| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| CHATHAM HEALTH & REHABILITATION CENTER | 100 RORER STREET CHATHAM, VA 24531 |

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| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 05/02/17 through 05/04/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.<br><br>The census in this 90 certified bed facility was 75 at the time of the survey. The survey sample consisted of 16 current Resident reviews (Residents 1 through 13, and17 through 19) and 3 closed record reviews (Residents *14 through 16). | F 000 | | |
| F 240 SS=D | CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE<br>CFR(s): 483.10(a)(1)(2)<br><br>(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interview and clinical record review it was determined the facility staff failed to provide meal service timely and | F 240 | 1. Resident #2's dinner tray was remade and served as soon as dietary staff was notified. The Dietary Manager apologized | 6/9/17 |

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

Electronically Signed | 05/26/2017

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| F 240 | Continued From page 1<br>coordinate dining service for meal companions for 1 of 19 residents (Resident #7).<br><br>Findings:<br><br>Facility staff failed to provide meal service timely and coordinate dining services for Resident #7. This resulted in Resident #7 having to sit and look on as her roommate ate her entire meal, 30 minutes prior to receiving her meal.<br><br>Resident #7 was admitted to the facility on 11/2315. Her diagnoses included hypertension, dementia, anxiety, dysphagia and heart failure. Her clinical record was reviewed on 5/2/17 at 3:50 PM.<br><br>The latest MDS (minimum data set) assessment, dated 4/18/17 coded this resident with some cognitive impairment. She required facility staff assistance to accomplish all the ADLs (activities of daily living) with the exception of eating, which required set-up and oversight only. Otherwise the resident was able to feed herself independently. She was coded as "usually" understood and as understanding others.<br><br>Resident #7's CCP (comprehensive care plan coded this resident with "increased nutrition/hydration risk related to: DX (diagnosis) of congestive heart failure, has....dentures but doesn't wear. Resident is on a mechanically altered diet, HX (history) of weight loss....." The CCP interventions included: "Monitor dietary intake" and "Provide diet per order."<br><br>On 5/2/17 at 5:35 PM the surveyor entered Resident #7's room to find her in bed watching as her roommate ate her dinner meal. The | F 240 | to resident #2 for the delay.<br>2. Current residents have the potential to be affected by this issue.<br>3. To prevent recurrence, dietary and nursing staff will be reeducated on preparing or delivering trays in an order to avoid any resident waiting for food while others around are eating .<br>4. The Dietary Manager or designee will document review of the tray line for completion of the preparation of all resident trays 5 times a week for 2 weeks, 3 times a week for 10 weeks. Dietary Manager or designee will also document review tray delivery 5 times a week for 2 weeks, 3 times a week for 10 weeks. Any issues identified will result in immediate reeducation or disciplinary action as appropriate.<br>The Dietary Manager will bring the results of the monitoring to the monthly QA Committee for review, identification of any patterns or trends and need for on-going education. | |

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| F 240 | Continued From page 2 | F 240 | | |

roommate was about 50 % through her meal, but Resident #7 did not have a tray and was watching her roommate eat.

The surveyor asked CNA I where her dinner tray was--since her roommate was already halfway through her meal. The CNA said she didn't know, "They usually come on the same cart but they didn't tonight. We're waiting for the second cart to come in now."

The second cart came and when meals were all delivered, Resident #7 still did not have a tray. At 5:50 PM CNA II was asked where the resident's meal was. She replied, "I don't know. That's not a CNA problem, that's a kitchen problem."

The surveyor stayed with Resident #7 from 5:35 PM through 6:20 PM monitoring the meal process. She asked the resident, still watching her roommate eat if she was hungry. Resident #7 stated, "Yes, I'm hungry!" When the surveyor asked of the resident would like for her to go find out what happened to her dinner tray, the resident nodded and said, "Yes." (By this time the resident was waving her arms and gesticulating that she wondered/questioned where her food was, as she pointed to her roomate.)

At 6:00 PM, CNA I was again asked where the resident's tray was. She was told another CNA had gone to the kitchen for it. At 6:05 PM CNA II came into the room with Resident #7's dinner tray and prepared to set it up for her. Her roommate was through eating her meal.

CNA II opened the tray and began to set it up for the resident on the overbed table. The dietary meal tray ticket said, "Regular/Ground Fortified

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| F 240 | Continued From page 3<br>Foods - all meals. The meal included a grilled cheese sandwich, which the CNA II picked up with her bare hands and broke in half--handing one-half to the resident and putting the other half back onto the plate.<br><br>These observations were reported to the administrator, DON and the corporate nurse consultant on 5/3/17 at 3:30 PM. No additional information was provided prior to the survey team exit. | F 240 | | |
| F 246 SS=D | REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES<br>CFR(s): 483.10(e)(3)<br><br>483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:<br><br>(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and clinical record review it was determined facility staff failed to provide an accessible call light to 1 of 19 residents (Resident #7) to summon staff when she needed assistance.<br><br>Findings:<br><br>The facility staff failed to provide an accessible call light for Resident #7. Her clinical record was reviewed on 5/2/17 at 3:50 PM. | F 246 | 1. Resident #7's call bell was placed within her reach.<br>2. Current residents have the potential to be affected by this issue<br>3. Nursing staff will be reeducated to ensure that the call bell is placed within the residents' reach prior to leaving the residents' rooms.<br>4. The Director of Nursing or designee will conduct weekly audits on random halls of at least 20 residents per week to ensure call bells are within reach. These audits | 6/9/17 |

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| F 246 | Continued From page 4<br>Resident #7 was admitted to the facility on 11/2315. Her diagnoses included: DYSPHAGIA (difficulty swallowing), hypertension, dementia, anxiety, and heart failure.<br><br>The latest MDS (minimum data set) assessment, dated 4/18/17 coded this resident with some cognitive impairment. She required facility staff assistance to accomplish all the ADLs (activities of daily living) with the exception of eating, which required set-up and oversight only. The resident could not ambulate or leave her bed independently. The resident triggered as a high fall risk on this assessment and the MDS is coded to care plan her for same.<br><br>Resident #7's CCP (comprehensive care plan), initiated on 11/24/15 and updated on 2/8/17, documented this resident "at risk for further falls related to decreased mobility, weakness, impaired vision.....dx (diagnosed with) abnormal posture and history of falls.....)". The interventions included "call bell within reach" and "fall mat x 2.....)".<br><br>On 5/2/17 at 2:15 PM, 3:45 PM and 5:30 PM and on 5/3/17 at 8:30 AM and 2:35 PM this resident was observed in her bed. Her call light was placed out of her reach and was stored in a basket on her nightstand. The resident responded "No" when asked if she could reach her call light.<br><br>These findings were reported to the administrator, DON and the corporate nurse consultant on 5/3/17 at 3:30 PM. No additional information was provided prior to the survey team exit. | F 246 | will be documented weekly x 12 weeks of the current residents any issues identified will result in immediate reeducation or disciplinary action as appropriate.<br>The Director of Nursing will bring the results of the monitoring to the monthly QA Committee for review, identification of any patterns or trends and need for on-going education. | |

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| F 272 | Continued From page 5 | F 272 | | |
| F 272 SS=D | COMPREHENSIVE ASSESSMENTS CFR(s): 483.20(b)(1)<br><br>(b) Comprehensive Assessments<br><br>(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:<br><br>(i) Identification and demographic information<br>(ii) Customary routine.<br>(iii) Cognitive patterns.<br>(iv) Communication.<br>(v) Vision.<br>(vi) Mood and behavior patterns.<br>(vii) Psychological well-being.<br>(viii) Physical functioning and structural problems.<br>(ix) Continence.<br>(x) Disease diagnosis and health conditions.<br>(xi) Dental and nutritional status.<br>(xii) Skin Conditions.<br>(xiii) Activity pursuit.<br>(xiv) Medications.<br>(xv) Special treatments and procedures.<br>(xvi) Discharge planning.<br>(xvii) Documentation of summary information regarding the additional assessment performed on the<br>care areas triggered by the completion of the Minimum Data Set (MDS).<br>(xviii) Documentation of participation in assessment. The assessment process must include direct<br>observation and communication with | F 272 | | 6/9/17 |

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| F 272 | Continued From page 6<br>the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.<br><br>The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review, the facility staff failed to accurately complete Section V of the MDS (Minimum Data Set) for 2 of 19 residents in the survey sample (Resident #2 and #5).<br><br>The findings included:<br><br>1. The facility staff failed to document the dates and/or locations for where the documentation could be found in Resident #2's clinical record for Section V of the Care Area assessment (CAA) Summary of the Minimum Data Set (MDS).<br><br>Resident #2 was originally admitted to the facility on 7/22/16 and readmitted on 4/22/17. The resident had the following diagnoses of, but not limited to atrial fibrillation, hemiarthroplasty, high blood pressure, diabetes, dementia, anxiety disorder and dysphagia. Resident was coded on the significant change MDS with an ARD (Assessment Reference Date) of 4/19/17 as having a BIMS (Brief Interview for Mental Status) score of 10 out of a possible score of 15. Resident #2 was also coded as requiring extensive assistance of 1 staff member for dressing, personal hygiene and was totally | F 272 | 1. The MDS assessment was reviewed for Resident #2 and #5 MDS. Corrections were made to reflect an accurate assessment of each resident.<br>2. Current residents who are being assessed using the MDS tools have the potential to be affected by this issue.<br>3. Reeducation was completed with the interdisciplinary team members that complete CAA to cite date and location from medical record where supporting documentation can be found.<br>4. Prior to signing comprehensive assessments as completed, MDS coordinator or designee will review individual CAA triggers in section V of the MDS to ensure all disciplines have documented dates and locations from the medical record where supporting documentation can be found. Any issues found will be addressed to and corrected by the team member responsible.<br>The MDS Coordinator will bring the results of the monitoring to the monthly QA Committee for review, identification of any patterns or trends and need for on-going | |

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| F 272 | Continued From page 7<br>dependent on 1 staff member for bathing.<br><br>The surveyor conducted a clinical record review of Resident #2's chart on 5/2/17. The surveyor noted that on the MDS with an ARD of 4/19/17 in Section V of the CAA Summary the dates and locations of the documentation to support the triggered area were not properly documented for the areas of Cognitive Loss/Dementia and Nutritional Status. Under the section for location and dates of CAA Documentation for Cognitive Loss/Dementia it stated "pos (physician order sheet) and h&p (history and physical). There were no dates to refer to for the surveyor to find the information needed to support this documentation. Under the section for Nutritional Status in the location and dates of CAA documentation it stated "CAA Worksheet 4/20/17. The surveyor could not find any information with dates to support this documentation.<br><br>On 5/3/17 at approximately 3:30 pm in the conference room, the administrative staff was notified of the above by the surveyor of the above documented findings.<br><br>The administrative team met again with the survey team on 5/4/17 at 12:30 pm in the conference room. The surveyor notified the administrative team of the above documented findings. The regional reimbursement staff member stated "This information is usually found in the CAA worksheet that the MDS nurse completes."<br><br>No further information was provided to the surveyor prior to the exit conference on 5/4/17.<br>2. For Resident #5 the facility staff failed to name the date and location of CAA (care area | F 272 | education. | |

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| F 272 | Continued From page 8<br>assessment) documentation.<br><br>Resident #5 was admitted to the facility on 02/04/11 and readmitted on 01/10/17. Diagnoses included but not limited to hypertension, diabetes mellitus, hip fracture, cerebrovascular accident, dementia, hemiplegia, anxiety, schizophrenia, chronic obstructive pulmonary disease, atrial fibrillation, gastroesophageal reflux disease, glaucoma, and dysphagia.<br>.<br>The most recent comprehensive MDS with an ARD (assessment reference date) of 01/17/17 coded the Resident as 8 of 15 in section C, cognitive patterns. Section V, care area assessment, was reviewed. The facility staff had not identified the date and location of the CAA information used to determine the nutritional care plan. The only documentation was "see CAA worksheet. The CAA worksheet was reviewed and the information could not be located.<br><br>The concern of the missing CAA documentation was discussed with the administrative staff during a meeting on 05/03/17 at approximately 1530.<br><br>No further information was provided prior to exit. | F 272 | | |
| F 280 SS=D | RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br>CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2)<br><br>483.10<br>(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:<br><br>(i) The right to participate in the planning process, including the right to identify individuals or roles to | F 280 | | 6/9/17 |

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| F 280 | Continued From page 9 | F 280 | | |

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

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

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

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

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

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

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

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

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

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

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| F 280 | Continued From page 10<br><br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br><br>(A) The attending physician.<br><br>(B) A registered nurse with responsibility for the resident.<br><br>(C) A nurse aide with responsibility for the resident.<br><br>(D) A member of food and nutrition services staff.<br><br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br><br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br><br>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan (CCP) for 2 of 19 residents in the survey sample (Resident #2 and #4).<br><br>The findings included: | F 280 | 1. Resident #2's care plan was reviewed and revised on 5/3/2017 to reflect the correct liquids consistency and to ensure all interventions in place to prevent falls/injury were present.<br>Resident #4's care plan was reviewed and revised on 5/3/2017 to reflect that their | |

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| F 280 | Continued From page 11<br><br>1. The facility staff failed to review Resident #2's comprehensive care plan for falls.<br><br>Resident #2 was originally admitted to the facility on 7/22/16 and readmitted on 4/22/17. The resident had the following diagnoses of, but not limited to atrial fibrillation, hemiarthroplasty, high blood pressure, diabetes, dementia, anxiety disorder and dysphagia. Resident was coded on the significant change MDS with an ARD (Assessment Reference Date) of 4/19/17 as having a BIMS (Brief Interview for Mental Status) score of 10 out of a possible score of 15. Resident #2 was also coded as requiring extensive assistance of 1 staff member for dressing, personal hygiene and was totally dependent on 1 staff member for bathing.<br><br>The surveyor conducted a clinical record review of Resident #2's chart on 5/2/17.<br>The resident's CCP was also reviewed. In the clinical record there was documentation for the following dates that the resident was known to have had a fall which included: 9/21/16, 10/23/16, 12/23/16 and 3/26/17. On the care plan these falls were not documented and a review of the interventions in place or placing new interventions to prevent the resident from falling was also not documented.<br><br>The surveyor also noted a physician order dated for 5/2/17 "to increase to thin liquids". The resident was receiving a mechanical soft diet with thickened liquids. This change in the CCP did not reflect the new physician order for thin liquids.<br><br>On 5/2/17 at 3:30 pm, MDS nurse #1 was asked by the surveyor how the CCP were updated when | F 280 | liquids needs to be served in a Provale cup.<br>2. Current residents with a change in their plan of care have the potential to be affected by this issue.<br>3. The Dietary Manager and the Licensed Nursing staff were reeducated on reviewing and revising resident care plans and resident care cards.<br>4. The Dietary Manager will document the review of new admissions and 5 current resident charts weekly for 12 weeks to ensure care plan and resident care card reflects current physician orders. Any issues will be corrected as soon as identified.<br>The Dietary Manager will bring the results of the reviews to the monthly QA Committee for review, identification of any patterns or trends and need for on-going education. | |

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they were new orders or resident was having increased falls. The MDS nurse #1 stated "We have a risk meeting each morning to go over what happened the prior day then the care plans are updated at that time."

On 5/3/17 at approximately 3:30 pm, the administrative team was notified of the above documented findings by the surveyor.

On 5/4/17 at 12:30 pm, the administrative team was once again notified of the above documented findings by the surveyor.

No further information was provided to the surveyor prior to the exit conference on 5/4/17.

2. Facility staff failed to review and revise Resident #4's CCP (comprehensive care plan) to reflect the use of a physician ordered Provale cup. The resident's clinical record was reviewed on 5/2/17 at 3:20 PM.

Resident #4 was admitted to the facility on 3/13/15. The diagnoses included: Dysphagia--oropharyngeal phase, anemia, atrial fibrillation, hypertension, dementia and depression.

The latest MDS (minimum data set) assessment, dated 3/3/17, coded the resident as cognitively intact. She required the help of nursing staff to accomplish all the ADLs (activities of daily living), including eating.

The MDS coded the resident with Dysphagia, Oropharyngeal Phase and with a mechanically altered diet and a therapeutic diet. When the Nutritional care area triggered on the MDS, the decision was made to care plan her for same.

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Resident #4's CCP, initiated on 7/20/15, did not include the use of a Provale cup for the resident.

The CCP included "Nutrition and Hydration. Hx (history) protein calorie malnutrition, some missing teeth (denies problem with diet), Hx of significant weight loss, mechanically altered diet, GERD." Interventions included "Diet as ordered". There was no revision to update the CCP for the use of a Provale cup.

The Resident Care Card (used by the CNA staff to determine daily care of each resident) did not include the use of a Provale cup. This card had not been updated to include the resident's eating status revisions, when she progressed from needing oversite only, to requiring the assistance of one staff member to feed her.

The resident's physician signed and dated orders on 4/5/17 for "Diet: mechanical soft, fortified foods every meal, thin liquids, provale cup at all times". (A Provale cup is one that meters out the amount of liquid that is accessible to a person who has difficulty swallowing and is at a higher risk for aspiration when trying to swallow larger amounts of fluid).

On 5/2/17 at 3:15 PM and 5/3/17 at 10:30 AM, the resident was observed in her bed. She had a standard, large, pink cup at her bedside. A drinking straw was in the cup full of ice water and was available to her on her bedside table.

On 5/3/17 at 11:30 AM the resident was observed in the dining room at the feeder table, where a CNA was assisting her to eat her lunch. She had a small cup full of tea with a standard sippy straw

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| F 280 | Continued From page 14<br>in it. The resident's dining tray card was observed to include "Mechanical soft...Fortified foods--all meals.... provale cup...".<br><br>No PROVALE cup was observed at anytime.<br><br>On 5/3/17 at 3:30 PM, the surveyor's findings were reported to the administrator, the DON and the CN (corporate nurse).<br><br>On 5/4/17, the the DON shared the revised CCP and Resident Care Card with the surveyor. Both items had been updated to include the PROVALE cup. No additional information was provided prior to the survey team exit. | F 280 | | |
| F 309 SS=D | PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br>CFR(s): 483.24, 483.25(k)(l)<br><br>483.24 Quality of life<br>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.<br><br>483.25 Quality of care<br>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 | F 309 | | 6/9/17 |

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| F 309 | Continued From page 15<br>but not limited to the following:<br><br>(k) Pain Management.<br>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.<br><br>(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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review, the facility staff failed to follow physician orders for 2 of 19 residents in the survey sample (Residents #8 and #10).<br><br>The findings included:<br><br>1. The facility staff failed to follow physician's orders for a labortory test for Resident #8.<br><br>Resident #8 was admitted to the facility on 6/7/10 with the following diagnoses of, but not limited to anemia, high blood pressure, dementia, anxiety disorder, depression, chronic obstructive pulmonary disease and high cholesterol. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 4/12/17 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 12 out of a possible score of 15. Resident #8 was also coded as requiring extensive assistance of 2 staff members for personal hygiene and being totally | F 309 | 1. The Resident Representative and MD were notified that lab ordered as a lipid panel was obtained as a lipid panel w/calculated LDL for Resident #8.<br>2. Current residents with orders to obtain a lipid panel have the potential to be affected by this issue.<br>3. Nursing staff educated by Director of Nursing and/or designee concerning ordering the lipid panel as ordered or clarify the order if not clearly written.<br>The Director of Nursing and/or designee will conduct 100% audit of all charts to ensure that the appropriate lipid panel was obtained as ordered within the last 3 months<br>4. The Director of Nursing and/or designee will review orders for lipid panel to ensure appropriate lipid panel is ordered and drawn. This will be documented as completed 5 times a week for 2 weeks, then 3 times a week for 2 | |

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| F 309 | Continued From page 16<br>dependent on 1 staff member for bathing.<br><br>During the clinical record review performed by the surveyor on 5/3/17, it was noted that the physician had ordered Resident #8 to have a Lipid Panel obtained on next lab draw day on 3/10/17. The surveyor noted in the clinical record that Resident #8 had results of a "Lipid Panel w/calc (with calculated) LDL" drawn on 3/10/17.<br><br>The administrative team was notified of the above documented findings on 5/3/17 at approximately 3:30 pm by the surveyor.<br><br>On 5/4/17 at 11:45 am, the director of nursing stated to the surveyor, "The nurse should had clarified this with the physician and ordered the correct one."<br><br>No further information was provided to the surveyor prior to the exit conference on 5/4/17.<br>2. For Resident #10 the facility staff failed to follow physician's orders for the administration of the medication Nexium.<br><br>Resident #10 was admitted to the facility on 04/19/17. Diagnoses included but not limited to anemia, congestive heart failure, hypertension, gastroesophageal reflux disease, benign prostatic hypertrophy, end stage renal disease, diabetes mellitus, hyperlipidemia, Alzheimer's disease, depression and asthma.<br><br>The most recent MDS (minimum data set) with an ARD (assessment reference date) of 04/26/17 coded the Resident as 11 out of 15 in section C, cognitive patterns.<br><br>The surveyor observed Resident #10 during a | F 309 | weeks, then weekly for 8 weeks.<br><br>The Director of Nursing will bring the results of the monitoring to the monthly QA Committee for review, identification of any patterns or trends and need for on-going education.<br><br>1. The Resident Representative and MD were notified of the medication error that occurred for Resident #10. Resident was assessed for adverse effects related to the medication error and none were noted.<br>2. Current residents being given medications have the potential to be affected by this issue.<br>3. Nursing staff educated by Director of Nursing or designee on medication administration and documentation. The Director of Nursing or designee will complete a med pass observation with current nurses to ensure that they are following MD orders when giving meds.<br>4. The Director of Nursing or designee will document review medication administration documentation daily for 12 weeks. The Director of Nursing or designee will document performing med pass observation with 2 nurses weekly x 12 weeks.<br><br>The Director of Nursing will bring the results of the monitoring to the monthly QA Committee for review, identification of any patterns or trends and need for on-going education. | |

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medication pass and pour observation on 05/03/17 at approximately 0850. Surveyor observed RN (registered nurse) #1 administer the medication Nexium to Resident #10 at this time.

Resident #10's clinical record was reviewed on 05/03/17 at approximately 0930 for medication reconciliation. The clinical record contained a signed POS (physician's order summary) which read in part "Esomeprazole magnesium 20mg capsule DR for > Nexium Delayed-Release. Take 1 cap by mouth every day for gastroesophageal reflux disease". Time listed for this was 0630.

Surveyor spoke with RN #1 at approximately 0945 regarding Resident #10's Nexium. Surveyor asked RN #1 to pull Resident #10's MAR (medication administration record) for review. The MAR contained an entry which read in part "Esomeprazole magnesium 20mg capsule DR for > Nexium Delayed-Release. Take 1 cap by mouth every day for gastroesophageal reflux disease". The time listed on the MAR for administration was 0630 and had been signed as having been administered at that time. Surveyor asked RN #1 if she had administered this medication and she stated that she had. Surveyor then asked RN#1 if the medication had already been administered at 0630 as documented and she stated yes.

The surveyor requested and was provided with a policy entitled "General Dose Preparation and Medication Administration on 05/03/17 at approximately1045. The policy read as follows:

"4. Prior to administration of medication, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following:

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| F 309 | Continued From page 18<br>4.1 Facility staff should:<br>4.1.1 Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct tine for the correct Resident as set forth in Appendix 17: Facility Medication Administration Time Schedule;"<br><br>The concern of administering the medication at the wrong time was discussed during a meeting with the administrative staff on 05/03/17 at approximately 1530.<br><br>No further information was provided prior to exit. | F 309 | | |
| F 323 SS=D | FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br>CFR(s): 483.25(d)(1)(2)(n)(1)-(3)<br><br>(d) Accidents.<br>The facility must ensure that -<br><br>(1) The resident environment remains as free from accident hazards as is possible; and<br><br>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>(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.<br><br>(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>(2) Review the risks and benefits of bed rails with | F 323 | | 6/9/17 |

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| F 323 | Continued From page 19<br>the resident or resident representative and obtain informed consent prior to installation.<br><br>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, and clinical record review it was determined the facility staff failed to implement care-planned safety interventions for 1 of 19 residents (Resident #7) who had been assessed as a high risk for falls.<br><br>Findings:<br><br>The facility staff failed to follow care-planned safety interventions for Resident #7 who was assessed as a high fall risk. Her clinical record was reviewed on 5/2/17 at 3:50 PM.<br><br>Resident #7 was admitted to the facility on 11/2315. Her diagnoses included: DYSPHAGIA (difficulty swallowing), hypertension, dementia, anxiety, and heart failure.<br><br>The latest MDS (minimum data set) assessment, dated 4/18/17 coded this resident with some cognitive impairment. She required facility staff assistance to accomplish all the ADLs (activities of daily living) with the exception of eating, which required set-up and oversight only. Otherwise the resident was able to feed herself independently. She was coded as "usually" understood and as understanding others. The resident triggered as a high fall risk on this assessment and the MDS is coded to care plan her for same.<br><br>Resident #7's CCP (comprehensive care plan documented this resident "at risk for further falls | F 323 | 1. Resident #7 was assessed. Fall mats placed down on the floor by the bed.<br>2. Current residents with fall mats have the potential to be affected by this issue.<br>3. The Director of Nursing or designee will reeducate nursing staff on the importance of placing the fall mats down when residents are in bed prior to leaving the room after care.<br>4. The Director of Nursing or designee will document audits of all residents care planned for the use of fall mats on the floor by the bed 5 times a week for 2 weeks, then 3 times a week for 2 weeks, then weekly x 8 weeks.<br>The Director of Nursing will bring the results of the monitoring to the monthly QA Committee for review, identification of any patterns or trends and need for on-going education. | |

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| F 323 | Continued From page 20<br>related to decreased mobility, weakness, impaired vision.....dx (diagnosed with) abnormal posture and history of falls.....)". The interventions included "call bell within reach" and "fall mat x 2.....)".<br><br>The resident card card contained the following measures for CNAs when providing care for Resident #7: "Fall mats".<br><br>On 5/2/17 at 2:15 PM, 3:45 PM and 5:30 PM this resident was observed in her bed without fall mats in place at the side of her bed. The fall mats were observed to be stored against the wail and a clothing wardrobe during each observation.<br><br>On 5/3/17 at 8:30 AM and 2:35 PM the same observations were made. The falls mats remained propped up against the wall next to the wardrobe.<br><br>These findings were reported to the administrator, DON and the corporate nurse consultant on 5/3/17 at 3:30 PM. No additional information was provided prior to the survey team exit. | F 323 | | |
| F 325 SS=D | MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE<br>CFR(s): 483.25(g)(1)(3)<br><br>(g) Assisted nutrition and hydration.<br>(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- | F 325 | | 6/9/17 |

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| F 325 | Continued From page 21<br>(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;<br><br>(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interview and clinical record review it was determined the facility staff failed to follow physician's orders for weight loss interventions for 1 of 19 residents (Resident #7), with a significant weight loss.<br><br>Findings:<br><br>Facility staff failed to provide a physician ordered weight loss plan for Resident #7, who had incurred a significant weight loss. Her clinical record was reviewed on 5/2/17 at 3:50 PM.<br><br>Resident #7 was admitted to the facility on 11/2315. Her diagnoses included: DYSPHAGIA (difficulty swallowing), hypertension, dementia, anxiety, and heart failure.<br><br>The latest MDS (minimum data set) assessment, dated 4/18/17 coded this resident with some cognitive impairment. She required facility staff assistance to accomplish all the ADLs (activities of daily living) with the exception of eating, which required set-up and oversight only. Otherwise the resident was able to feed herself independently. She was coded as "usually" understood and as understanding others. | F 325 | 1. The Registered Dietician's recommendation to the physician for resident #7 has been clarified and implemented as of 5/3/2017.<br>2. Residents that have had recommendations from the registered dietician to the physician have the potential to be affected by this issue.<br>3. Licensed nursing staff will be educated by the Director of Nursing or designee on proper transcription of the registered dietician recommendations, including the communication of the new orders written to the dietary department.<br>4. The Director of Nursing or designee will review all recommendations from the registered dietician to ensure proper transcription and communication to the dietary department was completed. This monitoring will be documented 5 times a week for 4 weeks, then weekly for 8 weeks.<br>The Director of Nursing will bring the results of the monitoring to the monthly QA Committee for review, identification of any patterns or trends and need for on-going education. | |

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Resident #7's CCP (comprehensive care plan coded this resident with "increased nutrition/hydration risk related to: DX (diagnosis) of congestive heart failure, has....dentures but doesn't wear. Resident is on a mechanically altered diet, HX (history) of weight loss....." The CCP interventions included: "Monitor dietary intake" and "Provide diet per order."

On 2/2/17 facility RD (registered dietician) reviewed Resident #7's weight records and documented: "Significant weight loss: 4 # in 30 days." She recommended the physician initiate "Fortified foods - Mechnical soft." (The clinical record showed the resident's weight had fallen from 110 lbs on 1/3/17, to 106 lbs on 2/1/17.)

On 3/9/17 the facility RD (registered dietican) checked Resident #7's weights and documented "Significant weight loss: 10.4 # in 90 days." She recommended the physician increase the Mighty Shakes from two to three a day. (The clinical record documented the resident's weight at 110 on 1/3/17 and 99.6 on 3/8/17. ***An additional 6.4 pounds since the initial recommendation for diet adjustments and mechanical soft diet."

Resident #7 had a physician's order, signed and dated 2/10/17, "Add fortified foods to diet/mechanical soft."

On 5/2/17 at 5:35 PM the surveyor entered Resident #7's room to find her in bed watching as her roommate eat her dinner meal. The roommate was about 50 % through her meal, but Resident #7 did not have a tray and was watching her roommate eat.

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At 6:00 PM, CNA I was again asked where the resident's tray was. She was told another CNA had gone to the kitchen for it. At 6:05 PM CNA II came into the room with Resident #7's dinner tray and prepared to set it up for her. Her roommate was through eating her meal.

CNA II opened the tray and began to set it up for the resident on the overbed table. The dietary meal tray ticket said, "Regular/Ground Fortified Foods - all meals." The meal included a grilled cheese sandwich, which the CNA II picked up with her bare hands and broke in half--handing one-half to the resident and putting the other half back onto the plate. The resident also received a whole cookie and a piece of cake, mixed vegetables and potato soup.

On 5/3/17 at 11:05 AM the DM (dietary manager) and RD were interviewed in the kitchen area. They were asked to clarify the difference between a dietary order for a "regular/ground diet" and a "mechnical soft diet". The DM told the surveyor that both diets contained ground meats, but the biggest difference between the two would be the bread items were pureed so to make it easier to swallow for residents with that difficulty.

The RD provided the surveyor with a meal/menu planner. This showed the ground diets vs mechanical soft diet items. This planner indicated the residen't meal was NOT supposed to contain a whole roll. The day prior, the grilled cheese sandwich should have been pureed--not served whole.

On 5/3/17 at 12:00 noon the resident was observed in the dining room with peers to eat her lunch. The meal arrived at 12:10. The dietary tray

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| F 325 | Continued From page 24<br>card was observed to read "Regular/ground diet Fortified foods - all meals"<br><br>The Resident fed herself after the aide set up her food. The meal consisted of a roll (whole), scalloped potatoes (whole), ground fried chicken and a cauliflower/broccoli vegetable mix (whole). Pudding was provided as a dessert.<br><br>These findings were reported to the administrator, DON and the corporate nurse consultant on 5/3/17 at 3:30 PM. No additional information was provided prior to the survey team exit. | F 325 | | |
| F 369 SS=D | ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS<br>CFR(s): 483.60(g)<br><br>(g) Assistive devices<br><br>The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and clinical record review it was determined the facility staff failed to provide physician ordered adaptive equipment (Provale cup) for 1 of 19 residents (Resident #4), who had a diagnosis of Dysphagia--oropharyngeal phase.<br><br>Findings:<br><br>The facility staff failed to provide physician ordered adaptive equipment (Provale cup) for | F 369 | 1. The facility provided a Provale cup for resident #4 at the next meal on 5/3/17.<br>2. Current residents with an order for a Provale cup have the potential to be affected by this issue.<br>3. The Dietary Manager will reeducate the dietary staff to ensure that ordered Provale cup is present on the tray prior to the tray being sent out for delivery.<br>4. The Dietary Manager or designee will document review of the tray line for | 6/9/17 |

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| F 369 | Continued From page 25<br>Resident #4), who had a diagnosis of Dysphagia--oropharyngeal phase. The resident's clinical record was reviewed on 5/2/17 at 3:20 PM.<br><br>Resident #4 was admitted to the facility on 3/13/15. The diagnoses included: Dysphagia--oropharyngeal phase, anemia, atrial fibrillation, hypertension, dementia and depression.<br><br>The latest MDS (minimum data set) assessment, dated 3/3/17, coded the resident as cognitively intact. She required the help of nursing staff to accomplish all the ADLs (activities of daily living), including eating.<br><br>The MDS coded the resident with Dysphagia, Oropharyngeal Phase and with a mechanically altered diet and a therapeutic diet. When the Nutritional care area triggered on the MDS, the decision was made to care plan her for same.<br><br>Resident #4's CCP, initiated on 7/20/15, did not include the use of a Provale cup for the resident.<br><br>The CCP included "Nutrition and Hydration. Hx (history) protein calorie malnutrition, some missing teeth (denies problem with diet), Hx of significant weight loss, mechanically altered diet, GERD." Interventions included "Diet as ordered". There was no revision to update the CCP for the use of a Provale cup.<br><br>The Resident Care Card (used by the CNA staff to determine daily care of each resident) did not include the use of a Provale cup. This card had not been updated to include the resident's eating status revisions, when she progressed from | F 369 | completion of the preparation of all resident trays according to the tray card 5 times a week for 2 weeks, 3 times a week for 10 weeks. Dietary Manager or designee will also document review tray delivery 5 times a week for 2 weeks, 3 times a week for 10 weeks. Any issues identified will result in immediate reeducation or disciplinary action as appropriate.<br>The Dietary Manger will bring the results of the monitoring to the monthly QA Committee for review, identification of any patterns or trends and need for on-going education. | |

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| F 369 | Continued From page 26<br>needing oversite only, to requiring the assistance of one staff member to feed her.<br><br>The resident's physician signed and dated orders on 4/5/17 for "Diet: mechanical soft, fortified foods every meal, thin liquids, provale cup at all times". (A Provale cup is one that meters out the amount of liquid that is accessible to a person who has difficulty swallowing and is at a higher risk for aspiration when trying to swallow larger amounts of fluid).<br><br>On 5/2/17 at 3:15 PM and 5/3/17 at 10:30 AM, the resident was observed in her bed. She had a standard, large, pink cup at her bedside. A drinking straw was in the cup full of ice water and was available to her on her bedside table.<br><br>On 5/3/17 at 11:30 AM the resident was observed in the dining room at the feeder table, where a CNA was assisting her to eat her lunch. She had a small cup full of tea with a standard sippy straw in it. The resident's dining tray card was observed to include "Mechanical soft...Fortified foods--all meals.... provale cup...".<br><br>No PROVALE cup was observed at anytime.<br><br>On 5/3/17 at 3:30 PM, the surveyor's findings were reported to the administrator, the DON and the CN (corporate nurse).<br><br>On 5/4/17, the the DON shared the revised CCP and Resident Care Card with the surveyor. Both items had been updated to include the PROVALE cup. No additional information was provided prior to the survey team exit. | F 369 | | |
| F 371 | FOOD PROCURE, STORE/PREPARE/SERVE - | F 371 | | 6/9/17 |

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| F 371 SS=F | Continued From page 27<br>SANITARY<br>CFR(s): 483.60(i)(1)-(3)<br><br>(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br><br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br><br>(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.<br><br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>(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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and facility document review it was determined the facility staff failed to store prepare and distribute food in a sanitary manner for facility residents.<br><br>Findings:<br><br>Facility staff failed to store prepare and distribute food in a sanitary manner for facility residents. | F 371 | 1. The out of date and improperly stored food items were disposed of on 5/2/2017. The kitchen stove was cleaned on 5/2/17. The crock pot was removed from the storage area, and cleaned. The handling of the sandwich was reviewed with the CNA when staff was made aware of the situation on 5/3/17.<br>2. Current residents have the potential to be affected by this issue. To identify other | |

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| F 371 | Continued From page 28<br>On 5/2/17 at 2:00 PM, during the initial tour of the facility. The surveyor inspected the facility's kitchen environment. The following were observations made during that inspection:<br>1. The facility kitchen stove had food crumbs and food debris in the six eyes of the cook stove. The DM (dietary manager) told the surveyor the stove was cleaned once every seven days.<br>2. In the walk-in freezer, three bags of food (fish nuggets, sweet potato tots and cut squash) were observed opened and without dates. The food was not resealed and the bags were open to freezer air. The DM picked up each bag and dated and resealed them appropriately. He told the surveyor the facility policy required resealing and dating of all opened bags of food prior to returning them to the freezer.<br>3. In the dry food storage area, a dirty pot with food debris and grease was observed to be stored on shelving next to and above resident food items. The DM told the surveyor the pan was used for staff "pot-luck" meals and was not used for residents--even though it was shelved with resident food. He removed the pot at that time.<br><br>On 5/3/17 at 6:05 PM CNA II was observed to open and set up a dinner tray up for Resident #7. The meal included a grilled cheese sandwich, which the CNA II picked up with her bare hands and broke in half--handing one-half to the resident and putting the other half back onto the plate. Current state regulations require staff to wear gloves when handling any "ready to eat foods". The CNA did not don gloves prior to handling the grilled cheese sandwich with her hands.<br><br>The surveyor requested the facility policies governing freezer and dry storage of foods and | F 371 | food items that may be out of date or improperly stored the DM/ designee verified items in kitchen and pantries and food storage areas were stored properly in labeled and dated containers and food items were within their use by date. Any issues identified were immediately corrected. All kitchen equipment was inspected for cleanliness by Dietary Manager and the Corporate RD on 5/3/17. To avoid improper food handling, CNA's re-educated on 5/3/17 by DON.<br>3. To prevent recurrence, dietary staff was educated by the dietary manager on managing expiration dates, following cleaning schedules for the stove and pots, and proper food storage on 5/4/17. DM will also inservice facility staff on proper food handling technique on 5/30/17.<br>4. Following system correction, to monitor for on-going compliance DM/ designee will monitor food items for proper storage and validate food items are not expired ten (10) times a week for two (2) weeks, then five (5) times a week continuously. Dietary Manager will monitor cleanliness of kitchen stove twice weekly for one month, then weekly continuously. Dietary Manager will monitor storage of pots twice weekly for one month, then weekly continuously. Dietary Manager or designee will monitor food handling by facility staff daily for one week, then weekly continuously.<br>The Dietary Manger will bring the results of the monitoring to the monthly QA Committee for review, identification of any patterns or trends and need for on-going education. | |

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| F 371 | Continued From page 29<br>handling and serving ready-to-eat food. The policy on food preparation and handling contained instructions to staff, "....do not use bare hands for mixing, portioning, preparing (sandwiches) or serving."<br><br>The policy on freezers and refrigerator storage contained the following guidance to staff: "All food shall be appropriately dated to ensure proper rotation by expiration dates....." The policy did not address resealing food items, even though the DM said that was the policy.<br><br>The dry food storage policy contained nothing specific about storing dirty cookware on the shelving alongside resident's food. It did say, "The dietary department will store dry food used in food preparation in such a manner as to avoid contamination that optimizes food safety and quality".<br><br>On 5/3/17 at 3:30 PM, the administrator, DON and corporate nurse were informed of the surveyor's findings. No additional information was provided prior to the survey team exit. | F 371 | | |
| F 425 SS=D | PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH<br>CFR(s): 483.45(a)(b)(1)<br><br>(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.<br><br>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- | F 425 | | 6/9/17 |

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| F 425 | Continued From page 30<br><br>(1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility document review and clinical record review the facility staff failed to ensure medications were available for administration for 3 of 19 Residents, Residents #17, #18, and #9.<br><br>The findings included:<br><br>1. For Resident #17 the facility staff failed to ensure the medications Zoloft and Losartan were available for administration.<br><br>Resident #17 was admitted to the facility on 08/12/15 and readmitted on 06/29/16. Diagnoses included but not limited to hypertension, diabetes mellitus, hyperlipidemia, seizure disorder, anxiety, bipolar disorder, and hypothyroidism.<br><br>The most recent MDS (minimum data set) with an ARD (assessment reference date) of 02/20/17 coded the Resident as 15 of 15 in section C, cognitive patterns. This is a quarterly MDS.<br><br>The surveyor observed LPN (licensed practical nurse) #1 preparing medications for Resident #17 during a medication pass and pour observation on 05/03/17 at approximately 0835. While preparing the medication, LPN #1 stated that Resident #17's Zoloft and Losartan were not available in the med cart, and that she would have to check to see where they were. LPN #1 asked RN #1 about the medications, and RN #1 stated that she had ordered them from the pharmacy on 05/02/17 at approximately 1530. RN | F 425 | 1. Resident #9, 17, an 18 medications were called to the pharmacy. The physician was notified and an order was given to administer the medication when available. Pharmacy notified back-up pharmacy about the needed medications. Staff picked medication up from back-up pharmacy. Medications given promptly after arriving to facility.<br>2. Current residents receiving medications from a pharmacy have the potential to be affected by this issue.<br>3. 100% audit completed by the Director of Nursing or designee to ensure all residents had appropriate medications available in the building.<br>The Director of Nursing or designee will educate staff on the process of ordering medication in a timely manner so the residents will have medications available as they are ordered.<br>4. Director of Nursing or designee will document the audit of medications available compared to orders 5 times a week for 2 weeks, then 3 times a week for 2 weeks, then weekly for 2 weeks.<br>The Director of Nursing will bring the results of the monitoring to the monthly QA Committee for review, identification of any patterns or trends and need for on-going education. | |

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#1 stated that the medications should have been delivered on 05/02/17, and she did not know why they were not.

Resident #17's clinical record was reviewed for medication reconciliation on 05/03/17 at approximately 0930. It contained a signed POS (physician's order summary) which read in part "Losartan potassium f/c 100mg tablet for > Cozaar U-M, F/C. Take 1 tab by mouth every day for hypertension" and Sertraline HCL F/C 100mg tablet for > Zoloft F/C. Take 1 tab by mouth every day for depression. Time listed for administration of these medications was 0900.

Resident #17's MAR (medication administration record) for May was reviewed and contained entries which read in part "Losartan potassium F/C 100mg tablet for > Cozaar U-M, F/C. Take 1 tab by mouth every day for hypertension" and "Sertraline HCL F/C 100mg tablet for > Zoloft F/C. Take 1 tab by mouth every day for depression". Time listed for administration of these medications was 0900.

Surveyor requested LPN #1 inform surveyor when the medication became available for administration. LPN #1 did so at approximately 1330. LPN #1 also provided surveyor with a copy of a physician's order dated 05/03/17 which read in part "May give losartan potassium 100mg tab po (by mouth) and Zoloft 100mg tab po upon arrival from pharmacy".

Surveyor requested and was provided with policy entitled "Medication Shortages/Unavailable Medications" which read in part "2. If a medication shortage is discovered during normal pharmacy hours: 2.1 Facility nurse should call

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Pharmacy to determine the status of the order. If the medication has not been ordered, the licensed Facility nurse should place the order or reorder for the next scheduled delivery. 2.2 If the next available delivery causes delay or a missed dose in the Resident's medication schedule, Facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose. 2.3 If the medication is not available in the Emergency Medication Supply, Facility staff should notify Pharmacy and arrange for an emergency delivery."

The concern of the medication not being available was discussed with the administrative team during a meeting on 05/03/17 at approximately 1530.

No further information was provided prior to exit.

2. For Resident #18, the facility staff failed to ensure the medication Lasix was available for administration.

Resident #18 was admitted to the facility on 11/13/15. Diagnoses included but not limited to hypertension, dementia, anxiety, and depression.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 02/12/17 coded the Resident as 13 of 15 in section C, cognitive patterns. This is a quarterly MDS.

The surveyor observed LPN (licensed practical nurse) #1 preparing medications for Resident #18 during a medication pass and pour observation on 05/03/17 at approximately 0845. While preparing the medication, LPN #1 stated that Resident #18's Lasix was not available in the med

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cart, and that she would have to check to see where it was. LPN #1 asked RN #1 about the medication, and RN #1 stated that she had ordered it from the pharmacy on 05/02/17 at approximately 1530. RN #1 stated that the medication should have been delivered on 05/02/17, and she did not know why it was not.

Resident #18's clinical record was reviewed for medication reconciliation on 05/03/17 at approximately 0930. It contained a signed POS (physician's order summary) which read in part "furosemide 20mg tablet for > Lasix. Take 1 tab by mouth every day for hypertension". Time listed for administration of these medications was 0900.

Resident #18's MAR (medication administration record) for May was reviewed and contained entries which read in part "furosemide 20mg tablet for > Lasix. Take 1 tab by mouth every day for hypertension". Time listed for administration of these medications was 0900.

Surveyor requested LPN #1 inform surveyor when the medication became available for administration. LPN #1 did so at approximately 1330. LPN #1 also provided surveyor with a copy of a physician's order dated 05/03/17 which read in part "May give Lasix 20mg po (by mouth) upon arrival from pharmacy".

Surveyor requested and was provided with policy entitled "Medication Shortages/Unavailable Medications" which read in part "2. If a medication shortage is discovered during normal pharmacy hours: 2.1 Facility nurse should call Pharmacy to determine the status of the order. If the medication has not been ordered, the licensed Facility nurse should place the order or

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reorder for the next scheduled delivery. 2.2 If the next available delivery causes delay or a missed dose in the Resident's medication schedule, Facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose. 2.3 If the medication is not available in the Emergency Medication Supply, Facility staff should notify Pharmacy and arrange for an emergency delivery."

The concern of the medication not being available was discussed with the administrative team during a meeting on 05/03/17 at approximately 1530.

No further information was provided prior to exit.
3. The facility staff failed to ensure Resident #9 had Fentanyl patch available for administration.

Resident #9 was admitted to the facility on 7/15/16 with the following diagnoses of, but not limited to high blood pressure, diabetes, high cholesterol, anxiety disorder, depression, affective mood disorder, osteoarthritis and morbid obesity. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 4/14/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #9 also requires assistance of 1 staff member for personal hygiene and extensive assistance of 1 staff member for bathing.

During the clinical record review performed by the surveyor on 5/3/17 and 5/4/17, it was noted on the resident's MAR (Medication Administration Record) dated for 4/10/17 that Fentanyl patch used for pain was "not received from pharmacy" therefore, it was not able to be administered as

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| F 425 | Continued From page 35<br>the physician had previously ordered.<br><br>The director of nursing was notified of the above documented findings by the surveyor on 5/4/17 at approximately 8:40 am. The director of nursing stated, "There was a problem with the pharmacy receiving a hard script for this narcotic patch and it was given to the resident as soon as it came to the facility on 4/12/17."<br><br>The administrative team was notified of the above documented findings on 5/4/17 at approximately 12:30 pm by the surveyor.<br><br>No further information was provided to the surveyor prior to the exit conference on 5/4/17. | F 425 | | |
| F 504 SS=D | LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN<br>CFR(s): 483.50(a)(2)(i)<br><br>(a) Laboratory Services<br><br>(2) The facility must-<br><br>(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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review the facility staff failed to obtain a physician order prior to obtaining a laboratory test on Resident #8.<br><br>The findings included: | F 504 | 1. The Resident Representative and MD were notified that a lab was obtained for a lipid panel with calculated LDL when a lipid panel was ordered for Resident #8. There were no new orders related to the notification of the MD<br>2. Current residents with orders to obtain | 6/9/17 |

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| F 504 | Continued From page 36<br>Resident #8 was admitted to the facility on 6/7/10 with the following diagnoses of, but not limited to anemia, high blood pressure, dementia, anxiety disorder, depression, chronic obstructive pulmonary disease and high cholesterol. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 4/12/17 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 12 out of a possible score of 15. Resident #8 was also coded as requiring extensive assistance of 2 staff members for personal hygiene and being totally dependent on 1 staff member for bathing.<br><br>During the clinical record review performed by the surveyor on 5/3/17, it was noted that the physician had ordered Resident #8 to have a Lipid Panel obtained on next lab draw day on 3/10/17. The surveyor noted in the clinical record that Resident #8 had results of a "Lipid Panel w/calc (with calculated) LDL" drawn on 3/10/17 in which the physician had not ordered.<br><br>The administrative team was notified of the above documented findings on 5/3/17 at approximately 3:30 pm by the surveyor.<br><br>On 5/4/17 at 11:45 am, the director of nursing stated to the surveyor, "The nurse should had clarified this with the physician and ordered the correct one."<br><br>No further information was provided to the surveyor prior to the exit conference on 5/4/17. | F 504 | a lipid panel have the potential to be affected by this issue.<br>3. Nursing staff educated by Director of Nursing and/or designee concerning ordering the lipid panel as ordered or clarify the order if not clearly written.<br>The Director of Nursing and/or designee will conduct 100% audit of all charts to ensure that the appropriate lipid panel was obtained as ordered within the last 3 months<br>4. The Director of Nursing and/or designee will review orders for lipid panel to ensure appropriate lipid panel is ordered and drawn. This will be documented as completed 5 times a week for 2 weeks, then 3 times a week for 2 weeks, then weekly for 8 weeks.<br>The Director of Nursing will bring the results of the monitoring to the monthly QA Committee for review, identification of any patterns or trends and need for on-going education. | |
| F 514 SS=E | RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br>CFR(s): 483.70(i)(1)(5) | F 514 | | 6/9/17 |

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| F 514 | Continued From page 37<br><br>(i) Medical records.<br>(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br><br>(i) Complete;<br><br>(ii) Accurately documented;<br><br>(iii) Readily accessible; and<br><br>(iv) Systematically organized<br><br>(5) The medical record must contain-<br><br>(i) Sufficient information to identify the resident;<br><br>(ii) A record of the resident's assessments;<br><br>(iii) The comprehensive plan of care and services provided;<br><br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br><br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br><br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and clinical record review, the facility staff failed to maintain an accurate and complete clinical record for 3 of 19 residents in the survey sample (Resident #2, #9 | F 514 | 1. MD and Resident Representative were notified of omitted doses of medication for Resident #2 and Resident #9. Residents were assessed for adverse effects, | |

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| F 514 | Continued From page 38<br>and #6).<br><br>The findings included:<br><br>1. The facility staff failed to maintain a complete and accurate clinical record for Resident #2.<br><br>Resident #2 was originally admitted to the facility on 7/22/16 and readmitted on 4/22/17. The resident had the following diagnoses of, but not limited to atrial fibrillation, hemiarthroplasty, high blood pressure, diabetes, dementia, anxiety disorder and dysphagia. Resident was coded on the significant change MDS with an ARD (Assessment Reference Date) of 4/19/17 as having a BIMS (Brief Interview for Mental Status) score of 10 out of a possible score of 15. Resident #2 was also coded as requiring extensive assistance of 1 staff member for dressing, personal hygiene and was totally dependent on 1 staff member for bathing.<br><br>The surveyor conducted a clinical record review of Resident #2's chart on 5/2/17. It was noted by the surveyor that on the following dates there was no documentation noted on the resident's MAR (Medication Administration Record) for the medication "Nystatin to be applied to groin twice daily and as needed": 7-3 shift for 3/9 to 3/13/17, 3/19/17, 3/20/17, 3/25/17 and 3/27/17. The following dates were missing documentation on the 3-11 shift: 3/6/17, 3/18/17, 3/19/17, 3/20/17, 3/23/17 and 3/27/17. Resident #2's behavioral monitoring sheets were also missing documentation for the following dates: 7-3 shift on 3/7/17, 3/14/17, 3/21/17, 3/24/17, 3/25/17 and 3/26/17 and 3-11 shift on 3/11/17, 3/17/17 and 3/18/17. | F 514 | related to omitted doses, none were noted.<br>2. Current residents receiving medications have the potential to be affected by this issue.<br>3. Nursing staff educated on May 12, 2017, on medication omissions and medication administration documentation, including the components required for the documentation of the fentanyl patch.<br>The Director of Nursing or designee will audit 100% MARS of current residents to identify any other residents with omitted medication. Corrective measures will be taken for any identified issues.<br>4. The Director of Nursing or designee will document review medication administration documentation daily for 12 weeks. Any issues identified will result in reeducation or disciplinary action as appropriate.<br>The Director of Nursing will bring the results of the monitoring to the monthly QA Committee for review, identification of any patterns or trends and need for on-going education.<br><br>1. Pharmacy Review pulled from thinned chart was placed on the chart of Resident #6 chart.<br>2. Current residents have the potential to be affected by this issue.<br>3. The Medical Records employee will be educated that the pharmacy review form is to remain in the residents' current medical records. The Medical Records employee will audit 100% charts to ensure that the pharmacy review paper is in the chart. | |

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| F 514 | Continued From page 39<br>The administrative team was notified of the above documented findings on 5/2/17 at approximately 3:30 pm by the surveyor.<br><br>The administrative team was again notified of the above documented findings on 5/4/17 at approximately 12:30 pm by the surveyor.<br><br>No further information was provided to the surveyor prior to the exit conference on 5/4/17.<br><br>2. The facility staff failed to maintain a complete and accurate clinical record for Resident #9.<br><br>Resident #9 was admitted to the facility on 7/15/16 with the following diagnoses of, but not limited to high blood pressure, diabetes, high cholesterol, anxiety disorder, depression, affective mood disorder, osteoarthritis and morbid obesity. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 4/14/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #9 also requires assistance of 1 staff member for personal hygiene and extensive assistance of 1 staff member for bathing.<br><br>During the clinical record review performed by the surveyor on 5/3/17 and 5/4/17, it was noted on the resident's MAR (Medication Administration Record) dated for February and March, 2017 under the medication Fentanyl patch "Apply 1 patch topically every 72 hours" under the site location, there was no documentation noted.<br><br>The director of nursing was notified of the above documented findings by the surveyor on 5/4/17 at approximately 8:40 am. The director of nursing | F 514 | 4. The Medical Records employee will document verifying the presence of the pharmacy review paper with each chart thinning she performs for the next 3 months.<br>The Medical Records employee will bring the results of the monitoring to the monthly QA Committee for review, identification of any patterns or trends and need for on-going education. | |

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stated, "They should always chart where they applied the new patch."

The administrative team was notified of the above documented findings on 5/4/17 at approximately 12:30 pm by the surveyor.

No further information was provided to the surveyor prior to the exit conference on 5/4/17.
3. For Resident #6 the facility staff thinned pharmacy reviews from the clinical record. Pharmacy reviews are not to be thinned from the clinical record.

Resident #6 was admitted to the facility on 07/25/1 and readmitted on08/21/14. Diagnoses included but not limited to hypertension, dementia, seizures, anxiety, depression, dysphagia, hypothyroidism, gastroesophageal reflux disease, and psychotic disorder.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 04/12/17 coded the Resident as 2 out of 15 in section C, cognitive patterns. This is a quarterly MDS

Resident #6's clinical record was reviewed on 05/03/17. It contained a "Medication Regimen Review" form that indicated the pharmacist had reviewed the Resident's medications for the months of February, March and April 2017. The surveyor could not locate any other "Medication Regimen Review" forms in the clinical record. At the bottom of the form it read in part "Please Do Not Thin From Chart".

Surveyor asked the administrator during a meeting on 05/03/17 at approximately 1530 if he could locate the missing "Medication Regimen

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| F 514 | Continued From page 41<br>Review" forms. The missing forms were provided to the surveyor on 05/04/17 at approximately 0830.<br><br>The concern of thinning the medication review forms from the clinical record was discussed with the administrative team during a meeting on 05/04/17 at approximately 1230.<br><br>No further information was provided prior to exit. | F 514 | | |