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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/28/17 through 8/31/17. Corrections are required for compliance with the following Federal Long Term Care requirements. Complaints were investigated during the survey. The Life Safety Code survey/report will follow. The census in this 130 certified bed facility was 125 at the time of the survey. The survey sample consisted of 24 current resident reviews (Residents #1 through #21, and #27 through #29) and 5 closed record reviews (Residents #22 through #26).	F 000	 RECEIVED SEP 25 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 commence a new form of treatment); or	F 157	1. Resident has not demonstrated any adverse outcomes from not receiving evening medications on 8/23/17. The resident has been receiving medications as ordered. On 8/31/17, MD and RP were notified of the evening doses of medications that had not been administered on 8/23/17. Resident #4 has not demonstrated any adverse outcomes from the change in behavior. On 8/31/17 MD and RP were notified of change in behavior which occurred on 7/17/17. 2. A 100% audit of MAR's for current residents will be completed by Unit Managers, DON, ADON or designee to ensure medications are being administered as ordered, MD and RP are notified of omissions.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bethany D _____, NHA	Administrator	9-22-17

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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(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, clinical record review and facility document review it was determined that facility staff failed to notify the RP (responsible party) and physician of a change of condition for two of 29 residents in the survey sample, Resident #13.

1. The facility staff failed to notify the physician and RP (responsible party) when 4 p.m. medications were not administered to Resident #13 as ordered on 8/23/17.

DON, ADON, Unit Managers or designee will review clinical documentations daily 5 times/week to ensure MD and RP are notified of changes in residents' behaviors.

3. Nursing staff (RN and LPN) will be re-educated by ADON, Unit Managers or designee on the importance of communicating medication omission (s) to MD and RP.

Staff will be re-educated to notify MD and RP of changes in a resident's behavior.

4. Audits of MARs will be completed by DON; ADON; Unit Managers and/or designee as follow; 10% of MARs will be audited 2 times per week x 4 weeks; weekly x 4 weeks and every-other-week x 1 month to ensure medications are being administered as ordered, MD and RP are notified of omissions.

DON, ADON or designee will randomly audit clinical records weekly to ensure MD and RP are notified of changes in residents' behaviors.

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2. The facility staff failed to notify the physician and responsible party (RP) of a change in behavior for Resident #4.

The findings include:

1. Resident #13 was admitted to the facility on 9/10/16 with diagnoses that included but were not limited to Alzheimer's disease, high cholesterol, anxiety disorder, and high blood pressure. Resident #13's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 6/18/17. Resident #13 was coded as being severely impaired in cognitive function scoring 03 out of 15 on the BIMS (brief interview for mental status) exam. Resident #13 was coded as requiring supervision with transfers, ambulation, and eating; and limited assistance with toileting and dressing.

Review of Resident #13's nursing notes revealed a note dated 8/23/17 that documented the following: "Patient found to have not taken 4 pm medications that were given by previous nurse. These meds (medications) were sitting in a cup at patient's bedside. Nurse that gave meds was notified by CNA (certified nursing assistant). This nurse observed and destroyed medications." This note was written by LPN (licensed practical nurse) #16.

Review of Resident #13's August 2017 MAR (medication administration record) revealed a circle with an initial around the signature on 8/23/17 for the following 4 p.m. medications:
" Oxcarbazepine [1]150 mg (milligrams) 0.5 tablet(s) by mouth three times daily for mood d/o

Variances in these audits will be investigated and corrections made as appropriate. An analysis of the audits will be provided to the QA Committee for additional oversight and recommendations.

5. The facility dutifully alleges compliance of these tasks on or before 10/15/2017.

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(disorder)
" Depakote [2] 125 mg 3 capsules by mouth three times a day for mood."

There was no evidence that the physician and responsible party were made aware of the missed medications.

Review of the nursing schedule dated 8/23/17 revealed the 3-11 unit manager of north unit was on a medication cart until the agency nurse, LPN#16, arrived to the unit at 5:15 p.m.

On 8/30/17 at 9:59 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked the process for administering medications to residents especially on the locked unit, LPN #1 stated nurses should never leave the room before the resident finishes taking all their medications. LPN #1 stated nurses have to ensure the resident takes all medications and is not pocketing pills. LPN #1 also stated there were a lot of wanderers on the locked unit that go into other people's room. When asked about the process followed if she were to find medications in a medication cup in a resident's room, LPN #1 stated that she would remove them, notify the MD (medical doctor), try to identify the medications, and come up with a plan such as monitoring. LPN #1 stated that a medication error report would be completed and the family would be notified. LPN #1 stated that MD/RP notification should be documented in a nursing note.

On 8/30/17 at 5:00 p.m., an interview was conducted with LPN (licensed practical nurse) #14. When asked the process for administering medications to residents, LPN #14 stated that she would give the medication in a medication cup

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and wait for the resident to take all medications before leaving the room. When asked if Resident #13 was allowed to self-administer medications, LPN #14 stated that she was not. When asked if she could recall working on 8/23/17 with Resident #13 on the 3-11 shift, LPN #14 stated she wasn't sure because she works every shift at the facility. When asked if she could recall leaving a cup full of medications next to Resident #13's bedside, LPN #14 stated, "I never leave medications in the rooms." When asked if it was her initials documented on Resident #13's August MAR (medication administration record) for 8/23/17, LPN #14 stated, "It appears to be my initials." When asked what circled initials meant on the MAR, LPN #14 stated that it meant that the medication was not given. LPN #14 could not remember why her initials were circled. LPN #14 could not remember the events of 8/23/17.

On 8/30/17 at 5:26 p.m., an interview was conducted with LPN #16, the nurse who wrote the note on 8/23/17. When asked if she could recall the events of 8/23/17, LPN #16 stated, "I don't recall seeing that. I don't recall writing that note."

On 8/30/17 at 5:30 p.m., an interview was conducted with LPN #4, the unit manager. LPN #4 stated that she had seen the note on 8/23/17 and was trying to get a statement from both nurses to do a medication error report. LPN #4 stated that this was the first day LPN #14 was back from being sick and she was going to get her statement. LPN #4 stated when she called LPN #16 to get a statement, LPN #16 stated that she could not remember seeing medications in a cup or writing the above note. LPN #4 stated that she could not figure out what actually happened. LPN #4 stated if the medication really wasn't

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given like the MAR indicated, a reason why the meds were not administered would be documented on the back of the MAR. LPN #4 stated she believed that the cup of medications were found by LPN #16 and in response LPN #16 circled LPN #14 initials to show the medications were not given. LPN #4 could not say for sure what she believed happened was what actually happened. When asked if the physician and responsible party should be notified if medications are not administered, LPN #4 stated yes. When asked if the physician was notified, LPN #4 stated that she was not sure. LPN #4 stated that she did not notify the physician or family.

On 8/31/17 at 8:34 a.m., an interview was conducted with ASM #5, the physician. ASM #5 could not recall being notified of Resident #13's missing her 4 p.m. medications.

On 8/31/17 at 9:00 a.m., ASM #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #4, the administrator in training, were made aware of the above concerns.

A policy could not be provided on RP notification. The facility policy titled, "Notification of Physicians for Clinical Problems" documents in part the following: "Non-Immediate Notification (sub acute) problems. The following types of problems should be reported to the physician, but not on an immediate basis. Non-immediate implies that the physician should be informed of the situation or event, but not immediately. Other ...3) Medication errors that do not require immediate notification."

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[1] Oxcarbazepine-used alone or in combination with other medications for the treatment of seizure disorders. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011528/.
[2] Depakote- used to treat seizures and also used to treat bipolar disorder. This information was obtained from The National Institutes of Health https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012594/?report=details.

2. The facility staff failed to notify the physician and responsible party (RP) of a change in behavior for Resident #4.

Resident #4 was admitted to the facility on 3/22/17 with diagnoses that included but were not limited to: dementia, high blood pressure and anxiety. The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/2/17 coded the resident have having scored a three out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely cognitively impaired. The resident was coded as requiring minimal assistance with activities of daily living. In section E -- Behavior, the resident was coded as not having any behaviors.

Review of the care plan created on 8/29/17 documented, "Focus. Behaviors--resident at times will ridicule other (sic). Intervention. redirect as resident will allow."

Review of the nurse's notes dated 7/17/17 at

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11:06 p.m. documented, "RESIDENT CONSTANTLY WITH A MALE RESIDENT AND WOULD ATTEMPT TO GO IN A ROOM TOGETHER; NEEDS CONSTANT REDIRECTION FROM STAFF TO NOT TOUCH AND BE INAPPROPRIATE WITH ANOTHER MALE RESIDENT; WHEN STAFF EXPLAINS THE REASON, RESIDENT WOULD GET AGGRESSIVE AND DEFENSIVE; STAFF ALWAYS ON ALERT WITH RESIDENT AND ANOTHER MALE RESIDENT TO ENSURE THEY DO NOT GO IN A ROOM ALONE OR EXHIBIT SEXUAL BEHAVIOR." There was no documentation that the physician or RP had been notified of the behavior.

Review of the nurse's notes dated 7/19/17 at 6:31 a.m. documented, "SLEPT QUIETY (sic) THIS SHIFT; NO INAPPROPRIATE OR NEGATIVE BEHAVIOR NOTED..."

A telephone interview was conducted on 8/30/17 at 1:45 p.m. with LPN (licensed practical nurse) #12, the nurse who wrote the note for Resident #4. When asked if the physician and RP would be notified of the resident's behavior, LPN #12 stated yes. When asked if they had been notified, LPN #12 couldn't remember.

On 8/30/17 at 4:25 p.m. ASM #1, the administrator and ASM #2 the director of nursing were made aware of the findings.

An interview was conducted on 8/31/17 at 10:45 a.m. with ASM (administrative staff member) #2, the assistant director of nursing. ASM #2 was asked to review the 7/17/17 nurse's note for Resident #4. When asked what process staff should follow when a resident exhibits sexual

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F 157	Continued From page 8 behaviors, ASM #2 stated, "They should further document in the chart. There would be a care plan update for anything that was done." When asked if anyone would be notified of the behavior, ASM #2 stated, "In a situation like that I would notify the family and physician." Review of the facility's policy titled, "Change in a Resident's Condition or Status" documented, "Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status...Policy Interpretation and Implementation. 1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been: d. A significant change in the resident's physical/emotional/mental condition..." 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 is responsible for directing the medical treatment of a patient.	F 157		
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to-	F 167	**Right to survey Results** 1. On 8-30-17 the survey results sign in the front lobby was updated to	

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(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 the facility staff failed to post a notice of the availability of the last three preceding year's survey results and their corresponding plan of corrections.

A notice was not posted to the residents and responsible parties that the results of the previous three years of survey results, with the plan of corrections, were available for review.

state that three (3) years of survey results with plan of corrections were available for review.

2. All signs related to the state survey results will be audited for correct wording.

3. The nursing home administrator will be educated on correct sign wording for the survey postings by the corporate compliance officer.

4. An audit of survey result postings will be completed 2 times a week by the executive assistant or designee two times a week for three weeks and then 1 time a week for an additional 3 weeks. Results will be brought to the facility QQA meeting.

5. Corrective action will be accomplished October 15th 2017.

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F 167	Continued From page 10 The findings include: On 8/31/17 at 6:15 p.m., an observation of the survey results was conducted. The survey binder was located on a low shelf in the front lobby with the words "Survey Results" posted on the binder. The survey binder contained the last three years of survey results. A small sign approximately 5 x 7 inches was located above the shelf that documented the following: "Survey Results located in binder below." The sign failed to post notice that the last three years of survey results were located in the survey binder and were available for review. Further observations failed to reveal any posted notice to the residents and responsible parties that the results of the previous three years of survey results, with the plan of corrections, were available for review. On 8/30/17 at 6:22 p.m., an interview was conducted with OSM (other staff member) #12, medical records. OSM #12 stated that she was responsible for maintaining the survey results binder. OSM #12 stated she was not aware the survey sign had to specify that all three years of survey results were available. OSM #12 took the sign down and created a new sign. On 8/31/17 at 9:00 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #4, the administrator in training were made aware of the above findings. No further information was presented prior to exit. A facility policy could not be provided.	F 167		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225	**Reporting Abuse, Neglect** 1. I. Facility Reported Incident was	

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F 225	Continued From page 11 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve	F 225	Continued From page 11 sent to appropriate agencies on 9-20-2017 for residents number 13 and number 12. II. Facility Reported Incident was sent to State agencies on 9-20-2017 for residents number 13 and number 12. III. Facility Reported Incident was sent to appropriate State agencies on 12-18-16 for resident number 11 in the required 24 hour reporting period. Staff member was educated on 12-18-16 on reporting allegations of abuse or neglect to supervisor immediately. 2. All resident to resident occurrences for the previous three months will be audited to determine whether or not they need to be reported at Facility Reported Incidents. 3. Staff education will be completed on timely reporting. The facility administrator and director of nursing will be educated on Facility Reported Incident reporting by the corporate compliance officer.	

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F 225	Continued From page 12 abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that facility staff failed to ensure allegations of abuse were immediately reported to the state agency and other officials in accordance with State law through established procedures for three of 29 residents in the survey sample, Resident #12, #13, and Resident #11. 1. The facility staff failed to report a sexual encounter that occurred on 7/19/17 between Resident #12 and Resident #13 2. The facility staff failed to report a sexual encounter that occurred on 7/19/17 between	F 225	Continued From page 12 4. Resident to resident and resident to staff occurrences will be reviewed daily (M-F) for 12 weeks by the DON or designee to ensure that reportable occurrences are reported timely and appropriately. 5. Corrective action will be accomplished October 15th 2017.	

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Resident #13 and Resident #12 to the appropriate state agencies.

3. The facility staff failed to immediately report an allegation of staff to resident abuse with Resident #11 to the facility administrator. The staff to resident incident was observed on 12-17-16 at 4:30 p.m., but was not reported to the facility administrator until 12/18/16.

The findings include:

1. The facility staff failed to report a sexual encounter that occurred on 7/19/17 between Resident #12 and Resident #13 to the appropriate state agencies.

Resident #12 was admitted to the facility on 3/8/16 with diagnoses that included but were not limited to Alzheimer's disease, hyperlipidemia, high blood pressure, and muscle weakness. Resident #12's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 6/16/17. Resident #12's 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 supervision for all ADLS (activities of daily living).

Review of Resident #12's chart revealed the first sexual encounter with Resident #12 occurred on 6/2/17. The following was documented in a nursing note: "called to room by cna (sic) (certified nursing assistant) who observed resident (Resident #12) receiving oral sex from resident number 4782 (Resident #13) residents (sic) were separated (sic) skin assessment done (sic) no marks on penis vital signs 126/78 (blood

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pressure), 70 (pulse), 20 (respirations), 98.6 (temp). np (nurse practitioner) notified unable to reach rp (responsible party) will continue to try to reach rp (responsible party)."

The above incident was reported to the appropriate state agencies in a timely manner.

Further review of Resident #12's clinical record revealed that his room was changed to a different hallway away from Resident #13. The following note was documented: "New T.O. (telephone order) filled out et (sic) faxed to pharmacy to transfer resident et (sic) belongings from 131 to 162 ...Resident oriented to new room et (sic) introduced to roommate. Res (resident) smiling et (sic) seems happy with placement at this time."

Review of Resident #12's nursing notes revealed a second sexual encounter with Resident #13 on 7/19/17. The following was documented: "Resident (Resident #12) observed in his room sitting beside resident 4782 (Resident #13) with his hands in 4782 (Resident #13's) pants. Residents were immediately separated. Second contact (Name of contact) and RP (responsible party) notified ..."

Review of the incident report dated 7/19/17 documented the following: "Resident 4074 (Resident #12) was sitting next to resident (Resident #13) in the room and he had his hands down her pants ...Resident with unpredictable behaviors r/t (related to) dementia."

A FRI (facility reported incident) could not be found regarding the above event.

Review of a social worker note dated 7/21/17 at

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3:50 p.m. documented the following: "Social work was asked to contact RP (responsible party) re (regarding): reported touching of a female res. (resident)/hands down pants. Social Worker attempted to contact RP (responsible party) x 3 with (zero) ability to leave mssg (message)/phone disconnected. SW spoke with emergency contact #2 who is aware of incident and stated comfort with staff intervention 1. Privacy in room 2. redirection (sic)/discourage behavior in public places. Emergency contact #2 said "I'm fine with it." She was asked to be a part of a conference call 7/24 at 11:30 to review with nursing staff-in agreement."

Further review of the social work notes revealed a note dated 7/24/17 documenting that an IDT (interdisciplinary) meeting was held with Resident #12's RP, the DON (director of nursing), Administrator, Geri-psych, NP (nurse practitioner), and the unit manager. The RP was documented as being fine with Resident #12 and Resident #13's relationship.

No further incidences have occurred between Resident #12 and Resident #13.

On 8/30/17 at 9:59 a.m., an interview was conducted with LPN (licensed practical nurse) #6. When asked the process if facility staff were to see two residents engaging in sexual activity, LPN #6 stated that initially she would separate the residents to determine if both residents are cognitively intact and that both residents consent to the behavior. LPN #6 stated that nursing staff should complete an incident report and notify the responsible parties if the residents are not their own representative. LPN #6 stated that she would also notify the medical doctor and

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administrator. LPN #6 stated that administration would initiate an investigation. LPN #6 stated that an investigation would be conducted to ensure there was no abuse between the residents engaging in the behavior. LPN #6 stated that if it is determined that both residents consent to the sexual activity, nursing staff should provide privacy. LPN #6 stated if two residents are not cognitively intact, she would separate the residents and follow the same process. LPN #6 stated that the interdisciplinary team would also meet to determine interventions to put into place to either keep the residents separated or to offer privacy for the residents during this behavior. When asked how she could describe Resident #12's and Resident #13's relationship, LPN #6 stated that the two residents are always walking around and holding hands in the hallways and dining room. LPN #6 stated that this relationship was addressed with the families and the families were ok it.

On 8/30/17 at 10:30 a.m., an interview was conducted with CNA (certified nursing assistant) #1, a CNA who frequently works with Resident #13 and Resident #12. When asked the process if she were to find two residents engaging in sexual behavior, CNA #1 stated that it depended on the residents. CNA #1 stated that for some residents it is ok to provide privacy during the encounter and other residents may have to be separated. CNA #1 stated that she would also notify the nurse if she found two residents engaging in sexual behaviors. When asked how she would know which residents would have to be separated, CNA #1 stated, "I would ask the nurses." CNA #1 stated that Resident #12 and Resident #13 were to be provided privacy when engaging in any sexual behavior with each other.

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On 8/31/17 at 9:00 a.m. an interview was conducted with ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing). When asked their role if they were to be made aware of a resident to resident sexual encounter, ASM #2 stated that she would first expect her nurses to separate the residents and do an incident report and report the incident to her immediately. ASM #2 stated that she would initiate an investigation and report the incident to the administrator. ASM #1, the administrator stated that once the incident is reported to her, she would notify the appropriate state agencies such as the office of licensure and certification, ombudsmen, adult protective services etc. and submit a FRI (facility reported incident). When asked the time frame to report a resident to resident sexual encounter or altercation, ASM #1 stated within 24 hours or 2 hours if abuse was found. ASM #1 stated a follow up would be sent to the appropriate state agencies within five working days. When asked why a FRI was not submitted for Resident #12 and #13 for the 7/19/17 sexual encounter, ASM #2 stated that the facility staff determined that the residents liked to be together and Geri-psychology had evaluated both residents and determined that there was no psychosocial harm allowing the residents to be together. ASM #1 stated that they had a meeting with both responsible parties and the social worker and everyone was on the same page to allow both residents to be together. When asked when this meeting occurred, ASM #1 stated that the meeting occurred right after the second incident. When asked when the responsible parties gave consent for the residents to be together, ASM #1 stated this happened right after the second

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incident. ASM #1 and ASM #2 were made aware that a note from a social worker documenting that the responsible parties gave consent to the sexual behavior was not until 7/24/17 (5 days after the 7/19/17 incident). Any evidence that the responsible parties gave permission for the residents to engage in sexual behavior prior to 7/19/17 was requested.

No further information could be presented prior to exit.

Review of the facility's abuse policy documents in part, the following: "3. Identification and Reporting a. Any allegation of abuse, involuntary seclusion, neglect, mistreatment, misappropriation of resident property, or the occurrence of any injury of unknown origin will be promptly reported to the supervisor in charge. The administrator or designee is to be informed immediately of all allegations c. Events such as bruises, skin tears, fall, inappropriate or abusive behaviors will be reported to the DON or designee. Pattern or trends will be identified that may constitute abuse. The information will be forwarded to the Administrator and an investigation will be initiated. 4. Response A. All allegations of abuse will be reported to appropriate state agencies immediately."

2. The facility staff failed to report a sexual encounter that occurred on 7/19/17 between Resident #13 and Resident #12 to the appropriate state agencies.

Resident #13 was admitted to the facility on 9/10/16 with diagnoses that included but were not

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limited to Alzheimer's disease, high cholesterol, anxiety disorder, and high blood pressure. Resident #13's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 6/18/17. Resident #13's was coded as being severely impaired in cognition scoring 03 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #13 was coded as requiring supervision with transfers, ambulation, and eating; and limited assistance with toileting and dressing.

Review of Resident #13's chart revealed the first sexual encounter with Resident #12 occurred on 6/2/17. The following was documented in a nursing note: "Called into room (room number) by cna (sic) (certified nursing assistant) who stated resident (Resident #13) was giving oral sex to male resident #4074 (Resident #12) upon his bed. On entering room, I noted both residents sitting upright on the side of bed fully clothed, they were calm and pleasant and resident (Resident #13) came readily with me to the day room. No distress noted. RP (responsible party) (Name of RP) left message to call (Name of facility). (Name of NP (nurse practitioner) made aware."

The above incident was reported to the appropriate state agencies in a timely manner.

Review of Resident #13's care plan dated 6/2/17 documented the following: "The resident is/has potential to be verbally and physically aggressive related r/t (related to) Dementia (sic) and Poor (sic) impulse control. Goal: The resident will not harm self or others through next review. Interventions: geri (sic) psych (psychology/psychiatry) as needed, redirect

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resident as she will allow."

Review of Resident #13's nursing notes revealed a second sexual encounter with Resident #12 on 7/19/17. The following note was documented, "Notified by housekeeper that resident (Resident #13) was seen in resident #4704 (Resident #12) room with his hands down her pants. They were immediately separated without incidence. Resident smiling and chatting in day room with other residents. (Name of N. P. [nurse practitioner]) made aware and message left for (Name of RP [responsible party]) to call (Name of facility)."

Review of the incident report dated 7/19/17 documented the following: "Resident 4074 (Resident #12) was sitting next to resident (Resident #13) in the room and he had his hands down her pants ...Resident (Name of Resident #13) with unpredictable behaviors r/t (related to) dementia."

A FRI (facility reported incident) could not be found regarding the above event.

On 7/21/17 at 3:24 p.m., a note from the social worker documented the following: "SW (social work) was asked to contact RP (responsible party) related to res (resident) reportedly with male res. who had his hands down her pants. RP aware and stating that he "is not surprised" res hx (history) with males in the past. RP stating that he is fine with male res (resident) being able to be with res. This worker told RP that res clearly likes this male attention he gives her. SW asked if RP was available to converse via phone on the matter with nursing as well -meeting set up at 11:00 a.m. 7/24. RP stated that he appreciates

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staff help with this and the direction presented for the f/u (follow up): 1. privacy (sic) to be given by drawing curtain in the room and 2. affection (sic) discouraged /redirected when in public spaces like the DR (dining room)."

On 7/24/17 the following note was written from the IDT (interdisciplinary meeting): "Mtg (meeting) held today with DON (Director of Nursing), NW (north wing) unit manager, Administrator, SW, RP and SW present. Purpose was to review incident and confirm RP in agreement with res. desire to have relationship with male res. He said that he isn't surprised and he's fine with how staff handle it."

On 8/30/17 at 9:59 a.m., an interview was conducted with LPN (licensed practical nurse) #6. When asked the process if facility staff were to see two residents engaging in sexual activity, LPN #6 stated that initially she would separate the residents to determine if both residents are cognitively intact and that both residents consent to the behavior. LPN #6 stated that nursing staff should complete an incident report and notify the responsible parties if the residents are not their own representative. LPN #6 stated that she would also notify the medical doctor and administrator. LPN #6 stated that administration would initiate an investigation. LPN #6 stated that an investigation would be conducted to ensure there was no abuse between the residents engaging in the behavior. LPN #6 stated that if it is determined that both residents consent to the sexual activity, nursing staff should provide privacy. LPN #6 stated if two residents are not cognitively intact, she would separate the residents and follow the same process.
LPN #6 stated that the interdisciplinary team

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would also meet to determine interventions to put into place to either keep the residents separated or to offer privacy for the residents during this behavior. When asked how she could describe Resident #12's and Resident #13's relationship, LPN #6 stated that the two residents are always walking around and holding hands in the hallways and dining room. LPN #6 stated that this relationship was addressed with the families and the families were ok it.

On 8/30/17 at 10:30 a.m., an interview was conducted with CNA (certified nursing assistant) #1, a CNA who frequently works with Resident #13 and Resident #12. When asked the process if she were to find two residents engaging in sexual behavior, CNA #1 stated that it depended on the residents. CNA #1 stated that for some residents it is ok to provide privacy during the encounter and other residents may have to be separated. CNA #1 stated that she would also notify the nurse if she found two residents engaging in sexual behaviors. When asked how she would know which residents would have to be separated, CNA #1 stated, "I would ask the nurses." CNA #1 was stated that Resident #13 and Resident #12 were to be given privacy when they were engaging in sexual behavior with each other.

On 8/31/17 at 9:00 a.m. an interview was conducted with ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing). When asked their role if they were to be made aware of a resident to resident sexual encounter, ASM #2 stated that she would first expect her nurses to separate the residents and do an incident report and report the incident to her immediately. ASM #2 stated that

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she would initiate an investigation and report the incident to the administrator. ASM #1, the administrator stated that once the incident is reported to her, she would notify the appropriate state agencies such as the office of licensure and certification, ombudsmen, adult protective services etc. and submit a FRI (facility reported incident). When asked the time frame to report a resident to resident sexual encounter or altercation, ASM #1 stated within 24 hours or 2 hours if abuse was found. ASM stated a follow up would be sent to the appropriate state agencies within five working days. When asked why a FRI was not submitted for Resident #12 and #13 for the 7/19/17 sexual encounter, ASM #2 stated that the facility staff determined that the residents liked to be together and Geri-psychology had evaluated both residents and determined that there was no psychosocial harm allowing the residents to be together. ASM #1 stated that they had a meeting with both responsible parties and the social worker and everyone was on the same page to allow both residents to be together. When asked when this meeting occurred, ASM #1 stated that the meeting occurred right after the second incident. When asked when the responsible parties gave consent for the residents to be together, ASM #1 stated this happened right after the second incident. ASM #1 and ASM #2 were made aware that a note from a social worker documenting that the responsible parties gave consent to the sexual behavior was not until 7/24/17 (5 days after the 7/19/17 incident). Any evidence that the responsible parties gave permission for the residents to engage in sexual behavior prior to 7/19/17 was requested.

No further information was presented prior to exit.

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3. The facility staff failed to immediately report an allegation of staff to resident abuse with Resident #11 to the facility administrator. The staff to resident incident was observed on 12-17-16 at 4:30 p.m., but was not reported to the facility administrator until 12/18/16.

Resident #11 was admitted to the facility on 2/24/14 and readmitted on 2/22/16 with diagnoses that included but were not limited to major depressive disorder, muscle weakness, stroke, atrial fibrillation, and COPD (chronic obstructive pulmonary disease). Resident #11's most recent MDS (minimum data set) was quarterly assessment with an ARD (assessment reference date) of 8/7/17. Resident #11 was coded as being severely impaired in cognitive status scoring 99 out of 15 on the BIMS (brief interview for mental status exam). Resident #11 was coded as requiring supervision with ambulation, and locomotion; extensive assistance from one staff member with dressing; extensive assistance from two or more staff members with toileting, and personal hygiene; and limited assistance with meals.

Review of a Facility Reported Incident (FRI) dated 12/18/17 and reported to the appropriate state agencies on 12-18-17, documented the following: "Incident date: 12-17-16, Report date: 12-18-16. Resident Involved: (Name of Resident #11), Injuries: No, Incident Type: Allegation of abuse/mistreatment. Describe Incident, including location, and action taken: (Name of OSM (other staff member) #10, resident helper alleges that (Name of alleged resident helper) "smacked" the right hand of resident (Name of Resident #11) on

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12-17-16 at 4:30 p.m. for reaching for food-0 (zero) injuries."

Review of the witness statement by OSM #10 documented the following: " Date of statement; 12-18-16: I was in the dining room passing sandwich out and (Name of Resident #11) was walking around touching people food and (Name of alleged resident helper) smack his hand and told him no do not touch people food. happen (sic) on 12-17-16 around 4:30."

Review of the alleged resident helper's witness statement dated 12-18-17 documented in part, the following: "(Name of other resident) was sitting in dining room, (Name of Resident #11) reached for it, I did tap his hand, I did not smack him, this was a natural instinct, He was reaching for hot chocolate with medicine in it ...My intention is not to hurt anyone. The nurse was nowhere to be around."

Further review of the witness statements revealed a statement by the RN (registered nurse) supervisor that documented the following: "Date of statement: 12-18-16. Interview with (Name of OSM #10) R/T (related to) incident with (Name of alleged resident helper) 12-17-16. North Unit dining room between pt (patient) and (Name of alleged resident helper). (Name of OSM #10) stated that she heard a loud smack to (Name of Resident #11's) hand (right). (Name of Resident #11) was walking around and taking food. (Name of alleged resident helper) smacked his hand rather than redirecting pt. (Name of alleged resident helper) to be taken off duty until completion of investigation. (Name of LPN [licensed practical nurse] #4), unit manager aware and brought this to my attention."

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A witness statement from LPN #4, the unit manager could not be found in the investigation.

Further review of the investigation revealed education provided to OSM #10. The following was documented: "12-18-16. Reason for Education: Timely reporting of any and all witnessed incidents immediately; the seriousness of patient abuse. Items reviewed: pt (patient) abuse and neglect, what to report and when, how and to who (sic) immediately!"

Review of the follow up report created by the administrator dated 12/21/17 and sent to the appropriate state agencies on 12/21/17, documented in part, the following: " ...On 12/17/16 at 4:30 p.m. (Name of OSM #10), resident helper states that she was passing sandwiches in the dining room on the NW (North Wing) unit. (Name of Resident #11) walked over and grabbed another residents (sic) sandwich. (Name of alleged resident helper), "smacked" (Name of Resident #11) on the right hand and removed the sandwich. (Name of OSM #10) reported this to the UM (unit manager) on 12/18/16 and it was reported to me. (Name of alleged resident helper) was suspended pending the investigation and did not work 3-11 on 12/18. (Name of Resident #11) was assessed by nursing staff and did not have any apparent injuries. Geripsych (Geri psychology/psychiatry) was notified and (Resident #11) was seen with no negative outcomes was noted due to employee striking resident ...On 12/20/16 (Name of RN)/acting DON (Director of Nursing) and (Name of HR (human resources) Director called (Name of alleged resident helper) and told her that she would no longer have her position as resident

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helper on the North Wing Unit. (Name of alleged resident helper) was offered a desk job on the SW (south wing) unit answering phones and clerical work but has not confirmed whether or not she will accept the new position. (Name of OSM #10) was re-educated on reporting timely. Both (Named of OSM #10) and (Name of alleged CNA) (if she takes new position) will re-take abuse reporting on Relias."

Review of the employee file for the alleged resident helper revealed that she was no longer employed with the facility on 12/20/16. Further review of her employee file revealed that she had no criminal record prior to her hire date in 2013.

On 8/30/17 at 10:32 a.m., an interview was conducted with OSM #10, the resident helper. When asked her title at the facility, OSM #10 stated that she was a resident helper. OSM #10 stated that her job responsibilities included assisting the resident with meals, passing out snacks and making resident beds. OSM #10 stated that she was not allowed to provide any other resident care. When asked if she received training on abuse, OSM #10 stated that she had monthly in-services she had to complete on abuse training. When asked the process if she were to witness a staff member hitting a resident, OSM #10 stated that she would report the abuse immediately to the nurse on duty. When asked if she could recall the events on 12/17/16 between Resident #11 and a staff member, OSM #10 stated that she was in the dining room on evening shift passing out sandwiches when she saw Resident #11 trying to grab other people's food. OSM #10 stated that when Resident #11 went to reach for a sandwich, a resident helper slapped his hand away. OSM #10 stated that she

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reported it to the evening floor nurse the night it happened but could not remember the nurse she reported it to. OSM #10 stated that she reported the incident because he was being treated like a child. OSM #10 stated that she reported the incident to the unit manager (LPN #4) the next day (12/18/16) just to make sure she was aware. OSM #10 could not recall the resident reaching for a hot chocolate full of medicine.

On 8/30/17 at 11:06 a.m., an interview was conducted with LPN #4, the unit manager. When asked LPN #4 the process if she were to see a staff to resident altercation, LPN #4 stated that she would intervene immediately, assess the resident for injuries, have the staff member clock out until further investigation, create an incident report and report this incident to the DON (Director of Nursing), Administrator and Medical Doctor. LPN #4 stated that the administrator would be responsible for creating a FRI (facility reported incident). When asked when she expected her nurses to report an allegation of abuse, LPN #4 stated, "Immediately." When asked if she could recall the events of the staff to resident altercation between Resident #11 and the Resident helper, LPN #4 stated, "I can't tell you exactly what happened." LPN #4 stated that the incident was not reported to her until 12/18/16 (the next day) by OSM #10. LPN #4 stated that it was determined then that OSM #10 reported the incident late. LPN #4 stated that OSM #10 was counseled on reporting abuse immediately. LPN #4 stated that the staff member who slapped Resident no longer works for the facility. When asked if this staff member was reported to the department of health professions, LPN #4 stated, "Helpers don't have a certification or anything. Anyone can come in and fill out an application to

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F 225	Continued From page 29 be a resident helper and then go through training." On 8/31/17 at 9:00 a.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing), and ASM #4, the administrator in training were made aware of the above concerns. No further information was presented prior to exit. Review of the facility's abuse policy documents in part, the following: "3. Identification and Reporting a. Any allegation of abuse, involuntary seclusion, neglect, mistreatment, misappropriation of resident property, or the occurrence of any injury of unknown origin will be promptly reported to the supervisor in charge. The administrator or designee is to be informed immediately of all allegations. b. All employees have a duty to respect the rights of all residents, to treat them with dignity and to prevent others from violating their rights. Any employee who witnesses or has knowledge of an act of abuse to a resident is obligated to report such information to the Nurse in charge, Director of Nursing, or the Administrator."	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	F 226	**Reporting Abuse, Neglect** 1. I. Facility Reported Incident was sent to appropriate agencies on 9-20-2017 for residents number 13 and number 12. II. Facility Reported Incident was sent to State agencies on 9-20-2017 for residents number 13 and number 12.	

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(2) Establish policies and procedures to investigate any such allegations, and

(3) Include training as required at paragraph §483.95,

483.95
(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-

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

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

(c)(3) Dementia management and resident abuse prevention.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, and facility document review, it was determined that facility staff failed to implement abuse policies and report an allegation of abuse for three of 29 residents, Resident #13, #12, and #11.

1. For Resident #12 the facility staff failed to implement abuse policies to report a sexual encounter that occurred on 7/19/17 with Resident #13 to the appropriate state agencies.

2. For Resident #13, facility staff failed to implement abuse policies and report a sexual

III. Facility Reported Incident was sent to appropriate State agencies on 12-18-16 for resident number 11 in the required 24 hour reporting period. Staff member was educated on 12-18-16 on reporting allegations of abuse or neglect to supervisor immediately.

2. All resident to resident occurrences for the previous three months will be audited to determine whether or not they need to be reported at Facility Reported Incidents.

3. Staff education will be completed on timely reporting. The facility administrator and director of nursing will be educated on Facility Reported Incident reporting by the corporate compliance officer.

4. Resident to resident and resident to staff occurrences will be reviewed daily (M-F) for 12 weeks by the DON or designee to ensure that reportable occurrences are reported timely and appropriately.

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encounter that occurred on 7/19/17 with Resident #12 to the appropriate state agencies.

3. The facility staff failed to implement abuse policies and report an allegation of staff to resident abuse with Resident #11 in a timely manner. The staff to resident incident was observed on 12-17-16 at 4:30 p.m., but was not reported to the facility administrator until 12/18/16.

The findings include:

1. For Resident #12 the facility staff failed to implement abuse policies to report a sexual encounter that occurred on 7/19/17 with Resident #13 to the appropriate state agencies.

Resident #12 was admitted to the facility on 3/8/16 with diagnoses that included but were not limited to Alzheimer's disease, hyperlipidemia, high blood pressure, and muscle weakness. Resident #12's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 6/16/17. Resident #12's 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 supervision for all ADLS (activities of daily living).

Review of Resident #12's chart revealed the first sexual encounter with Resident #12 occurred on 6/2/17. The following was documented in a nursing note: "called to room by cna (sic) (certified nursing assistant) who observed resident (Resident #12) receiving oral sex from

5. Corrective action will be accomplished October 15th 2017.

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resident number 4782 (Resident #13) residents (sic) were separated (sic) skin assessment done (sic) no marks on penis vital signs 126/78 (blood pressure), 70 (pulse), 20 (respirations), 98.6 (temp). np (nurse practitioner) notified unable to reach rp (responsible party) will continue to try to reach rp (responsible party)."

The above incident was reported to the appropriate state agencies in a timely manner.

Further review of Resident #12's clinical record revealed that his room was changed to a different hallway away from Resident #13. The following note was documented: "New T.O. (telephone order) filled out et (sic) faxed to pharmacy to transfer resident et (sic) belongings from 131 to 162 ...Resident oriented to new room et (sic) introduced to roommate. Res (resident) smiling et (sic) seems happy with placement at this time."

Review of Resident #12's nursing notes revealed a second sexual encounter with Resident #13 on 7/19/17. The following was documented: "Resident (Resident #12) observed in his room sitting beside resident 4782 (Resident #13) with his hands in 4782 (Resident #13's) pants. Residents were immediately separated. Second contact (Name of contact) and RP (responsible party) notified ..."

Review of the incident report dated 7/19/17 documented the following: "Resident 4074 (Resident #12) was sitting next to resident (Resident #13) in the room and he had his hands down her pants ...Resident with unpredictable behaviors r/t (related to) dementia."

A FRI (facility reported incident) could not be

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found regarding the above event.

Review of a social worker note dated 7/21/17 at 3:50 p.m. documented the following: "Social work was asked to contact RP (responsible party) re (regarding): reported touching of a female res. (resident)/hands down pants. Social Worker attempted to contact RP (responsible party) x 3 with (zero) ability to leave mssg (message)/phone disconnected. SW spoke with emergency contact #2 who is aware of incident and stated comfort with staff intervention 1. Privacy in room 2. redirection (sic)/discourage behavior in public places. Emergency contact #2 said "I'm fine with it." She was asked to be a part of a conference call 7/24 at 11:30 to review with nursing staff-in agreement."

Further review of the social work notes revealed a note dated 7/24/17 documenting that an IDT (interdisciplinary) meeting was held with Resident #12's RP, the DON (director of nursing), Administrator, Geri-psych, NP (nurse practitioner), and the unit manager. The RP was documented as being fine with Resident #12 and Resident #13's relationship.

No further incidences have occurred between Resident #12 and Resident #13.

On 8/30/17 at 9:59 a.m., an interview was conducted with LPN (licensed practical nurse) #6. When asked the process if facility staff were to see two residents engaging in sexual activity, LPN #6 stated that initially she would separate the residents to determine if both residents are cognitively intact and that both residents consent to the behavior. LPN #6 stated that nursing staff should complete an incident report and notify the

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responsible parties if the residents are not their own representative. LPN #6 stated that she would also notify the medical doctor and administrator. LPN #6 stated that administration would initiate an investigation. LPN #6 stated that an investigation would be conducted to ensure there was no abuse between the residents engaging in the behavior. LPN #6 stated that if it is determined that both residents consent to the sexual activity, nursing staff should provide privacy. LPN #6 stated if two residents are not cognitively intact, she would separate the residents and follow the same process. LPN #6 stated that the interdisciplinary team would also meet to determine interventions to put into place to either keep the residents separated or to offer privacy for the residents during this behavior. When asked how she could describe Resident #12's and Resident #13's relationship, LPN #6 stated that the two residents are always walking around and holding hands in the hallways and dining room. LPN #6 stated that this relationship was addressed with the families and the families were ok it.

On 8/30/17 at 10:30 a.m., an interview was conducted with CNA (certified nursing assistant) #1, a CNA who frequently works with Resident #13 and Resident #12. When asked the process if she were to find two residents engaging in sexual behavior, CNA #1 stated that it depended on the residents. CNA #1 stated that for some residents it is ok to provide privacy during the encounter and other residents may have to be separated. CNA #1 stated that she would also notify the nurse if she found two residents engaging in sexual behaviors. When asked how she would know which residents would have to be separated, CNA #1 stated, "I would ask the

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nurses." CNA #1 stated that Resident #12 and Resident #13 were to be provided privacy when engaging in any sexual behavior with each other.

On 8/31/17 at 9:00 a.m. an interview was conducted with ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing). When asked their role if they were to be made aware of a resident to resident sexual encounter, ASM #2 stated that she would first expect her nurses to separate the residents and do an incident report and report the incident to her immediately. ASM #2 stated that she would initiate an investigation and report the incident to the administrator. ASM #1, the administrator stated that once the incident is reported to her, she would notify the appropriate state agencies such as the office of licensure and certification, ombudsmen, adult protective services etc. and submit a FRI (facility reported incident). When asked the time frame to report a resident to resident sexual encounter or altercation, ASM #1 stated within 24 hours or 2 hours if abuse was found. ASM #1 stated a follow up would be sent to the appropriate state agencies within five working days. When asked why a FRI was not submitted for Resident #12 and #13 for the 7/19/17 sexual encounter, ASM #2 stated that the facility staff determined that the residents liked to be together and Geri-psychology had evaluated both residents and determined that there was no psychosocial harm allowing the residents to be together. ASM #1 stated that they had a meeting with both responsible parties and the social worker and everyone was on the same page to allow both residents to be together. When asked when this meeting occurred, ASM #1 stated that the meeting occurred right after the second incident.

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When asked when the responsible parties gave consent for the residents to be together, ASM #1 stated this happened right after the second incident. ASM #1 and ASM #2 were made aware that a note from a social worker documenting that the responsible parties gave consent to the sexual behavior was not until 7/24/17 (5 days after the 7/19/17 incident). Any evidence that the responsible parties gave permission for the residents to engage in sexual behavior prior to 7/19/17 was requested.

No further information could be presented prior to exit.

Review of the facility's abuse policy documents in part, the following: "3. Identification and Reporting a. Any allegation of abuse, involuntary seclusion, neglect, mistreatment, misappropriation of resident property, or the occurrence of any injury of unknown origin will be promptly reported to the supervisor in charge. The administrator or designee is to be informed immediately of all allegations c. Events such as bruises, skin tears, fall, inappropriate or abusive behaviors will be reported to the DON or designee. Pattern or trends will be identified that may constitute abuse. The information will be forwarded to the Administrator and an investigation will be initiated. 4. Response A. All allegations of abuse will be reported to appropriate state agencies immediately."

2. For Resident #13, facility staff failed to implement abuse policies and report a sexual encounter that occurred on 7/19/17 with Resident #12 to the appropriate state agencies.

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Resident #13 was admitted to the facility on 9/10/16 with diagnoses that included but were not limited to Alzheimer's disease, high cholesterol, anxiety disorder, and high blood pressure. Resident #13's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 6/18/17. Resident #13's was coded as being severely impaired in cognition scoring 03 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #13 was coded as requiring supervision with transfers, ambulation, and eating; and limited assistance with toileting and dressing.

Review of Resident #13's chart revealed the first sexual encounter with Resident #12 occurred on 6/2/17. The following was documented in a nursing note: "Called into room (room number) by cna (sic) (certified nursing assistant) who stated resident (Resident #13) was giving oral sex to male resident #4074 (Resident #12) upon his bed. On entering room, I noted both residents sitting upright on the side of bed fully clothed, they were calm and pleasant and resident (Resident #13) came readily with me to the day room. No distress noted. RP (responsible party) (Name of RP) left message to call (Name of facility). (Name of NP (nurse practitioner) made aware."

The above incident was reported to the appropriate state agencies in a timely manner.

Review of Resident #13's care plan dated 6/2/17 documented the following: "The resident is/has potential to be verbally and physically aggressive related r/t (related to) Dementia (sic) and Poor (sic) impulse control. Goal: The resident will not

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harm self or others through next review. Interventions: geri (sic) psych (psychology/psychiatry) as needed, redirect resident as she will allow."

Review of Resident #13's nursing notes revealed a second sexual encounter with Resident #12 on 7/19/17. The following note was documented, "Notified by housekeeper that resident (Resident #13) was seen in resident #4704 (Resident #12) room with his hands down her pants. They were immediately separated without incidence. Resident smiling and chatting in day room with other residents. (Name of N. P. [nurse practitioner]) made aware and message left for (Name of RP [responsible party]) to call (Name of facility)."

Review of the incident report dated 7/19/17 documented the following: "Resident 4074 (Resident #12) was sitting next to resident (Resident #13) in the room and he had his hands down her pants ...Resident (Name of Resident #13) with unpredictable behaviors r/t (related to) dementia."

A FRI (facility reported incident) could not be found regarding the above event.

On 7/21/17 at 3:24 p.m., a note from the social worker documented the following: "SW (social work) was asked to contact RP (responsible party) related to res (resident) reportedly with male res. who had his hands down her pants. RP aware and stating that he "is not surprised" res hx (history) with males in the past. RP stating that he is fine with male res (resident) being able to be with res. This worker told RP that res clearly likes this male attention he gives her. SW asked if RP

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was available to converse via phone on the matter with nursing as well -meeting set up at 11:00 a.m. 7/24. RP stated that he appreciates staff help with this and the direction presented for the f/u (follow up): 1. privacy (sic) to be given by drawing curtain in the room and 2. affection (sic) discouraged /redirected when in public spaces like the DR (dining room)."

On 7/24/17 the following note was written from the IDT (interdisciplinary meeting): "Mtg (meeting) held today with DON (Director of Nursing), NW (north wing) unit manager, Administrator, SW, RP and SW present. Purpose was to review incident and confirm RP in agreement with res. desire to have relationship with male res. He said that he isn't surprised and he's fine with how staff handle it."

On 8/30/17 at 9:59 a.m., an interview was conducted with LPN (licensed practical nurse) #6. When asked the process if facility staff were to see two residents engaging in sexual activity, LPN #6 stated that initially she would separate the residents to determine if both residents are cognitively intact and that both residents consent to the behavior. LPN #6 stated that nursing staff should complete an incident report and notify the responsible parties if the residents are not their own representative. LPN #6 stated that she would also notify the medical doctor and administrator. LPN #6 stated that administration would initiate an investigation. LPN #6 stated that an investigation would be conducted to ensure there was no abuse between the residents engaging in the behavior. LPN #6 stated that if it is determined that both residents consent to the sexual activity, nursing staff should provide privacy. LPN #6 stated if two residents are not

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cognitively intact, she would separate the residents and follow the same process. LPN #6 stated that the interdisciplinary team would also meet to determine interventions to put into place to either keep the residents separated or to offer privacy for the residents during this behavior. When asked how she could describe Resident #12's and Resident #13's relationship, LPN #6 stated that the two residents are always walking around and holding hands in the hallways and dining room. LPN #6 stated that this relationship was addressed with the families and the families were ok it.

On 8/30/17 at 10:30 a.m., an interview was conducted with CNA (certified nursing assistant) #1, a CNA who frequently works with Resident #13 and Resident #12. When asked the process if she were to find two residents engaging in sexual behavior, CNA #1 stated that it depended on the residents. CNA #1 stated that for some residents it is ok to provide privacy during the encounter and other residents may have to be separated. CNA #1 stated that she would also notify the nurse if she found two residents engaging in sexual behaviors. When asked how she would know which residents would have to be separated, CNA #1 stated, "I would ask the nurses." CNA #1 was stated that Resident #13 and Resident #12 were to be given privacy when they were engaging in sexual behavior with each other.

On 8/31/17 at 9:00 a.m. an interview was conducted with ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing). When asked their role if they were to be made aware of a resident to resident sexual encounter, ASM #2 stated that

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she would first expect her nurses to separate the residents and do an incident report and report the incident to her immediately. ASM #2 stated that she would initiate an investigation and report the incident to the administrator. ASM #1, the administrator stated that once the incident is reported to her, she would notify the appropriate state agencies such as the office of licensure and certification, ombudsmen, adult protective services etc. and submit a FRI (facility reported incident). When asked the time frame to report a resident to resident sexual encounter or altercation, ASM #1 stated within 24 hours or 2 hours if abuse was found. ASM stated a follow up would be sent to the appropriate state agencies within five working days. When asked why a FRI was not submitted for Resident #12 and #13 for the 7/19/17 sexual encounter, ASM #2 stated that the facility staff determined that the residents liked to be together and Geri-psychology had evaluated both residents and determined that there was no psychosocial harm allowing the residents to be together. ASM #1 stated that they had a meeting with both responsible parties and the social worker and everyone was on the same page to allow both residents to be together. When asked when this meeting occurred, ASM #1 stated that the meeting occurred right after the second incident. When asked when the responsible parties gave consent for the residents to be together, ASM #1 stated this happened right after the second incident. ASM #1 and ASM #2 were made aware that a note from a social worker documenting that the responsible parties gave consent to the sexual behavior was not until 7/24/17 (5 days after the 7/19/17 incident). Any evidence that the responsible parties gave permission for the residents to engage in sexual behavior prior to

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7/19/17 was requested.

No further information was presented prior to exit.

3. The facility staff failed to implement abuse policies and report an allegation of staff to resident abuse with Resident #11 in a timely manner. The staff to resident incident was observed on 12-17-16 at 4:30 p.m., but was not reported to the facility administrator until 12/18/16.

Resident #11 was admitted to the facility on 2/24/14 and readmitted on 2/22/16 with diagnoses that included but were not limited to major depressive disorder, muscle weakness, stroke, atrial fibrillation, and COPD (chronic obstructive pulmonary disease). Resident #11's most recent MDS (minimum data set) was quarterly assessment with an ARD (assessment reference date) of 8/7/17. Resident #11 was coded as being severely impaired in cognitive status scoring 99 out of 15 on the BIMS (brief interview for mental status exam). Resident #11 was coded as requiring supervision with ambulation, and locomotion; extensive assistance from one staff member with dressing; extensive assistance from two or more staff members with toileting, and personal hygiene; and limited assistance with meals.

Review of a Facility Reported Incident (FRI) dated 12/18/17 and reported to the appropriate state agencies on 12-18-17, documented the following: "Incident date: 12-17-16, Report date: 12-18-16. Resident Involved: (Name of Resident #11), Injuries: No, Incident Type: Allegation of abuse/mistreatment. Describe Incident, including

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location, and action taken: (Name of OSM (other staff member) #10, resident helper alleges that (Name of alleged resident helper) "smacked" the right hand of resident (Name of Resident #11) on 12-17-16 at 4:30 p.m. for reaching for food-0 (zero) injuries."

Review of the witness statement by OSM #10 documented the following: " Date of statement; 12-18-16: I was in the dining room passing sandwich out and (Name of Resident #11) was walking around touching people food and (Name of alleged resident helper) smack his hand and told him no do not touch people food. happen (sic) on 12-17-16 around 4:30."

Review of the alleged resident helper's witness statement dated 12-18-17 documented in part, the following: "(Name of other resident) was sitting in dining room, (Name of Resident #11) reached for it, I did tap his hand, I did not smack him, this was a natural instinct, He was reaching for hot chocolate with medicine in it ...My intention is not to hurt anyone. The nurse was nowhere to be around."

Further review of the witness statements revealed a statement by the RN (registered nurse) supervisor that documented the following: "Date of statement: 12-18-16. Interview with (Name of OSM #10) R/T (related to) incident with (Name of alleged resident helper) 12-17-16. North Unit dining room between pt (patient) and (Name of alleged resident helper). (Name of OSM #10) stated that she heard a loud smack to (Name of Resident #11's) hand (right). (Name of Resident #11) was walking around and taking food. (Name of alleged resident helper) smacked his hand rather than redirecting pt. (Name of alleged

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resident helper) to be taken off duty until completion of investigation. (Name of LPN [licensed practical nurse] #4), unit manager aware and brought this to my attention."

A witness statement from LPN #4, the unit manager could not be found in the investigation.

Further review of the investigation revealed education provided to OSM #10. The following was documented: "12-18-16. Reason for Education: Timely reporting of any and all witnessed incidents immediately; the seriousness of patient abuse. Items reviewed: pt (patient) abuse and neglect, what to report and when, how and to who (sic) immediately!"

Review of the follow up report created by the administrator dated 12/21/17 and sent to the appropriate state agencies on 12/21/17, documented in part, the following: " ...On 12/17/16 at 4:30 p.m. (Name of OSM #10), resident helper states that she was passing sandwiches in the dining room on the NW (North Wing) unit. (Name of Resident #11) walked over and grabbed another residents (sic) sandwich. (Name of alleged resident helper), "smacked" (Name of Resident #11) on the right hand and removed the sandwich. (Name of OSM #10) reported this to the UM (unit manager) on 12/18/16 and it was reported to me. (Name of alleged resident helper) was suspended pending the investigation and did not work 3-11 on 12/18. (Name of Resident #11) was assessed by nursing staff and did not have any apparent injuries. Geripsych (Geri psychology/psychiatry) was notified and (Resident #11) was seen with no negative outcomes was noted due to employee striking resident ...On 12/20/16 (Name of

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RN)/acting DON (Director of Nursing) and (Name of HR (human resources) Director called (Name of alleged resident helper) and told her that she would no longer have her position as resident helper on the North Wing Unit. (Name of alleged resident helper) was offered a desk job on the SW (south wing) unit answering phones and clerical work but has not confirmed whether or not she will accept the new position. (Name of OSM #10) was re-educated on reporting timely. Both (Named of OSM #10) and (Name of alleged CNA) (if she takes new position) will re-take abuse reporting on Relias."

Review of the employee file for the alleged resident helper revealed that she was no longer employed with the facility on 12/20/16. Further review of her employee file revealed that she had no criminal record prior to her hire date in 2013.

On 8/30/17 at 10:32 a.m., an interview was conducted with OSM #10, the resident helper. When asked her title at the facility, OSM #10 stated that she was a resident helper. OSM #10 stated that her job responsibilities included assisting the resident with meals, passing out snacks and making resident beds. OSM #10 stated that she was not allowed to provide any other resident care. When asked if she received training on abuse, OSM #10 stated that she had monthly in-services she had to complete on abuse training. When asked the process if she were to witness a staff member hitting a resident, OSM #10 stated that she would report the abuse immediately to the nurse on duty. When asked if she could recall the events on 12/17/16 between Resident #11 and a staff member, OSM #10 stated that she was in the dining room on evening shift passing out sandwiches when she saw

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Resident #11 trying to grab other people's food. OSM #10 stated that when Resident #11 went to reach for a sandwich, a resident helper slapped his hand away. OSM #10 stated that she reported it to the evening floor nurse the night it happened but could not remember the nurse she reported it to. OSM #10 stated that she reported the incident because he was being treated like a child. OSM #10 stated that she reported the incident to the unit manager (LPN #4) the next day (12/18/16) just to make sure she was aware. OSM #10 could not recall the resident reaching for a hot chocolate full of medicine.

On 8/30/17 at 11:06 a.m., an interview was conducted with LPN #4, the unit manager. When asked LPN #4 the process if she were to see a staff to resident altercation, LPN #4 stated that she would intervene immediately, assess the resident for injuries, have the staff member clock out until further investigation, create an incident report and report this incident to the DON (Director of Nursing), Administrator and Medical Doctor. LPN #4 stated that the administrator would be responsible for creating a FRI (facility reported incident). When asked when she expected her nurses to report an allegation of abuse, LPN #4 stated, "Immediately." When asked if she could recall the events of the staff to resident altercation between Resident #11 and the Resident helper, LPN #4 stated, "I can't tell you exactly what happened." LPN #4 stated that the incident was not reported to her until 12/18/16 (the next day) by OSM #10. LPN #4 stated that it was determined then that OSM #10 reported the incident late. LPN #4 stated that OSM #10 was counseled on reporting abuse immediately. LPN #4 stated that the staff member who slapped Resident no longer works for the facility. When

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F 226	Continued From page 47 asked if this staff member was reported to the department of health professions, LPN #4 stated, "Helpers don't have a certification or anything. Anyone can come in and fill out an application to be a resident helper and then go through training." On 8/31/17 at 9:00 a.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing), and ASM #4, the administrator in training were made aware of the above concerns. No further information was presented prior to exit. Review of the facility's abuse policy documents in part, the following: "3. Identification and Reporting a. Any allegation of abuse, involuntary seclusion, neglect, mistreatment, misappropriation of resident property, or the occurrence of any injury of unknown origin will be promptly reported to the supervisor in charge. The administrator or designee is to be informed immediately of all allegations. b. All employees have a duty to respect the rights of all residents, to treat them with dignity and to prevent others from violating their rights. Any employee who witnesses or has knowledge of an act of abuse to a resident is obligated to report such information to the Nurse in charge, Director of Nursing, or the Administrator."	F 226		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate	F 278	1. On 8/30/17, Section O of the Significant Change Assessment date 8/2/17 was modified to reflect resident #5 is receiving hospice care. 2. A 100% audit of Significant Change Assessments for current residents receiving hospice care will be	

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F 278	Continued From page 48 each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to maintain an accurate MDS (minimum data set) assessment for one of 29 residents in the survey sample, Residents # 5. Review of the Resident # 5's MDS, a Significant Change Assessment, dated 8/2/17 in section O coded the resident as not receiving hospice care	F 278	Continued From page 48 completed by DON, ADON and/or designee for all current residents who are receiving hospice care to ensure section O is accurately coded. 3. MDS Coordinators will be re-educated by DON, MDS Consultant and/or designee on MDS accuracy. 4. Audits will be completed by DON and/or designee on Significant Change Assessments as follow: 10% of assessments will be audited weekly x 1 month; every-other-week x 2 months; and monthly x 2 months. Variances will be investigated and follow-up made as appropriate. An analysis of the audits will be provided to the QA Committee for additional oversight and recommendations. 5. The facility dutifully alleges compliance of these tasks on or before 10/15/2017.	

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when Resident #5 was receiving hospice services.

The findings include:

Resident # 5 was admitted to the facility on 4/14/15 and most recently readmitted on 5/27/15 with diagnoses that included but were not limited to: congestive heart failure (CHF), peripheral vascular disease, diabetes, and cerebral vascular accident (stroke).

Resident # 5's most recent MDS (minimum data set) assessment, a Significant Change Assessment, with an ARD (assessment reference date) of 8/2/17 coded Resident # 5 as usually understood by others and as usually able to understand others. Resident # 5 was coded on the BIMS (Brief Interview for Mental Status) with a score of 14 out of 15, indicating that the Resident is cognitively intact.

During a clinical record review a physician order dated 7/26/17 documented, "Admit to (name of the hospice provider) for terminal diagnosis of CHF." The Significant Change Assessment with an ARD of 8/2/17 was also reviewed and revealed that in Section O Hospice was not checked.

During an interview on 8/30/17 at 11:45 a.m. with LPN (licensed practical nurse) # 6, an MDS Coordinator, Resident # 5's Significant Change MDS and the physician order for hospice were reviewed. LPN # 6 stated that Resident # 5 should have been coded in Section O as being on hospice. When asked what guidance they use to complete the MDS LPN # 6 stated, "We follow the RAI (resident assessment instrument) manual."

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F 278	Continued From page 50 During the end of day interview on 8/30/17 at 4:25 p.m. with ASM (Administrative Staff Member) # 1, the administrator, ASM # 2, the Director of Nurses, and ASM # 4, the Administrator in Training, the concern of the miscoded MDS was discussed. No further information was provided by completion of the survey.	F 278		
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	F 279	1. Resident #4 has not demonstrated any adverse outcomes from the change in behavior. On 8/31/17 MD and RP were notified of change in behavior which occurred on 7/17/17. On 8/31/17, the plan of care was updated to address Resident #4's inappropriate behavior. 2. A 100% audit of plan of care for current residents will be completed by DON, ADON, Unit Managers or designee for current residents who display inappropriate behaviors to ensure that behavior is being addressed. 3. Nursing staff will be re-educated on the importance of updating the plan of care when a resident displays inappropriate behaviors. 4. Audits will be conducted by Unit Manager and/or designee on plan of care for residents who display inappropriate behaviors as follow: 10 % of plans of care will be audited	

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F 279	Continued From page 51 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care 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 care plan for one of 29 residents' in the survey sample, Resident #4. The facility staff failed to develop a care plan to address Resident #4's inappropriate behavior on	F 279	Continued From page 51 2 times per week x 4 weeks; weekly x 4 weeks; and bi-weekly x 2 weeks. Variances will be investigated and follow-up made as appropriate. An analysis of the audits will be provided to the QA Committee for additional oversight and recommendations. 5. The facility dutifully alleges compliance of these tasks on or before 10/15/2017	

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7/17/17.

The findings include:

Resident #4 was admitted to the facility on 3/22/17 with diagnoses that included but were not limited to: dementia, high blood pressure and anxiety. The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/2/17 coded the resident as scoring three out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely cognitively impaired. Resident #4 was coded as requiring minimum assistance with activities of daily living. In section E -- Behavior, the resident was coded as not having any behaviors.

Review of the notes dated 7/17/17 at 11:06 p.m. documented, "RESIDENT CONSTANTLY WITH A MALE RESIDENT AND WOULD ATTEMPT TO GO IN A ROOM TOGETHER; NEEDS CONSTANT REDIRECTION FROM STAFF TO NOT TOUCH AND BE INAPPROPRIATE WITH ANOTHER MALE RESIDENT; WHEN STAFF EXPLAINS THE REASON, RESIDENT WOULD GET AGGRESSIVE AND DEFENSIVE; STAFF ALWAYS ON ALERT WITH RESIDENT AND ANOTHER MALE RESIDENT TO ENSURE THEY DO NOT GO IN A ROOM ALONE OR EXHIBIT SEXUAL BEHAVIOR." There was no documentation that the physician or RP had been notified of the behavior.

Review of the nurse's notes dated 7/19/17 at 6:31 a.m. documented, "SLEPT QUIETLY (sic) THIS SHIFT; NO INAPPROPRIATE OR NEGATIVE BEHAVIOR NOTED..."

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Review of Resident #4's comprehensive care plan failed to evidence any documentation or interventions addressing Resident #4's behaviors on 7/17/17.

A telephone interview was conducted on 8/30/17 at 1:45 p.m. with LPN (licensed practical nurse) #12, the nurse who wrote the note on 7/17/17 for Resident #4. When asked if staff updated care plans, LPN #4 stated, "Yes. When I have to." When asked when a care plan would be updated, LPN #4 stated, "When I was asked to do if for a change in condition." LPN #4's note for Resident #4 on 7/17/17 was reviewed. When asked if the care plan would have been updated following Resident #4's behaviors, LPN #4 stated, "If it's not already in the care plan." When informed there was no care plan regarding this behavior, LPN #4 stated, "I didn't think I needed to update the care plan."

On 8/30/17 at 4:25 p.m. ASM #1, the administrator and ASM #2 the director of nursing were made aware of the findings.

An interview was conducted on 8/31/17 at 8:55 a.m. with ASM (administrative staff member) #2, the assistant director of nursing. ASM #2 was asked to review the 7/17/17 nurse's note for Resident #4. When asked what process staff follow when a resident exhibits sexual behaviors, ASM #2 stated, "They should further document in the chart. There would be a care plan update for anything that was done." When asked who updated the care plan, ASM #2 stated, "The nurse manager. We go over things that happened and we would update the care plan." When asked when the care plan would be updated, "ASM #2 stated, "It should be updated right after it

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happened so we would know this is something she tends to do. It might have been an isolated incident. It still should have been care planned." When asked to review Resident #4's care plan for behaviors, ASM #2 stated, "I don't see it."

Review of the facility's policy titled, "Using the Care Plan" documented, "The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident." There was no further documentation specifically regarding developing a care plan.

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, 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.

Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care,

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F 279	Continued From page 55 promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care."	F 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: (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	F 280	1. On 8/29/17, the plan of care was updated to address resident # 12's sexual encounter with another resident. On 8/29/17, the plan of care was updated to address resident # 13's sexual encounter with another resident On 8/31/17, the care cards were updated to address resident #12 and resident # 13's sexual encounters. On 9/19/17, the plan of care was updated to address resident # 11's involvement in a resident to resident altercation. On 9/19/17, the plan of care was updated to address resident # 28's involvement in a resident to resident altercation.	

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of care.

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

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

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

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

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

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

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

(A) The attending physician.

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

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

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

(E) To the extent practicable, the participation of

Since 6/14/17 resident to resident altercation, resident #28 has been seen by Geri-Psych on 7/11/17, 7/24/17, 8/9/17, 8/14/17 and 8/25/17.

2. A 100% audit of plan of care and care cards for current residents will be completed by Unit Managers or designee for current residents who display sexual behaviors to ensure that behavior is being addressed.

   A 100% audits of medical records for current residents will be completed by Social Services or designee for all current residents who have been involved in resident to resident altercations to ensure Geri-Psych is consulted as appropriate

3. Nursing staff will be re-educated by DON, ADON and/or designee on the importance of updating the plan of care when a resident displays sexual behaviors.

   Nursing staff will also be re-educated on the importance of updating the plan of care after a resident to resident altercation has occurred and the need for Geri-Psych consult as appropriate.

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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, clinical record review, and facility document review, it was determined that the facility staff failed to review and revise the comprehensive care plan for 4 of 29 residents in the survey sample; Residents #12, #13, #11, and #28.

1. The facility staff failed to review or revise Resident #12's comprehensive care plan after two sexual encounters that occurred with Resident #13 on 6/2/17 and 7/19/17 and failed to revise the care plan and care card after the 7/24/17 IDT (interdisciplinary) meeting.

2. The facility staff failed to review or revise Resident #13's comprehensive care plan after a sexual encounter that occurred with Resident #12 on 7/19/17 and failed to revise the care plan and care card after the 7/24/17 IDT meeting.

3. The facility staff failed to review or revise Resident #11's comprehensive care plan after a

4. Audits will be completed by Social Services and/or designee on plan of care for residents who display sexual behaviors and resident to resident altercations as follow: 10% of plans of care will be audited 2 times per week x 4 weeks; weekly x 4 weeks; and bi-weekly x 1 month. Variances will be investigated and corrections made as appropriate. An analysis of the audits will be provided to the QA Committee for additional oversight and recommendations.

5. The facility dutifully alleges compliance of these tasks on or before 10/15/2017

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resident to resident altercation with Resident #28.

4. The facility staff failed to review and revise Resident #28's comprehensive care plan after a resident to resident altercation with Resident #11 on 6/14/17.

The findings include:

1. Resident #12 was admitted to the facility on 3/8/16 with diagnoses that included but were not limited to Alzheimer's disease, hyperlipidemia, high blood pressure, and muscle weakness. Resident #12's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 6/16/17. Resident #12's 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 supervision for all ADLS (activities of daily living).

Review of Resident #12's chart revealed the first sexual encounter with Resident #12 occurred on 6/2/17. The following was documented in a nursing note: "called to room by cna (sic) (certified nursing assistant) who observed resident (Resident #12) receiving oral sex from resident number 4782 (Resident #13) residents (sic) were separated (sic) skin assessment done (sic) no marks on penis vital signs 126/78 (blood pressure), 70 (pulse), 20 (respirations), 98.6 (temp). np (nurse practitioner) notified unable to reach rp (responsible party) will continue to try to reach rp (responsible party)."

Review of Resident #12's behavior care plan

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dated 5/9/16, failed to address the above 6/2/17 incident.

Review of Resident #12's nursing notes revealed a second sexual encounter with Resident #13 on 7/19/17. The following was documented: "Resident (Resident #12) observed in his room sitting beside resident 4782 (Resident #13) with his hands in 4782 (Resident #13's) pants. Residents were immediately separated. Second contact (Name of contact) and RP (responsible party) notified ..."
Review of the incident report dated 7/19/17 documented the following: "Resident 4074 (Resident #12) was sitting next to resident (Resident #13) in the room and he had his hands down her pants ...Resident with unpredictable behaviors r/t (related to) dementia."

Review of Resident #12's comprehensive care plan dated 5/9/16 and revised 5/11/17 failed to address the above incident.

Review of a social worker note dated 7/21/17 at 3:50 p.m. documented the following: "Social work was asked to contact RP (responsible party) to contact RP (responsible party) re (regarding): reported touching of a female res. (resident)/hands down pants. Social Worker attempted to contact RP (responsible party) x 3 with (zero) ability to leave mssg (message)/phone disconnected. SW spoke with emergency contact #2 who is aware of incident and stated comfort with staff intervention 1. Privacy in room 2. redirection/discourage behavior in public places. Emergency contact #2 said "I'm fine with it." She was asked to be a part of a conference call 7/24 at 11:30 to review with nursing staff -in agreement."

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Further review of the social work notes revealed a note dated 7/24/17 documenting that an IDT (interdisciplinary) meeting was held with Resident #12's RP, DON (director of nursing), Administrator, geripsy (Geri psychology/psychiatry), NP (nurse practitioner), and the unit manager. The RP was documented as being fine with Resident #12 and Resident #13's relationship.

On 8/28/17 review of Resident #12's care plan dated 5/9/16 failed to evidence that the care plan was revised after the IDT meeting on 7/24/17 with the new interventions regarding his relationship with Resident #13.

On 8/30/17 a copy of Resident #12's 5/9/16 behavior care plan was provided. The following interventions were updated on 8/29/17 (during survey), "1. Offer Geri psychologist/Geri psychiatrist prn (as needed), offer privacy as needed, (Name of Resident) will be redirected when this behavior occurs in a public area."

On 8/30/17 at 9:59 a.m., an interview was conducted with LPN (licensed practical nurse) #6, the MDS nurse. When asked the process if facility staff were to see two residents engaging in sexual activity, LPN #6 stated that initially she would separate the residents to determine if both residents are cognitively intact and that both residents consent to the behavior. LPN #6 stated that nursing staff should complete an incident report and notify the responsible parties if the residents are not their own representative. LPN #6 stated that she would also notify the medical doctor and administrator. LPN #6 stated that administration would initiate an investigation. LPN

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#6 stated that an investigation would be conducted to ensure there was no abuse between the residents engaging in the behavior. LPN #6 stated that if it is determined that both residents consent to the sexual activity, nursing staff should provide privacy. LPN #6 stated if two residents are not cognitively intact, she would separate the residents and follow the same process. LPN #6 stated that the interdisciplinary team would also meet to determine interventions to put into place to either keep the residents separated or to offer privacy for the residents during this behavior. When asked how staff would know whether to separate the residents or provide them privacy during a sexual encounter, LPN #6 stated that nursing staff have access to the care plans with the updated interventions. When asked who was responsible for updating the care plans, LPN #6 stated that she was responsible as the MDS nurse or the nurses on the unit. LPN #6 stated that the care plans are updated immediately after any change in care. When asked if Resident #12's care plan was updated after his two sexual encounters with Resident #13, LPN #6 stated that she was not sure and would have to check. LPN #6 stated, "I would hope there is something."

When asked if CNAs (certified nursing assistants) had access to the care plans, LPN #6 stated that the CNAs use care cards that are in the inside of each resident's closet. When asked if the care cards would address the interventions put into place for the residents engaging in sexual behavior, LPN #6 stated that she wasn't sure if the care cards would address that. LPN #6 stated that the CNAs can also be told verbally.

When asked how she could describe Resident

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#12's and Resident #13's relationship, LPN #6 stated that the two residents are always walking around and holding hands in the hallways and dining room. LPN #6 stated that this relationship was addressed with the families and the families were ok with it. LPN #6 stated that the residents were to be provided privacy if they were to engage in sexual behavior. When asked how the CNAs would know that it was ok for Resident #12 and Resident #13 to engage in sexual behavior, LPN #6 stated that they would be told verbally by the nurses. When LPN #6 was asked if she could show this writer Resident #12's care card, LPN #6 presented the care card.

Review of Resident #12's most recent care card did not evidence interventions to provide Resident #12 privacy when engaging in sexual activity with Resident #13.

On 8/30/17 at 10:30 a.m., an interview was conducted with CNA (certified nursing assistant) #1, a CNA who frequently works with Resident #12 and Resident #13. When asked the process if she were to find two residents engaging in sexual behavior, CNA #1 stated that it depended on the residents. CNA #1 stated that for some residents it is ok to provide privacy during the encounter and other residents may have to be separated. CNA #1 stated that she would also notify the nurse if she found two residents engaging in sexual behaviors. When asked how she would know which residents would have to be separated, CNA #1 stated, "I would ask the nurses." When asked how CNAs determine the needs of each resident, CNA #1 stated that the CNAs utilized a care card that listed out each resident's needs. When asked if the care card would address if the resident should be separated

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from a particular resident due to a sexual encounter or that a resident can have privacy during a sexual encounter with a particular resident, CNA #1 stated, "I am assuming it would be." When asked if she could describe Resident #12's relationship with Resident #13, CNA #1 stated, "They seem to think they are married. They are allowed to do things and we provide them with privacy." When asked if this was on Resident #12's care card, CNA #1 stated, "I don't think so." When asked if she had access to the care plan, CNA #1 stated that the care plans were on the computer and she did not have access to the computer system. CNA #1 stated that she would have to sign in under a nurse's login to get access to the care plan.

On 8/31/17 at 9:00 a.m., an interview was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2 the DON (Director of Nursing). ASM #1 stated that she was certain Resident #12 and Resident #13's care plans were updated after each sexual encounter and after the IDT (interdisciplinary meeting). ASM #2 stated that she would have LPN #4, the unit manager, look for this information.

On 8/31/17 at 9:45 a.m., an interview was conducted with LPN #4, the unit manager. LPN #4 confirmed that she could not find where Resident #12's care plan was updated after his sexual encounter with Resident #13 on 6/2/17 and 7/19/17. LPN #4 stated that his care plan was updated after the IDT meeting on 7/24/17. LPN #4 stated that these interventions were updated prior to 8/29/17, but could not find that evidence.

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No further information was presented prior to exit.

Facility policy titled, "Using the Care Plan," documents in part, the following: "The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident...5. changes in the resident's condition must be reported to the MDS Assessment Coordinator so that a review of the resident's assessment and care plan can be made. 6. Documentation must be consistent with the resident's care plan."

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

2. The facility staff failed to review or revise Resident #13's comprehensive care plan after a sexual encounter that occurred with Resident #12 on 7/19/17 and failed to revise the care plan and care card after the 7/24/17 IDT meeting.

Resident #13 was admitted to the facility on 9/10/16 with diagnoses that included but were not limited to Alzheimer's disease, high cholesterol,

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anxiety disorder, and high blood pressure. Resident #13's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 6/18/17. Resident #13 was coded as being severely impaired in cognition scoring 03 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #13 was coded as requiring supervision with transfers, ambulation, and eating; and limited assistance with toileting and dressing.

Review of Resident #13's chart revealed the first sexual encounter with Resident #12 occurred on 6/2/17. The following was documented in a nursing note: "Called into room (room number) by cna (sic) (certified nursing assistant) who stated resident (Resident #13) was giving oral sex to male resident #4074 (Resident #12) upon his bed. On entering room, I noted both residents sitting upright on the side of bed fully clothed, they were calm and pleasant and resident (Resident #13) came readily with me to the day room. No distress noted. RP (responsible party) (Name of RP) left message to call (Name of facility). (Name of NP (nurse practitioner) made aware."

Review of Resident #13's care plan dated 9/19/16 and revised 6/2/17, documented the following: "The resident is/has potential to be verbally and physically aggressive related r/t (related to) Dementia (sic) and Poor (sic) impulse control. Goal: The resident will not harm self or others through next review. Interventions: geri pysch (psychology/psychiatry) as needed, redirect resident as she will allow."

Review of Resident #13's nursing notes revealed a second sexual encounter with Resident #12 on

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7/19/17. The following note was documented, "Notified by housekeeper that resident (Resident #13) was seen in resident #4704 (Resident #12) room with his hands down her pants. They were immediately separated without incidence. Resident smiling and chatting in day room with other residents. (Name of N. P. [nurse practitioner]) made aware and message left for (Name of RP [responsible party]) to call (Name of facility)."

Review of the incident report dated 7/19/17 documented the following: "Resident 4074 (Resident #12) was sitting next to resident (Resident #13) in the room and he had his hands down her pants ...Resident (Name of Resident #13) with unpredictable behaviors r/t (related to) dementia."

Review of Resident #13's behavior care plan dated 9/19/16 and revised 6/22/17, failed to evidence that the care plan was updated after the 7/19/17 incident.

On 7/21/17 at 3:24 p.m., a note from the social worker documented the following: "SW (social work) was asked to contact RP (responsible party) related to res (resident) reportedly with male res. who had his hands down her pants. RP aware and stating that he "is not surprised" res hx (history) with males in the past. RP stating that he is fine with male res (resident) being able to be with res. This worker told RP that res clearly likes this male attention he gives her. SW asked if RP was available to converse via phone on the matter with nursing as well -meeting set up at 11:00 a.m. 7/24. RP stated that he appreciates staff help with this and the direction presented for the f/u (follow up): 1. privacy to be given by

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drawing curtain in the room and 2. affection (sic) discouraged /redirected when in public spaces like the DR (dining room)."

On 7/24/17 the following note was written from the IDT (interdisciplinary meeting): "Mtg (meeting) held today with DON (Director of Nursing), NW (north wing) unit manager, Administrator, SW, RP and SW present. Purpose was to review incident and confirm RP in agreement with res. desire to have relationship with make res. He said that he isn't surprised and he's fine with how staff handle it."

Review of Resident #13's care plan dated 9/19/16 and revised 6/22/17 failed to evidence that the care plan was revised after the IDT meeting on 7/24/17 with the new interventions regarding her relationship with Resident #12.

On 8/30/17 at 9:59 a.m., an interview was conducted with LPN (licensed practical nurse) #6, the MDS nurse. When asked the process if facility staff were to see two residents engaging in sexual activity, LPN #6 stated that initially she would separate the residents to determine if both residents are cognitively intact and that both residents consent to the behavior. LPN #6 stated that nursing staff should complete an incident report and notify the responsible parties if the residents are not their own representative. LPN #6 stated that she would also notify the medical doctor and administrator. LPN #6 stated that administration would initiate an investigation. LPN #6 stated that an investigation would be conducted to ensure there was no abuse between the residents engaging in the behavior. LPN #6 stated that if it is determined that both residents consent to the sexual activity, nursing

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staff should provide privacy. LPN #6 stated if two residents are not cognitively intact, she would separate the residents and follow the same process. LPN #6 stated that the interdisciplinary team would also meet to determine interventions to put into place to either keep the residents separated or to offer privacy for the residents during this behavior. When asked how staff would know whether to separate the residents or provide them privacy during a sexual encounter, LPN #6 stated that nursing staff have access to the care plans with the updated interventions. When asked who was responsible for updating the care plans, LPN #6 stated that she was responsible as the MDS nurse or the nurses on the unit. LPN #6 stated that the care plans are updated immediately after any change in care. When asked if Resident #13's care plan was updated after her sexual encounter with Resident #13, LPN #6 stated that she was not sure and would have to check. LPN #6 stated, "I would hope there is something."

When asked if CNAs (certified nursing assistants) had access to the care plans, LPN #6 stated that the CNAs use care cards that are in the inside of each resident's closet. When asked if the care cards would address the interventions put into place for the residents engaging in sexual behavior, LPN #6 stated that she wasn't sure if the care cards would address that. LPN #6 stated that the CNAs can also be told verbally.

When asked how she could describe Resident #13's and Resident #12's relationship, LPN #6 stated that the two residents are always walking around and holding hands in the hallways and dining room. LPN #6 stated that this relationship was addressed with the families and the families

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were ok it. LPN #6 stated that the residents were to be provided privacy if they were to engage in sexual behavior. When asked how the CNAs would know that it was ok for Resident #12 and Resident #13 to engage in sexual behavior, LPN #6 stated that they would be told verbally by the nurses. When asked if LPN #6 could show this writer Resident #13's care card, LPN #6 presented the care card.

Review of Resident #13's most recent care card did not evidence interventions to provide Resident #13 privacy when engaging in sexual activity with Resident #12.

On 8/30/17 at 10:30 a.m., an interview was conducted with CNA (certified nursing assistant) #1, a CNA who frequently works with Resident #13 and Resident #12. When asked the process if she were to find two residents engaging in sexual behavior, CNA #1 stated that it depended on the residents. CNA #1 stated that for some residents it is ok to provide privacy during the encounter and other residents may have to be separated. CNA #1 stated that she would also notify the nurse if she found two residents engaging in sexual behaviors. When asked how she would know which residents would have to be separated, CNA #1 stated, "I would ask the nurses." When asked how CNAs determine the needs of each resident, CNA #1 stated that the CNAs utilized a care card that listed out each resident's needs. When asked if the care card would address if the resident should be separated from a particular resident due to a sexual encounter or that a resident can have privacy during a sexual encounter with a particular resident, CNA #1 stated, "I am assuming it would be." When asked if she could describe Resident

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#13's relationship with Resident #12, CNA #1 stated, "They seem to think they are married. They are allowed to do things and we provide them with privacy." When asked if this was on Resident #13's care card, CNA #1 stated, "I don't think so." When asked if she had access to the care plan, CNA #1 stated that the care plans were on the computer and she did not have access to the computer system. CNA #1 stated that she would have to sign in under a nurse's login to get access to the care plan.

On 8/31/17 at 9:00 a.m., an interview was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2 the DON (Director of Nursing). ASM #1 stated that she was certain Resident #12 and Resident #13's care plans were updated after each sexual encounter and after the IDT (interdisciplinary meeting). ASM #2 stated that she would have LPN #4, the unit manager, look for this information.

On 8/31/17 at 9:45 a.m., an interview was conducted with LPN #4, the unit manager. LPN #4 stated that she could not find Resident #13's printed copy of her care plan and could not determine if her care plan was updated after the 7/19/17 incident and after the 7/24/17 IDT meeting.

No further information was presented prior to exit.

3. The facility staff failed to review or revise Resident #11's comprehensive care plan after a resident to resident altercation with Resident #28.

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Resident #11 was admitted to the facility on 2/24/14 and readmitted on 2/22/16 with diagnoses that included but were not limited to major depressive disorder, muscle weakness, stroke, atrial fibrillation, and COPD (chronic obstructive pulmonary disease). Resident #11's most recent MDS (minimum data set) was quarterly assessment with an ARD (assessment reference date) of 8/7/17. Resident #11 was coded as being severely impaired in cognitive function scoring 99 out of 15 on the BIMS (Brief Interview for Mental Status exam). Resident #11 was coded as requiring supervision with ambulation, and locomotion; extensive assistance from one staff member with dressing; extensive assistance from two or more staff members with toileting, and personal hygiene; and limited assistance with meals.

Review of Resident #11's nursing notes revealed the following note dated 6/14/17 that documented the following: "Resident was witnessed by another nurse in a resident to resident situation; Resident was hitting a female resident's head onto the table in the dining room; Immediately separated and both assessed; placed a call to daughter and informed of aggressive behavior, Resident is not easily redirected; Needs two people to redirect and during dinner he kept going from table to table trying to take other resident's food; No further episode of aggressive behavior noted but will continue to monitor, wanders around unit aimlessly."

Review of the incident report dated 6/14/17, documented the following intervention: "Additional comments and/or steps taken to prevent reoccurrence: "Geripsych (Geri psychology)."

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BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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Further review of Resident #11's clinical record revealed that Geri-psychology had visited Resident #11 on 6/22/17 and make medication adjustments.

Review of Resident #11's behavior care plan dated 12/20/16 and revised 5/25/17, failed to reveal this altercation with Resident #28.

On 8/31/17 at 7:58 a.m., an interview was conducted with OSM (other staff member) #9, the social worker and OSM #11, the social work assistant. When asked the social worker's role and the process when there is a resident to resident altercation, OSM #9 stated that whenever there is a resident to resident altercation, the incident report and care plan for each resident is brought to the morning stand up meeting the next day. OSM #9 stated that the IDT (interdisciplinary team) will collectively discuss what had happened and refer both residents; the aggressor and victim, to Geri-psychology. OSM #9 stated that Geri-psychology is usually the go-to intervention for residents on the North (locked) unit because most residents are on a variety of psychoactive medications that may need adjustment. OSM #9 stated that it was her, the social worker who was responsible for ensuring the resident is evaluated by Geri psychology. OSM #9 stated that other interventions would also be implemented after a resident to resident altercation for both the aggressor and victim to ensure resident safety. OSM #9 stated that sometimes residents will be given a barrier strip to deter wandering resident to enter their rooms. OSM #9 stated that anyone in the IDT meeting could update the care plans with the new interventions. OSM #9 confirmed that she could not find where Resident #11's care plan

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was updated after the 6/14/17 altercation.

On 8/31/17 at 9:00 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #4, the administrator in training were made aware of the above concerns.

No further information was presented prior to exit.

4. The facility staff failed to review and revise Resident #28's comprehensive care plan after a resident to resident altercation with Resident #11 on 6/14/17.

Resident #28 was admitted to the facility on 7/716 with diagnoses that included but were not limited to Alzheimer's disease, anxiety disorder, and dysphagia (difficulty swallowing). Resident #28's most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 7/18/17. Resident #28 was coded as being severely impaired in cognitive function scoring 99 on the BIMS (Brief Interview for Mental Status) exam. Resident #28 was coded as requiring supervision for transfers, ambulation, and eating; limited assistance with one-person physical assist with toileting, and extensive assistance of one staff member with personal hygiene, dressing and bathing.

Review of an incident report dated 6/14/17 documented the following: "Reported observed male resident smashing her head into table. Resident crying and small red area on forehead...additional comments and/or steps taken to prevent reoccurrence: Geri psych."

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Review of Resident #28's nursing notes revealed the following note dated 6/14/17: "crying (sic), holding head with hand, Objective: red area on forehead. no (sic) swelling, no pain or discomfort when palpitated. Assessment: No swelling, no s/s (signs/symptoms) of pain or discomfort. Plan: monitor for late bruising. monitor (sic) for s/s of pain in frontal cranial region x 3 days. offer (sic) resting in evening."

Review of Resident #28's care plan dated 7/21/16 and revised 7/25/17 failed to reveal the altercation between Resident #28 and Resident #11.

Review of Resident #28's clinical record failed to reveal that an intervention was put into place to keep her safe from Resident #11. Further review of Resident #28's clinical record failed to an appointment with Geri-psych was made.

On 8/30/17 at 9:59 a.m., an interview was conducted with LPN (licensed practical nurse) #6. When asked the process if she were to see a resident to resident altercation, LPN #6 stated that she would immediately separate the residents, interview and assess the situation to see what the issue was, assess for injuries and then she complete an incident report. LPN #6 stated that she would also refer both resident to Geri pysch, especially for any resident on the north (locked) unit. LPN #6 stated that the residents on the north unit may need medication adjustments. LPN #6 stated that both the aggressor and the victim should have interventions in place to prevent future altercations and to ensure resident safety. When asked if the care plan should be updated after an altercation, LPN #6 stated the care plan should

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be updated especially if there is any injury. LPN #6 could not recall the incident between Resident #28 and Resident #11.

On 8/30/17 at approximately 11:15 a.m., an interview was conducted with LPN #4, the unit manager. When asked how she would ensure a resident was safe from another resident after a resident to resident altercation on the north unit, LPN #4 stated that there was only so much they could do because most residents were demented on the north unit and forget about the altercation. LPN #4 stated the next day the two residents may want to sit near each other. LPN #4 stated that both residents would be referred to Geri-psychology for an assessment and medical review. LPN #4 stated that both care plans (the aggressor and victim) should be updated after a resident to resident altercation. LPN #4 stated the care plans could be updated by any nurse.

On 8/31/17 at 7:58 a.m., an interview was conducted with OSM (other staff member) #9, the social worker and OSM #14, the social work assistant. When asked the social worker's role and the process when there is a resident to resident altercation, OSM #9 stated that whenever there is a resident to resident altercation, the incident report and care plan for each resident is brought to the morning stand up meeting the next day. OSM #9 stated that the IDT (interdisciplinary team) will collectively discuss what had happened and refer both residents; the aggressor and victim, to Geri-psychology. OSM #9 stated that Geri-psychology is usually the go-to intervention for residents on the North (locked) unit because most residents are on a variety of psychoactive medications that may need adjustment. OSM #9

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F 280	Continued From page 76 stated that it was her, the social worker who was responsible for ensuring the resident is evaluated by Geri-psychology. OSM #9 stated that other interventions would also be implemented after a resident to resident altercation for both the aggressor and victim to ensure resident safety. OSM #9 stated that sometimes residents will be given a barrier strip to deter wandering resident to enter their rooms. When asked what was put into place to ensure resident safety for Resident #28 from Resident #11, OSM #9 stated that she was not made aware of the resident to resident altercation between her and Resident #11 on 6/14/17 until now. OSM #9 stated that the altercation was not on the incident and accident log for June. OSM #9 could not determine what the facility had put into place to ensure Resident #28's safety after her incident with Resident #11. When asked who was responsible for updating the care plan after a resident to resident altercation, OSM #9 stated that anyone in the IDT meeting could update the care plans with the new interventions. OSM #9 confirmed that she could not find where Resident #28's care plan was updated after the 6/14/17 altercation. On 8/31/17 at 9:00 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #4, the administrator in training were made aware of the above concerns. No further information was presented prior to exit.	F 280		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281	**1.** Resident #9 has not demonstrated any adverse outcome from not receiving the Buspar from 7/1/2017-	

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(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 staff interview, facility policy review and clinical record review, it was determined that the facility staff failed to follow professional standards of care for one of 29 residents in the survey sample, Resident #9.

The facility staff failed to ensure the physician's order for Buspar (1) was transcribed onto the July 2017 MAR (medication administration record) for Resident #9. The resident did not receive Buspar 5 mg (milligrams) twice a day as ordered by the physician from 7/1/17 through 7/22/17.

The findings include:

Resident #9 was admitted to the facility yon 3/10/16 with diagnoses that included but were not limited to: dementia, high blood pressure, difficulty swallowing and hallucinations. The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 8/18/17 coded the resident as having a three out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely cognitively impaired. The resident was coded as requiring assistance from staff for all activities of daily living. In section D -- Mood, the resident was coded as "B. Feeling or appearing down, depressed, or hopeless." This was documented as occurring two to six days

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2/22/2017. MD and RP had been notified on 7/31/2017.

2. A 100% audit of MARs will be completed by DON, ADON, Unit Managers or designee for current residents with orders for routine Anti-anxiety medication(s) to ensure orders are being followed as ordered by the physician.

3. Nursing staff (RN and LPN) will be re-educated by DON, ADON and/or designee on professional standards of care and on the process of checking physicians' orders to ensure orders are transcribed timely as ordered. This process will include 24 hour chart checks, daily check of physicians' orders by Unit Managers or designee.

4. Audits will be completed by DON; ADON; Unit Managers and/or designee; 2 times per week x 4 weeks; weekly x 4 weeks and every-other-week x 1 month; 5 current residents and 5 new admissions/re-admissions orders will be validated to ensure orders for routine anti-anxiety medications are transcribed in the MARs timely. Variances will be investigated and corrections

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during the assessment. Review of Resident #9's care plan created on 3/16/17 documented, "Focus. (Name of resident) triggered for little interest/pleasure in doing things, feeling down, trouble sleeping, feeling tired/little energy, poor appetite, feeling bad about herself and trouble concentrating. Interventions. Administer medications as ordered. Monitor/document for side effects and effectiveness."

Review of the physician's orders dated and signed on 6/22/17 documented, "Buspar 5 mg i (one) po (by mouth) Bid (twice a day) -- anxiety."

Review of the July 2017 MAR documented, "Buspar 5 mg i po Bid - anxiety. 6-22-17." Review of the MAR did not evidence documentation that the Buspar had been given from 7/1/17 through 7/22/17.

Review of the nurse's notes dated 7/31/17 at 12:15 p.m. documented, "rp (responsible party) is aware resident has not received her buspar in July (sic), she is aware residents (sic) remeron (2) dose has been increased....rp is in agreement with new orders."

Review of the medication error report dated 7/31/17 documented, "buspar not transcribed to July 2017 MAR. resident did not receive buspar in July 2017 no negative outcome."

Review of the July 2017 nurse's notes did not evidence documentation regarding a change in the resident's behavior.

Review of the physician's notes dated 7/31/17 at 2:43 p.m. documented, "was asked to see pt (patient) due to med (medication) review. it

made as appropriate. An analysis of the audits will be provided to the QA Committee for additional oversight and recommendations.

5. The facility dutifully alleges compliance of these tasks on or before 10/15/2017.

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appears that buspar has not been given for aprox. (sic) 1 month so will continue as d/c (discontinue) order. pt has reportedly had a decrease in appetite. no behavioral issues reported or noted.

An interview was conducted on 8/30/17 at 12:10 p.m. with LPN (licensed practical nurse) #4, the unit manager. When asked the process staff follow to check the MAR from month to month, LPN #4 stated, "After the MARs are completed, usually an RN (registered) nurse does a second check." When asked about Resident #9's Buspar, LPN #4 stated, "I was following up on something else and noticed it (the Buspar) hadn't been given. I had to check the orders and notify the doctor, RP, director of nursing and administrator." When asked what occurred next, LPN #4 stated, "Then the NP (nurse practitioner) would check to see if there had been any change in behavior."

An interview was conducted on 8/30/17 at 12:45 p.m. with LPN #3, the nurse who performed the second check on Resident #9's July 2017 MAR. When asked the process staff follow to check the MAR from month to month, LPN #4 stated, "Okay, they (the MARs) come in between the 15th and 18th. They have to check the old MAR with the new MAR and the POS (physician order set) and verbal orders. Then you have to make any changes on the new set of MARs." When asked to review Resident #9's July 2017 MAR, LPN #3 stated, "That one (the Buspar) didn't get transcribed over. I think it was when we moved to the new pharmacy and we got new verbal orders and sometimes you can't see it on the carbon (copy). That's the only thing I can think of."

On 8/30/17 at 4:25 p.m. ASM (administrative staff

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

On 8/31/17 at 8:45 a.m. ASM #3, the assistant director of nursing was asked what professional standards the staff used, ASM #3 stated, "We use MED-PASS." Review of the facility's policy titled, "Medication Orders" did not evidence documentation regarding month to month MAR review or transcription of physicians orders.

According to "Fundamentals of Nursing-Lippincott, Williams and Wilkins 2007 page 169, "After you receive a written medication order, transcribe it onto a working document approved by your health care facility...read the order carefully, concentrate on copying it correctly, check it when you're finished."

No further information was provided prior to exit.

(1) Buspar -- Buspirone hydrochloride tablets, USP are an antianxiety agent that is not chemically or pharmacologically related to the benzodiazepines, barbiturates, or other sedative/anxiolytic drugs. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=33accd6b-10a6-5bd3-e054-00144ff88e88

(2) Remeron -- Mirtazapine is a tetracyclic antidepressant with a somewhat unique mechanism of action. This information was obtained from: https://pubchem.ncbi.nlm.nih.gov/compound/mirtazapine#section=Top

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F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 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 staff interview, facility document review	F 309	**1.** We are unable to document blood pressures not previously documented in June, July and August for resident #4. Resident #4 has not demonstrated any adverse outcomes from blood pressure not obtained 5 out of 13 opportunities in June, July and August. NP was notified on 9/19/17. We are not able to document on application and removal of TED stockings not previously documented during the months of November and December for resident #26. **2.** A 100% audit of MARs for current residents with orders for weekly blood pressure will be audited by Unit Managers, ADON and/or designee to ensure physicians' orders for weekly blood pressure checks are followed and documented accordingly. A 100% audit of TAR's for current resident with orders for TED stockings will be completed by Unit Managers, ADON and/or designee to ensure application and removal of TED stockings occur and documented per physicians' orders.	

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and clinical record review and during the course of a complaint investigation, it was determined that facility staff failed to provide care and services to maintain the highest level of well-being for two of 29 residents, Resident #4 and Resident #26.

1. The facility staff failed to obtain Resident #4's blood pressures every Friday as ordered by the physician for five out of 13 opportunities in June, July and August 2017.

2. The facility staff failed to apply TED (1) stockings to Resident #26 as ordered by the physician.

The findings include:

1. The facility staff failed to obtain Resident #4's blood pressures every Friday as ordered by the physician for five out of 13 opportunities in June, July and August 2017.

Resident #4 was admitted to the facility on 3/22/17 with diagnoses that included but were not limited to: dementia, high blood pressure and anxiety. The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/2/17 coded the resident have having scored a three out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely cognitively impaired. The resident was coded as requiring minimum assistance with activities of daily living.

Review of the physician's orders dated August 2017 documented, "OBTAIN BLOOD PRESSURE EVERY FRIDAY 3-11 (3:00 p.m. to

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3. Nursing staff will be re-educated on the standards of care and services to maintain the highest level of well-being to include, the importance of checking and recording weekly blood pressures and the application and removal of TED stockings as ordered by physician.

4. Audits will be completed by Unit Managers, DON, ADON and/or designee for current residents, new admissions/re-admissions with physicians' orders for weekly blood pressure checks to ensure physicians' orders for weekly blood pressure checks are followed and documented accordingly: 10% of physicians' orders will be audited 2 times per week x 4 weeks; then weekly x 4 weeks; and then bi-weekly x 1 month. Variances will be investigated and corrections made as appropriate. An analysis of the audits will be provided to the QA Committee for additional oversight and recommendations.

Audits will be completed by Unit Managers, DON, ADON and/or designee for current residents, new admissions/re-admissions with physicians' orders for TED stockings to ensure application and

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11:00 p.m. shift)." The order date was documented as 3/29/17.

Review of the care plan did not evidence documentation regarding the resident's high blood pressure.

Review of the June 2017 MAR (medication administration record) documented, "OBTAIN BLOOD PRESSURE EVERY FRIDAY." There was no blood pressure documented on 6/2/17, 6/9/17, 6/16/17.

Review of the July MAR documented, "OBTAIN BLOOD PRESSURE EVERY FRIDAY." There was no blood pressure documented for 7/14/17.

Review of the August MAR documented, "OBTAIN BLOOD PRESSURE EVERY FRIDAY." There was no blood pressure documented for 8/4/17.

Review of the June, July and August 2017 nurses' notes did not evidence documentation of the blood pressures.

Review of the vital sign summary sheet did not evidence documentation of the blood pressures.

An interview was conducted on 8/30/17 at 12:10 p.m. with LPN (licensed practical nurse) #4, the nurse who cared for Resident #4 on 8/4/17. When asked to review the August 2017 MAR for Resident #4's blood pressure, LPN #4 stated, "Those look like my initials." When asked what the blank space on the MAR indicated, LPN #4 stated, "I'll have to check the nurse's notes." LPN #4 checked the nurse's notes for 8/4/17 and stated, "I don't see one (blood pressure) either."

removal of TED stockings occur and documented per physicians' orders: 10% of physicians' orders will be audited 2 times per week x 4 weeks; then weekly x 4 weeks; and then bi-weekly x 1 month. Variances will be investigated and corrections made as appropriate. An analysis of the audits will be provided to the QA Committee for additional oversight and recommendations.

5. The facility dutifully alleges compliance of these tasks on or before 10/15/2017.

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When asked if the blood pressure was taken, LPN #4 stated, "No."

On 8/30/17 at 4:25 p.m. ASM #1, the administrator and ASM #2, the director of nursing was made aware of the findings.

An interview was conducted on 8/31/17 at 8:30 a.m. with ASM (administrative staff member) #3, the assistant director of nursing. When asked what the blank spaces for blood pressures meant on Resident #4's June, July and August 2017 MARs, ASM #3 stated, "Huh. If it's not documented, it wasn't done."

Review of the facility's policy titled, "Medication and Treatment Orders" did not address following physician's orders.

No further information was provided prior to exit.

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

2. The facility staff failed to apply TED (1) stockings to Resident #26 as ordered by the physician.

The resident no longer resided at the facility. The closed record was reviewed. Resident #26 was admitted to the facility on 4/7/16 and readmitted on 1/1/17 with diagnoses that included but were

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not limited to: stroke, high blood pressure, dementia, urinary retention and kidney disease. The most recent MDS, a 14-day assessment, with an ARD of 7/24/16 coded the resident as having scored a "99" on the BIMS indicating the resident did not answer any of the questions. The resident was coded as sometimes understanding and sometimes being understood. The resident was coded as having short and long term memory problems and as moderately impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could do after the meal tray was prepared.

Review of the care plan created on 9/20/16 and revised on 1/4/17 documented, "(Name of resident) received a one-time chemotherapy infusion into tumor in arm. Interventions. "TED stockings as resident tolerates."

Review of the physician's order dated and signed on 11/2/16 documented, "Ted hose ble (bilateral lower extremities) on in AM off HS (hour of sleep)."

Review of the November 2016 treatment records documented, "TED HOSE ON EVERY MORNING AND OFF AT BEDTIME (COMPRESSION STOCKINGS TO BLE.)" The stockings were documented as being applied and removed five times out of 28 days.

Review of the December 2016 treatment records documented, "TED HOSE ON EVERY MORNING AND OFF AT BEDTIME (COMPRESSION STOCKINGS TO BLA.)" The stockings were documented as being applied 14 out of 31 days and were documented as being removed ten out

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of 31 days.

Review of the November 2016 and December 2016 nurse's notes did not evidence documentation regarding the TED stockings.

Review of the 11/4/16 IDT (interdisciplinary team) meeting documented, "Need to be putting the Ted (sic) stockings on every day."

Review of the 11/11/16 IDT meeting documented, "Concerned that Ted (sic) stockings were not on and Resident's legs were very swollen."

Review of the nurse's note dated 1/3/17 documented, "He did have a hospital admission prior to that for lower ext (extremity) edema and increased confusion. This was 11/6/16. His pain meds (medications) were increased at that time. He had an order for Ted (sic) stockings and MD (medical doctor) ordered for them to be left off D/T (due to) (arrow pointing up indicating increased) pain."

Further review of the physician's orders did not evidence documentation that the TED stockings had been discontinued.

An interview was conducted on 8/31/17 at 6:45 a.m. with CNA (certified nursing assistant) #4, an aide who worked with Resident #26. When asked who put the TED stockings on the resident, CNA #4 stated, "We do sometimes." When asked how staff knew a resident needed to have the TED stockings applied, CNA #4 stated, "The nurses let us know which ones have TEDs." When asked if she remembered if Resident #26 had TED stockings, CNA #4 could not recall.

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An interview was conducted on 8/31/17 at 6:55 a.m. with LPN (licensed practical nurse) #5, the unit manager where Resident #26 had resided. When asked who put TED stockings on the residents, LPN #5 stated, "The CNA's in the morning and they get removed at night. The nurses should be checking that they (the TED stockings) are on." When asked if this would be documented, LPN #5 stated, "Yes." LPN #5 was asked to review Resident #26's treatment records (TAR) for November and December 2016. After reviewing the TARs, LPN #5 stated, "Yes, some signatures are missing and there's no documentation on the back. That's what they should be doing. I thought he (the doctor) may have discontinued them (the TED stockings) because his heels were getting boggy (soft) and we thought it might have been the TED hose were too tight."

An interview was conducted on 8/31/17 at 8:30 a.m. with ASM (administrative staff member) #3, the assistant director of nursing and the nurse who wrote the 1/3/17 nurse's note for Resident #26. When asked if she recalled the family voicing concerns that Resident #26's TED stockings were not put on, ASM #3 stated, "Yes I do. I remember they complained about the TEDs. I remember doing education about which CNA was to put them on and to ensure they were on when he got up." When asked why the TED stockings were ordered, ASM #3 stated, "He had lower extremity edema." When asked about the order to discontinue the TED stockings, ASM #3 stated, "I wouldn't have put that, there must be an order somewhere." ASM #3 stated she was going to check for the order. ASM #3 never returned with the discontinuation order.

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F 309	Continued From page 88 On 8/31/17 at 10:50 a.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. (1) TED stockings -- Compression stockings play an important role in the management of venous disease, venous ulcers, and preventing thromboembolic disease of the deep venous system in the legs. This information was obtained from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4032012/	F 309		
F 315 SS=D	COMPLAINT DEFICIENCY 483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one	F 315	1. We are unable to document assessment or monitoring of urinary output in the Foley catheter for resident #26 not previously documented on 12/31/16 and 1/1/17. 2. A 100% audit of TAR's and urinary output flow sheet for current residents will be completed by ADON, Unit Managers and/or designee to ensure appropriate assessment and monitoring of residents with Foley catheter. 3. Nursing staff will be re-educated by DON, ADON, Unit Managers and/or designee on the importance of assessing, monitoring and documenting the health status of residents who use a Foley catheter.	

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is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and

(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to provide one of 29 residents in the survey sample, (Resident #26) the appropriate care & services for the care of an indwelling urinary catheter.

The facility staff failed to assess and monitor Resident #26's lack of urinary output in the Foley catheter on 12/31/16 on the 3:00 p.m. to 11:00 p.m. and 11:00 p.m. to 7:00 a.m. shifts and on 1/1/17 on the 7:00 a.m. to 3:00 p.m. shift.

The findings include:

Resident #26 no longer resided at the facility. The closed record was reviewed.

Resident #26 was admitted to the facility on 4/7/16 and readmitted on 1/1/17 with diagnoses

4. Audits will be completed by Unit Managers, DON, ADON and/or designee for current residents, new admissions/re-admissions with physicians' orders for use of Foley catheter to ensure appropriate assessment and monitoring of residents with Foley catheter: 10% of output flow sheets will be audited 3 times per week x 4 weeks; then 2 times/week x 4 weeks; and then bi-weekly x 1 month. Variances will be investigated and corrections made as appropriate. An analysis of the audits will be provided to the QA Committee for additional oversight and recommendations.

5. The facility dutifully alleges compliance of these tasks on or before 10/15/2017.

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that included but were not limited to: stroke, high blood pressure, dementia, urinary retention and kidney disease. The most recent MDS, a 14-day assessment, with an ARD of 7/24/16 coded the resident as having a "99" on the BIMS indicating the resident did not answer any of the questions. The resident was coded as sometimes understanding and sometimes being understood. The resident was coded as having short and long term memory problems and was moderately impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could do after the meal tray was prepared. The resident was coded as having a urinary catheter.

Review of Resident #26's care plan initiated on 9/9/16 and revised on 11/6/16 documented, "Focus. (Name of Resident #26) has Indwelling Catheter: DX: obstructive uropathy (inability to pass urine). Interventions. Monitor and document intake and output as per facility policy. Monitor/record/report to MD (medical doctor) for s/sx (signs and symptoms) UTI (urinary tract infections): ... no output..."

Review of the physician's orders dated and signed 10/11/16 documented, "(Change) foley (urinary catheter) Q (every) Tuesday..."

Review of the December 2016 treatment record documented, "Indwelling Foley." It was documented Resident #26's catheter was in place.

Review of Resident #26's intake and output record for 12/31/16 on the 3:00 p.m. to 11:00 p.m. shift documented, "0 [a line through it] (Sometimes empties himself)." On 12/31/16 on

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the 11:00 p.m. to 7:00 a.m. shift the resident's output section was blank. On 1/1/17 on the 7:00 a.m. to 3:00 p.m. shift the output section was blank.

Review of the nurses' notes for 12/31/16 did not evidence documentation regarding Resident #26's lack of urinary output from his Foley catheter or an assessment of the resident.

Review of the nurses' notes for 1/1/17 on the 7:00 a.m. to 3:00 p.m. shift did not evidence documentation regarding Resident #26's lack of urinary output from his Foley catheter or an assessment of the resident.

Review of the nurse's notes for 1/1/17 at 5:00 p.m. documented, "Res (resident) noted (with) (no) output 7-3 [7:00 a.m. to 3:00 p.m.] shift. Res noted with blood around penis. Attempted to (change) foley (without) success. Res ABD (abdomen) noted to be distended. Res has (increased) pain. At time blood streaming from penis...On Call (name of physician) gave N.O. (new order) to send to ER (emergency room) 911. RP (responsible party) phone + is aware."

Review of the emergency room notes for 1/1/17 at 6:39 p.m. documented, "16 f (french) foley cath (catheter) place with ease and 700mls (milliliters) purple urine returned."

Review of the emergency room nurse's note for 1/1/17 at 9:05 p.m. documented, "900 cc (cubic centimeters) merlot color (sic) urine drained from foley bag."

Review of the physician's note at the hospital for

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1/1/17 at 7:29 p.m. documented, "He (Resident #26) was brought to ED (emergency department) because of hematuria (bloody urine) after Foley catheter was removed today. He is a (name of nursing facility) nursing home resident, his nurse aid noted the he had not passed any urine output since yesterday. She manipulated Foley to drain his urine but did not work, then removed Foley catheter. She noted large amount of hematuria and she could placed (sic) Foley back...In ER, he was found to be dehydrated...and Foley catheter was placed and 1800 cc of dark bloody urine was drained. Details: (1) AKI (acute kidney injury) AKI due to dehydration and/underlying urinary retention..."

The CNAs who worked with Resident #26 no longer worked at the facility and could not be interviewed.

The nurses who cared for the resident on 12/31/16 3:00 p.m. to 11:00 and 11:00 p.m. to 7:00 a.m. were unable to be contacted.

An interview was conducted on 8/30/17 at 5:20 p.m. with CNA (certified nursing assistant) #8. When asked how often a urinary catheter bag is emptied, CNA #8 stated, "You empty it at least every shift and as needed." When asked what staff did if the resident did not have any urine in the catheter bag, CNA #8 stated, "We would tell the nurse. There's a book in there (indicating the nurses' station) for the nurse to see it." When asked if there would be any time an output would not be documented, CNA #8 stated, "No."

An interview was conducted on 8/31/17 at 6:45 a.m. with CNA #4. When asked how often a urinary catheter bag was emptied, CNA #4 stated,

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"Each shift. Mostly empty it at the end of the shift." When asked if this was documented, CNA #4 stated, "We used to but they told us we don't have to measure it." When asked when this occurred, CNA #4 stated, "A few months ago." When asked what staff did if there was no urine in the catheter bag, CNA #4 stated, "I tell the nurse and they usually have us push fluids on them." When asked if she remembered Resident #26 she stated she did not.

An interview was conducted on 8/31/17 at 7:15 a.m. with LPN (licensed practical nurse) #5, the unit manager. When asked when staff had stopped measuring the urinary output from the catheter bags, LPN #5 stated, "When (name of previous director of nursing) was here, yes we did I and Os (intake and outputs). (Name of assistant director of nursing) said it was more a nursing measure and we didn't have do I and Os." When asked when this occurred LPN #5 stated, "Probably around mid-December." When asked what staff were to do if a resident did not have any urinary output, LPN #5 stated, "Go and assess why (no output). The first thing I would do is to make sure the catheter is intact. Palpate (the abdomen) for distention and call the doctor." When asked if she recalled Resident #26's lack of urinary output on 12/31/16 and 1/1/17, LPN #5 stated, "I remember when there was no urinary output. I was told it was overnight. The aide didn't report that there wasn't any urine in the bed bag."

An interview was conducted on 8/31/17 at 8:30 a.m. with ASM (administrative staff member) #3, the assistant director of nursing. When asked what staff should do if a resident did not have any urine output in their catheter bag, ASM #3 stated, "Give it about eight hours. If there's no output in

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eight hours, I know something's wrong." When asked what staff should do then, ASM #3 stated, "It should be communicated." When asked if she recalled when Resident #26 had no urinary output, ASM #3 stated, "What I understood was he wasn't having much output. The nurse irrigated the Foley. She couldn't get the Foley and the doctor said to send him to the hospital."

An interview was conducted on 8/31/17 at 10:15 a.m. with LPN #10, the nurse who cared for the resident on 1/1/17. When asked what she remembered about Resident #26 and the lack of urinary output on 1/1/17, LPN #10 stated, "The CNA came to me. It was during shift change. At the end of the shift there wasn't much output in his Foley." When asked if that was the first time she had been made aware of the resident's lack of output, LPN #10 stated it was. When asked if the night shift had reported that the resident did not have any urinary output for the past 16 hours, LPN #10 stated they hadn't. When asked what occurred next, LPN #10 stated, "I let the doctor know and I called the family which was the granddaughter. the patient was not in distress; his vital signs were stable. The granddaughter thought we had done something wrong." When asked if the resident was able to empty his own catheter bag, LPN #10 stated, "No he wasn't able to empty it. But he would pull on it at times."

On 8/31/17 at 10:50 a.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled, "Catheter Care, Urinary" documented, "Input/Output 1. Observe the resident's urine level for noticeable increases or decreases."

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F 315	Continued From page 95 No further information was provided prior to exit. COMPLAINT DEFICIENCY	F 315		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review it was determined that facility staff failed to maintain a safe environment for two of 29 residents in the survey	F 323	**1.** Resident #28 has not demonstrated any residual adverse outcomes from the resident to resident altercation which occurred on 6/14/2017. Resident #28 was seen by Geri-Psych on 7/11/17, 7/24/17, 8/9/17, 8/14/17 and 8/25/17. Resident #11 has not demonstrated any residual adverse outcomes from the resident to resident altercation which occurred on 6/14/2017 On 9/19/17, the plan of care was updated to address resident # 11's involvement in a resident to resident altercation. On 9/19/17, the plan of care was updated to address resident # 28's involvement in a resident to resident altercation. **2.** A 100% audits of incidents involving resident to resident altercations starting from 8/1/2017 will be completed by Social Services, ADON, DON or designee for current residents to ensure implementation of interventions to maintain residents' safety.	

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sample, Resident #28 and for one of two nursing units, the north unit.

The facility staff failed to implement intervention to ensure Resident #28 was safe from Resident #11 after a resident to resident altercation occurred on 6/14/17.

The findings include:

The facility staff failed to implement intervention to ensure Resident #28 was safe from Resident #11 after a resident to resident altercation occurred on 6/14/17.

Resident #28 was admitted to the facility on 7/716 with diagnoses that included but were not limited to Alzheimer's disease, anxiety disorder, and dysphagia (difficulty swallowing). Resident #28's most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 7/18/17. Resident #28 was coded as being severely impaired in cognitive function scoring 99 on the BIMS (Brief Interview for Mental Status) exam.

Resident #11 was admitted to the facility on 2/24/14 and readmitted on 2/22/16 with diagnoses that included but were not limited to major depressive disorder, muscle weakness, stroke, atrial fibrillation, and COPD (chronic obstructive pulmonary disease). Resident #11's most recent MDS (minimum data set) was quarterly assessment with an ARD (assessment reference date) of 8/7/17. Resident #11 was coded as being severely cognitively impaired in the ability to make daily decisions scoring 99 out

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3. Nursing staff will also be re-educated by DON, ADON and/or designee on the importance of updating the plan of care after a resident to resident altercation has occurred and the need for Geri-Psych consult as appropriate.

   Nursing staff will be re-educated by Social Services, DON, ADON and/or designee on the importance of implementing interventions to maintain residents' safety after a resident to resident altercation has occurred.

4. Audits will be completed by Social Services and/or designee on plan of care for residents involved in resident to resident altercations as follow: 10% of plans of care will be audited 2 times per week x 4 weeks; weekly x 4 weeks; and then bi-weekly x 1 month. Variances will be investigated and corrections made as appropriate. An analysis of the audits will be provided to the QA Committee for additional oversight and recommendations.

   Audits will be completed by Social Services and/or designee to ensure implementation of interventions for

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of 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of an incident report dated 6/14/17 documented the following: "Reported observed male resident (Resident #11) smashing her (Resident #11) head into table. Resident crying and small red area on forehead...additional comments and/or steps taken to prevent reoccurrence: Geri psych. (geriatric psychiatry)"

Review of Resident #28's nursing notes revealed the following note dated 6/14/17: "crying (sic), holding head with hand, Objective: red area on forehead. no (sic) swelling, no pain or discomfort when palpitated. Assessment: No swelling, no s/s (signs/symptoms) of pain or discomfort. Plan: monitor for late bruising. monitor (sic) for s/s of pain in frontal cranial region x 3 days. offer (sic) resting in evening."

Review of Resident #28's care plan dated 7/21/16 and revised 7/25/17 failed to reveal the altercation between Resident #28 and Resident #11.

Review of Resident #28's clinical record failed to reveal that an intervention was put into place to keep her safe from Resident #11. Further review of Resident #28's clinical record failed to an appointment with Geri-psych was made.

Review of Resident #11's clinical record revealed Geri-psych had seen him on 6/22/17 and made medication adjustments.

On 8/30/17 at 9:59 a.m., an interview was conducted with LPN (licensed practical nurse) #6. When asked the process if she were to see a resident to resident altercation, LPN #6 stated

residents involved in resident to resident altercations as follow: 10% of interventions will be audited 2 times per week x 4 weeks; then weekly x 4 weeks; and then bi-weekly x 1 month. Variances will be investigated and corrections made as appropriate. An analysis of the audits will be provided to the QA Committee for additional oversight and recommendations.

5. The facility dutifully alleges compliance of these tasks on or before 10/15/2017

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that she would immediately separate the residents, interview and assess the situation to see what the issue was, assess for injuries and then complete an incident report. LPN #6 stated that she would also refer both resident to geri pysch, especially for any resident on the north (locked) unit. LPN #6 stated that the residents on the north unit may need medication adjustments. LPN #6 stated that both the aggressor and the victim should have interventions in place to prevent future altercations and to ensure resident safety. When asked if the care plan should be updated after an altercation, LPN #6 stated the care plan should be updated especially if there is any injury. LPN #6 was not aware of an altercation between Resident #28 and Resident #11.

On 8/30/17 at 10:55 a.m., an interview was conducted with CNA (certified nursing assistant) #1, a CNA who frequently works with Resident #11 and #28. When asked about Resident #11's behaviors, CNA #1 stated that Resident #11 did not have too many behaviors and that he is sometimes resistant to care. CNA #1 stated that he will sometimes try to grab other resident's food during meals if he does not receive his meal first. CNA #1 was not aware of an altercation between Resident #28 and Resident #11.

On 8/30/17 at approximately 11:15 a.m., an interview was conducted with LPN #4, the unit manager. When asked how she would ensure a resident was safe from another resident after a resident to resident altercation on the north unit, LPN #4 stated that facility staff would try to redirect the residents from going near each other but there was only so much they could do because most residents were demented on the

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north unit and forget that the altercation had occurred. LPN #4 stated that both residents would also be referred to Geri-psychology for an assessment and medical review. LPN #4 stated that both care plans (the aggressor and victim) should be updated after a resident to resident altercation. LPN #4 stated the care plans could be updated by any nurse.

On 8/31/17 at 7:58 a.m., an interview was conducted with OSM (other staff member) #9, the social worker and OSM #11, the social work assistant. When asked the social worker's role and the process when there is a resident to resident altercation, OSM #9 stated that whenever there is a resident to resident altercation, the incident report and care plan for each resident is brought to the morning stand up meeting the next day. OSM #9 stated that the IDT (interdisciplinary team) will collectively discuss what had happened and refer both residents; the aggressor and victim, to Geri-psychology. OSM #9 stated that Geri-psychology is usually the go-to intervention for residents on the North (locked) unit because most residents are on a variety of psychoactive medications that may need adjustment. OSM #9 stated that it was her, the social worker who was responsible for ensuring residents are evaluated by Geri-psychology. OSM #9 stated that other interventions would also be implemented after a resident to resident altercation for both the aggressor and victim to ensure resident safety. OSM #9 stated that sometimes residents will be given a barrier strip to deter wandering resident to enter their rooms. OSM #9 stated that social work will also assess the resident's psychosocial well-being if a nurse alerts them that the resident involved in the altercation is having distress or

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behavior changes. When asked if they only assess a resident if a nurse alerts them; OSM #11 stated, "That is actually not true. We are always on the unit making rounds, so if we see a change in behavior we will assess the resident. We would only document if there was change."

When asked what was put into place to ensure resident safety for Resident #28 from Resident #11, OSM #9 stated that she was not made aware of the resident to resident altercation between her and Resident #11 on 6/14/17 until now. OSM #9 stated that the altercation was not on the incident and accident log for June. OSM #9 could not determine what the facility had put into place to ensure Resident #28's safety after her incident with Resident #11. When asked who was responsible for updating the care plan after a resident to resident altercation, OSM #9 stated that anyone in the IDT meeting could update the care plans with the new interventions. OSM #9 confirmed that she could not find where Resident #28's care plan was updated after the 6/14/17 altercation.

On 8/31/17 at 9:00 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #4, the administrator in training were made aware of the above concerns.

The facility policy titled "Safety and Supervision of Residents" documents in part, the following: "Our facility strives to make the environment as free from accidents hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities...Resident-oriented approach to safety. 1. Our resident-oriented approach to safety and

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F 323	Continued From page 101 accident hazards for individual residents. 2. Staff shall use various sources to identify risk factors for residents, including the information obtained from the medical history, physical exam, observation of the resident, and the MDS. 3. The interdisciplinary team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for that resident. The care team shall target interventions to reduce the potential for accidents. 4. Implementing interventions to reduce accident risks and hazards shall include the following: a. community specific interventions to all relevant staff; b. assigning responsibility for carrying out interventions; c. providing training, as necessary. d. ensuring that interventions are implemented; and e. documenting interventions."	F 323		
F 360 SS=E	483.60 PROVIDED DIET MEETS NEEDS OF EACH RESIDENT The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. 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 provide food at the correct nutritive value on one of two units, the North Unit. The facility staff failed to provide residents the correct portion of roast pork and gravy for the	F 360	**Provided Diet Meets Needs of Each Resident** 1. On 8-29-17 residents on North Unit that were not served the proper 3oz portion of pork with gravy were offered additional food to ensure that nutritive values were met. 2. On 8-29-17 current in-house residents on all units were offered additional food to ensure that nutritive values were met. Education was completed by the	

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F 360	Continued From page 102 8/29/17 noon meal. The findings include: An observation was made on 8/29/17 at 11:55 a.m. of the noon meal for the North Unit. The servings of the roast pork ranged from approximately three inches long and one-inch-wide and one-inch-thick to three inches long and three inches wide and one inch thick. The pork was sitting in a gravy. The dietary aide would put the pork on the plate using tongs without adding gravy to the meat. A request was made on 8/29/17 at 12:38 p.m. from OSM (other staff member) #6, the dietary manager for a food scale. OSM #6 returned stating she couldn't find her scale. An interview was conducted with OSM #18, the dietary aide who served the pork. When asked if she noticed anything about the pork, OSM #18 stated, "Some were big and some were small." When asked if there was supposed to be gravy on the pork, OSM #18 stated, "It was with the pork." When asked how much gravy should have been given with the pork OSM #18 didn't have a response. When asked what the serving size of the pork should be, OSM #18 didn't have a response. An interview was conducted on 12:41 p.m. with OSM #6, the dietary manager. When asked about the portion sizes, OSM #6 stated, "They should use the three-ounce scoop. Not the tongs." An interview was conducted on 8/29/17 at 12:45 p.m. with OSM #19, the cook. When asked how the roast pork was to be served, OSM #19 stated, "Use the tongs and use the spoon to ladle gravy	F 360	Continued From page 102 Dietary Manager on using the correct serving utensils. 3. Education on serving size will be completed and Serving size menu and scoop chart placed on each serving cart and in cook's area. 4. A weekly audit to be completed by facility management or designee three times a week for 6 weeks during meal service to ensure proper utensil usage. Audits will be brought to facility quality assurance meetings monthly and quarterly. 5. Corrective action will be accomplished October 15th 2017.	

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F 360	Continued From page 103 on top." OSM #19 was asked what he thought the portion size was for the roast pork that had been sent to the North Unit. OSM #19 stated, "I try to give them at least three ounces." When informed of the above observation of portion sizes, OSM #19 agreed that the residents probably did not all receive three ounces as ordered. Review of the facility's menu documented, "Tuesday, Aug 29. Lunch. Caribbean Pork Roast 3 oz. (ounces) pro (protein) + 1 oz. sce (sauce)." On 8/29/17 at 6:00 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit.	F 360		
F 364 SS=B	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (d) Food and drink Each resident receives and the facility provides- (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and facility document review, it was determined that the facility staff failed to provide food that was palatable on one of two units, the North Unit. The facility staff failed to keep food at a palatable	F 364	**Nutritive Value / Appearance / Palatability / Preferred Temp** 1. On 8-29-17 it was determined by sampling a test tray on the North Unit that the lunch meal that was being served was not at a palatable temperature and consistency. Additional food was offered to current in-house residents on all units that offered complaints of the food not being to a palatable. 2. Food items to be temped at each meal at the point of serving. Current vegetable inventory to be audited to ensure product is satisfactory and as written in menu.	

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temperature and to ensure that breads did not get placed on the resident's tray to prevent it from becoming soggy.

The findings include:

Review of the last three months of the resident council meeting minutes documented, "June 13, 2017 New Business. Food issues and concerns addressed Dietary. August 21, 2017. New Business. Food issues/Concerns were forwarded to Dietary manager."

A group resident interview was conducted on 8/28/17 at 2:00 p.m. with seven residents, six of the residents were cognitively intact and one of the residents was severely impaired cognitively. When asked if the food was hot when it was supposed to be the residents stated, "The food is cold in the dining room and in our rooms." When asked how the food tasted, the residents stated, "It's terrible. We don't get what we order. When we get broccoli we only get the stalks, we never get the florets. They put the bread on the plate and it gets all wet. I can't eat them." A resident stated, "We gave them a 13-page list of concerns in February." When asked what the response had been, the resident stated they had not been responded to and the food had not improved.

An observation was made on 8/29/17 at 11:55 a.m. of the noon meal. When the food arrived from the kitchen OSM #18, the dietary aide asked this surveyor if she should check the temperature of the food. This surveyor asked OSM #18 to follow the normal routine. OSM #18 then began serving the residents. OSM #18 placed the pork, cauliflower and sweet potatoes on the plate and then put a corn meal muffin on top of the food. At

3. Education will be conducted for dietary cooks on the importance of taking and documenting temperatures of food items at the point of serving , and proper serving technique of food items.

4. A Test tray audit will be completed three times a week for 6 weeks to include bread is wrapped, vegetables are in bowls and are good quality, and food items temperature is palatable by a non-dietary staff member. Audit results will be brought to the facility QQA meeting.

5. Corrective action will be accomplished October 15th 2017.

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approximately 12:10 p.m. staff began requesting foil covers on the food that was being delivered to residents in the dining room. When asked if this was normal routine, OSM #18 stated it was.

When all of the residents were eating a request for a test tray was made. OSM #6, the dietary manager was in attendance. OSM #18 checked the temperature of the food and the pureed peas were 120 degrees and the pureed chicken was 118 degrees. OSM #6 was asked what temperature she wanted the food to be served at, OSM #6 stated, "I like it to be 135 degrees." OSM #18 and this surveyor sampled the food. The pureed peas were cool and had a bitter taste and the hulls were present throughout. The pureed chicken was cool in temperature. The corn meal muffin was soggy on the bottom. OSM #18 agreed with the findings.

An interview was conducted on 8/29/17 at 1:15 p.m. with OSM #6, the dietary manager. When asked if she was aware of a 13-page letter the residents had provided regarding their concerns about the food, OSM #6 stated, "That went to our corporate guy. He came to the meeting." When asked what the outcome of those concerns were, OSM #6 stated, "No, I'll have to email (name of corporate employee). I'm having problems with this vendor." When asked if they were aware that the residents received broccoli stalks, OSM #6 stated, "It's a horrible product. They want florets but they're only getting the stalks." When asked if the resident's received what they chose from the menu, OSM #6 stated, "Not always. We're not getting what we asked for." When asked if it was normal routine to cover the food with foil for those residents eating in the dining room, OSM #6 stated, "No. They shouldn't do that." OSM #6

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F 364	Continued From page 106 attempted to find an aide who had served the meal but was not able to. When asked if she was aware that the residents complained that the food was cold, OSM #6 stated, "That's a consistent complaint." When asked if staff did any test trays to check the temperature and palatability, OSM #6 stated, "Not typically no." OSM #6 did not have a response to how this problem would be corrected. On 8/29/17 at 4:25 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. On 8/30/17 at 8:45 a.m. OSM #6 stated she did not have a response yet (from the corporate employee) about the resident's concerns.	F 364		
F 371 SS=E	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	F 371	**Food Procedures / Storage / Preparation / Service / Sanitation** 1. On 8-29-17 additional food was offered to any resident with a complaint of the food not being to a palatable temperature or consistency. 2. On 8-29-17 current in-house residents on all units were offered additional food to ensure that nutritive values were met. Education was completed by the Dietary Manager on using the correct serving utensils.	

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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 serve food in a sanitary manner for one of two units, the North Unit.

The facility staff failed to check the temperature of the food prior to serving the 8/29/17 noon meal on the north unit.

The findings include:

A group resident interview was conducted on 8/28/17 at 2:00 p.m. with seven residents, six of the residents were cognitively intact and one of the residents was severely impaired cognitively. When asked if the food was hot when it was supposed to be the residents stated, "The food is cold in the dining room and in our rooms." When asked how the food tasted, the residents stated, "It's terrible. We don't get what we order. When we get broccoli we only get the stalks, we never get the florets. The put the bread on the plate and gets all wet. I can't eat them." A resident stated, "We gave them a 13-page list of concerns in February." When asked what the response had been, the resident stated they had not been responded to and the food had not improved.

An observation was made on 8/29/17 at 11:55 a.m. of the noon meal. When the food arrived from the kitchen OSM (other staff member) #18,

3. CDM to begin test tray program and education will be conducted for dietary cooks on the importance of taking and documenting temperatures. Bread will be wrapped to keep it from getting soggy. The peas that were ordered will be removed from our inventory selection.

4. A Test tray audit will be completed three times a week for 6 weeks to include bread is wrapped, vegetables are in bowls and are good quality and temperature is palatable by a non dietary staff member. Audit results will be brought to the facility QQA meeting.

5. Corrective action will be accomplished by October 15th 2017.

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the dietary aide asked this surveyor if she should check the temperature of the food. This surveyor asked OSM #18 to follow the normal routine. OSM #18 then began serving the residents.

When all of the residents were eating a request for a test tray was made. OSM #6, the dietary manager was in attendance. OSM #18 checked the temperature of the food and the pureed peas were 120 degrees and the pureed chicken was 118 degrees. OSM #6 was asked what temperature she wanted the food to be served at, OSM #6 stated, "I like it to be 135 degrees." OSM #18 and this surveyor sampled the food. The pureed peas were cool and had a bitter taste and the hulls were present throughout. The pureed chicken was cool in temperature. The corn meal muffin was soggy on the bottom. OSM #18 agreed with the findings.

An interview was conducted on 8/29/17 at 12:40 p.m. with OSM #18, the dietary aide. When asked who checked the temperature of the food before serving. OSM #18 stated "The cook does temperatures before it comes up here.

An interview was conducted on 8/29/17 at 12:45 p.m. with OSM #6, the dietary manager. When asked who checked the temperature of the North Unit's food before serving, OSM #6 stated, "They are supposed to do it when the food gets here (the north wing). The cook does not check the temperature before it's sent out." When asked why food temperatures were taken OSM #6 stated it was to ensure the food was the proper temperature to prevent illness.

On 8/29/17 at 4:25 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the

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F 371	Continued From page 109 director of nursing were made aware of the findings. Review of the facility's policy titled, "Food Temperatures" documented, "Food will be served to the residents at an acceptable temperature. 4. Temperatures of the food in the steam table will be taken by the cook approximately 10 minutes before the star of tray service and again just as serving begins."	F 371		
F 372 SS=D	483.60(i)(4) DISPOSE GARBAGE & REFUSE PROPERLY (i)(4)- Dispose of garbage and refuse properly. 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 maintain the dumpster area in a manner to prevent pests. The findings include: On 8/29/17 at approximately 11:30 p.m., during an off-hours investigation, the dumpster was noted to have the side sliding doors open. A cat was noted outside the building in the area closest to the dumpster. On 8/30/17 at 10:28 a.m., in an interview with OSM #6 (Other Staff Member) the dietary manager, she stated that the dietary department is responsible for maintaining the dumpster and the dumpster doors should be closed to prevent pests. She stated that while she educated her staff on keeping the doors closed, that staff from other departments may not be as diligent in maintaining the dumpster area.	F 372	**Dispose of Garbage and Refuse** 1. The side sliding door was found to be open during an off hours visit at approximately 1130pm was closed. 2. An initial audit will be completed for proper use of the facility dumpsters located outside the building. 3. Facility wide education to be completed to ensure that all staff know proper dumpster usage. 4. Staff on 11pm to 7am shift will complete audits of the dumpster area to ensure doors are remaining closed after use 3 times a week for 6 weeks to ensure compliance. Results will be brought to the facility QQA meeting.	

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F 372	Continued From page 110 A review of the facility policy, "Disposal of Dietary Garbage & Refuse" documented, "4. Dumpster Area: A. Lid to dumpster is kept closed, when not in use. B. Maintenance /Housekeeping is responsible to ensure the area is free of debris, no foul odors and that the area is maintained in a sanitary fashion, to discourage harborage of pests." On 8/31/17 at approximately 12:50 p.m., the Administrator was made aware of the findings. No further information was provided by the end of the survey. According to the Federal Food and Drug Administration (FDA) regulations 2013; 5-501.110 Storing Refuse, Recyclables, and Returnables. REFUSE, recyclables, and returnables shall be stored in receptacles or waste handling units so that they are inaccessible to insects and rodents. 5-501.111 Areas, Enclosures, and Receptacles, Good Repair. Storage areas, enclosures, and receptacles for REFUSE, recyclables, and returnables shall be maintained in good repair. 5-501.113 Covering Receptacles. Receptacles and waste handling units for REFUSE, recyclables, and returnables shall be kept covered:.... (B) With tight-fitting lids or doors if kept outside the FOOD ESTABLISHMENT.	F 372	Continued From page 110 5. Corrective action will be accomplished October 15th 2017.	
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide	F 425	1. Resident #10 has not demonstrated any adverse outcome from not receiving the Clozaril on 4/12/17 and 4/13/17. On 4/13/17, the	

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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--

(1) Provides consultation on all aspects of the provision of pharmacy services in the facility;
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, resident interview, staff interview, and facility document review, it was determined that the facility staff failed to ensure a medication prescribed by the physician was available for administration for one of 29 residents in the survey sample; Resident #10.

Resident #10's Clozaril [1] (used to treat schizophrenia) was not available for administration on 4/12/17 and 4/13/17 as ordered by the physician.

The findings include:

Resident #10 was admitted to the facility on 7/23/15 with the diagnoses of but not limited to paranoid schizophrenia, hypoxemia, rheumatic mitral valve, hypothyroidism, anxiety, depression, asthma, and breast cancer.

The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 7/14/17. The resident was coded as being cognitively intact in ability to make

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physician was notified of the medication (Clozaril) not administered on 4/12/17 and 4/13/17.

2. A 100% audit of MARs will be completed by DON, ADON, Unit Managers or designee for current residents with orders for Clozaril and corresponding lab orders to ensure medication is available to be administered as ordered.

3. Nursing staff will be re-educated on the importance of ordering medication in a timely manner.

   Nursing staff will also be re-educated on the facility's protocol when faxing lab results with corresponding medication(s) to pharmacy , to include communicating with pharmacy personnel to ensure lab results have been received and obtain an expected delivery time for the medication.

4. Audits of MARs will be completed by ADON, Unit Managers and/or designee as follow; 2 times per week x 4 weeks; then weekly x 4 weeks, and then every-other-week x 1 month for 5 current residents and

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daily life decisions, scoring a 14 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam.

On 8/28/17 at 2:00 p.m., a group interview was held with 7 facility residents. Resident #10 was in the group and reported to a list of dates that she had written down in a notebook, when she said she did not get her Clozaril.

A review of the clinical record revealed a physician's order for clozapine 50 mg (milligrams) (most recently renewed on 7/4/17), daily at bedtime.

A review of the MAR (Medication Administration Record) revealed that the resident did not receive her Clozaril on 4/12/17 and 4/13/17, as evidenced by the nurse's initials being circled and the back of the MAR containing documentation that the medication was not available from the pharmacy.

On 8/31/17 at approximately 10:00 a.m., in an interview with LPN #5 (Licensed Practical Nurse) she stated that the resident's CBC (Complete Blood Count [2]) is taken monthly and faxed to the pharmacy at least a week before the Clozaril refill is due. LPN #5 stated that many times, the pharmacy would state they never received the lab work and would not send the Clozaril. She provided a copy of the resident's March CBC dated 3/24/17, and April 2017 CBC, dated 4/7/17. She stated that each was faxed to the pharmacy, yet when it was time to refill the Clozaril, the pharmacy claimed they did not have the lab work required to refill the medication. The lab for March 2017 had hand written dates of 3/27/17 and 4/10/17 on them and the April 2017 lab had hand written dates of 4/19/17, 4/12/17 and

5 new admissions/re-admissions to ensure availability of medication(s). Variances will be investigated and corrections made as appropriate. An analysis of the audits will be provided to the QA Committee for additional oversight and recommendations.

5. The facility dutifully alleges compliance of these tasks on or before 10/15/2017.

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4/13/17 on them. It was not entirely clear which, if any, of these dates correlated with the labs being faxed to the pharmacy. LPN #5 stated they are faxed as soon as they receive the lab results back. A copy of the facility policy for Clozaril protocol was requested at this time. None was provided by the end of the survey.

A review of Resident #10's care plan revealed one dated 8/3/15 for "Psychotropic Medication....Paranoid Schizophrenia...." Interventions included "MD/Pharmacy review of medications per policy."

The care plan also included one dated 11/3/15 for "...risk for mood problems r/t (related to) her history of psychiatric illness as well as her long term use of psychotropic medication." Interventions included "Administer medications as ordered..."

A review of the facility policy "Medication Ordering and Receiving from Pharmacy" did not address Clozaril, or lab-specific medication refill procedures.

On 8/31/17 at 10:50 a.m., the Administrator was made aware of the findings. No further information was provided by the end of the survey.

No policies specific to Clozapine protocols was provided.

[1] Clozapine (Clozaril) is used to treat schizophrenia.
Under the "What if I forget a dose" section of the

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below website, was documented, "If you miss taking clozapine for more than 2 days, you should call your doctor before taking any more medication. Your doctor may want to restart your medication at a lower dose."
Under the "Important Warnings" section of the below website, was documented, "Clozapine can cause a serious blood condition. Your doctor will order certain lab tests before you start your treatment, during your treatment, and for at least 4 weeks after your treatment. Your doctor will order the lab tests once a week at first and may order the tests less often as your treatment continues.....Because of the risks with this medication, clozapine is available only through a special restricted distribution program. A program has been set up by the manufacturers of clozapine to be sure that people do not take clozapine without the necessary monitoring called the Clozapine Risk Evaluation and Mitigation Strategies (REMS) Program. Your doctor and your pharmacist must be registered with the Clozapine REMS program, and your pharmacist will not dispense your medication unless he or she has received the results of your blood tests. Ask your doctor for more information about this program and how you will receive your medication."
Information obtained from https://medlineplus.gov/druginfo/meds/a691001.html

[2] According to Mosby's Medical Dictionary, sixth edition, 2002. St. Louis, MO: Mosby, Inc. Page 405, a CBC (complete blood count) is a blood test used to determine the number of red and white blood cells per cubic millimeter of blood; and is one of the most valuable screening and diagnostic techniques.

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F 425	Continued From page 115 Also, information obtained from https://medlineplus.gov/bloodcounttests.html In addition, the WBC (white blood count) component of the CBC is the component that is monitored for the use of Clozaril. WBC's help fight infection and Clozaril use can cause low WBC levels. Information obtained from https://medlineplus.gov/ency/article/003643.htm	F 425		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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	F 431	1. Residents were not identified as having adverse outcome (s) from the unlocked medication cart. 2. A 100% audit of med carts will be completed by ADON, Unit Managers and/or designee to ensure that medications carts are kept secured when nursing staff (RN or LPN) is not in attendance. 3. Nursing staff will be re-educated by ADON, Unit Manager and/or designee on the importance of securing the medication cart when not in attendance. 4. Audits of medication carts will be completed by Unit Managers and/or designee as follow; 3 out of 5 carts will be audited 2 times/week x 4 weeks, then weekly x 4 weeks to ensure compliance with securing medication carts. Variances will be	

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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 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 review of facility documentation it was determined the facility staff failed to ensure medications were safely secured on one of two units, the North Unit.

LPN (licensed practical nurse) #15 failed to lock a medication cart while administering medications to residents in the dining room. The medication cart was observed out of LPN #15's line of sight, and residents and staff were observed near and

investigated and corrections made as appropriate. An analysis of the audits will be provided to the QA Committee for additional oversight and recommendations.

5. The facility dutifully alleges compliance of these tasks on or before 10/15/2017.

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or passing by the unsecured medication cart on the North Unit.

The findings include:

An observation was made on 8/30/17 at 8:28 a.m. of an unlocked medication cart on the North Unit. The medication cart was facing the hallway and the back of the cart faced the resident dining room. There was no staff in attendance with the medication cart. At that time two staff members walked past the medication cart. There was a resident sitting on a bench approximately five feet from the medication cart. There were staff and residents in the dining room preparing for breakfast. There was a nurse in the dining room with her back partially turned away from the medication cart. The nurse was getting juice for a resident.

At 8:32 a.m. LPN (licensed practical nurse) #7 walked past the medication cart, slowed down, looked at the cart and then continued to walk away. Immediately behind the nurse was a staff member with a resident who walked past the cart.

At 8:33 a.m. LPN #7 walked past the medication cart with a male resident.

At 8:34 a.m. the nurse, LPN #15 was at the medication cart.

An interview was conducted on 8/30/17 at 8:34 a.m. with LPN #15, the nurse who was responsible for the medication cart. LPN #15 was asked when a medication cart was to be locked. LPN #15 stated, "When you're away from your cart. If you're not within eyesight." When asked if she was in direct line of sight with the medication

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cart while she was in the dining room, LPN #15 stated, "Yes, I only turned a little away." When asked if she was aware there was a resident sitting five feet in front of the medication cart or that staff and residents had passed her unlocked cart, LPN #15 did not respond.

An interview was conducted on 8/301/17 at 8:38 a.m. with ASM (administrative staff member) #3, the assistant director of nursing. ASM #3 was present at the nurse's station during the interview with LPN #15. When asked when staff locked the medication cart, ASM #3 stated, "Whenever she leaves that cart it needs to be locked." When asked why staff needed to lock the medication cart, ASM #3 stated, "To prevent anybody from going in and getting drugs that could include staff. The nurse is responsible for the cart; she has the keys."

On 8/30/17 at 8:36 a.m. an interview was conducted with LPN #7, the nurse who walked past the medication cart. When asked if she noticed anything about the medication cart, LPN #7 stated, "Yes, I noticed it was unlocked but I had to take care of a gentleman first." LPN #7 was unoccupied when she passed the medication cart at 8:32 a.m.

On 8/30/17 at 4:25 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled, "Security of Medication Cart" documented, "The medication cart shall be secured during medication passes. 1. The nurse must secure the medication cart during the medication pass to prevent unauthorized entry. 2. The medication cart should

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F 431	Continued From page 119 be parked in the doorway of the resident's room during the medication pass. The cart doors and drawers should be facing the resident's room. 3. When it is not possible to park the medication cart in the doorway, the cart should be parked in the hallway against the wall with doors and drawers facing the wall. The cart must be locked before the nurse enters the resident's room. 4. Medication carts must be securely locked at all times when out of the nurse's view." No further information was provided prior to exit.	F 431		
F 504 SS=D	483.50(a)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN (a) Laboratory Services (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, facility document review and clinical record review, it was determined that the facility staff failed to obtain a physician's order prior to obtaining a laboratory specimen for one of 29 residents in the survey sample, Resident #3. The facility staff failed obtained a TSH [1] (thyroid stimulating hormone) laboratory specimen on 8/16/17, without a physician's order. The findings include:	F 504	1. Resident #3 has not demonstrated any adverse outcomes from obtaining a TSH level on 8/16/2017. NP and RP were notified on 8/29/2017 of THS being obtained without a physician's order. 2. A 100% audit of lab results obtained starting from 9/1/2017 will be completed by DON, ADON, Unit Managers and/or designee to ensure labs results have corresponding physician's order. 3. Nursing staff (RN and LPN) will be re-educated by ADON, Unit Managers or designee on nursing scope of practice to include obtaining a physician's order prior to obtaining labs. 4. Audits of lab results and corresponding orders will be	

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Resident #3 was admitted on 5/6/17 with diagnoses that included but were not limited to: thyroid disease, dementia, kidney disease and anxiety. The most recent MDS (minimum data set), a quarterly assessment, dated 7/4/17 coded the resident as having scored a three out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely cognitively impaired. The resident was coded as requiring assistance for all activities of daily living.

A review of the clinical record documented a TSH laboratory specimen result on 8/16/17.

Review of the physician's orders did not document an order for the TSH specimen.

Review of the care plan did not evidence documentation regarding laboratory specimens.

Review of the laboratory request book documented that Resident # 3 had a TSH laboratory specimen obtained on 8/16/17.

On 8/29/17 at 2:25 p.m. a request was made to ASM (administrative staff member) #2, the director of nursing for the 8/16/17 physician's order for the TSH laboratory specimen.

On 8/30/17 at 10:15 a.m. a repeat request was made to ASM #2, the assistant director of nursing for the 8/16/17 physician's order for the TSH laboratory specimen.

On 8/30/17 at 12:50 p.m. ASM (administrative staff member) #2, the director of nursing stated they could not locate the order. ASM #2 stated, "But I have a plan that is addressing this issue."

completed by Unit Managers and/or designee as follow: 10% of lab results and corresponding orders will be audited 3 times/week x 4 weeks, then weekly x 4 weeks and then every-other-week x one month. Variances will be investigated and corrections made as appropriate. An analysis of the audits will be provided to the QA Committee for additional oversight and recommendations.

5. The facility dutifully alleges compliance of these tasks on or before 10/15/2017.

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F 504	Continued From page 121 An interview was conducted on 8/30/17 at 1:25 p.m. with LPN (licensed practical nurse) #2. When asked the process for obtaining a laboratory specimen, LPN #2 stated, "We get the doctor's order. We send it to the laboratory and we put it in the laboratory book." When asked how a laboratory specimen could be obtained without a physician's order, LPN #2 stated, "I don't know." On 8/30/17 at 4:25 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. Review of the facility's policy titled, "Medication and Treatment Orders" did not specify how to obtain a physician's order for a laboratory specimen. No further information was provided prior to exit. (1) A TSH test measures the amount of thyroid stimulating hormone (TSH) in your blood. TSH is produced by the pituitary gland. It tells the thyroid gland to make and release thyroid hormones into the blood. This information was obtained from the website: https://medlineplus.gov/ency/article/003684.htm	F 504		
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:	F 507	1. Results of CBC and CMP obtained on 1/16/17 were reviewed by NP and filed in resident #13 medical records on 8/31/17. 2. A 100% audit of clinical records for lab results obtained starting from 9/1/2017 will be completed by DON, ADON, Unit Managers and/or designee to ensure labs results have reviewed by physician and filed by	

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Based on staff interview, clinical record review and facility document review, it was determined that facility staff failed to file a laboratory test in the clinical record for one of 29 residents in the survey sample, Resident #13.

The facility staff failed to file Resident #13's CMP (complete metabolic panel) and CBC (complete blood count) test results that were ordered on 1/16/17 into the clinical record.

The findings include:

Resident #13 was admitted to the facility on 9/10/16 with diagnoses that included but were not limited to Alzheimer's disease, high cholesterol, anxiety disorder, and high blood pressure. Resident #13's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 6/18/17. Resident #13 was coded as being severely impaired in cognitive function scoring 03 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #13 was coded as requiring supervision with transfers, ambulation, eating; and limited assistance with toileting and dressing.

Review of Resident #13's physician telephone order revealed the following order dated 1/16/17: "CBC [1] (complete blood count) CMP [2] (comprehensive metabolic panel) - med (medication) mgmt (management)."

Review of Resident #13's clinical record revealed no evidence of the 1/16/17 CBC and CMP laboratory test results.

On 8/30/17 at approximately 3:27 p.m., LPN (licensed practical nurse) # 2 presented a copy of

Unit Secretary or designee.

3. Nursing staff (RN and LPN) and Unit Secretary will be re-educated by ADON and Unit Managers or designee on the facility's protocol to ensure lab results are filed in residents' clinical records timely.

4. Audits of clinical records will be completed by Unit Managers and/or designee as follow: 10% of clinical records will be audited 3 times/week x 4 weeks, then weekly x 4 weeks and then every-other-week x one month to ensure lab results are filed in the residents' clinical records. Variances will be investigated and corrections made as appropriate. An analysis of the audits will be provided to the QA Committee for additional oversight and recommendations.

5. The facility dutifully alleges compliance of these tasks on or before 10/15/2017.

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the 1/16/17 CBC and CMP laboratory test results. LPN #2 stated that she had called the laboratory company to get a copy of the result. When asked if the CBC, CMP laboratory test results were in the clinical record, LPN #2 stated that she probably should have checked the thinned record first and was going to check. When asked the process for obtaining a laboratory test result, LPN #2 stated that results were usually faxed to the facility from the laboratory company. From there the nurse working the floor would fax the results to the physician or the results would go into the physician's box for review. Once the physician signs the laboratory test, the nurse is responsible for filing the test result into the clinical record. When asked if the physician saw Resident #13's CBC and CMP laboratory test results, LPN #2 stated, "We don't know because it was not in the chart."

On 8/30/17 at approximately 5:25 p.m., LPN #4, the unit manager stated they could not find the laboratory test in Resident #13's thinned record. LPN #4 could not determine if the physician was made aware of laboratory results from 1/16/17.

On 8/30/17 at approximately 5:26 p.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). ASM #2 stated that the facility had put a plan in place to ensure laboratory tests were being completed and that the results were being obtained in a timely manner. ASM #2 stated that the facility started the plan on 7/14/17 and audits were ongoing.

Review of the audits revealed that Resident #13's CBC and CMP were identified as not being in the clinical record on 7/13/17.

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F 507	Continued From page 124 On 8/31/17 at 9:00 a.m., ASM #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #4, the administrator in training were made aware of the above findings. the facility policy titled, "Lab and Diagnostic test results- Clinical Protocol" did not address filing laboratory tests into the clinical record. No further information was presented prior to exit. [1] CBC (complete blood count)- "Blood count tests measure the number and types of cells in your blood. This helps doctors check on your overall health. The tests can also help to diagnose diseases and conditions such as anemia, infections, clotting problems, blood cancers, and immune system disorders." This information was obtained from The National Institutes of Health. https://medlineplus.gov/bloodcounttests.html. [2] CMP (comprehensive metabolic panel)- "A metabolic panel is a group of tests that measures different chemicals in the blood. These tests are usually done on the fluid (plasma) part of blood. The tests provide information about your body's chemical balance and metabolism. They can give doctors information about your muscles (including the heart), bones, and organs, such as the kidneys and liver." This information was obtained from The National Institutes of Health. https://medlineplus.gov/metabolicpanel.html.	F 507		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514	**1.** Clinical records for residents #1, and #5 were audited on 8/30/2017, no other resident (s) information was found in the records.	

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F 514	Continued From page 125 (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; (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, clinical record review and facility document review it was determined that the facility staff failed to maintain a complete and accurate clinical record for three of 29 residents in the survey sample, Residents # 1, #	F 514	Continued From page 125 Consultant Pharmacist review for resident #7 done in June 2017 was obtained, no Pharmacist recommendations were made during the month of June for resident #7, result was filed in the clinical records on 8/30/17. 2. A 100% audit of clinical records will be completed by Unit Secretary, Medical Records personnel, unit Manager and/or designee to ensure accuracy of clinical records. 3. Nursing staff (RN and LPN) and Unit Secretary will be re-educated by ADON and Unit Managers or designee on the facility's protocol to ensure accuracy of clinical records. 4. Audits of clinical records will be completed by Unit Managers and/or designee as follow: 10% of clinical records will be audited weekly x 4 weeks, and then every-other-week x one 2 months to ensure accuracy of residents' clinical records. Variances will be investigated and corrections made as appropriate. An analysis of the audits will be provided to the QA Committee for additional oversight and recommendations.	

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5, and # 17.

1. For Resident # 1, another resident's information was filed on the clinical record.

2. For Resident # 5, two other residents' information was filed on the clinical record.

3. For Resident # 7, the consultant pharmacy review for June 2017 was not in the clinical record.

The findings include:

1. For Resident # 1, another resident's information was filed on the clinical record.

Resident # 1 was admitted to the facility on 10/17/16 with diagnoses that included but were not limited to: respiratory failure, hypothyroidism, pneumonia, and sleep apnea.

Resident # 1's most recent MDS (minimum data set) assessment, a Significant Change Assessment, with an ARD (assessment reference date) of 6/14/17 coded Resident # 1 as understood by others and as able to understand others. Resident # 1 was coded on the BIMS (Brief Interview for Mental Status) with a score of 15 out of 15, indicating that the Resident is cognitively intact.

Review of Resident # 1's clinical revealed documentation from another Resident. A Hospital Discharge Summary belonging to another resident was printed on the back of a laboratory report belonging to Resident # 1.

5. The facility dutifully alleges compliance of these tasks on or before 10/15/2017.

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During an interview on 8/29/17 at 5:45 pm. with ASM (Administrative Staff Member) # 2, the Director of Nurses, this document was shared and a request for a copy of the Hospital Discharge Summary was made. When ASM # 2 was asked who was responsible for filing documents she (ASM # 2) stated that the nurses do the filing.

During the end of day interview on 8/30/17 at 4:25 p.m. with ASM # 1, the administrator, ASM # 2, and ASM # 4, the Administrator in Training, the concern of another resident's documents in Resident # 1's clinical record was discussed.

Review of the facility policy, "Clinical Records" documented under "A. The nursing facility shall maintain an organized clinical record system in accordance with recognized professional practices...B. Clinical records shall be confidential..."

No further documentation was provided prior to exit.

According to Fundamentals of Nursing Made Incredibly Easy, Lippincott Williams and Wilkins, Philadelphia PA, page 23: "Nursing documentation is a highly significant issue since documentation is a fundamental feature of nursing care. Patient records are legally valid, and need to be accurate and comprehensive so that care can be communicated effectively to the health care team. Unless the content of documentation provides an accurate depiction of patient and family care, quality of care may not be possible. Many nurses do not realize that what they document or fail to record can produce an enormous effect on the care that is provided by

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other members of the health care team."

According to "Fundamental Nursing Skills and Concepts": Eighth edition, Chapter 3, pg. 36 read: "Each healthcare setting requires accurate and complete documentation. The medical record is a legal document....Records must be timely, objective, accurate, complete and legible..."

2. For Resident # 5, two other residents' information was filed on the clinical record.

Resident # 5 was admitted to the facility on 4/14/15 and most recently readmitted on 5/27/15 with diagnoses that included but were not limited to: congestive heart failure, peripheral vascular disease, diabetes, and cerebral vascular accident (stroke).

Resident # 5's most recent MDS (minimum data set) assessment, a Significant Change Assessment, with an ARD (assessment reference date) of 8/2/17 coded Resident # 5 as usually understood by others and as usually able to understand others. Resident # 5 was coded on the BIMS (Brief Interview for Mental Status) with a score of 14 out of 15, indicating that the Resident is cognitively intact.

Review of Resident # 5's clinical record revealed documentation from two other residents. A Daily Skilled Nurse's Note dated 8/28/17 belonging to another resident was found in Resident # 5's clinical record. Also, a Communication for (name of physician) dated 5/30/17 belonging to another resident was found in Resident # 5's clinical record.

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During an interview on 8/29/17 at 5:45 pm. with ASM (Administrative Staff Member) # 2, the Director of Nurses, these documents were shared and a request for a copy was made. When ASM # 2 was asked who was responsible for filing documents she (ASM # 2) stated that the nurses do the filing and in this case were probably writing the notes and just put them into the wrong resident's chart.

During the end of day interview on 8/30/17 at 4:25 p.m. with ASM (Administrative Staff Member) # 1, the administrator, ASM # 2, the Director of Nurses, and ASM # 4, the Administrator in Training, the concern of the two residents' documents in Resident # 5's clinical record was discussed.

No further documentation was provided prior to exit.

3. For Resident # 7, the Consultant Pharmacy Review for June 2017 was not in the clinical record.

Resident # 7 was admitted to the facility on 9/13/16 with diagnoses that included but were not limited to: hypertension (high blood pressure), diabetes, dementia, anxiety, depression, stroke, and gastroesophageal reflux disease.

Resident # 7's most recent MDS (minimum data set) assessment, a Quarterly Assessment, with an ARD (assessment reference date) of 6/4/17 coded Resident # 7 as sometimes understood by others and as able to sometimes understand others. Resident # 2 was coded as having short

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term and long term memory problems and as being moderately impaired for daily decision making (decision poor; cues/supervision required).

During a review of Resident # 7's clinical record the Consultant Pharmacy Reviews were located. When the review was done all reviews could be found except for the review for June 2017.

A request was made on 8/30/17 of facility staff for a copy of the missing June 2017 Consultant Pharmacy Review.

During an interview on 8/30/17 at 10:40 a.m. with LPN (licensed practical nurse) # 5 revealed that she could not find a copy of the Consultant Pharmacy Review for June. LPN # 5 further stated that she called the pharmacy to get a copy.

During the end of day interview on 8/30/17 at 4:25 p.m. with ASM (Administrative Staff Member) # 1, the administrator, ASM # 2, the Director of Nurses, and ASM # 4, the Administrator in Training, the concern of the missing consultant pharmacy review was discussed. ASM # 2 stated that the pharmacy had to be called to request a copy of the review. A request for the policy on Consultant Pharmacy Reviews was requested.

During an interview on 8/31/17 at 10:08 a.m. with ASM # 2, ASM # 2 reviewed the process for Consultant Pharmacist Reviews by stating that the pharmacy consultant comes in, completes the review then prints the review and leaves the copy for ASM # 2. ASM # 2 then reviews the review and those that have recommendations go to the physician. If the physician makes any changes those changes are noted and followed. If there

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE REHAB & NURSING CENTER	614 HASTINGS LANE WARRENTON, VA 20186

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 8/28/17 through 8/31/17. Corrections are required for compliance with the following with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 130 certified bed facility was 125 at the time of the survey. The survey sample consisted of 24 current resident reviews (Residents #1 through #21, and #27 through #29) and 5 closed record reviews (Residents #22 through #26).	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements:	F 001		
	This RULE: is not met as evidenced by: 12VAC5-371-140. Policies and procedures. Cross Reference to F372 and F425	F372 F425	12VAC5-371-140. Policies and procedures. Cross Reference to F372 and F425 see plan of correction.	
	12VAC5-371-300. Pharmaceutical services. Cross Reference to F372		12VAC-5-371-300. Pharmaceutical services. Cross Reference to F372 see plan of correction.	
	12VAC5-421-2640. Outside receptacles. Cross Reference to F372	F372	12VAC5-421-2640. Outside receptacles. Cross Reference F372 see plan of correction.	
	12VAC5-371-110 B1, 2 cross references to F225	F225	12VAC5-371-110, cross references to F225 see plan of correction.	
	12VAC5-371-110 B1, 2, 3, cross references to F226	F226	12VAC5-371-110 B1, 2, 3, cross references to F226 see plan of correction.	
	12VAC5-371-130B. Resident Rights cross references to F167, F157	F167 F157	12VQD5-371-130B. Resident Rights cross references to F167, F157 see plan of correction.	
	12VAC5-371-220. Nursing Services cross references to F157, F280, F323	F157 F280 F323	12VAC5-371-220. Nursing Services cross references to F157, F280, F323 see plan of correction.	
	12VAC-371-360. Clinical Records cross	F360	12VAC-371-360. Clinical Records cross references to F360 see plan of correction.	

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

Bethany D [illegible], RN — Administrator — 9-22-17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495267	A. BUILDING _____ B. WING _____	08/31/2017

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F 001	Continued From Page 1 references to F360. 12VACS-220.H cross references to CFR 157 12VACS 250.G cross references to CFR 279 12VACS 200.B.1 cross references to CFR 281 12VACS 220.B cross references to CFR 309 12VACS 340 cross references to CFR 371 12VACS-310 cross references to CFR 504 12VAC5-371-250 Resident assessment and care planning -- A, D, E cross-referenced to F 278 12VAC5-371-360 Clinical records --E cross-referenced to 514	F 001 F157 F279 F281 F309 F371 F504 F278 F514	12VACS-220.H cross references to CFR 157 see plan of correction. 12VACS 250.G cross references to CFR 279 see plan of correction. 12VACS 200.B 1 cross references to CFR 281 see plan of correction. 12VACS 220.B cross references to CFR 309 see plan of correction. 12VACS 340 cross references to CFR 371 see plan of correction. 12VACS-310 cross references to CFR 504 see plan of correction. 12VACS-371-250 Resident assessment and care planning - A, D, E cross-referenced to F278 see plan of correction. 12VAC-371-360 Clinical records - E cross-referenced to 514 see plan of correction.	