.m. ASM #2, the director of nursing/clinical services, informed this surveyor

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that the June TAR for Resident #4 was not available. ASM #2 stated, "I have given you what I have."

A second interview was conducted with LPN #4 on 9/28/17 at 8:25 a.m. When asked what was in place prior to the identification of the pressure sores on 7/6/17, LPN #4 slated, "We had an air mattress in place, he has a cushion in his wheelchair." When asked if there was any treatment in place prior to the physician orders of 7/6/17, LPN #4 stated, "There was no treatment in place that I was aware of." LPN #4 further stated that the facility has barrier cream for all incontinent residents.

An interview was conducted with LPN #6, the unit manager, on 9/28/17 at 8:35 a.m. When asked who completes the residents skin assessments, LPN #6 stated, "They (Skin assessments) are done on bath days by the nurse. All A bed residents are completed on day shift and all B bed residents are completed on the evening shift. The nurse's document in the skin sweep book. If the CNAs (certified nursing assistant) see an area, they are to notify the nurse. The nurse and I go in and address it right away. If it's serious, then we get the wound doctor involved but a treatment will be put in place immediately." When asked if there was any treatment in place prior to 7/6/17 for Resident #4, LPN #6 stated she's have to look and would get back to this surveyor.

An interview was conducted with LPN #11 on 9/28/17 at 8:58 a.m., regarding Resident #4's wounds, LPN #11 stated, "I found his wounds on 7/3/17 and called (name of the attending physician). He gave me an order for alginate and told me to contact (name of wound care doctor)

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on Monday." When asked where the physician order and nurse's note for this was documented, LPN #11 stated she didn't know where any of that was."

An interview was conducted with ASM #2, the director of nursing/clinical services, on 9/28/17 at 9:11 a.m. ASM #2 was asked to provide any documentation that a treatment was in place prior to 7/6/17 for Resident #4's pressure wounds.

An interview was conducted with ASM #2 on 9/28/17 at approximately 10:30 a.m. ASM #2 stated they could not find the June 2017 TAR or any orders to correspond with treatment for the pressure area. When asked the process for skin assessment and treatment, ASM #2 stated, "The residents get showers twice a week. The CNAs look at the skin and if abnormal they note it on the skin sheet. The nurse is then to follow up if needed. The nurse's do a weekly skin assessment. If orders are needed they call the doctor. If the area is pressure the implement something, update the TAR and get (Name of wound doctor) involved. He comes on Mondays. I'm trying to show you something was done. The resident is non-compliant with positioning, it's on the care plan."

An interview was conducted with CNA #4 on 9/28/17 at 11:10 a.m. When asked what the process is for checking a resident's skin, CNA #4 stated, "I check them every time I am giving care; bathing them, changing them or giving showers." When asked if she finds anything different than before what does she do, CNA #4 stated, "I tell the nurse." When asked if the nurses are responsive when they tell them changing in the skin, CNA #4 stated, "Yes."

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The executive director/administrator, ASM #1, ASM #2, the director of nursing/clinical services, and ASM #4, the regional director of clinical services, were made aware of the concern for harm on 9/28/17 at 11:32 a.m. ASM #2 presented a form, "Guidelines for Unavoidable Wounds" dated, 8/26/16. ASM #2 stated, "He has the unavoidable form. Nothing has changed. He is always at risk for pressure ulcers. Nothing has changed in his condition or his comorbidities." ASM #4 stated, that the facility did have a plan of action in place dated in January and revised in March of 2017. When asked the AOC (allegation of compliance date) ASM #4 stated it was in March. ASM #4 was informed Resident #4's wounds were found in July 2017 after this date of alleged compliance.

An interview was conducted with ASM #3, the wound care doctor on 9/28/17 at 12:00 p.m. When asked when he first saw Resident #4's wounds, ASM #3 stated, "I didn't see him until 7/24/17. I was out of town and out for unscheduled time off during the month of July." When asked to describe the wounds when he saw them, ASM #3 stated, "The one wound was black eschar when I first saw it and the second wound was a stage III wound. The resident is known to me. He had previously heel pressure wounds that we healed. He is a dependent young man who dislikes to offload pressure. He spends much of his day in the wheelchair. I have got him to go back to bed around 4:00 p.m. every day." When asked if the resident can lift himself up to relieve pressure, ASM #3 stated, "Yes, I believe he can but he doesn't do it that often. He's not offloading every 2 hours as I would like him to do so." When asked if therapy has been

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involved in his pressure ulcers treatments, ASM #3 stated, "I do not know about that."

An interview was conducted with other staff member (OSM) #10, the director of therapy, on 9/28/17 at 2:15 p.m. When asked if therapy was involved with Resident #4, OSM #10 stated Resident #4 was currently on caseload for bowel training program. When asked if they were working with him for bed mobility and transfers, OSM #10 stated he would have to check.

OSM #10 returned at 9/28/17 at 2:38 p.m. When asked if he the resident had a cushion in his wheelchair for pressure reduction, OSM #10 stated, "He's had the same cushion since last year when I came. I did an audit when I arrived last year. It's the highest level of cushion that is on the market." When asked if the slide board is the most appropriate transfer technique in light of his pressure ulcers, OSM #10 stated, "Yes, it's the most appropriate transfers type for him." OSM #10 presented documentation of when therapy was seeing the resident. The documentation provided documented that Resident #4 was under physical therapy caseload from 3/8/17 through 4/6/17. The resident was on restorative therapy case load from May 2017 through June 2017 for arm strengthening, and Omni cycle for his legs. There was no documentation provided for July 2017, for the Restorative program. Occupational therapy started working with Resident #4 on 8/21/17 until 9/19/17, after his pressure ulcers were found on 7/6/17.

On 9/29/17 at 7:45 a.m. ASM #2, the director of nursing/clinical services presented to this surveyor a June 2017 TAR and a telephone physician order. The physician order was dated,

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6/19/17 and documented, "Clean with NS (normal saline) apply bacitracin and cover with dry dressing." The June 2017 TAR documented in part, "Clean with Normal saline apply bacitracin and cover." The treatment was documented every day except, 6/23/17, 6/26/17, 6/27/17 and 6/30/17. This physician order and treatment on the TAR did not document where to put this treatment. This treatment was not transferred to the July TAR.

The order of 6/19/17, presented as being put in place for Resident #4's pressure sores, was not documented as administered every day by staff. There were missing treatments as noted above. The July 2017 TAR failed to document any treatment for Resident #4's pressure ulcers until the wound care nurse implemented treatment orders on 7/6/17. Per the documentation, Resident #4's wounds went untreated for six straight days. When the wound nurse was made aware of the wounds, they were assessed and documented as stage III and unstageable wounds.

The facility policy, "Clinical Guideline - Skin & Wound" documented in part, "Overview: To provide a system for identifying skin at risk, implementing interventions including evaluation and monitoring as indicated to promote skin health, healing and decrease worsening of/prevention of pressure injury. Process: On admission/readmission the resident' skin will be evaluated for baseline skin condition and documentation in the medication record. Braden Risk Evaluation to be completed on admission/re-admission, weekly for 4 weeks from admission, quarterly and with a significant change in condition. Licensed Nurse to complete skin

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evaluation weekly and prior to transfer/discharge and document in the medical record. CNA to complete skin observations and report changes to Licensed Nurse. Licensed Nurse to document presence of skin impairment/new skin impairment when observed and weekly until resolved. License Nurse to report changes in skin integrity to the physician/practitioner and resident/responsible party and document in the medical record. Develop individualized goals and interventions and document on the care plan and the CNA Kardex. Refer to therapy as indicated. Monitor resident's response to treatment and modify treatment as indicated. Evaluate the effectiveness of interventions, and progress towards goals during the care management meting and as needed."

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition; Rothenberg and Chapman; page 522
(2) This information was obtained from the following website:
http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/
(3) This information was obtained from the following website:
http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/
(4) This information was obtained from the following website:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3223967/

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(c) Mobility.

(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to provide treatment and services to maintain ROM (range of motion) for one of 34 residents in the survey sample, Resident #12.

The facility staff failed to ensure Resident #12's right hand splint and left hand palm protector was in place per the plan of care and physician's order to prevent further contractures.

The findings include:

Resident #12 was admitted to the facility on 8/12/15 with diagnoses that included but were not limited to: enlarged prostate, heart failure, muscle weakness, hypothyroidism, dementia, and COPD (chronic obstructive pulmonary disease).
Resident #12's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/11/17.
Resident #12 was coded as being severely impaired in cognitive function scoring 03 out of 15

1.Resident #12 has his right hand splint applied and left hand palm protector applied as per physician's order. Resident #12 currently resides in the facility and has no s/s of adverse effects. LPN #10 has been counseled on not following Physician orders and educated on following physician orders LPN #10 has been counseled on not following Physician orders and educated on following physician orders as indicated.

2.A quality review of current residents with Physician orders for hand splints/palms protectors has been performed. Follow up based on findings.

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on the BIMS (Brief Interview for Mental Status) exam. Resident #12 was coded as requiring total dependence on one staff member with dressing, locomotion on the unit, eating, and bathing; and extensive assistance from one staff member with personal hygiene.

On 9/26/17 at 5:15 p.m., an observation was made of Resident #12. He was lying in bed with his hands at his side. The fingers to his left hand appeared to be slightly contracted. His right hand was under the covers and was not visible. He was not wearing a palm protector to his left hand.

On 9/27/17 at 7:38 a.m., an observation was made of Resident #12. He was lying in bed with his hands at his side. The fingers to his left and right hands appeared to be slightly contracted. He was not wearing a splint or palm protector to his bilateral hands.

On 9/27/17 at 10:05 a.m., an observation was made of Resident #12. He was lying in bed with his hands at his side. The fingers to his left and right hands appeared to be slightly contracted. He was not wearing a splint or palm protector to his bilateral hands.

On 9/27/17 at 12:35 p.m., an observation was made of Resident #12. He was lying in bed with his hands at his side. The fingers to his left hand appeared to be slightly contracted. His right hand was under the covers and was not visible. He was not wearing a palm protector to his left hand.

On 9/27/17 at 2:15 p.m., an observation was made of Resident #12. He was lying in bed with his hands at his side. The fingers to his left hand appeared to be slightly contracted. His right hand

3.Licensed Nurses re-educated by DCS/Designee regarding following Physician orders on application of hand splints and palm protectors.
DCS/Designee during Morning Clinical Meeting to conduct quality monitoring of application of hand splints and palm protectors x4 weeks, weekly x4weeks and then monthly, PRN and as indicated.

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was under the covers and was not visible. He was not wearing a palm protector to his left hand.

On 9/28/17 at 10:30 a.m., an observation was made of Resident #12. He was not wearing his left hand palm guard or his right hand splint.

Review of Resident #12's POS (physician order sheet) signed by the physician on 8/28/17, documented the following orders: "Right hand splints on during the day, check skin once removed. Left hand palm protector on at all times. May remove for hygiene, skin checks, check placement every shift."

Review of Resident #12's "Impaired skin integrity" care plan dated 8/31/16, documented the following interventions: "Left hand palm protector as ordered. Right hand splint as ordered." These interventions were initiated on 2/2/17.

Resident #12's most recent "Nursing Tech Information Kardex" documented the following: "Splint: R (right) hand/palm protectors." The Kardex failed to mention Resident #12's palm protector to his left hand.

Review of Resident #12's September 2017 TAR (treatment administration record) revealed blanks (no signatures) under the following treatment: "Right hand splints on during the day check skin once removed."

Further review of the September 2017 TAR revealed initials or signatures on 9/26/17 for 3-11 shift and 9/27/17 for 7-3 and 3-11 shifts indicating that the left hand splint was in place.

On 9/28/17 11:05 a.m., an interview was

4.DCS/Designee to conduct quality monitoring regarding physician notification with documentation in the medical record as indicated. Findings to be communicated to the QAPI committee monthly and as indicated. Quality monitoring schedules modified based on findings
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conducted with LPN (licensed practical nurse) #10, Resident #12's nurse. When asked if Resident #12 was supposed to have a splint to his right hand and a palm protector to his left hand, LPN #10 looked at his physician's orders and stated that he was supposed to have splints in place. When asked if they were in place, LPN #10 stated that she was not sure.

When asked what initials meant on the TAR, LPN #10 stated that initials meant that a treatment was completed. When asked why there were blanks (no signatures) for the right hand splint on Resident #12's September TAR, LPN #10 stated, "That is supposed to just be an FYI." When asked if it was her initials documented on 9/27/17 for 7-3 and 3-11 shift documenting that Resident #12's left palm protector was in place, LPN #10 stated, "yes." When asked if his palm protector was in place on 9/27/17, LPN #10 stated, "No. I probably should have circled my initials."

When asked who was responsible for putting on splints, and palm protectors; LPN #10 stated that the CNAs put on the splints and the nurses have to ensure that the splints are in place. LPN #10 was asked to review Resident #12's Kardex with this surveyor. LPN #10 showed this writer Resident #12's Kardex. When asked how CNA's would know to put a palm protector to Resident #12's left hand if it is not documented on the Kardex, LPN #10 stated that CNA's would get that information in a verbal report. At this time LPN #10 accompanied this surveyor to Resident #12's room. LPN #10 confirmed that Resident #12's splint and palm protector were not in place.

On 9/28/17 at 11:33 a.m., an interview was conducted with CNA (certified nursing assistant)

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F 318	Continued From page 172 #4, Resident #12's CNA. When asked how CNAs would know what to put into place for skin preventive measures etc., CNA #4 stated that she would get report from the nurses or other CNAs. When asked if she had a reference to use that documented resident needs, CNA #4 stated, "If there is, I don't know where it is." On 9/28/17 at 2:08 p.m., an interview was conducted with OSM (other staff member) #10, the director of therapy. When asked about the process followed for recommending a splint or palm guard, OSM #10 stated that therapy will evaluate a resident, start a trial with a resident to see if they can tolerate the splint and then discharge the resident with the splints after nursing staff had been educated on how to apply the splint. When asked if a palm protector was a type of splint, OSM #10 stated, "yes." When asked if Resident #12 needed splints in place to his right and left hand, OSM #10 stated that he should be wearing splints to prevent his hands and fingers from contracting. On 9/28/17 at 5:15 p.m., ASM (administrative staff member) #1, the administrator/executive director and ASM #2, the DON (Director of Nursing)/clinical services were made aware of the above concerns. No further information was presented prior to exit.	F 318	F328 1.Resident #16 nebulizer and CPAP machine are stored in a sanitary manner. Resident #16 is currently using CPAP machine as indicated by Physician order. Resident #31's external filter on oxygen concentrator has been cleaned appropriately. Resident #14's external filter on the oxygen concentrator has been cleaned appropriately. 2.A quality review of current residents with Physician orders for oxygen and CPAP machine has been performed. 3.Licensed Nurses re-educated by DCS/Designee regarding following Physician	
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:	F 328		

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F 328	Continued From page 173 (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the	F 328	orders on oxygen and CPAP machines and cleanliness and storage of Oxygen and CPAP equipment. DCS/Designee during Morning Clinical Meeting to conduct quality monitoring of Oxygen/CPAP Physician orders and cleanliness and storage of oxygen and CPAP equipment x4 weeks,, x4 weeks and then monthly, PRN and as indicated.	

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comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.

(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain respiratory equipment in a sanitary manner for three of 34 residents in the survey sample, Residents #16, #31 and #14; and failed to have a physician order for the use of respiratory equipment for one of 34 residents in the survey sample, Resident #16.

1.a. The facility staff failed to store Resident #16's nebulizer and CPAP (continuous positive airway pressure) machine in a sanitary manner.

1. b. The facility staff failed to obtain a physician order for Resident #16's use of a CPAP machine.

2. The facility staff failed to ensure a clean external filter on Resident #31's oxygen concentrator that was being used to deliver oxygen to Resident #31 when he was seated in his room.

3. The facility staff failed to ensure a clean external filter on Resident #14's oxygen concentrator that was being used to deliver

4.DCS/Designee to conduct quality monitoring regarding physician notification with documentation in the medical record as indicated. Findings to be communicated to the QAPI committee monthly and as indicated. Quality monitoring schedules modified based on findings
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oxygen to Resident #14 when she was seated in her room.

The findings include:

1.a. The facility staff failed to store Resident #16's nebulizer and CPAP machine in a sanitary manner.

Resident #16 was admitted to the facility on 7/13/17 with diagnoses that included but were not limited to: stroke, muscle spasms of back, COPD (chronic obstructive pulmonary disease) (general term for chronic nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (1)), BPH (benign prostatic hypertrophy) (Benign prostatic hyperplasia-also called BPH-is a condition in men in which the prostate gland is enlarged and not cancerous. Benign prostatic hyperplasia is also called benign prostatic hypertrophy or benign prostatic obstruction (2)), restless leg syndrome, and high blood pressure.

The most recent MDS (minimum data set), an admission assessment, with an assessment reference date (ARD) of 7/25/17, coded the resident as being cognitively intact to make daily decisions. Resident #16 was coded as requiring supervision to extensive assistance of one staff member for all of his activities of daily living. In Section O - Special Treatments, Procedures and Programs, Resident #16 was not coded as having a CPAP* or any respiratory equipment.

* C-PAP, Continuous Positive Airway Pressure, is a machine used to assist people who are diagnosed with sleep apnea. A C-Pap machine

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increased air pressure in the throat so that the airway does not collapse when you breathe in. (3)

Observation was made during the initial tour on 9/26/17 at 1:05 p.m. Resident #16's nebulizer mask and tubing was sitting on top of the night stand, not in a plastic bag. Resident #16's CPAP tubing was lying in the top drawer of the nightstand, not in a plastic bag. On 9/26/17 at 4:28 p.m., the nebulizer mask and tubing and CPAP tubing were in the same location as they were at 1:05 p.m. Observation was made of the nebulizer mask and tubing and CPAP tubing on 9/27/17 at 9:28 a.m. The nebulizer mask and tubing and the CPAP tubing were both in the top drawer of the night stand and both were uncovered.

On 9/27/17 at 3:25 p.m., observation was made of the Resident #16's room. The nebulizer mask and the CPAP tubing were observed in the top drawer of the night stand and were both uncovered. Resident #16 entered the room. When asked if he used his nebulizer mask and CPAP machine, Resident #16 stated that he uses the CPAP every night and he has used the nebulizer recently for an upper respiratory infection.

The comprehensive care plan dated, 7/26/17, documented in part, "Focus: The resident has the potential for an ineffective breathing pattern r/t (related to) GERD (gastroesophageal reflux disease), COPD, hx (history) of smoking and dyspnea (difficulty breathing)." The "Interventions" documented in part, "Oxygen as ordered." Resident #16's care plan, further documented in part, "Focus: The resident has the potential for alteration in perfusion r/t (related/to) COPD,

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arrhythmias, hypertension (high blood pressure)." The "Interventions" documented in part, "Monitor for S/S (signs and symptoms) of decreased cardiac output including changes in pulse, weakness, dizziness, shortness of breath, edema, lethargy, syncope. Notify physician of any change in lung sounds or increasing edema: Vital signs as ordered and prn (as needed)."

An interview was conducted with LPN (licensed practical nurse) #16 on 9/27/17 at 3:30 p.m. LPN #16 was asked how a resident's nebulizer should be stored after being used. LPN #16 stated, "It should be stored in a plastic bag with their name and date on it." When asked if the same applied to a CPAP mask, LPN #16 stated, "Yes, it's the same thing, in a plastic bag when not in use." When asked why the respiratory equipment should be stored in plastic bags when not in use, LPN #16 stated, "It's for infection control purposes."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing/clinical services, on 9/27/17 at 4:32 p.m. When asked how respiratory equipment, such as nebulizer masks and CPAP masks should be stored when not in use, ASM #2 stated, "They should be stored in a plastic bag and changed every seven days or as needed."

The facility policy, "Nebulizer" documented in part, "Disassemble device and rinse the mouthpiece and nebulizer cup with water and air dry. Place entire unit in a bag to be maintained in the resident's room."

The facility policy, "General Administration of CPAP and BIPAP*" did not document anything

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related to the storage of the equipment after use. *Bi - PAP, bi-level Positive Airway Pressure, is a machine used to assist people who are diagnosed with sleep apnea. Bi Pap machine can be set for breathing in and breathing out pressure settings. (4)

"The humidification system may be a source of bacteria. Pseudomonas aeruginosa is frequently the organism involved. Oxygen delivery equipment such as cannulas and masks can also harbor organisms." (Ignatavicius, D. & Workman, L. (2002) Medical Surgical Nursing, Critical Thinking for Collaborative Care, 4th edition. (p.492) Philadelphia, Pennsylvania: W. B. Saunders Company.)

The executive director/administrator, (ASM #1), ASM #2, the director of nursing/clinical services and ASM #4 the regional director of clinical services, were made aware of the above findings on 9/27/17 at 5:23 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition; Rothenberg and Chapman; page 124.
(2) This information was obtained from the following website: https://www.niddk.nih.gov/health-information/urologic-diseases/prostate-problems/prostate-enlargement-benign-prostatic-hyperplasia.
(3) Also known as continuous positive airway pressure. CPAP is a treatment that uses mild air pressure to keep your breathing airways open. It involves using a CPAP machine that includes a mask or other device that fits over your nose or your nose and mouth, straps to position the

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mask, a tube that connects the mask to the machine ' s motor, and a motor that blows air into the tube. CPAP is used to treat sleep-related breathing disorders including sleep apnea. This information was obtained from the following website: https://www.nhlbi.nih.gov/health/health-topics/topics/cpap/

(4) This information was obtained from the following website: www.webmd.com/sleep-disorders/sleep-apnea.

1. b. The facility staff failed to obtain a physician order for Resident #16's use of a CPAP machine.

Observation was made during the initial tour on 9/26/17 at 1:05 p.m. Resident #16's CPAP tubing was lying in the top drawer of the nightstand, not in a plastic bag. On 9/26/17 at 4:28 p.m., the CPAP tubing was in the same location as it was at 1:05 p.m. Observation was made of Resident #16's CPAP tubing on 9/27/17 at 9:28 a.m. The CPAP tubing was in the top drawer of the night stand and was uncovered.

Review of the clinical record did not evidence any physician order for the CPAP machine and its use.

An interview was conducted with Resident #16 on 9/27/17 at 3:25 p.m. When asked if he uses his CPAP machine, Resident #16 acknowledged that he did indeed use it every night. When asked if he's used it since coming to the facility, Resident #16 stated he has used it for a long time now. He stated he had obtained it from the VA (veteran's administration). He stated he puts it on every

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night by himself.

An interview was conducted with LPN #16 on 9/27/17 at 3:40 p.m. When asked if Resident #16 had any special equipment, LPN #16 stated, "He as a CPAP." When asked if a physician order is needed for the administration of a CPAP machine, LPN #16 stated, "Yes, Ma'am." The physician orders for Resident #16 were reviewed with LPN #16. No physician order was found related to the use of the CPAP machine.

An interview was conducted with ASM #2, the director of nursing/clinical services, on 9/27/17 at 4:32 p.m. When asked if a physician order is required for the use of a CPAP by a resident, ASM #2 stated, "Yes."

The facility policy, "General Administration of CPAP and BIPAP" documented in part, "Physician orders for CPAP/BIPAP therapy to include: Specific mode of therapy (CPAP or BIPAP), pressure settings, source gas (oxygen) if ordered, administrative device, duration of therapy and frequency, if not continuous."

The executive director/administrator, (ASM #1), ASM #2, the director of nursing/clinical services and ASM #4 the regional director of clinical services, were made aware of the above findings on 9/27/17 at 5:23 p.m.

No further information was provided prior to exit.

2. The facility staff failed to ensure a clean external filter on Resident #31's oxygen concentrator that was being used to deliver oxygen to Resident #31 when he was seated in

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his room.

Resident #31 was admitted to the facility on 1/1/17 with a readmission date of 6/9/17 with diagnoses that included, but were not limited to: anxiety, depression, asthma (a disease causing difficulty with breathing), kidney failure and shortness of breath.

Resident #31's most recent MDS (minimum data set), a 14-day assessment with an ARD (assessment reference date) of 6/23/17, coded Resident #31 as scoring a 15 out of a possible 15 on the BIMS (brief interview for mental status) indicating that Resident #31 was cognitively intact. Resident #31 was also coded as using oxygen.

On 9/26/17 at approximately 1:00 p.m. a tour of the facility was conducted and Resident #31's oxygen concentrator in his room was inspected. On inspection, the external filter attached to the back of the machine was observed with a thick light colored substance attached to the filter.

On 9/27/17 at 4:00 p.m. Resident #31's oxygen concentrator was inspected and the filter on the back was observed in the same condition as on the previous day.

On 9/28/17 at 10:25 a.m., ASM (administrative staff member) #1, the executive director/administrator, was asked to accompany this surveyor into Resident #31's room to look at the oxygen concentrator. ASM #1 asked OSM (other staff member) #3, the medical supplies director, to come observe the equipment. OSM #3 stated that he was responsible for the filters on the oxygen concentrators in the resident rooms.

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ASM #1 and OSM #3 were asked to pull the filter from the oxygen concentrator in Resident #31's room, OSM #3 pulled the filter off and stated, "It is filthy, and I just came in here yesterday." When asked if he had changed the filter when he was in the room on 9/27/17, OSM #3 stated that he had not. OSM #3 was asked when he had last changed the filter on Resident #31's oxygen concentrator, OSM #3 stated, "Last Tuesday." This writer confirmed that "last Tuesday" was over seven days ago. When asked the purpose of the external filter, OSM #3 stated, "It is to stop particles from entering the machine." A policy was requested at this time regarding maintenance and cleaning of the oxygen concentrators. OSM #3 stated that the therapy department maintained the machines, out that he was responsible for the filters.

A review of the facility document "Oxygen Therapy" did not reveal any documentation relative to maintaining the oxygen concentrator.

A review of the facility document titled "Equipment Maintenance. Oxygen Concentrator" revealed, in part, the following documentation; "(Name of external maintenance company) will perform maintenance on concentrators according to manufacturer's guidelines and the frequency specified in the site of service contract, but no less than every six months." There is no further documentation regarding changing the filters on the oxygen concentrators.

A review of the manufacturers guidelines revealed, in part, the following documentation; "The (trade name) concentrator uses a molecular sieve and pressure swing absorption methodology to produce the oxygen gas output.

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Ambient air enters the device, is filtered and then compressed. There is one cabinet filter located on the back of the cabinet. Remove the filter and clean as needed. Environmental conditions that may require more frequent inspection and cleaning of the filter include, but are not limited to: high dust, air pollutants etc., Clean the cabinet filter with a vacuum cleaner or wash with a mild liquid dish detergent and water. Rinse thoroughly. Thoroughly dry the filter and inspect for fraying, crumbling, tears and holes. Reinstall the cabinet filter.

No further information was provided prior to the end of the survey process.

3. The facility staff failed to ensure a clean external filter on Resident #14's oxygen concentrator that was being used to deliver oxygen to Resident #14 when she was seated in her room.

Resident #14 was admitted to the facility on 3/7/13 with a readmission date of 1/21/15 with diagnoses that included, but were not limited to: high blood pressure, asthma (a disease causing difficulty with breathing), chronic respiratory failure, diabetes and low red blood count.

Resident #14's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 8/24/17, coded Resident #14 as scoring a three out of a possible 15 on the BIMS (brief interview for mental status) indicating that Resident #14 is severely cognitively impaired for daily decision making. Resident #14 was also coded as using

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oxygen.

On 9/26/17 at approximately 1:00 p.m., a tour of the facility was conducted and Resident #14's oxygen concentrator in her room was inspected. On inspection the external filter that is supposed to be attached to the back of the machine was observed missing.

On 9/27/17 at 4:00 p.m. Resident #14's oxygen concentrator was inspected and the filter continued to be missing from the back of the equipment.

On 9/28/17 at 10:25 a.m. ASM (administrative staff member) #1, the executive director/administrator, was asked to accompany this surveyor into Resident #14's room to look at the oxygen concentrator. ASM #1 asked OSM (other staff member) #3, the medical supplies director, to come observe the equipment. OSM #3 stated that he was responsible for the filters on the oxygen concentrators in the resident rooms. ASM #1 and OSM #3 were asked to pull the filter from the oxygen concentrator in Resident #14's room, OSM #3 looked behind the oxygen concentrator and stated there was no filter on the machine. When asked if there was supposed to be a filter present OSM #3 stated that a filter should be attached to the back of the oxygen concentrator. OSM #3 was asked when he had last checked the filter on Resident #14's oxygen concentrator, OSM #3 stated, "Last Tuesday." This writer confirmed that "last Tuesday" was over seven days ago. When asked the purpose of the external filter, OSM #3 stated, "It is to stop particles from entering the machine." A policy was requested at this time regarding maintenance and cleaning of the oxygen

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concentrators. OSM #3 stated that the therapy department maintained the machines, but that he was responsible for the filters.

A review of the facility document "Oxygen Therapy" did not reveal any documentation relative to maintaining the oxygen concentrator.

A review of the facility document titled "Equipment Maintenance. Oxygen Concentrator" revealed, in part, the following documentation; "(Name of external maintenance company) will perform maintenance on concentrators according to manufacturer's guidelines and the frequency specified in the site of service contract, but no less than every six months." There is no further documentation regarding changing the filters on the oxygen concentrators.

A review of the manufacturers guidelines revealed, in part, the following documentation; "The (trade name) concentrator uses a molecular sieve and pressure swing absorption methodology to produce the oxygen gas output. Ambient air enters the device, is filtered and then compressed. There is one cabinet filter located on the back of the cabinet. Remove the filter and clean as needed: Environmental conditions that may require more frequent inspection and cleaning of the filter include, but are not limited to: high dust, air pollutants etc., Clean the cabinet filter with a vacuum cleaner or wash with a mild liquid dish detergent and water. Rinse thoroughly. Thoroughly dry the filter and inspect for fraying, crumbling, tears and holes. Reinstall the cabinet filter.

No further information was provided prior to the end of the survey process.

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

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

(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;

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1.Resident#32's antianxiety medication is being admitted as per Physician order. Resident#32 suffered no adverse s/s and did not require being transfer to a higher level of care secondary to extra dose

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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 residents the drug regimen for three of 34 residents in the survey sample (Resident #32, #1 and #12) were free from unnecessary medications.

1. The facility staff failed to administer antianxiety medication to Resident #32 per physician's order. The facility staff administered an extra dose of Xanax to the resident on 7/17/17.

2. The facility staff failed to monitor Resident #1's behaviors for the use of the antipsychotic medication, Seroquel from May 2017 through September 2017.

3. The facility staff failed to attempt non-pharmacological interventions prior to the administration of Ativan [1] to Resident #12 on 7/5/17, 7/15/17 and 7/28/17; and failed to document behaviors that required Ativan to be administered on 7/15/17 and 7/28/17.

The findings include:

1. The facility staff failed to administer antianxiety medication to Resident #32 per physician's order. The facility staff administered an extra dose of Xanax (1) to the resident on 7/17/17.

Resident #32 was admitted to the facility on 5/26/17. Resident #32's diagnoses included but were not limited to: anxiety disorder, disease of the spinal cord and osteomyelitis (2). Resident #32's most recent MDS (minimum data set), a

of Xanax. Physician notification is documented.
Resident#1 is currently being monitored daily for behaviors. A behavior sheet has been added to Resident#1's medication record. The facility has added non-pharmacological intervention has been added to Resident#12's profile.

2.A quality review of current residents with Physician orders for Antipsychotic medications has been performed.

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quarterly assessment with an ARD (assessment reference date) of 9/12/17, coded the resident as being cognitively intact.

Review of Resident #32's clinical record revealed a physician's order dated 5/26/17 for Xanax 0.5 milligrams by mouth every six hours. The medication was scheduled on Resident #32's July 2017 MAR (medication administration record) to be given at 12:00 a.m. 6:00 a.m., 12:00 p.m., and 6:00 p.m.

Review of Resident #32's Xanax controlled medication utilization record (a record of documentation that accounts for each pill) for July 2017 revealed the resident was administered Xanax on 7/17/17 at 12:00 a.m., 6:00 a.m., 10:00 a.m., 2:00 p.m. and 6:00 p.m. Further review of Resident #32's clinical record failed to reveal documentation that the physician ordered an extra dose of Xanax on this date.

Resident #32's comprehensive care plan initiated on 6/13/17 documented, "Psychoactive Medication Use Anti-anxiety medication used for dx (diagnosis) of: Depression and uses and (sic) Anti-Depressant medication...Interventions: Medication as ordered (see MAR [medication administration record]) ..."

On 9/29/17 at 8:58 a.m., an interview was conducted with LPN (licensed practical nurse) #10. When asked what should be done regarding a physician's order on the MAR, LPN #10 stated, "Follow the order." When asked if medications should be given as ordered, LPN #10 stated, "Yes." LPN #10 was shown the physician's order for Resident #32's Xanax and shown the doses of the medication signed off on

3.Licensed Nurses re-educated by DCS/Designee regarding following Physician orders on Antipsychotic medication use.
Licensed Nurses re-educated by DCS/Designee on Consulate policy on behavior flow sheet and non-pharmacological interventions.
DCS/Designee during Morning Clinical Meeting to conduct quality monitoring of Antipsychotic medication use, behavior monitoring sheets and non-pharmacological

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the controlled medication utilization record on 7/17/17. When asked if Resident #32 was administered an extra dose of Xanax, LPN #10 stated, "Yeah. It looks like it."

On 9/29/17 at 9:45 a.m. ASM (administrative staff member) #1 (the executive director)/administrator and ASM #2 (the director of nursing/clinical services) were made aware of the above concern.

The facility/pharmacy policy titled, "General Dose Preparation and Medication Administration" documented, "4. Prior to administration of medication, Facility staff should take all rneasures required by Facility policy and Applicable Law, including but not limited to the following: 4.1 Facility staff should: 4.1.1 Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time..."

No further information was presented prior to exit.

(1) Xanax is used to treat anxiety. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a684001.html

(2) Osteomyelitis is a bone infection. This information was obtained from the website: https://kidshealth.org/en/teens/osteomyelitis.html

2. The facility staff failed to monitor Resident #1's behaviors for the use of the antipsychotic medication, Seroquel from May 2017 through September 2017.

medication x4 weeks, weekly x 4 weeks and then monthly, PRN and as indicated.

4.DCS/Designee to conduct quality monitoring regarding physician notification with documentation in the medical record as indicated. Findings to be communicated to the QAPI committee monthly and as indicated. Quality monitoring schedules modified based on findings.

5. November 14, 2017

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Resident #1 was admitted to the facility on 3/28/16. Resident #1's diagnoses included but were not limited to: repeated falls, dementia and blindness. Resident #1's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 8/4/17, coded the resident's cognitive skills for daily decision making as severely impaired. Section N coded Resident #1 as having received antipsychotic medication seven out of the last seven days during the look back period.

Review of Resident #1's clinical record revealed a physician's order dated 4/4/17 for Seroquel (1) 12.5 milligrams by mouth twice daily for agitation/psychosis.

A behavior symptom monitoring flow record for the month of April 2017 documented Resident #1's targeted behaviors as impulsive, standing up from the wheelchair and sitting on the table. The record documented the resident presented with impulsive behavior and was redirected on 4/20/17. Resident #1's clinical record failed to reveal any behavior symptom monitoring flow records for the months of May 2017 through September 2017. Further review of Resident #1's clinical record (including nurses' notes) failed to reveal qualitative or quantitative behavior monitoring for the use of Seroquel for the months of May 2017 through September 2017.

Resident #1's comprehensive care plan initiated on 8/29/16 documented, "Potential for impaired or inappropriate behaviors r/t (related to) combative behavior, aggressive with care: AEB (as evidenced by) self care deficit, Plays (sic) with feces, difficult to re-direct, attempts to stand

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up/transfer with out (sic) staff assistance. Refuses meds (medications)...Psychoactive Medication Antipsychotic medication in use for Dx (diagnosis) of (Psychosis) Behaviors of (agitation)...Interventions: Antipsychotic-Monitor behavioral symptoms..."

On 9/27/17 at 4:43 p.m. an interview was conducted with LPN (licensed practical nurse) #14 regarding the facility process for behavior monitoring for residents receiving antipsychotic medication. LPN #14 stated residents who have behaviors should have a behavior flowsheet in the front of their MAR (medication administration record). LPN #14 stated the top of the flowsheet will document the type of behaviors, triggers, non-pharmacological interventions and pharmacological interventions that can be provided. LPN #14 stated nurses should document the type of behavior, cause and intervention provided when residents present with behaviors. LPN #14 stated this process should be done each time residents present with behaviors. When asked the purpose of behavior monitoring, LPN #14 stated, "If on an antipsychotic (medication), that will let the psych (psychiatric) doctor or MD (medical doctor) know if the medication is working or if it needs adjusting or if it is controlling behaviors."

On 9/27/17 at 6:10 p.m. ASM (administrative staff member) #1 (the executive director/administrator), ASM #2 (the director of nursing/clinical services) and ASM #3 (the regional director of clinical services) were made aware of the above concern. ASM #2 stated according to the company policy, not all residents have behaviors but residents with behaviors should have behavior flowsheets for nurses to

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document when behaviors occur.

The facility policy titled, "Psychoactive Medications" documented, "Residents receiving psychoactive medication should have behaviors monitored every shift..."

No further information was presented prior to exit.

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

3. The facility staff failed to attempt non-pharmacological interventions prior to the administration of Ativan [1] to Resident #12 on

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7/5/17, 7/15/17 and 7/28/17; and failed to document behaviors that required Ativan to be administered on 7/15/17 and 7/28/17.

Review of Resident #12's clinical record revealed that he was admitted under hospice services on 3/29/17 and the following order was written: "Ativan 2 MG (milligrams)/ML (milliliter) give 0.25 mg q (every) 4 hours prn (as needed) anxiety."

Review of Resident #12's "Psychoactive medication Use" care plan dated 9/08/16, documented the following intervention: "Anti-Anxiety-Non-drug interventions." This intervention was initiated on 4/4/17.

Review of Resident #12's July 2017 MAR (medication administration record) revealed that Resident #12 received Ativan 0.25 mg on 7/5/17, 7/15/17, and 7/28/17. There was no evidence in the clinical record that non-pharmacological interventions were attempted prior to the administration of Ativan.

Further review of the MAR dated 7/2017, documented the following under "Nurse's Medication Notes: "Date: 7/5. Drug/Strength Dose: Ativan 0.25. Reason: aggitated (sic)." Behaviors that required Ativan to be administered on 7/15/17 and 7/28/17 could not be found on the July 2017 MAR or in the July 2017 nursing notes.

On 9/28/17 at 11:05 a.m., an interview was conducted with LPN (licensed practical nurse) #10, Resident #12's nurse. When asked the process prior to administering a prn (as needed) anti-anxiety medication, LPN #10 stated that she would observe the resident and their behaviors, try to calm them down by redirection and

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distraction before administering medication. LPN #10 stated that if non-pharmacological interventions are ineffective, she would administer the prn anti-anxiety medication. When asked if she would always attempt non-pharmacological interventions, LPN #10 stated that she would. When asked if non-pharmacological interventions attempted are documented, LPN #10 stated that non-pharmacological interventions should be documented on a behavior sheet or nursing note. When asked how she would know if a nurse attempted non-pharmacological interventions prior to administering Ativan if it is not documented, LPN #10 stated, "You wouldn't." When asked if Resident #12's care plan was followed if non-pharmacological interventions were not attempted prior to administering prn Ativan, LPN #10 stated that if non-pharmacological (interventions) were not attempted then the care plan was not followed.

A July 2017 behavior sheet for Resident #12 could not be found in the clinical record.

On 9/28/17 at 5:15 p.m.., ASM (administrative staff member) #1, the executive director/administrator, and ASM #2, the DON (Director of Nursing)/clinical services, were made aware of the above findings.

Facility policy titled, "Psychotropic Medication Use" did not address the above concerns.

No further information was presented prior to exit.

[1] Ativan-used to treat anxiety disorders. This information was obtained from The National Institutes of Health.

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F 329	Continued From page 195 https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010988/?report=details.	F 329	F 371 1. The cookware has been washed and stored in a sanitary manner. 2. The Administrator and or designee has reviewed the kitchen with emphasis on cookware for kitchen maintained in a sanitary condition. 3. The Administrator and or designee to re-educate dietary staff on properly washing and storing cookware in a sanitary manner and maintaining the kitchen in a sanitary condition to ensure compliance is attained and maintained. 4. The Administrator and or designee to conduct quality monitoring of the cookware being washed and stored in a sanitary manner and kitchen being maintained in a sanitary	
F 371 SS=D	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (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 wash and store cookware in a sanitary manner. The facility staff failed to allow cookware to air dry, and stacked multiple wet pans on top of each	F 371		

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F 371	Continued From page 196 other (wet nested). The findings include: During the initial tour of the kitchen on 9/26/17 at 1:02 p.m. with OSM (other staff member) # 4, the director of dietary, observation of the kitchen was made. A storage rack that contained multiple sheet pans was observed. Eight of the sheet pans were stacked on top of each other. When the sheet pans were examined they were found to be wet and were wet nested. This observation was verified by OSM # 4. A review of the facility policy "Storage of Pots, Dishes, Flatware, Utensils" documented, "Air dry pots, dishes, flatware, and utensils before storage, or store in a self-draining position." During an interview on 9/27/17 at 5:50 p.m. with ASM (administrative staff member) # 1, the executive director/administrator, ASM # 2, the director of nurses/clinical services, and ASM # 4, the regional Director of clinical services, this concern was reviewed. During an interview on 9/28/17 at 4:50 p.m. with ASM # 1 and ASM # 2 this concern was again shared. No further information was provided by the end of the survey.	F 371	condition. Quality monitoring to be conducted 3X a week per week for 4 weeks to ensure compliance and then 1X a week for 4 weeks then quarterly thereafter. Quality Monitoring schedule to be modified based on findings of quality reviews. The results of the quality monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis and further recommendations. 5. November 14, 2017	
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature

F431
1.The facility has discarded the expired Vancomycin intravenous bags from the medication room on Unit#2. The facility has discarded the expired eight ounce bottle of magic mouthwash from the medication room on Unit#2. The facility has discarded Two vials of Tuberculin solution, Humulin pen, Six vials of Copaxin, Novo log pen, Twelve Promethazine suppositories, eleven Marinol capsules, One vial of Lorazepam, ,Cathfloactivase, Three biscodyl suppositories, one bottle of Atropine and five Acetaminophen suppositories. All medications have been reordered as per Physician order. The

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F 431	Continued From page 198	F 431		

controls; and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility policy review, it was determined that the facility staff failed to label and store medications safely in two of 2 medication rooms and one of 9 medication carts.

1.a. The facility staff failed to discard expired medications. In the medication room on unit two, two Vancomycin (1) intravenous bags that expired on 9/21/7 and one full eight-ounce bottle of magic mouthwash (2) that was labelled as expired on 8/19/17 were observed available for use.

b. The facility staff failed to maintain the medication refrigerator temperature between 36 degrees and 46 degrees on unit one.

c. The facility staff failed to lock one of nine medication carts in the facility.

The findings include:

1.a. The facility staff failed to discard expired medications. In the medication room on unit two,

temperature of the refrigerator on Unit#1 is maintained at a temperature of 38 degrees. All medication carts in the facility are locked.

2.A quality review of medication rooms on each unit has been performed. A quality review of each refrigerator temperature in the medication rooms has been performed. A quality review of each medication cart has been performed.

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F 431	Continued From page 199 two Vancomycin (1) intravenous bags that expired on 9/21/7 and one full eight-ounce bottle of magic mouthwash (2) that was labelled as expired on 8/19/17 were observed available for use. A tour of unit two's medication room was conducted on 9/28/17 with LPN (licensed practical nurse) #10. In the medication room refrigerator were two 100 cc (cubic centimeter) bags of Vancomycin. The expiration date was noted as 9/21/17. A full eight-ounce bottle of magic mouthwash was also in the refrigerator with an expiration date of 8/19/17. When asked. who checked the medication rooms for expired medications, LPN #10 stated, "The night shift checks the refrigerator. I would think they'd check for expired meds (medications)." LPN #10 removed the medications from the refrigerator. On 9/28/17 5:00 p.m. ASM (administrative staff member), the administrator/executive director, and ASM #2, the director of nursing/clinical services, were made aware of the findings. Review of the facility's policy title, "Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles" documented, "4. Facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guideline; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier." No further information was obtained prior to exit.	F 431	3.Licensed Nurses re-educated by DCS/Designee regarding medication storage, maintaining refrigerator temperature and keeping medication carts secured. DCS/Designee to conduct quality monitoring of and storage of medications, Refrigerator temperature logs and Secure medication carts x4 weeks, weekly x4 weeks and then monthly, PRN and as indicated. 4.DCS/Designee to conduct quality monitoring regarding	

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F 431	Continued From page 200 b. The facility staff failed to maintain the medication refrigerator temperature between 36 degrees and 46 degrees on unit one. A tour of unit one's medication room was conducted on 9/28/17 at 12:20 p.m. with LPN #3. The refrigerator temperature was 48 degrees. When asked what the refrigerator temperature should be, LPN #3 stated, "36 to 46 degrees." When asked why they kept the refrigerator at that temperature, LPN #3 stated it was to store the medications. When asked what process staff followed if the refrigerator temperature was too high, LPN #3 stated, "We would turn up the temp [temperature] in the refrigerator." LPN #3 then adjusted the temperature in the refrigerator. At 12:45 p.m. LPN #3 checked the temperature with this surveyor and stated, "It's 58 degrees. I must have turned it the wrong way." LPN #3 readjusted the refrigerator temperature. Review of the September 2017 refrigerator temperature log recorded the temperature as being 40 degrees every day that month. The medications in the refrigerator at the time were: Two vials of Tuberculin purified protein (3). Instructions on the box was to store the medication between 36 and 46 degrees. One Humulin (4) pen. Instructions on the box was to store the medication between 36 and 46 degrees and that it may be stored at room temperature for 14 days. Six vials of Copaxone (5) 40 gram/1 milliliter. Instructions were to store medication at 36 to 46 degrees.	F 431	physician notification with documentation in the medical record as indicated. Findings to be communicated to the QAPI committee monthly and as indicated. Quality monitoring schedules modified based on findings 5. November 14, 2017	

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One Novolog (6) flex pen. "Refrigerate until opened." No specific temperature was given.

Twelve Promethazine HCL (hydrochloride) (7) 25 mg suppositories. No specific instructions given.

Nine Marinol (8) 2.5 mg capsules and two Marinol 5 mg capsules with no specific instructions.

One Lorazepam (9) 2mg/ml vial. Instructions were to store the medication between 36 and 46 degrees.

Cathfloactivase (10) 2mg. Instructions were to store between 36 and 36 degrees.

Three hospice boxes containing: Three Biscodyl (11)- evac 10 mg suppositories; Haloperidal (12) 2mg/ml with instructions to store between 68 and 77 degrees; Atropine (13) solution 1% bottle; and five Acetaminophen (Tylenol) suppositories. With no other instructions.

On 9/28/17 at 1:47 p.m. the refrigerator temperature in the unit one medication room was 52 degrees.

A telephone interview was conducted on 9/28/17 at 2:10 p.m. with OSM (other staff member) #8, a pharmacist. When asked if storing medications above the recommended temperature could affect the medication, OSM #8 stated, "It depends, sometimes." OSM #8 stated, "You would have to call each individual manufacturer to see what the effect would be on each drug."

On 9/28/17 at 5:00 p.m. ASM (administrative staff member) #1, the administrator/executive director,

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and ASM #2, the director of nursing/clinical services, were made aware of the findings. ASM #1 stated, "It's a new refrigerator. We'll have maintenance check it."

Review of the facility's policy titled, "Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles" documented, "11. Facility should ensure that medications and biologicals are stored at their appropriate temperatures according to the United States Pharmacopeia guidelines for temperature ranges. Facility Staff should monitor the temperature of vaccines twice a day. 11.2 Refrigeration 36 (degrees) - 48 (degrees)..."

No further information was provided prior to exit.

1. Vancomycin - Vancomycin is a broad spectrum antibiotic that has activity against methicillin-resistant strains of Staphylococcus aureus and is generally reserved for serious drug resistant gram-positive infections. This information was obtained from: https://livertox.nlm.nih.gov/Vancomycin.htm

2. Magic Mouthwash - An oral suspension containing diphenydramine hydrochloride, dexamethasone and nystatin, with antihistaminic, anti-inflammatory, and chemotherapy and radiation therapy. This information was obtained from: https://www.cancer.gov/publications/dictionaries/cancer-drug?cdrid=632630

3. Tuberculin - TUBERSOL, Tuberculin Purified Protein Derivative (Mantoux), is indicated to aid diagnosis of tuberculosis infection (TB) in persons at increased risk of developing active

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disease. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?id=96432

4. Humulin - Insulin is a hormone produced by the pancreas, a large gland that lies near the stomach. This hormone is necessary for the body's correct use of food, especially sugar. Diabetes occurs when the pancreas does not make enough insulin to meet your body ' s needs. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=5696

5. Copaxone - COPAXONE (glatiramer acetate injection) is indicated for the treatment of patients with relapsing forms of multiple sclerosis. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=aa88f583-4f5f-433b-80b4-1f4c9fb28357

6. Novolog - NOVOLOG is a rapid acting human insulin analog indicated to improve glycemic control in adults and children with diabetes mellitus. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3a1e73a2-3009-40d0-876c-b4cb2be56fc5

7. Promethazine - Promethazine is a phenothiazine derivative with histamine H1-blocking, antimuscarinic, and sedative properties. It is used as an antiallergic, in pruritus, for motion sickness and sedation, and also in animals. This information was obtained from: https://pubchem.ncbi.nlm.nih.gov/compound/promethazine#section=Top

8. Marinol - Dronabinol is an orally active

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cannabinoid which, like other cannabinoids, has complex effects on the central nervous system (CNS), including central sympathomimetic activity. Cannabinoid receptors have been discovered in neural tissues. These receptors may play a role in mediating the effects of dronabinol and other cannabinoids. This information was obtained from: htlps://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=6035https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=6035

9. Lorazepam - Lorazepam tablets are indicated for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=01809ec0-133e-4764-86b9-0435588c57c6

10. Cathfloactivase - Alteplase is an enzyme (serine protease) that has the property of fibrin-enhanced conversion of plasminogen to plasmin. It produces limited conversion of plasminogen in the absence of fibrin. Alteplase binds to fibrin in a thrombus and converts the entrapped plasminogen to plasmin, thereby initiating local fibrinolysis (1). This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=91ecdef2-95ff-42dd-a31c-c8a09cab3ad9

11. Biscodyl - Bisacodyl is commonly used,

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over-the-counter laxative used to treat constipation or bowel irregularity. This information was obtained from: https://livertox.nih.gov/Bisacodyl.htm

12. Haloperidol - Haloperidol is indicated for use in the management of manifestations of psychotic disorders. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=da0be2a5-b6f3-4e08-83e8-84b0985de497 13. Atropine - Atropine sulfate is given parenterally as a preanesthetic medication to decrease salivation and bronchial secretions. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=5d45eb2f-b964-4f64-b277-eef807520466

1.c. The facility staff failed to lock one of nine medication carts in the facility, the medication cart on unit one.

An observation of the medication administration was conducted on unit one on 9/27/17 at 12:15 p.m. with LPN (licensed practical nurse) #7. LPN #7 pulled the medication cart up to the resident's door and went into the resident's room. The door to the room was half closed and LPN #7 could not be observed from the medication cart. LPN #7 was in the room for approximately 45 seconds and then returned to the medication cart. She pulled the lock button out all the way and opened the medication cart. LPN #7 did not use any keys to open up the medication cart.

An interview was conducted on 9/27/17 at 12:20 p.m. with LPN #7. When asked if she had line of

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F 431	Continued From page 206 sight to the medication cart when she was in the resident's room, LPN #7 stated, "I was just in there with her and I came back out. The cart was near the door. I thought it was locked." When asked if the locked medication cart could be opened without keys, LPN #7 stated, "I thought it was safe when I went into the room." When asked if she was able to see the cart and this writer when she was in the room, LPN #7 stated, "No." When asked why the medication cart is locked when out of line of sight, LPN #7 stated, "Secure the cart to protect the medications." On 9/28/17 5:00 p.m. ASM (administrative staff member), the administrator/executive director, and ASM #2, the director of nursing/clinical services, were made aware of the findings. Review of the facility's policy titled, "Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles" documented, "PROCEDURE. 3.3 Facility should ensure that all medications and biologicals, including treatment items, are securely store in a locked cabinet/cart or locked medication room this is inaccessible by residents and visitors." No further information was provided prior to exit. According to "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 703. "Make sure that all medications are in locked containers in a room (e.g., medication room) or are under constant surveillance."	F 431		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 207 (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; (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	F 441	1. The LPN no longer works for the facility that failed to wash her hands during the medication pass with resident #15. The nylon cord attached to the call bell has been replaced. The dried up material has been removed and disinfected behind the headboard of 301B. The dirty gloves and towels were removed from the sink in Unit 1 shower room.	

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	495362	A. BUILDING _____ B. WING _____	C 09/29/2017

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F 441	Continued From page 208 (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 observation, staff interview and facility document review, it was determined that the facility staff failed to follow infection control practices for three of 7 residents in the medication pass observation; and in one of 14 resident bathrooms on the Hanover unit and one of 16 resident rooms on the Hanover unit and one of 3 shower rooms, unit one. 1. The facility staff failed to wash their hands during the medication pass on 9/26/17 at 4:45 p.m. for Resident #33 and Resident #34 and on 9/27/17 at 12:08 p.m. with Resident #15.	F 441	2. The DCS and or Unit Manager and or designee completed random medication pass observations on all three shifts with emphasis on handwashing. Administrator and or designee conducted environmental rounds on resident rooms for call bell cords and cleanliness of resident rooms/bathrooms and resident shower rooms. Follow up based on findings.	

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2. The bathroom between room 306 and 308 was observed to have a brown substance on the nylon cord attached to the call bell on the Hanover Station unit.

3. Dried up feces was observed on the wall behind the headboard of the second bed (B-bed) in room 301 on the Hanover Station unit.

4. The unit one shower room was observed with dirty gloves and towels in the sink.

The findings include:

1. The facility staff failed to wash their hands during the medication pass on 9/26/17 at 4:45 p.m. for Resident #33 and Resident #34 and on 9/27/17 at 12:08 p.m. with Resident #15.

Resident #33 was admitted to the facility on 7/6/15 with diagnoses that included but were not limited to: high blood pressure, arthritis, anemia and muscle weakness. The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 7/3/17 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions.

Resident #34 was admitted to the facility on 8/31/12 with diagnoses that included but were not limited to: dementia, low blood pressure and blood vessel disease. The most recent MDS, a quarterly assessment, with an ARD of 7/15/17 coded the resident as having scored a three out of 15 on the BIMS, indicating the resident was

3. The Director of Clinical Services and or designee re-educated licensed nurses on hand washing prior to Medication administration. The Administrator and or designee re-educated housekeeping staff on cleaning call bell cords, cleaning resident rooms and Shower rooms. Nursing staff educated on role of maintaining resident rooms, resident bath rooms and resident shower rooms in a clean and orderly condition. Facility IDT to complete customer service rounds weekly for cleanliness of resident rooms and bathrooms and report using Mock Survey Tool.

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severely impaired cognitively.

Resident #15 was admitted to the facility on 10/3/16 with diagnoses that included but were not limited to: seizures, schizophrenia, kidney disease, diabetes, high blood pressure and stroke. The most recent MDS, a quarterly assessment, with an ARD of 7/7/17 coded the resident as having scored a 13 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions.

An observation of the medication pass was made on 9/26/17 at 4:45 p.m. with LPN (licensed practical nurse) #7. LPN #7 was preparing medications for Resident #33. LPN #7 put iron sulfate 325 mg (milligrams) one tablet and gabapentin (1) 100 mg two tablets into a medication cup. LPN #7 filled a plastic cup with water. LPN #7 then went into Resident #33's room and gave the medication cup and plastic cup to the resident. While Resident #33 was taking the medication, LPN #7 reached into her uniform pocket and retrieved some lip balm that she applied to her lips. LPN #7 put the lip balm back into her pocket and took the medication and plastic cups from the resident and discarded them. LPN #7 washed her hands and returned to the medication cart. LPN #7 then put her fingers into a plastic water cup to pull two cups apart she then used the cup she had put her fingers into and filled it with water. LPN #7 then went to the medication room to obtain two cephalexin 250 (2) mg. LPN #7 returned to the cart, put the pills into the medication cup and then took the medication and cup of water into Resident #34's room, she gave the resident the medication and water cups and then took them from the Resident #34 and

4. The DCS and or unit Manager and or designee to conduct quality monitoring of handwashing during Medication Pass 3 times per week for 4 weeks then weekly times 4 weeks then monthly. Administrator and or Housekeeping Supervisor and or designee to conduct quality monitoring call bell cords, cleanliness of rooms, and cleanliness

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discarded them. LPN #7 did not sanitize her hands after going into the medication room and obtaining the medication and before giving Resident #34 the medication.

An observation of the medication pass for Resident #15 was made on 9/27/17 at 12:08 p.m. with LPN #7. LPN #7 placed Renvela (3) 800 mg one tablet, Seroquel (4) 200 mg one tablet and oxycodone (5) 5 mg/325 mg one tablet into a medication cup. LPN #7 then filled a plastic cup with water and took a straw from the cup on the medication cart. A covered straw fell to the floor. LPN #7 picked up the straw, put it back in the cup on the medication cart and then took the medications into Resident #15's room. LPN #7 did not discard the straw or wash her hands after picking the straw up off the floor.

An interview was conducted on 9/27/17 at 12:20 p.m. with LPN #7. When asked when staff wash their hands, LPN #7 stated, "Before and after working with the residents." When asked why staff washed their hands, LPN #7 stated, "Infection control." When made aware of the above observation of LPN #7 during medication administration going into the medication room and returning to the medication cart, LPN #7 stated, "I should have washed my hands." When made aware of using lip balm in a resident's room and then taking the medication cup and water cup from the resident, LPN #7 stated, "That's probably not good." When made aware of the straw on the floor and having it returned to the cup on the medication cart and then not washing her hands, LPN #7 stated, "I should have thrown it away and washed my hands."

An interview was conducted on 9/28/17 at 8:40

of shower rooms.
Quality monitoring to be conducted 3X a week per week for 4 weeks to ensure compliance and then 1X a week for 4 weeks then quarterly thereafter. Quality monitoring schedule to be modified based on findings of quality reviews. The results of the quality monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis and further recommendations.

5. November 14, 2017

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a.m. with ASM (administrative staff member) #2, the director of nursing/clinical services. When asked when staff washed their hands, ASM #2 stated, "After every patient encounter and periodically throughout the day." When asked what staff should do if there was a straw on the floor, ASM #2 stated, "Throw it away." ASM #2 was made aware of the findings at that time.

Review of the facility's policy titled, "Handwashing" documented, "Policy: An essential component of infection control is hand washing. All staff members must wash their hands using the following procedures."

No further information was obtained prior to exit.

In Fundamentals of Nursing, Lippincott Williams and Wilkins page 140-143 concerning hand washing and the use of hand sanitizer: "The hands are conduits for almost every transfer of potential pathogens from one patient to another, from a contaminated object to the patient, or from a staff member to the patient. Hand hygiene is the single most important procedure in preventing infection.... typically, hands are washed with soap before coming on duty; before and after direct or indirect patient contact;...before preparing or administering medications...always wash your hands with soap after removing gloves...when using hand sanitizer, apply a small amount of the alcohol-based hand rub to all surfaces of the hands. Rub hands together until all of the product has dried (usually about 30 seconds)."

1. Gabapentin - Gabapentin capsules, are indicated for: Management of post herpetic neuralgia in adults
Adjunctive therapy in the treatment of partial

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onset seizures, with and without secondary generalization, in adults and pediatric patients 3 years and older with epilepsy This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/druglnfo.cfm?setid=f7c1fd34-d615-43a2-8989-898fe11f90df

2. Cephalexin - Cephalexin, USP is a semisynthetic cephalosporin antibiotic intended for oral administration. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=37ec3f8b-51d1-4d74-a4ee-9240c734b1a6

3. Renvela - is a phosphate binder This information was obtained from: Dailymed.nlm.nih.gov/dailymed/getFile.cfm?setid=970da28b-04e4-4ec8-9d7b-1b74a0ec411d&name=970da28b

4. Seroquel - SEROQUEL is indicated for the treatment of schizophrenia. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/druglnfo.cfm?setid=0584dda8-bc3c-48fe-1a90-79608f78e8a0 4.

5. Oxycodone - Oxycodone is a semisynthetic pure opioid agonist whose principal therapeutic action is analgesia. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/archives/fdaDruglnfo.cfm?archiveid=17971

2. The bathroom between room 306 and 308 was observed to have a brown substance on the nylon cord attached to the call bell on the Hanover Station unit.

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On 9/26/17 at 1:25 p.m., observation of room 308 was conducted. The bathroom for room 308 that was shared with room 306 was observed. The call bell was located on the wall next to the toilet. The nylon string attached to the call bell was covered with a brown substance.

On 9/26/17 at 3:00 p.m., an interview was conducted with CNA (certified nursing assistant) #12, a CNA on the Hanover Station unit. When asked what she would do if she noticed a dirty nylon string to the call bell, CNA #12 stated that she would contact maintenance to have them appiy a new string. CNA #12 followed this writer into the bathroom shared by 306 and 308 to observed the call bell string. CNA #12 observed the call bell string and stated the call bell string was brown. CNA #12 could not determine what was on the nylon string. CNA #12 stated that it was unsanitary for the residents to be using the brown call bell.

On 9/27/17 at 8:15 a.m., OSM (other staff member) #12, the housekeeping director, followed this writer into the bathroom of room 308. When asked what color the nylon string attached to the call bell should be, OSM #12 stated, "white." When asked what he noticed about the nylon string, OSM #12 stated the cord was brown and needed to be replaced. OSM #12 stated he would replace the call bell string immediately. OSM #12 stated that he was not sure what the brown substance was.

On 9/28/17 at 5:15 p.m., ASM (administrative staff member) #1, the executive director/administrator and ASM #2, the DON (Director of Nursing)/clinical services, were made

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aware of the above concerns. No further information was presented prior to exit.

3. Dried up brown feces like substance was observed on the wall behind the headboard of the second bed (B-bed) in room 301 on the Hanover Station unit.

On 9/26/17 at 1:20 p.m., observation of room 301 was conducted. Two large gouges were observed behind the second bed. While measuring the gouges in the wall; this writer noticed a foul odor and dried up brown feces like substance stuck to the wall behind the headboard of the bed.

On 9/26/17 at 3:00 p.m., a second observation was made of room 301. Dried up brown feces like substance remained stuck to the wall behind the headboard of the bed.

On 9/26/17 at 4:10 p.m., an interview was conducted with CNA (certified nursing assistant) #12. When asked how often CNAs made rounds on the resident's rooms, CNA #12 stated, "Every 2 hours." When asked what Resident #12 looks for on her rounds, CNA #12 stated that she checks on the residents and looks at the cleanliness of the rooms. When asked when the last time she went into room 301, CNA #12 stated she was in room 301 at approximately 3:30 p.m. When asked if she noticed anything unusual in the room, CNA #12 stated, "No." CNA #12 followed this writer into room 301. When asked what she noticed behind the head board of the second bed, CNA #12 stated, "That looks like BM (bowel movement). It looks very old and dry."

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When asked why feces on the wall is a concern, CNA #12 stated that feces on the wall was unsanitary. CNA #12 then took a paper towel and removed the feces from the wall. CNA #12 alerted a housekeeper that was across the hall to disinfect the area.

On 9/26/17 at 4:33 p.m., an interview was conducted with OSM (other staff member) # 13, the housekeeping director. When asked how often housekeeping made rounds in resident rooms on the dementia unit, OSM #13 stated that housekeeping rounded on resident rooms at least four times a day on the dementia unit. OSM #13 stated that he tries to round at least every hour. When asked what he checked while rounding, OSM #13 stated that he checked rooms, floors, and bathrooms for cleanliness. OSM #13 also stated that each room received a deep cleaning on certain days of the weeks. When asked if rounding and deep cleaning included checking behind and under the beds, OSM #13 stated that sometimes he will check behind the beds and he always checks underneath the beds. A copy of the deep cleaning schedule was requested.

On 9/26/17 at approximately 6 p.m., the deep cleaning schedule was presented. Room 301 received a deep cleaning on 9/1/17.

On 9/28/17 at 5:15 p.m., ASM (administrative staff member) #1, the executive director/administrator and ASM #2, the DON (Director of Nursing)/clinical services, were made aware of the above concerns. No further information was presented prior to exit.

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4. The unit one shower room was observed with dirty gloves and towels in the sink.

On 9/26/17 at 4:05 p.m., observation of the shower rooms was conducted. On 9/16/17 at 4:10 p.m., the Wing One shower room was observed. Dirty towels and used gloves was observed in the sink of the shower room.

On 9/26/17 at 4:10 p.m., an interview was conducted with CNA (certified nursing assistant) #13. When asked when the shower rooms were cleaned, CNA #13 stated that the nursing aides were supposed to clean the shower rooms after each resident use. CNA #13 stated that nursing aides will wipe down the shower chairs and place dirty linens and towels in a trash bag to be taken to the dirty linen barrel. CNA #13 stated that trash should also be bagged separately and taken to the trash bin immediately after a shower. When asked if it was ever ok to leave trash and linen in the sink of the shower rooms, CNA #13 stated that it was not. When asked if she could tell this writer what was in the sink of the shower room, CNA #13 stated, "Something that shouldn't be." CNA #13 immediately placed on gloves and discarded the dirty towels and gloves from the sink. When asked when the last time the shower room was used, CNA #13 stated that it must have been that morning. CNA #13 stated that she had arrived to the facility at 3 p.m. for evening shift.

On 9/28/17 at 5:15 p.m., ASM (administrative staff member) #1, the executive director/administrator and ASM #2, the DON (Director of Nursing)/clinical services, were made aware of the above concerns.

The facility policy titled, "Handling of soiled linen"

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F 441	Continued From page 218 documents in part, the following: "Policy: To promote and encourage the concept that all soiled linen is considered contaminated...Procedure: Do not sort or pre-rinse soiled linen in the resident areas. Perform hand hygiene, Don Gloves, Place dirty linen into bad (carefully, not to touch outside of bag), remove gloves, perform hand hygiene, secure plastic bag, place bag in designated barrel in hallway or soiled utility room. Perform hand hygiene."	F 441	F502 1.Resident#2 suffered no adverse effects and did not require transfer to a higher level of care. A physician order was obtained to discontinue Resident #'s order for Urinalysis. The Physician and responsible party were notified. Resident #15 suffered no adverse effects and did not require transfer to higher level of care. A Physician order for was obtained for Resident #15's order for Sputum culture to be discontinued. The Physician and responsible party received notification	
F 502 SS=D	483.50(a)(1) ADMINISTRATION (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 and clinical record review, it was determined that the facility staff failed to obtain laboratory specimens for two of 34 residents in the survey sample, Resident #2 and Resident #15. 1. The facility staff failed to obtain a urine specimen for Resident #2 as ordered by the physician on 5/30/17. 2. The facility staff failed to obtain a sputum culture from Resident #15 as ordered by the physician on 9/21/17. The findings include:	F 502	2.A quality review of current residents with physician orders for laboratory testing has been performed. Physician notification	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETION DATE
F 502	Continued From page 219	F 502		

1. Resident #2 was admitted to the facility on 5/1/17 with diagnoses that included but were not limited to: HIV (human immunodeficiency virus (1)), dementia, depression, difficulty swallowing and elevated cholesterol. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 8/8/17 coded the resident as having both short and long term memory problems and as severely impaired cognitively. Resident #2 was coded as rarely or never being able to understand others or to be understood. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the resident's care plan developed on 5/6/17 did not address obtaining urine specimens.

Review of Resident #2's physician orders dated on 5/26/17 documented, "Clean Catch U + A (urine and analysis) on 5/30/17."

Review of the clinical record did not evidence documentation of the urine specimen results.

A request was made on 9/27/17 at 1:46 p.m. of ASM (administrative staff member) #1, the administrator/executive director, for a copy of Resident #2's urine specimen results.

An interview was conducted on 9/28/17 at 10:58 a.m. with ASM #2, the director of nursing/clinical services. ASM #2 stated, "I don't have the lab (laboratory specimen) which is why the order was discontinued." (The staff obtained an order to discontinue the urine specimen order on 9/27/17.)

Review of the facility's policy titled, "Laboratory, Diagnostic and X-Ray" did not evidence

related to laboratory results is in present in the chart.

3.Licensed Nurses re-educated by DCS/Designee regarding following Physician orders on obtaining laboratory specimen and the process in following up with laboratory results including Physician and RP notification. DCS/Designee during Morning Clinical Meeting to conduct quality monitoring of physician laboratory orders, contacting the Physician and RP notification daily x4, weeklyx4 and then monthly, PRN and as indicated.

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	495362	A. BUILDING _____ B. WING _____	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 502	Continued From page 220	F 502		

documentation regarding notifying the physician if staff were not able to obtain a laboratory specimen.

No further information was provided prior to exit.

1. HIV stands for human immunodeficiency virus, which is the virus that causes HIV infection. The abbreviation "HIV" can refer to the virus or to HIV infection. HIV is the virus that causes HIV infection. AIDS is the most advanced stage of HIV infection.
HIV is spread through contact with the blood, semen, pre-seminal fluid, rectal fluids, vaginal fluids, or breast milk of a person with HIV. In the United States, HIV is spread mainly by having anal or vaginal sex or sharing drug injection equipment with a person who has HIV.
Antiretroviral therapy (ART) is the use of HIV medicines to treat HIV infection. People on ART take a combination of HIV medicines (called an HIV regimen) every day.
ART can't cure HIV infection, but it can help people with HIV live longer, healthier lives. HIV medicines can also reduce the risk of transmission of HIV. This information was obtained from the website: https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/19/45/hiv-aids--the-basics

2. The facility staff failed to obtain a sputum culture and sensitivity as ordered on 9/2/17 for Resident #15.

Resident #15 was admitted to the facility on 10/3/16 with diagnoses that included but were not limited to: seizures, schizophrenia, kidney

4.DCS/Designee to conduct quality monitoring regarding physician notification with documentation in the medical record as indicated. Findings to be communicated to the QAPI committee monthly and as indicated. Quality monitoring schedules modified based on findings
5. November 14, 2017

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	495362	A. BUILOING _____ B. WING _____	C 09/29/2017

NAME OF PROVIOER OR SUPPLIER	STREET AOORESS. CITY. STATE. ZIP COOE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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disease, diabetes, high blood pressure and stroke. The most recent MDS, a quarterly assessment, with an ARD of 7/7/17 coded the resident as having scored a 13 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. Resident #15 was coded as requiring assistance from staff for all activities of daily living.

Review of Resident #15's care plan initiated on 10/13/16 and revised on 7/26/17 did not evidence documentation related to obtaining sputum specimens.

Review of the physician's orders dated 9/2/17 documented, "Obtain sputum c+s (culture and sensitivity) on Tuesday (9/5/17)."

Review of the clinical record did not evidence documentation of the sputum specimen results. A request was made on 9/27/17 at 1:45 p.m. of ASM #1, the administrator/executive director, for a copy of the sputum specimen results.

An interview was conducted on 9/28/17 at 10:58 a.m. with ASM #2, the director of nursing/clinical services. ASM #2 stated, "I don't have the lab (laboratory specimen) which is why the order was discontinued." (The staff obtained an order to discontinue the sputum specimen on 9/27/17.)

No further information was provided prior to exit.

F 504 SS=D — 483.50(a)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN — F 504

(a) Laboratory Services

F504

1. A physician order been obtained for the BMP (basic metabolic panel) blood test) and lab work has been obtained for resident #10. Physician was notified of results

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F 504	Continued From page 222	F 504		

(2) The facility must-

(i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to obtain a physician's order prior to obtaining a laboratory test for one of 34 residents in the survey sample; Resident #10.

The facility staff failed to obtain a physician order to obtain a BMP [1] (basic metabolic panel) blood test on 4/5/17 for Resident #10.

The findings include:

Resident #10 was admitted to the facility on 5/2/13 with a readmission date of 9/14/14 with diagnoses that included, but were not limited to: dementia, difficulty swallowing, convulsions, depression and psychosis.

Resident #10's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/6/17, coded Resident #10 as being unable to complete the BIMS (brief interview for mental status). The staff assessment of Resident #10's cognitive status was coded as a "3" (three) indicating that Resident #10 was severely cognitively impaired with daily decision making. Resident #10 was also coded as requiring extensive assistance of one to two staff members for all activities of daily

and he did not give any new orders.

2. The Director of Clinical Services or designee has reviewed current resident's physician orders to ensure the physician was notified of results.
3. The Director of Clinical Services or designee re-educated licensed nursing staff on ensuring physician orders are written prior to the resident receiving lab services.

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living and as rarely understanding or being understood when communicating with others.

A review of Resident #10's clinical record revealed a laboratory result for a BMP dated 4/5/17 without a corresponding physician order.

A review of Resident #10's physician order summary dated 8/31/17 revealed, in part, the following laboratory orders; "Labs: BMP every 6 (six) months (may and Nov (November))."

A request was made of the facility staff to provide evidence that an order was received to obtain the BMP on 4/5/17.

On 9/27/17 at 4:35 p.m., ASM (administrative staff member) #2, the director of nursing/clinical services, stated that she was unable to locate an order in Resident #10's clinical record for the 4/5/17 BMP. When asked if an order was required to obtain a laboratory test, ASM #2 stated that it was required.

On 9/28/17 at 7:30 a.m., ASM #1, the executive director, was made aware of the above concern. A policy was requested at this time regarding collecting laboratory tests.

A review of the facility document titled "Laboratory, Diagnostic and X-Ray" revealed, in part, the following documentation; "Procedure: Obtain a physician's order for laboratory work, diagnostic testing and x-ray."

No further information was provided prior to the end of the survey process.

[1] BMP is a blood test that measures your sugar

4. The Director of Clinical Services and or designee to conduct quality monitoring of physician orders. Quality monitoring to be conducted 3X a week per week for 4 weeks to ensure compliance and then 1X a week for 4 weeks then quarterly thereafter. Quality Monitoring schedule to be modified based on findings of quality reviews. The results of the quality monitoring to be reviewed a the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis and further recommendations.
5. November 14, 2017

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F 504	Continued From page 224 (glucose) level, electrolyte and fluid balance, and kidney camera.gif function. This information was obtained from the following website; http://www.webmd.com/a-to-z-guides/tc/basic-metabolic-panel-topic-overview	F 504	F507 1. The Depakote level results dated 8/30/17 was filed in resident #1's clinical record and the Depakote level was within normal limits. The CBC (complete blood count) results dated 7/5/17 for resident #17 has been filed in the resident's clinical record and the CBC was within normal limits. 2. Medical Records has reviewed current residents' clinical records for labs filed in the clinical record for the past year. 3. The Administrator and or designee re-educated	
F 507 SS=D	483.50(a)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS (a) Laboratory Services (2) The facility must- (iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. 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 file laboratory results in the clinical record for two of 34 residents in the survey sample, Residents #1 and #17. 1. The facility staff failed to file Resident #1's Depakote level results dated 8/30/17 in the clinical record. 2. The facility staff failed to file Resident #17's CBC (complete blood count) results dated 7/5/17 in the clinical record. The findings include: 1. The facility staff failed to file Resident #1's Depakote level (1) results dated 8/30/17 in the clinical record.	F 507		

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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F 507	Continued From page 225	F 507		

Resident #1 was admitted to the facility on 3/28/16. Resident #1's diagnoses included but were not limited to: repeated falls, dementia and blindness. Resident #1's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 8/4/17, coded the resident's cognitive skills for daily decision making as severely impaired.

Review of Resident #1's clinical record revealed a physician's order dated 8/21/17 for a Depakote level to be obtained on 8/30/17. Further review of the resident's clinical record failed to reveal the results of a Depakote level obtained on 8/30/17.

On 9/27/17 at 12:05 p.m., per this surveyor's request, ASM (administrative staff member) #1 (the director of nursing/clinical services) presented the results of a Depakote level dated 8/30/17. The fax date at the top of the results was 9/27/17. ASM #2 stated she had the results faxed to the facility because she looked in the clinical record for the results but didn't see them.

On 9/27/17 at 5:19 p.m. an interview was conducted with LPN (licensed practical nurse) #6 (unit manager) regarding the filing of laboratory results in the clinical record. LPN #6 stated, "Sometimes I have to do it. It's an ongoing process. Nurses try to get to it. I go through the doctor's book and clean out the ones signed. We file as many as we can."

On 9/27/17 at 6:10 p.m. ASM #1 (the executive director/administrator), ASM #2 and ASM #3 (the regional director of clinical services) were made aware of the above concern.

Medical records staff on filing labs on the clinical records to ensure compliance is attained and maintained regarding filing labs on clinical records.

4. The Administrator and or designee to conduct Quality monitoring of filing labs in the clinical records. Quality monitoring to be conducted 3X a week per week for 4 weeks to ensure compliance and then 1X a week per month and then quarterly thereafter.

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The facility policy titled, "Laboratory, Diagnostic and X-Ray" documented, "Laboratory work, diagnostic testing and x-rays to be filed in the medical record..."

No further information was presented prior to exit.

(1) Depakote is used to treat seizures, certain mood disorders and migraine headaches. A Depakote level is a blood test used the amount of the medication in the blood to ensure a therapeutic drug level. This information was obtained from the websites: https://medlineplus.gov/druginfo/meds/a682412.html and https://medlineplus.gov/ency/article/003430.htm

2. The facility staff failed to file Resident #17's CBC (complete blood count) (1) results dated 7/5/17 in the clinical record.

Resident #17 was admitted to the facility on 1/28/17. Resident #17's diagnoses included but were not limited to: fractured vertebrae, diabetes and heart failure. Resident #17's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/7/17, coded the resident as being cognitively intact.

Review of Resident #17's clinical record revealed a physician's order dated 7/3/17 for a CBC on 7/5/17. Further review of Resident #17's clinical record failed to reveal the results of the CBC obtained on 7/5/17.

On 9/27/17 at 5:19 p.m. an interview was

Quality monitoring schedule to be modified based on findings of quality reviews. The results of the quality monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis and further recommendations.

5. November 14, 2017

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conducted with LPN (licensed practical nurse) #6 (unit manager) regarding the filing of laboratory results in the clinical record. LPN #6 stated, "Sometimes I have to do it. It's an ongoing process. Nurses try to get to it. I go through the doctor's book and clean out the ones signed. We file as many as we can."

On 9/28/17 at 2:35 p.m., per this surveyor's request, ASM (administrative staff member) #1 (the executive director/administrator), presented the results for Resident #17's CBC obtained on 7/5/17. The fax date at the top of the results was 9/28/17. ASM #1 confirmed the results were faxed to the facility and were not present in the clinical record.

On 9/29/17 at 9:45 a.m., ASM #1 and ASM #2 (the director of clinical services/nursing) were made aware of the above concern.

No further information was presented prior to exit.

(1) "A complete blood count (CBC) test measures the following:
- The number of red blood cells (RBC count)
- The number of white blood cells (WBC count)
- The total amount of hemoglobin in the blood
- The fraction of the blood composed of red blood cells (hematocrit)..." This information was obtained from the website: https://medlineplus.gov/ency/article/003642.htm

F 513 SS=D 483.50(b)(2)(iv) X-RAY/DIAGNOSTIC REPORT IN RECORD-SIGN/DATED — F 513

(b) Radiology and other diagnostic services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 513	Continued From page 228	F 513		

(2) The facility must-

(iv) File in the resident's clinical record signed and dated reports of radiologic and other diagnostic 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 file x-ray reports in the clinical record for two of 34 residents in the survey sample, Resident #1.

The facility staff failed to file Resident #1's chest x-ray results dated 9/19/17 in the resident's clinical record.

The findings include:

Resident #1 was admitted to the facility on 3/28/16. Resident #1's diagnoses included but were not limited to: repeated falls, dementia and blindness. Resident #1's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 8/4/17, coded the resident's cognitive skills for daily decision making as severely impaired.

Review of Resident #1's clinical record revealed a physician's order dated 9/18/17 for a STAT (immediate) chest x-ray. Further review of Resident #1's clinical record failed to reveal the results of the chest x-ray.

On 9/27/17 at 12:05 p.m., per this surveyor's request, ASM (administrative staff member) #1 (the director of clinical services/nursing)

F513

1. The chest x-ray dated 9/19/17 for resident #1 has been filed in the resident's clinical record.
2. Medical Records has reviewed current resident's clinical records for x-rays filed in the clinical record for the past year.
3. The Administrator and or designee re-educated Medical Records staff on filing x-ray results timely to include newly hired Medical Records Coordinator to ensure compliance is attained and maintained regarding filing labs on clinical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 513	Continued From page 229 presented the results of a chest x-ray dated 9/19/17. The fax date at the top of the results was 9/27/17. ASM #2 stated she had the results faxed to the facility because she looked in the clinical record for the results but didn't see them. On 9/27/17 at 5:19 p.m. an interview was conducted with LPN (licensed practical nurse) #6 (unit manager) regarding the filing of x-ray results in the clinical record. LPN #6 stated, "Sometimes I have to do it. It's an ongoing process. Nurses try to get to it. I go through the doctor's book and clean out the ones signed. We file as many as we can." On 9/27/17 at 6:10 p.m. ASM #1 (the executive director/administrator), ASM #2 and ASM #3 (the regional director of clinical services) were made aware of the above concern. The facility policy titled,"Laboratory, Diagnostic and X-Ray" documented, "Laboratory work, diagnostic testing and x-rays to be filed in the medical record..." No further information was presented prior to exit.	F 513	4. The Administrator and or designee to conduct Quality monitoring of filing of x-ray results in the clinical record. Quality Monitoring to be conducted 3X a week per week for 4 weeks to ensure compliance and then 1X a week per month and then quarterly thereafter. Quality monitoring schedule to be modified based on findings of quality reviews. The results of the quality monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis and further recommendations. 5. Date of compliance	
F 514 SS=E	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 514		

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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F 514	Continued From page 230 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure a complete and accurate clinical record for five of 34 residents in the survey sample, Residents #4, #5, #9, #13 and #32. 1. The facility staff failed to document the treatment administration for Resident #4. 2. The facility staff failed to maintain Resident #5's July 2017 and August 2017 MAR's (medication administration record) on the clinical	F 514	F514 1. Resident # 4 receives treatments per physician orders. Residents Treatment Administration Record (TAR) has treatments documented as ordered. The treatment administration for resident #4 has been documented. Resident #5's July 2017 and August 2017 Medication Administration Record (MAR) is currently in the Resident's clinical record. Resident #9's June 2017 MAR is in the Resident's clinical record. Resident number 13's June 2017, July 2017 and August	

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	495362	A. BUILDING _____ B. WING _____	C 09/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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
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record.

3. The facility staff failed to maintain Resident #9's June 2017 MAR's on the clinical record.

4. The facility staff failed to maintain Resident #13's June 2017, July 2017, and August 2017 MAR's on the clinical record.

5. The facility staff failed to file Resident #32's June 2017 MAR (medication administration record) in the resident's clinical record.

The findings include:

1. The facility staff failed to document the treatment administration for Resident #4.

Resident #4 was admitted to the facility on 7/20/15 with a readmission on 10/30/15 with diagnoses that included, but were not limited to: schizophrenia (a group of mental disorders characterized by gross distortions of reality, withdrawal from social contacts and disturbances of thought, language, perception and emotional response (1)), paraplegia, edema, suicide attempt, traumatic brain injury, high blood pressure and drug overdose. Resident #4 was 47 years old.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date (ARD) of 8/28/17, coded the resident as being cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance for most of his activities of daily living. In Section M - Skin Conditions, the resident was coded as having one

2017 is currently in the Resident's clinical record. Resident #32's June 2017 MAR is currently in the residents clinical record.

2. Medical Records has reviewed current residents clinical records for MAR's being filed in the clinical record for the past 3 months.
3. The Administrator and or designee re-educated Medical Records staff including newly hired Medical Record Coordinator on filing MARS in the clinical record to ensure compliance is attained and maintained regarding filing three months of MARS on the clinical records.

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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F 514	Continued From page 232 stage III pressure ulcer and one Stage IV pressure ulcer. The dimensions of the unhealed Stage III or Stage IV pressure ulcer documented, 5.5 cm (centimeters) in length, 8.6 cm in width, and 5.4 cm in depth. It was coded as being "eschar - black, brown or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin. The MDS assessment, a quarterly assessment, with an ARD of 7/5/17, did not code the resident in Section M as having any pressure ulcers. Review of the June 2017 TAR (treatment administration record) documented, "Clean with normal saline apply bacitracin and cover." There was no start date on the order. The first documented date was on 6/19/17. There were blanks on 6/23/17, 6/26/17, 6/27/17 and 6/30/17, where the staff were to initial in the box that the treatment had been administered. An interview was conducted with LPN (licensed practical nurse) #15 on 9/29/17 at 8:23 a.m. LPN #15 was asked to review the June TAR for Resident #4. When asked what the blank boxes on the treatment orders indicate, LPN #15 stated, "If nothing is in the box, then it's either someone didn't sign it or it wasn't done." An interview was conducted with LPN #6, the unit manager, on 9/29/17 at 8:24 a.m. LPN #6 was asked to review the June TAR for Resident #4. When asked what the blank boxes on the treatment orders indicate, LPN #6 stated, "Blanks are if not documented, it's not done." An interview was conducted with ASM (administrative staff member) #2, the director of	F 514	4. The Administrator and or designee to conduct quality monitoring of maintaining the filing of MARS in the clinical record for the most current three months. Quality monitoring of MAR filing to be conducted 3X a week per week for 4 weeks to ensure compliance and then 1X a week per month and then quarterly thereafter. Quality monitoring schedule to be modified based on findings of quality reviews. The results of the quality monitoring to be reviewed a the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis and further recommendations. 5. November 14, 2017	

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clinical services/nursing, on 9/29/17 at 8:35 a.m. When asked what blank boxes on the TAR indicate, ASM #2 stated, "It's either the treatment was done and not charted or the treatment was not done."

The facility policy, "Clinical/Medical Records" documented in part, "Clinical Records are maintained in accordance with professional practice standards to provide complete and accurate information on each resident for continuity of care. The purpose of the clinical record is to document the course of the resident's plan of care and to provide a medium of communication among health care professionals involved in this care."

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

ASM #2 was made aware of the above concern on 9/29/17 at 8:35 a.m. No further information was provided by completion of the survey.

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(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition; Rothenberg and Chapman; page 522.

2. The facility staff failed to maintain Resident #5's July 2017 and August 2017 MAR's (medication administration record) on the clinical record.

Resident #5 was admitted to the facility on 4/28/14 with the diagnoses of but not limited to: heart disease, dysphasia, epilepsy, diabetes, high blood pressure, urinary retention, alcohol abuse, chronic kidney disease, and coronary artery disease. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 7/27/17. Resident #5 was coded as being cognitively intact in ability to make daily life decisions. The resident was coded requiring total care for bathing; extensive care for hygiene, transfers, and dressing; supervision for eating; as having a catheter for bladder and as incontinent of bowel.

A review of the clinical record was conducted to review the MAR's (Medication Administration Record) for June 2017, July 2017 and August 2017. The MARs were not filed on the chart. On 9/28/17 at 5:20 p.m., at the end of day meeting with the administrator/executive director ASM (administrative staff member) #1, Resident #15's MAR's were requested for review. On 9/29/17 at approximately 8:30 a.m., ASM #1 stated the July 2017 MAR's and August 2017 MAR's could not be located. She stated that a nurse that was fired was suspected of throwing documents away after she was fired.

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

3. The facility staff failed to maintain Resident #9's June 2017 MAR's on the clinical record.

Resident #9 was admitted to the facility on 4/19/17 with the diagnoses of but not limited to: altered mental status, dementia, delusional disorder, borderline personality disorder, depression, anxiety, chronic kidney disease, stroke, and cataracts. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 7/27/17. Resident #9 was coded as being moderately impaired in ability to make daily life decisions, scoring a 9 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring extensive assistance for bathing; supervision for hygiene, eating and ambulation; as independent for transfers; and continent of bowel and bladder.

A review of the clinical record was conducted to review Resident #9's MAR's (Medication Administration Record) for June 2017, July 2017 and August 2017. They were not filed on the chart. On 9/28/17 at 5:20 p.m., at the end-of day meeting with the Administrator/Executive Director, ASM #1, Resident #9's MAR's were requested for review. On 9/29/17 at approximately 8:30 a.m., the ASM #1 stated the June 2017 MAR's could not be located. She stated that a nurse that was fired was suspected of throwing documents away after she was fired.

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

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4. The facility staff failed to maintain Resident #13's June 2017, July 2017, and August 2017 MAR's on the clinical record.

Resident #13 was admitted to the facility on 6/18/12 with the diagnoses of but not limited to: high blood pressure, chronic obstructive pulmonary disease, dysphagia, diabetes, adult failure to thrive, dementia, schizophrenia, schizo-affective disorder, depression, and bipolar disorder. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 8/3/17. Resident #13 was coded as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; limited assistance for hygiene and dressing; supervision for transfers, ambulation, and eating; and as usually continent of bowel and bladder.

A review of the clinical record was conducted to review Resident #13's MAR's (Medication Administration Record) for June 2017, July 2017 and August 2017. They were not filed on the chart. On 9/28/17 at 5:20 p.m., at the end of day meeting with the Administrator/Executive Director, ASM #1, the MAR's were requested for review. On 9/29/17 at approximately 8:30 a.m., the ASM #1, stated Resident #13's June 2017, July 2017 MAR's and August 2017 MAR's could not be located. She stated that a nurse that was fired was suspected of throwing documents away after she was fired.

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

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5. The facility staff failed to file Resident #32's June 2017 MAR (medication administration record) in the resident's clinical record.

Resident #32 was admitted to the facility on 5/26/17. Resident #32's diagnoses included but were not limited to: anxiety disorder, disease of the spinal cord and osteomyelitis (1). Resident #32's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/12/17, coded the resident as being cognitively intact.

Review of Resident #32's clinical record failed to reveal the resident's June 2017 MAR.

On 9/29/17 at 11:22 a.m., ASM (administrative staff member) #2 (the director of nursing/clinical services) stated she could not locate the above MAR. ASM #2 was asked the facility process for filing MARs. ASM #2 stated on the first day of the new month, the MAR from the previous month is sent to the MDS employees for review then the medical records employee is supposed to file the MAR.

On 9/29/17 at 11:29 a.m. ASM #1 (the executive director/administrator) and ASM #2 were made aware of the above concern.

No further information was presented prior to exit.

(1) Osteomyelitis is a bone infection. This information was obtained from the website: https://kidshealth.org/en/teens/osteomyelitis.html