STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495375	A. BUILDING ______ B. WING ______	01/29/2018

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 01/24/18 through 01/26/18, and 1/29/18. The facility was in substantial compliance with 42 CFR Part 483.73, (emergency preparedness) Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/24/18 through 1/26/18, and 1/29/18. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety survey/report will follow. The census in this 120- bed facility was 92 at the time of the survey. The survey sample consisted of 19 current resident reviews (#77, #66, #64, #40, #29, #43, #60, #10, #65, #47, #46, #83, #50, #21, #29, #45, #71, #15, #39) and 2 closed record reviews (#94, #93).	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review the facility staff failed for 1 resident (Resident #77) of 21 residents in the survey sample to ensure the resident had been assessed to self administer medications.	F 554	F 554 1. Resident #77 signed admission form requesting that facility staff administer all medications. This was verified with the resident and family. 2. Admission forms were reviewed for	3/5/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/15/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 554	Continued From page 1 Resident #77's medications were left at the bedside. She took the medications without supervision. The findings included: Resident #77, a 78 year old, was admitted to the facility on 7/16/15. Her diagnoses included chronic pain, dysphagia, breast cancer, cerebrovscular disease, and anxiety. Her most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 1/3/18. She was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment. She required limited assistance with activities of daily living. On 1/24/18 at 10:20 a.m., Resident #77 was in her room. She was heard coughing repeatedly. Upon entrance to the room, Resident #77 was seated in her wheel chair in front of the overbed table. On top of the table were two medication cups full of pills (approximately 6-8) in applesauce. The resident was attempting to swallow the pills. She stated that the pills were making her cough. She stated that she usually had one cup per pill and that the nurse that gave her the medications today was new. After standing and talking with the resident for a few minutes, this surveyor left the room to find a nurse while a second surveyor stayed with the resident. Licensed Practical Nurse C (LPN C) was in the hallway walking towards the room. LPN C was asked why she left the medications with the resident. She stated that the resident said she had a swallowing problem and wanted the pills in individual cups with applesauce. LPN C stated that she left the room to check with	F 554	any residents requesting to self administer their own medications and the required assessment to be completed if so requested. 3. Nursing staff, were in-serviced by the Director of Nursing on the policy for self administration of medication and the required assessment to be completed, and the policy on administering medications for those who are not assessed, or require staff intervention/assistance. Medication Administration competency will be completed by DON (designee) with each Licensed nurse, including agency staff, to ensure compliance with policy, & resident safety with the actual intake of medications observed. DON (designee) will complete med pass audits, on all shifts 3 times per week to ensure compliance. 4. Director of Nursing will bring a summary of audit findings to the monthly QAPI meeting to evaluate, with the committee, if each med pass goal has been met sufficiently. Barriers will be reviewed/discussed for areas that do not show improvement.	

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F 554	Continued From page 2 another nurse about how the pills were to be administered. She stated that she told the resident not to take the pills while she was out of the room. The issue was reviewed with the Administrator and Director of Nursing (DON) at the end of day meeting on 1/26/18. When asked if it was allowable for LPN C to leave the pills at the bedside, the DON stated no. When asked if Resident #77 had been assessed to self administer medications, the DON stated no. No further information was provided.	F 554		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(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 (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)	F 580		3/5/18

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F 580	Continued From page 3 (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). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to notify the responsible party of falls for 1 Resident (Resident #60) in a survey sample of 21 Residents. For Resident #60, the facility staff failed to notify the Responsible party of recurring falls. The findings included:	F 580	F 580 1.The resident representative for resident□s #60 was made aware of the residents falls since admission 2.The facility has identified all residents as having the potential to be affected by this alleged deficient practice. Resident records were checked against incident investigations for the past 60	

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F 580	Continued From page 4 Resident #60, was admitted to the facility on 12-6-17. Diagnoses included; stroke, diabetes, drug and alcohol abuse, high blood pressure and high cholesterol. Resident #60's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12-15-17 was coded as a full admission assessment. Resident #60 was coded as having a BIMS (brief interview of mental status) score of "15" out of a possible 15, or cognitively intact. This was an error, as the Resident was not cognitively intact. Resident #60 was also coded as requiring extensive assistance of one staff member to perform activities of daily living, such as bed mobility, transferring, eating, locomotion, and toileting. Resident #60 was coded with one fall since admission, no floor mats used for falls, bed fast or wheel chair bound, at risk for falls, on depression medication, which increased the risk for falls. The Resident was assessed as always continent of bowel and bladder. On 1-24-18 at approximately 11:00 AM, Resident #60 was observed in his bed with his mother at bedside, the bed was in high position. An interview was requested, and was completed with the Responsible party (RP), (mother) in the resident's room. The Resident was encouraged to take part, and only responded with grinding teeth, and groaning. Resident #60's RP stated that the Resident was confused at times, and usually only answered yes and no questions, and would often not answer correctly. When asked if the Resident had been kept safe while in the facility, the RP answered yes, and that the Resident had fallen once on his first week after admission, but that was the only problem. Resident #60's room mate stated that was	F 580	days to ensure resident representatives were made aware all incidents and any significant changes in condition 3.Licensed staff were in-serviced by DON/designee on proper notification of changes, to include incidents and accidents, and significant changes in resident condition. The 24-hour report sheet will be reviewed Monday Friday during morning meeting to ensure resident representatives have been notified of incidents. DON/Designee will audit Incident reports ongoing, for resident representative notification, prior to closing in the electronic charting system. Administrator will not sign incidents as completed until he verifies, notification name, and dates have been entered on the reports. 4.The findings of audits will be reported to the QAPI committee until audit thresholds are met .	

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F 580	Continued From page 5	F 580		

incorrect, that the Resident had fallen several times, and the room mate was afraid for Resident #60, because if he fell, "he could not call for help". The room mate stated that he himself had to call staff during the last fall which had occurred "about a week ago", and the staff had removed Resident #60's floor mat, so he had fallen on the "hard floor". The RP stated she had not been made aware of the other falls, and was concerned.

Review of the resident's clinical record and MAR (medication administration record) revealed an order for Citalopram for depression, taken every day at 8:00 a.m.

Review of the nursing baseline care plan, nursing progress notes, the MDS "Care Area Assessment (CAA) Summary, and the revisions to that care plan revealed that a floor mat was ordered for Resident #60 on 12-11-17 due to falls on 12-7-17, 12-9-17, and 12-10-17. The order was discontinued on 1-10-18. "Will obtain low bed" was ordered on 1-15-18, and at the time of survey, the Resident was still in a regular bed, identical to the other beds on the nursing unit.

On 1-26-18 all nursing notes were reviewed in the clinical record since Resident #60's admission. The DON was asked to provide copies of all nursing notes, and they were supplied. Only two nursing notes existed at the time of survey, which documented only two of Resident #60's five falls. The documentation stated that these two falls were reported to the responsible party.

Further review of nursing progress notes revealed that the Resident had falls on 12-19-17, and 1-12-18, after the 3 falls occurring between the

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F 580	Continued From page 6 12-6-17 admission and the 12-11-17 order for the fall mat. The 3 falls occurring between 12-5-17, and 12-11-17 were not coded correctly on the 12-15-17 MDS, as it documented only one fall since admission. The nursing progress notes, and the care area assessment notes in the MDS indicate at least 5 falls since admission, only two of which the RP was documented as being aware of. After the 1-12-18 fall, the fall mat had not been reordered for safety, up until the time of survey on 1-24-18. On 1-25-18 at 9:05 AM, an interview was conducted with the Director of Nursing (DON) regarding the lack of notification of Resident #60's RP about his falls, and she stated that perhaps the RP had just forgotten she had been notified. On 1-26-18 at 1:00 p.m., the DON and Administrator were notified of above findings, and other findings. The DON stated, "We have talked to (resident's name) (mother) RP, and she will be set for attendance in the Resident's upcoming care plan meeting. We have also given her a copy of the care plan." No further information was provided by staff.	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes	F 583		3/5/18

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F 583	Continued From page 7 accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed for 1 resident (Resident #65) of 21 residents in the survey sample to ensure personal privacy. For Resident #65, the facility staff failed to knock on the door, and or announce themselves prior to entering the bedroom. The Findings included:	F 583	F 583 1. LPN A was counseled on her failure to knock on the door of resident #65 2.The facility has identified all residents as having the potential to be affected by this alleged deficient practice and the Resident Rights was reviewed with staff. 3. Staff were in-serviced by the Social	

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F 583	Continued From page 8 Resident #65 was a 53 year old who was admitted to the facility on 2/20/13. Resident #65's diagnoses included Major Depressive Disorder, Seizures, Hemiplegia, and Hypertension. The Minimum Data Set, which was a Annual Assessment with an Assessment Reference Date of 12/19/17, coded Resident #65 as having a Brief Interview of Mental Status Score of 1, indicating severely impaired cognition. On 1/24/18 at 9:00 A.M. an observation was conducted of the medication pass. Licensed Practical Nurse A was observed entering Resident #65's room in order to wash her hands. LPN A entered to the bedroom without knocking or announcing herself to either Resident #65 or his roommate. LPN A quickly washed her hands for about 10 seconds. She then poured and administered Resident #65's medications. An interview was immediately conducted with LPN A. When asked why she didn't knock on the door or announce herself to the residents, she stated, "I don't have an explanation. I didn't knock before entering. It is important for respect and privacy." When asked why she only washed her hands for approximately 10 seconds, she stated, "I probably should have used the hand sanitizer. I know I didn't wash them long enough. We are supposed to sing the birthday song for 30 seconds." LPN A also stated that she was from an agency, and that it was her first day at the facility. Therefore, she said that she was unfamiliar with the residents. On 1/29/18 at 1:12 P.M. an interview was conducted with the Director of Nursing (DON	F 583	Service Director on Resident Rights including Residents Personal Privacy and Confidentiality and the need to knock on resident□s doors. Department Heads will complete audits 3 times per week monitoring staff during care throughout the day and bring audit results to the Social Service Director. 4.Social Service will complete a summary of the audits weekly and bring results to the Administrator for review. A monthly summary will be brought to the QAPI meeting for review by the committee, until thresh holds have been met.	

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F 583	Continued From page 9 Administration B). When asked about her expectations regarding hand washing standards, she stated, "They are supposed to knock and wait to be asked in if resident is able to do so. It's a privacy and dignity issue." No further information was received.	F 583		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		3/5/18

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F 584	Continued From page 10 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on Observation and Staff Interview, the facility staff failed to maintain a safe, clean, comfortable environment for one resident (Resident #21) in a sample of 21 residents. For Resident #21, the right arm of the wheel chair was torn and taped. The findings included: Resident #21 was admitted on 12/16/16. Resident #21's diagnoses included: Hypothyroidism, unspecified dementia without behavioral disturbances, major depressive disorder, Parkinson's Disease, other chronic pain, essential hypertension, chronic atrial fibrillation, Gastro-Esophageal Reflux Disease with esophagitis, Bilateral Primary Osteoarthritis of the knees, difficulty walking, and lack of coordination. Resident #21's most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an ARD (Assessment Reference Date) of 11/09/17. The assessment coded Resident #21 with a BIMS (Brief Interview of Mental Status, an evaluation of cognitive status) score of 8, indicating Moderate Impairment.	F 584	F 584 1- Resident□s wheelchair arm was repaired same day. 2- Audit of facility wheelchairs has been conducted. 3- Maintenance Director or designee will inspect all wheelchairs weekly and document on maintenance inspection log. 4- Weekly inspection reports of wheelchairs will be reported to the monthly QAPI meeting	

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F 584	Continued From page 11 On 1/24/18, Resident #21 was observed in his room watching television. It was observed that Resident #21's wheelchair had white tape wrapped around the right arm padding of the chair, securing it to the metal frame. On 1/25/18 at 9:20am, a brief interview was conducted with Facility Maintenance Staff, Employees B and C. Employee B stated that wheelchairs are serviced or repaired at the facility, by the facility maintenance staff. Employee B stated that audits of resident equipment are done "about every two weeks". Employee B stated that no paper log to track needed and completed repairs was kept. Employee C stated that it had been "about 2 weeks" since Resident #21's wheelchair had been inspected. At 10:35am on 1/25/18, Employee B was observed repairing the arm of Resident #21's wheelchair. The Admin and DON were notified of the issue at the end of day meeting on 1/26/18.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to complete an accurate MDS (minimum data set) RAI (Resident Assessment Instrument) for two Residents (Resident #60 and Resident #66) in a survey sample of 21 Residents.	F 641	F 641 Accuracy of Assessment 1. Resident # 60 i. BIMS (brief interview mental status) completed on assessment 12/15/17 score of 15. Stated Resident #60's most recent MDS (minimum dataset) with an ARD (assessment reference date) of 12-15-17	3/5/18

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F 641

Continued From page 12

For Resident #60, the facility staff failed to accurately code number of falls since admission (1900A), cognitive status (C0500) in the admission MDS, and Bowel and bladder Continence was also inaccurate from comparison between the care plan, MDS, and the CAA's.

The findings included:

Resident #60, was admitted to the facility on 12-6-17. Diagnoses included; stroke, diabetes, drug and alcohol abuse, high blood pressure and high cholesterol.

Resident #60's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12-15-17 was coded as a full admission assessment. Resident #60 was coded as having a BIMS (brief interview of mental status) score of "15" out of a possible 15, or cognitively intact. This was an error, as the Resident was not cognitively intact. Resident #60 was also coded as requiring extensive assistance of one staff member to perform activities of daily living, such as bed mobility, transferring, eating, locomotion, and toileting. Resident #60 was coded with one fall since admission, no floor mats used for falls, bed fast or wheel chair bound, at risk for falls, on depression medication, which increased the risk for falls. The Resident was assessed and coded on the MDS as always continent of bowel and bladder.

The baseline care plan stated the Resident was "incontinent of bowel and bladder, and required adult briefs." The Resident was wearing incontinent briefs during observations, and the

F 641

was coded as a full admission assessment. Resident #60 was coded as having a BIMS (brief interview of mental status) score of "15" out of a possible 15, or cognitively intact. This was an error, as the Resident was not cognitively intact. Resident with diagnosis stroke with unclear speech but usually makes self-understood with allotted time for communication. Reviewed for accuracy by completing BIMs on 2/12/18 with score of 15.; no change warranted.

ii. Resident # 60 Coded extensive assistance of one member to perform activities of daily living with CAA documented resident□s most dependent ADL self-performance of total assistance. Review of ADL Self Performance Record with resident participation with ADL□s except dressing during the look back period. Per the RAI manual Chapter 3 G-5 code total assistance if the resident must be unwilling or unable to perform the activity for the entire 7-day look back period; extensive assistance per the RAI guidelines; no change warranted.

iii. Resident # 60 coded continent of bowel and bladder on assessment with ARD 12/15/17. Review of ADL documentation during the look back period, resident noted with four times incontinence of bladder, no incontinence of bowel noted; modification completed for occasional incontinence of bladder.

2. Assessments have a potential to be affected due to new MDS coder with less than six months experience and, review of comprehensive assessment in the last 90 days with two assessments required

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Resident's RP stated the Resident was incontinent.

On 1-24-18 at approximately 11:00 AM, Resident #60 was observed in his bed, with his mother at bedside, the bed was in high position. An interview was requested, and was completed with the Responsible party (RP), (mother) in the resident's room. The Resident was encouraged to take part, and only responded with grinding teeth, and groaning. Resident #60's RP stated that the Resident was confused at times, and usually only answered yes and no questions, and would often not answer correctly.

Review of the nursing baseline care plan, the MDS "Care Area Assessment (CAA) Summary, and the revisions to that care plan revealed that a floor mat was ordered for Resident #60 on 12-11-17 due to falls on 12-7-17, 12-9-17, and 12-10-17. The order was discontinued on 1-10-18. "Will obtain low bed" was ordered on 1-15-18, and at the time of survey, the Resident was still in a regular bed, identical to the other beds on the nursing unit.

Review of nursing progress notes revealed that the Resident also had falls on 12-19-17, and 1-12-18, after the 3 falls occurring between the 12-6-17 admission and the 12-15-17 MDS. These documents indicate at least 5 falls since admission, only one of which the RP was aware of. After the 1-12-18 fall the fall mat had not been reordered for safety, up until the time of survey on 1-24-18.

On 1-24-18, LPN (licensed practical nurse) D, the MDS coordinator, was interviewed and stated that

F 641

modifications.

3. Review of policy of certifying accuracy completed with the Interdisciplinary team that completes the MDS. Education provided by master teacher of the resident assessment of accuracy of Assessment and certified resident assessment MDS consultant 2/12/18 & 2/13/18. New MDS Coordinator attended two training of MDS basic of line by line of the MDS coding in January 2018. MDS Coders attend a 2-day MDS seminar 2/14/18 & 2/15/18. Weekly audit will be completed x 2 months, then monthly to review for accuracy by the MDS or designee.

4. MDS Coordinator will report finding to QAPI monthly The QAPI committee will determine the need for continued monitoring and amendment of the plan as necessary.

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F 641	Continued From page 14 the MDS was coded incorrectly for Resident #60, and she was not the individual who completed the assessment. The administrator and DON (director of nursing) were informed of the failure of the staff to accurately code the number of falls since admission, and cognitive sections of the MDS, and the inaccuracy of the resident's continence on 1-26-18 at the end of day meeting. No further information was provided by the facility.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-	F 655		3/5/18

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F 655	Continued From page 15 (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on family interview, staff interview and clinical record review, the facility staff failed to provide a summary of the care and services for the Resident, to the Resident's Responsible party in a manner that was understandable to that individual. Also, the facility staff did not give updated interventions as they became available, for one Resident (Resident #60) in a survey sample of 21 Residents. For Resident #60, the facility staff failed to provide the Responsible party with a baseline care plan of services, and failed to provide the Responsible party with revisions of care plan interventions as they became available and necessary. The findings included:	F 655	F 655 Baseline Care Plan 1. Resident # 60 admitted 12/6/17 with baseline care plan developed and implemented. A summary of the baseline was provided to representative on 12/6/17 at 4:00 p.m., baseline care plan is discontinued due to comprehensive care plans developed. A Care Conference was held on 1/24/18 to review the plan of care with representative present. 2. One new admitted with a potential to be affected, baseline care plan in place with summary provided. 3. Interdisciplinary team educated on baseline care plan policy and procedure on 2/13/18 & 2/14/18. MDS coordinator will complete weekly audit will be completed x 2 months, then monthly x 1 month for baseline care plan developed	

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F 655 Continued From page 16

Resident #60, was admitted to the facility on 12-6-17. Diagnoses included; stroke, diabetes, drug and alcohol abuse, high blood pressure and high cholesterol.

Resident #60's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12-15-17 was coded as a full admission assessment. Resident #60 was coded as having a BIMS (brief interview of mental status) score of "15" out of a possible 15, or cognitively intact. This was an error, as the Resident was not cognitively intact. Resident #60 was also coded as requiring extensive assistance of one staff member to perform activities of daily living, such as bed mobility, transferring, eating, locomotion, and toileting. Resident #60 was coded with one fall since admission, no floor mats used for falls, bed fast or wheel chair bound, at risk for falls, on depression medication, which increased the risk for falls. The Resident was assessed and coded on the MDS as always continent of bowel and bladder.

The baseline care plan stated the Resident was "incontinent of bowel and bladder, and required adult briefs." The Resident was wearing incontinent briefs during observations, and the Resident's RP stated the Resident was incontinent.

On 1-24-18 at approximately 11:00 AM, Resident #60 was observed in his bed with his mother at bedside, the bed was in high position. An interview was requested, and was completed with the Responsible party (RP), (mother) in the resident's room. The Resident was encouraged to take part, and only responded with grinding teeth, and groaning. Resident #60's RP stated

F 655

and implemented in 48 hours, summary provided before the comprehensive care plan developed and resident and/or representative provided updates to the baseline care plan after summary provided.

4. MDS Coordinator will report finding to QAPI monthly x 3 months.

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F 655	Continued From page 17	F 655		

that the Resident was confused at times, and usually only answered yes and no questions, and would often not answer correctly. When asked if the Resident had been kept safe while in the facility, the RP answered yes, and that the Resident had fallen once on his first week after admission, but that was the only problem. Resident #60's room mate stated that was incorrect, that the Resident had fallen several times, and the room mate was afraid for Resident #60, because if he fell, "he could not call for help". The room mate stated that he himself had to call staff during the last fall which had occurred "about a week ago", and the staff had removed Resident #60's floor mat, so he had fallen on the "hard floor". The RP stated she had not been made aware of the other falls, and was concerned.

Resident #60's RP was asked if she had been invited to the Resident's care plan meeting, and had been given a copy of the care plan, which should denote falls, and interventions for the concern. She replied she did not know that these meetings should occur, and she had not received a copy of the care plan. She stated her expectation was that the Resident would receive therapy.

Review of the nursing baseline care plan and the revisions to that care plan revealed that a floor mat was ordered for Resident #60 due to falls on 12-11-17. The order was discontinued on 1-10-18. "Will obtain low bed" was ordered on 1-15-18, and at the time of survey, the Resident was still in a regular bed, identical to the other beds on the nursing unit.

Review of nursing progress notes revealed that

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F 655	Continued From page 18 the Resident also had falls on 12-19-17, and 1-12-18, after the 3 falls occurring between the 12-6-17 admission and the 12-11-17 order for the fall mat, and the 12-15-17 MDS. These documents indicate at least 5 falls since admission, only one of which the RP was aware of. After the 1-12-18 fall, the fall mat had not been reordered for safety, up until the time of survey on 1-24-18. On 1-25-18 at 9:05 AM, an interview was conducted with the Director of Nursing (DON) regarding the lack of care planning notification of Resident #60's RP, and she stated that perhaps the RP had not understood what care planning was, and that the RP had been informed of the care the Resident was receiving. On 1-26-18 at 1:00 p.m., the DON and Administrator were notified of above findings, and other findings. The DON stated, "We have talked to (resident's name) (mother) RP, and she will be set for attendance in the Resident's upcoming care plan meeting. We have also given her a copy of the care plan." No further information was provided by staff.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(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	F 656		3/5/18

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F 656	Continued From page 19 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its 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 Observation, staff interview, facility document review, and clinical record review, the facility failed to develop a comprehensive care plan for two residents (Resident #60 and Resident #21) in a survey sample of 21 residents.	F 656	F 656 Comprehensive Care Plan 1. Resident # 60 Care Area triggers reviewed. Care Plans in place for all triggered completed by 1/27/18, Fall care plan updated with lowbed in place. Resident # 21 Pain care plan	

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F 656	Continued From page 20 1. For Resident #60, the facility staff signed as having completed the comprehensive care plan, and failed to address all of the care areas triggered in the MDS assessment. 2. For Resident #21, the comprehensive care plan did not document that the resident suffered from chronic pain. The findings included: Resident #60, was admitted to the facility on 12-6-17. Diagnoses included; stroke, diabetes, drug and alcohol abuse, high blood pressure and high cholesterol. Resident #60's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12-15-17 was coded as a full admission assessment. Resident #60 was coded as having a BIMS (brief interview of mental status) score of "15" out of a possible 15, or cognitively intact. This was an error, as the Resident was not cognitively intact. Resident #60 was also coded as requiring extensive assistance of one staff member to perform activities of daily living, such as bed mobility, transferring, eating, locomotion, and toileting. Resident #60 was coded with one fall since admission, no floor mats used for falls, bed fast or wheel chair bound, at risk for falls, on depression medication, which increased the risk for falls. The Resident was assessed and coded on the MDS as always continent of bowel and bladder. The baseline care plan stated the Resident was "incontinent of bowel and bladder, and required adult briefs." The Resident was wearing incontinent briefs during observations, and the	F 656	implemented 1/26/18 with review of current regiment with ID team and physician. And resident involvement with plan of care. 2. A review of 40 comprehensive assessment reviewed with 12 affected, care plans identified will be completed by 2/23/18. 3. Interdisciplinary team educated on care plan policy and development on 2/13/18 & 2/14/18. Weekly audit will be completed x 2 months, then monthly for areas triggered on the assessment by the MDS department or designee. 4. MDS Coordinator will report finding to QAPI monthly.	

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F 656	Continued From page 21	F 656		

Resident's RP stated the Resident was incontinent.

On 1-24-18 at approximately 11:00 AM, Resident #60 was observed in his bed with his mother at bedside, the bed was in high position. An interview was requested, and was completed with the Responsible party (RP), (mother) in the resident's room. The Resident was encouraged to take part, and only responded with grinding teeth, and groaning. Resident #60's RP stated that the Resident was confused at times, and usually only answered yes and no questions, and would often not answer correctly. When asked if the Resident had been kept safe while in the facility, the RP answered yes, and that the Resident had fallen once on his first week after admission, but that was the only problem. Resident #60's room mate stated that was incorrect, that the Resident had fallen several times, and the room mate was afraid for Resident #60, because if he fell, "he could not call for help". The room mate stated that he himself had to call staff during the last fall which had occurred "about a week ago", and the staff had removed Resident #60's floor mat, so he had fallen on the "hard floor". The RP stated she had not been made aware of the other falls, and was concerned.

The baseline care plan was completed on 12-7-17 (24 hours after admission), and had a single revision on 12-11-17 (5 days after admission) denoting that the Resident would remain in the facility as a long term care resident.

The comprehensive Care plan must be completed within 7 days after the comprehensive MDS assessment is completed, and the

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Registered Nurse (RN) responsible for that plan signed the attestation of care plan completion on 12-19-17 on the MDS form Z0400, at area V0500, V0200B, and V0200C.

That care plan was not a comprehensive care plan as it only included interventions from the baseline care plan done the day after admission, and the revision of accepting the Resident into Long term care. The MDS triggered areas for care planning included the following;

Activities, communication, functional rehab potential, incontinence with indwelling catheter, falls, nutrition, pressure ulcer prevention, functional limitation in range of motion, broken or fractured teeth, mechanically altered therapeutic diet and chewing difficulties, eating assistance and proper positioning for eating, psychotropic drug use increasing likelihood of falls, aphasia, antidepressants, unclear speech, voice production, total assistance for ADL's, diabetes, generalized weakness, impaired balance during transitions, immobility, bedfast or wheel chair bound, gait disturbance, and sedation.

The baseline care plan which was incomplete, not specific in all areas to the resident, and not measurable, was revised again on 12-22-17 (16 days after admission), and 3 days after the RN signed the care plan as complete, with several new revisions including (1) Activities of Daily Living (ADL) assistance needed, (2) skin integrity, (3) communication, (4) weight loss, and finally (5) falls.

On 1-19-18 a final revision was completed which denoted two new interventions, which were; (1) adverse (antidepressant) drug reactions, and (2)

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added falls interventions. At the time of survey on 1-24-18, the care plan was still not complete as a comprehensive developed and implemented care plan in review of the MDS triggered areas for care planning for Resident #60.

On 1-24-18, LPN (licensed practical nurse) D, the MDS coordinator, was interviewed and stated that the MDS was coded incorrectly for Resident #60, and she was not the individual who completed the assessment, or the care plan.

The administrator and DON (director of nursing) were informed of the failure of the staff to develop and implement a comprehensive care plan, and to complete it timely, on 1-26-18 at the end of day meeting. At the time of survey all areas had still not been care planned that were triggered on the comprehensive assessment. No further information was provided by the facility.

2. For Resident #21, the comprehensive care plan did not document that the resident suffered from chronic pain.

Resident #21 was admitted on 12/16/2016. Resident #21's diagnoses included: Hypothyroidism, unspecified dementia without behavioral disturbances, major depressive disorder, Parkinson's Disease, other chronic pain, essential hypertension, chronic atrial fibrillation, Gastro-Esophageal Reflux Disease with

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F 656	Continued From page 24 esophagitis, Bilateral Primary Osteoarthritis of the knees, difficulty walking, and lack of coordination. Resident #21's most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an ARD (Assessment Reference Date) of 11/09/17. The assessment coded Resident #21 with a BIMS (Brief Interview of Mental Status, an evaluation of cognitive status) score of 8, indicating Moderate Impairment. The assessment coded Resident #21 as having chronic pain. On 1/24/18 at 10:05 am, an interview was conducted with Resident #21. Resident #21 stated that he suffered from chronic pain to his legs and knees due to arthritis. Resident #21 stated that this pain was chronic and was what led him to retire from his job. Resident #21's current care plan was kept in a binder at the unit nurse's station. On 1/24/18, a review of Resident #21's Care Plan was conducted. Upon examination, Resident #21's Care Plan had no documentation addressing pain management. The issues with the care plan were reviewed with the Administrator and Director of Nursing (DON) at the end of day meeting on 1/26/18. No further information was provided.	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(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:	F 658		3/5/18

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F 658	Continued From page 25 Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to follow the professional standards of nursing practice for medication and treatment administration for five Residents (Residents' #10, #29, #40, #64, and #47) in the survey sample of 21 Residents. 1. For Resident #10, the facility staff failed to ensure/document that medications and treatments were administered per physician's orders; 2. For Resident #29, the facility staff failed to ensure/document that medications and treatments were administered per physician's orders; 3. For Resident #40, the facility staff failed to ensure/document that medications and treatments were administered per physician's orders; 4. For Resident # 64 the facility failed to document medications as having been administered. 5. For Resident # 47, the facility staff failed to document administration of medications as ordered. The findings included: 1. Resident #10, was admitted to the facility on 5-20-17. Diagnoses included; left tibia fracture with surgical repair infection and revision of implanted device, hypertension, seizures,	F 658	F 658 1.The physicians and families for resident□s #10, #29, #40, #64, #47 were made aware of the medication and treatment omissions discovered in the medical record and medication errors were completed and filed in the DON office. 2.The facility has identified residents that have the potential to be affected by this alleged deficient practice. An audit of current Medication Administration and Treatment records were reviewed for errors and omissions. Staff were counseled as necessary and the physicians were made aware of the findings as needed. 3. Licensed staff were in-serviced by the DON (designee) on proper Medication Administration and the importance of appropriate documentation and (MAR) medication administration record accuracy. DON (designee) will audit Medication Administration Records to ensure proper medication documentation for medications given and/or held with the reason identified. 4. A weekly summary of audit results, will be reported to the Nursing Home Administrator by the DON. DON to report a monthly summary to the QAPI committee for review until all medication administration thresholds are met.	

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contractures, and congestive heart failure.

Resident #10's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1-17-18 was coded as an admission assessment. Resident #10 was coded as having a BIMS (brief interview of mental status) score of "13" out of a possible 15, or, mild to no cognitive impairment. Resident #10 was also coded as requiring extensive to total assistance of staff to perform activities of daily living, such as bed mobility, transferring, eating, locomotion, and toileting.

Review of Resident #10's clinical record revealed no evidence the following three medications were administered on the days and times indicated:

1. Aspirin 325 mg (milligram) twice daily at 8:00 a.m., and 8:00 p.m. (heart health, stroke prevention): 1-1-18 (8 a.m.), 1-5-18 (8 a.m.), 1-12-18 (8 a.m.), 1-21-18 (8 a.m.), 1-24-18 (8 a.m.), and 1-26-18 (8 a.m.).

2. Levetiracetam 1000 mg (milligram) twice daily at 8:00 a.m., and 8:00 p.m. (anti-seizure): 1-1-18 (8 a.m.),
1-12-18 (8 a.m.), 1-21-18 (8 a.m.), 1-24-18 (8 a.m.), and 1-26-18 (8 a.m.).

3. Metoprolol tartrate 100 mg (milligram) twice daily at 8:00 a.m., and 8:00 p.m. (blood pressure): 1-1-18 (8 a.m.),
1-21-18 (8 a.m.), 1-24-18 (8 a.m.), and 1-26-18 (8 a.m.).

Valid physician's orders were evident for the medications in question. A thorough review of Resident #10's clinical record, including nursing progress notes, revealed no evidence he was

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away from the facility, nor refused the medication in question.

Review of the facility's policy entitled, "Medication Administration" revealed that all medications are to be given according to the prescriber's order and signed/documented by the administering individual as soon as the medication is given.

When interviewed on 1-26-18 at 4:00 p.m., the DON (director of nursing) stated that she had identified the failure of the staff to ensure medications and treatments were documented as being administered. The DON stated her expectation was for staff to administer medications and treatments per physician's orders and to document them as having been administered, immediately following administration.

The administrator and DON were informed of the failure of the staff to ensure medications and treatments were administered and documented, on 1-26-18 at 4:00 p.m. No further information was provided by the facility.

2. Resident #29, was admitted to the facility on 9-12-16. Diagnoses included; hypertension, vascular dementia, stroke, diabetes, glaucoma, depression, high cholesterol, sleep apnea, gout, and gastro-esophageal reflux disease.

Resident #29's most recent MDS (minimum data set) with an ARD (assessment reference date) of 11-20-17 was coded as a quarterly assessment. Resident #29 was coded as having a BIMS (brief

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interview of mental status) score of "15" out of a possible 15, or, no cognitive impairment. Resident #29 was also coded as requiring extensive to total assistance of staff to perform activities of daily living, such as bed mobility, transferring, eating, locomotion, and toileting.

Review of Resident #29's clinical record revealed no evidence the following twelve medications and treatments were administered on the days and times indicated:

1. Metformin 500 mg (milligram) twice daily at 9:00 a.m., and 5:00 p.m. (blood pressure): 1-5-18 (9 a.m.),

2. Trusopt 2% eye drops, one drop in both eyes twice daily at 8:00 a.m., and 8:00 p.m. (Glaucoma): 1-5-18 (8 a.m.).

3. Sertraline HCL 25 mg (milligram) every day at 9:00 a.m. (antidepressant): 1-5-18 (9 a.m.).

4. Allopurinol 300 mg (milligram) every day at 8:00 a.m. (anti-gout agent): 1-5-18 (8 a.m.), and 1-12-18 (8 a.m.).

5. Amlodipine Besylate 5 mg (milligram) every day at 8:00 a.m. (blood pressure): 1-5-18 (8 a.m.), and 1-12-18 (8 a.m.).

6. Aspirin 81 mg (milligram) daily at 8:00 a.m. (heart health): 1-5-18 (8 a.m.).

7. Bumetanide 0.5 mg (milligram) daily at 8:00 a.m. (blood pressure): 1-5-18 (8 a.m.).

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8. Ceravite one tab daily at 8:00 a.m., and 8:00 p.m. (supplement): 1-5-18 (8 a.m.).

9. Lisinopril 20 mg (milligram) daily at 8:00 a.m., (blood pressure): 1-5-18 (8 a.m.).

10. Metoprolol succinate ER 50 mg (milligram) daily at 8:00 a.m., (blood pressure): 1-5-18 (8 a.m.).

11. Novolog 100 unit/ml (milliliters) per sliding scale sub cutaneous injection insulin at 6:30 a.m., and 4:30 p.m., (diabetes): 1-1-18 (6:30 a.m.), 1-10-18 (6:30 a.m.), 1-14-18 (6:30 a.m.), 1-19-18 (6:30 a.m.), 1-24-18 (6:30 a.m.).

12. Mycolog cream apply to crease under left breast and crease under abdomen, between thigh and abdomen on left side, every day at 9:00 a.m. (Rash): 1-2-18 (9 a.m.), 1-3-18 (9 a.m.), 1-5-18 (9 a.m.).

Valid physician's orders were evident for the medications and treatment in question. A thorough review of Resident #10's clinical record, including nursing progress notes, revealed no evidence she was away from the facility, nor refused the medications and treatment in question.

Review of the facility's policy entitled, "Medication Administration" revealed that all medications are to be given according to the prescriber's order and signed/documented by the administering individual as soon as the medication is given.

When interviewed on 1-26-18 at 4:00 p.m., the DON (director of nursing) stated that she had

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identified the failure of the staff to ensure medications and treatments were documented as being administered. The DON stated her expectation was for staff to administer medications and treatments per physician's orders and to document them as having been administered, immediately following administration.

The administrator and DON were informed of the failure of the staff to ensure medications and treatments were administered and documented, on 1-26-18 at 4:00 p.m. No further information was provided by the facility.

3. Resident #40 was admitted to the facility on 12-09-16. Diagnoses included; Pneumonia, stroke, dysphagia, dementia, psychosis, gastrostomy.

Resident #40's most recent MDS (minimum data set) with an ARD (assessment reference date) of 11-17-17 was coded as a readmission assessment. Resident #40 was coded as having a BIMS (brief interview of mental status) score of "1" out of a possible 15, or, severe cognitive impairment. Resident #40 was also coded as requiring total assistance of staff to perform activities of daily living, such as bed mobility, transferring, eating, locomotion, and toileting.

Review of Resident #40's clinical record revealed no evidence the following eleven medications were administered on the days and times indicated:

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1. Levetiracetam 750 mg (milligram) twice daily at 8:00 a.m., and 8:00 p.m. (seizures): 1-3-18 (8 a.m.), 1-6-18
(8 p.m.), 1-7-18 (8 p.m.).

2. Mucinex ER 600 mg (milligrams) twice daily at 8:00 a.m., and 8:00 p.m. (pneumonia): 1-3-18 (8 a.m.), 1-6-18
(8 p.m.), 1-7-18 (8 p.m.).

3. Valproic Acid 250 mg (milligram) twice daily at 8:00 a.m., and 8:00 p.m. (seizures): 1-3-18 (8 a.m.), 1-6-18
(8 p.m.), 1-7-18 (8 p.m.).

4. Benztropine MES 1 mg (milligram) every day at 8:00 p.m. (anti-tremor drug): 1-6-18 (8 p.m.), 1-7-18 (8 p.m.).

5. Florastor 250 mg (milligram) 4 times every day at 8:00 a.m., 12:00 noon, 4:00 p.m., and 8:00 p.m. (probiotic supplement): 1-3-18 (8 a.m., 12 noon), 1-6-18 (4 p.m., 8 p.m.), 1-7-18 (4 p.m., 8 p.m.), 1-8-18 (8 p.m.),
1-20-18 (12 noon)

6. Famotidine 20 mg (milligram) daily at 8:00 a.m. (peg tube gastric): 1-3-18 (8 a.m.).

7. Geravim liquid 5 ml (milliliters) daily at 8:00 a.m. (supplement): 1-3-18 (8 a.m.).

8. Quetipine fum 25 mg (milligrams) at 8:00 p.m., (psychosis): 1-6-18 (8 p.m.), and 1-7-18 (8 p.m.).

9. Ferrous sulfate 220 mg (milligram) per 5 ml (milliliters) elixir, give 7.5 ml three times per day at 8:00 a.m., 2:00 p.m., and 8:00 p.m., (anemia): 1-3-18 (8 a.m., 2 p.m.), 1-6-18 (8 p.m.), 1-7-18 (8

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p.m.), 1-12-18 (2 p.m.),
1-20-18 (2 p.m.)

10. Ativan 1 mg (milligram) daily at 8:00 p.m., (anxiety). 1-6-18 (8 p.m.), 1-7-18 (8 p.m.).

11. Proctozone HC cream 2.5% per rectum every day at 8:00 p.m., (hemorrhoids). 1-6-18 (8 p.m.), and 1-7-18
(8 p.m.).

Valid physician's orders were evident for the medications in question. A thorough review of Resident #40's clinical record, including nursing progress notes, revealed no evidence he was away from the facility, nor refused the medications in question.

Review of the facility's policy entitled, "Medication Administration" revealed that all medications are to be given according to the prescriber's order and signed/documented by the administering individual as soon as the medication is given.

When interviewed on 1-26-18 at 4:00 p.m., the DON (director of nursing) stated that she had identified the failure of the staff to ensure medications and treatments were documented as being administered. The DON stated her expectation was for staff to administer medications and treatments per physician's orders and to document them as having been administered, immediately following administration.

The administrator and DON were informed of the failure of the staff to ensure medications and treatments were administered and documented, on 1-26-18 at 4:00 p.m. No further information

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was provided by the facility.

4. For Resident # 64 the facility failed to document medications as having been administered.

Resident #64, a 72 year old, was admitted to the facility on 12/14/17. His diagnoses included diabetes, chronic kidney disease, pressure ulcer, and hypertension. The most recent Minimum Data Set assessment was an annual assessment with an assessment reference date of 12/19/17. He was coded with a Brief Interview of Mental Status score of 15 indicting no cognitive impairment. He required extensive assistance with activities of daily living.

Resident #64's January 2018 Medication Administration Record (MAR) was reviewed. On the 3-11 shift, there were multiple instances where the nurse failed to document the administration of medications. Medications were not documented as having been administered on the following occasions:

Docusate 9:00 p.m.: 1/4/18, 1/15/18, 1/17/18 and 1/22/18
Acetaminophen 8:00 p.m.: : 1/4/18, 1/15/-1/17/18, 1/22/18
Alfuzosin 8:00 p.m.: 1/4/18, 1/15/, 1/17/18, 1/22/18
Atorvastatin 8:00 p.m. : 1/4/18, 1/15/, 1/17/18,

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1/22/18
Gabapentin 8:00 p.m.: 1/4/18, 1/15/, 1/17/18, 1/22/18
Cardizem 8:00 p.m.: 1/4/18, 1/15/, 1/17/18, 1/22/18
Glipizide 6:30 a.m.: 1/1/18, 1/5/18, 1/10/18, 1/14/18, 1/15/18, 1/17/18, 1/19/18
Metformin 6:30 a.m.: 1/1/18, 1/5/18, 1/10/18, 1/14/18, 1/15/18, 1/17/18, 1/19/18
Lantus 6:30 a.m.: 1/1/18, 1/5/18, 1/14/18, 1/15/18, 1/17/18, 1/19/18

Valid physician orders for the above medications were evident in the clinical record.

The issue was reviewed with the Administrator and Director of Nursing at the end of day meeting on 1/16/18.

5. For Resident # 47, the facility staff failed to document that medications were administered as ordered by the physician.

Resident # 47 was an 81 year old female admitted to the facility on 8/20/2016 with the diagnoses of, but not limited to, Seizure Disorder, Major Depressive disorder, Dysphagia , PEG tube (Percutaneous Endoscopic Gastrostomy), GERD (Gastroesophageal Reflux Disease) and Cerebrovascular Disease.

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12/5/2017. The MDS coded Resident # 47 with a BIMS (Brief Interview

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for Mental Status) of 1/15 indicating severe cognitive impairment; Resident # 47 required limited assistance of one staff person with activities of daily living for dressing, hygiene, bathing and toileting and required minimal assistance of one staff person for transfer, ambulation, and bed mobility;Resident # 47 required total assistance of one staff person for eating and was also coded as always continent of bowel and bladder.

On 1/25/2018 at 9:30 AM, review of the clinical record was conducted.

Review of the Medication Administration Record (MAR) for December 2017 revealed missing documentation of medications:

Keppra 100 milligrams per milliliter oral solution , give 7.5 milliliters (750 milligrams) per PEG tube twice daily for seizures,
12/17/17 at 8 PM, 12/18/17 at 8 PM. 12/19/17 at 8 PM

Valproic Acid 250 milligrams per 5 milliliters solution (Depakene) give 10 milliliters (500 milligrams) per PEG tube twice daily for seizures.
12/17/17 at 8 PM, 12/18/17 at 8 PM. 12/19/17 at 8 PM

Zantac 10 milliliters (150 milligrams) per PEG tube twice daily for GERD, 12/17/17 at 8 PM, 12/18/17 at 8 PM. 12/19/17 at 8 PM

Fiber Source HN one can every 4 hours via Gastrostomy tube for a total of 1440 cubic centimeters/1728 calories per 24 hours 12/17/17 at 4 AM, 12/17/17 at 4 PM. 12/17/17 at 8 PM, 12/18/17 at 4 AM, 12/18/17 at 4 PM. 12/18/17 at

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8 PM, 12/19/17 at 4 AM, 12/19/17 at 4 PM. 12/19/17 at 8 PM

Ferrous Sulfate 7.5 milliliters (325 milligrams) per PEG tube three times per day for iron supplement,
12/17/17 at 6 PM, 12/18/17 at 6 PM. 12/19/17 at 6 PM

Increase Depakote dose to 250 milligrams per 5 milliliters three times a day-Valproic Acid 250 milligrams per 5 milliliters solution
12/25/2017 at 2 PM

Review of the Medication Administration Record (MAR) for January 2018 revealed missing documentation of medications:

Keppra 100 milligrams per milliliter oral solution , give 7.5 milliliters (750 milligrams) per PEG tube twice daily for seizures,
1/11/18 at 8 PM

Increase Depakote dose to 250 milligrams per 5 milliliters three times a day-Valproic Acid 250 milligrams per 5 milliliters solution (Depakene) give 10 milliliters (500 milligrams) per PEG tube three times per day for seizures.
1/11/18 at 8 PM

Zantac 10 milliliters (150 milligrams) per PEG tube twice daily for GERD,
1/11/18 at 8 PM

Fiber Source HN one can every 4 hours via Gastrostomy tube for a total of 1440 cubic centimeters/1728 calories per 24 hours
1/11/18 at 4 AM, 1/11/18 at 8 PM

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Ferrous Sulfate 7.5 milliliters (325 milligrams) per PEF tube three times per day for iron supplement,
1/11/18 at 6 PM

On 1/25/2018 at 1:45 PM, an interview was conducted with LPN E (Licensed Practical Nurse A) who stated that nurses were expected to administer medications and treatments as ordered by the physician and document on the MAR and TAR at the time of administration.

On 1/26/2018 at approximately 1:20 PM during the end of day debriefing, the Administrator and Director of Nursing (DON) were informed of the missing documentation of administration of medications for Resident # 47. The DON stated she had identified problems with documentation of medications as an issue at the facility. The DON stated she had been working with the facility staff on improving the documentation of medications and treatments. The DON stated that since facility used several Agency nurses who sometimes had difficulty with the electronic program to document on the MAR. The DON stated the expectation was for nurses to administer medications and treatments as ordered by the physician and to sign the MAR immediately after administering the medications.

On 1/26/2018 at approximately 1:30 PM, the DON stated the facility used "Med-Pass" for professional nursing guidance. The DON presented a copy of the Medication Administration Policy.

Review of the facility policy on "Administering Medications" from Nursing Services Policy and

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F 658	Continued From page 38 Procedure Manual for Long-Term Care Revised December 2012 revealed on Page 5, Under Policy Interpretation and Implementation, under the Highlights: Timely Administration: "3. Medications must be administered in accordance with the orders, including any required time frame." On Page 6, "18. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose. 19. The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones. " Valid Physician's orders were evident for the medications and treatments not documented as having been administered. During the end of day debriefing on 1/29/2018, the DON and Administrator again were informed of the findings. No further information was provided.	F 658		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the	F 679		3/5/18

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F 679	Continued From page 39 physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review and clinical record review, the facility staff failed to provide activities for six residents (Residents # 65, 47, 46, 83, 10 and 60) in a survey sample of 21 residents. 1. For Resident # 65, the facility staff failed to provide Activities to residents during survey 1/24/2018 through 1/26/2018. 2. For Resident # 47, the facility staff failed to provide Activities during 3 days of survey 1/24-1/26/2018. 3. For Resident # 46, the facility staff failed to provide Activities during 3 days of survey 1/24-1/26/2018. 4. For Resident # 83, the facility staff failed to provide Activities during 3 days of survey 1/24-1/26/2018. 5. No meaningful activities were assessed for, nor planned for Resident #10. 6. No meaningful activities were assessed for, nor planned for Resident #60. Findings included: During the first 3 days of survey on January 24, 25 and 26, 2018, there were no Activities observed being conducted in the facility. On all 3	F 679	1- Residents # 65, 47, 46, 83, 10, 60 have been assessed for activities designed to meet the interest of and support the physical, mental and psychological well-being of the resident, encouraging independence and interaction with others and care planned 2- The facility has identified all residents as having the potential by completing a audit of activity assessments and care plans. 3- Quarterly assessments will be completed and care planned. All new admissions with be assessed for activities and care planned. Activity calendar will be designed to be resident specific and meet the needs of all residents. The activity calendar will be posted for all residents and staff. Residents and staff will be notified of any changes to the schedule. Acting Activity Director has been promoted to Director. Just completing Phase I of a week seminar by the VHCA, will enroll in Phase II of the VHCA certification program in June. Activity assistant will be hired. Inservices will be held with nursing staff on importance of act ivies. 4- Results the audit and the quarterly assessments will be reported to the quarterly QAPI meeting.	

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days, between 11 and 15 residents were observed to be sitting in the Day Room on the 300 Unit at various times. There was a television on in the room. Facility nursing assistant staff members were observed to be sitting in the room while residents were in the room. The Certified Nursing Assistants were documenting in binders each time the surveyor checked. Occasionally staff members were observed interacting with the residents and asking if they were ready to go to eat. No group or individual Activities were in progress during the observations.

Review of the Activities calendar revealed Activities that were scheduled each day.

On 1/25/2018 at 1:40 PM, observed two Certified Nursing Assistants (CNA) walking with residents in the hallway on the 300 unit. Each CNA took the residents to the Day Room where the television was on and other residents were sitting in there. CNA A was observed sitting in the Day Room documenting in a binder. CNA B was observed taking one resident into the Day Room and then taking another resident into her room for ADL care.

On 1/25/2018 at 1:55 PM, an interview was conducted with LPN E (Licensed Practical Nurse E) who stated that an Activities calendar was located in each resident's room and staff would take residents to those activities. LPN E stated she had not seen any Activities conducted that day. LPN E presented a copy of the calendar located in the resident's rooms. According to the calendar, at 2:00 PM on 1/25/2018, there was supposed to be an activity called "Snowman Bowling". The surveyor went to all of the Day Rooms on all three units and found no Activities

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being conducted. There were residents sitting in each of the day rooms but no activities were being conducted.

On 1/25/2018 at 2:10 PM, an interview was conducted with Certified Nursing Assistant A (CNA A) who stated she had not seen any activities done that day in the facility. CNA A stated the residents on the 300 Unit were not taken to the other Day rooms for activities because none had been conducted.

On 1/25/2018 at 2:15 PM, an interview was conducted with CNA B who stated she had not seen any activities being conducted that day.

On 1/25/2018 at 3 PM, an interview was conducted with the Director of Nursing and Administrator who stated the Activities Coordinator was not in the facility that week due to a training conference. The Administrator stated the previous Activities Coordinator had left the facility about a month before and the new coordinator was in the process of establishing new programs. The Administrator stated other staff members were assigned to conduct Activities in the absence of the Activities Coordinator.

On 1/25/2018 at 3:15 PM, an interview was conducted with LPN D who stated the Activities Coordinator was not in the facility but other staff members were assigned to conduct activities in her absence. LPN D stated residents on Unit 1 were given word puzzles to complete. There were three residents observed sitting in the Day Room on Unit 1 at 2:15 PM. All three had a sheet of paper with Word Puzzles on it. There were five

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residents sitting in the Day Room on Unit 2. None of the residents were participating in an Activity. There were 14 residents on Unit 3. None of the residents were participating in an Activity.

On 1/26/2018 at 1:20 PM, an interview was conducted with the Social Worker who stated she and other staff members were assigned to conduct various activities while the Activities Coordinator was away at the conference during the week of January 22-26, 2018. The Social Worker (Employee D) stated she did conduct Bingo one day and the residents seemed to enjoy it. The Social Worker stated the facility changed the schedule for Resident Council from Wednesday 1/24/2018 to Thursday 1/25/2018 once the surveyors came to the facility because the surveyors needed to meet with the residents.

On 1/29/2018 at 11:50 AM, an interview was conducted with the Activities Coordinator (Employee D) who stated she had been employed at the facility for a year and a half as an assistant Activities Coordinator but was new in the role of Cavities Coordinator. She stated she had been at a training conference all of the previous week but had left other staff members in charge to conduct Activities in her absence. Employee D stated normally the facility staff make an announcement to inform the Residents and Staff of upcoming Activities. Employee D stated all Activities are subject to change and that is noted on the calendar. When asked how the staff would know when and where to take residents if the Activities had changed, Employee D stated she guessed they would not know. Employee D stated the announcements are not heard on Unit 3 the 300 hall because they have

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Dementia. Employee D stated that during her training the previous week, she learned many new activities to try at the facility. Employee D stated she was excited to try to improve the Activities program at the facility to include more activities for those on the 300 Unit.

Employee D presented a revised calendar labeled "Reminder for Activities for the Week of January 22-26, 2018. Activities scheduled two group Activities for each weekday Monday through Friday.

The Administrator and Director of Nursing were informed of the findings during the end of day debriefing on 1/29/2018.

No further information was provided.

1. For Resident # 65, the facility staff failed to provide Activities to residents during survey 1/24/2018 through 1/26/2018.

Resident # 65 was a 53-year-old male admitted to the facility on 2/20/2013 with the diagnoses of, but not limited to, Seizure Disorder, Anxiety, Depression, Psychotic Disorder, Hemiplegia and Cerebrovascular Accident (CVA).

The most recent Minimum Data Set (MDS) was an Annual assessment with an Assessment Reference Date (ARD) of 12/19/2017. The MDS coded Resident # 65 with a BIMS (Brief Interview for Mental Status) of 1/15 indicating severe cognitive impairment. Resident # 65 required minimal assistance of one staff person with activities of daily living except required limited assistance of one staff person for hygiene and

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total assistance of one staff person for bathing; Resident # 65 was also coded as always continent of bowel and bladder.

During the initial tour on 1/24/2018 at 9:30 AM, Resident # 65 was observed lying in the bed by the window. The curtain was drawn between the two beds. Resident # 65 spoke to the surveyor and offered no complaints.

On 1/25/2018 at approximately 2:30 PM, Resident # 65 was observed sitting in a wheelchair at the nurses' station. Resident # 65 asked the nurse if he could use the phone to call his brother. Resident # 65 talked with someone on the phone. Resident # 65 was overheard stating he was "fine but doing the same old stuff."

On 1/25/2018 at approximately 4:00 PM, Resident # 65 was observed sitting in the Day Room with other residents. No Activities were being conducted.

On 1/26/2018 at 11:00 AM, observed Resident # 65 sitting in hallway.

Observations revealed Resident # 65 did not participate in any activities and activities did not occur as scheduled.

2. For Resident # 47, the facility staff failed to provide Activities during 3 days of survey 1/24-1/26/2018.

Resident # 47 was an 81 year old female admitted to the facility on 8/20/2016 with the diagnoses of, but not limited to, Seizure Disorder,

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Major Depressive disorder, Dysphagia , PEG tube (Percutaneous Endoscopic Gastrostomy), GERD (Gastroesophageal Reflux Disease) and Cerebrovascular Disease.

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12/5/2017. The MDS coded Resident # 47 with a BIMS (Brief Interview for Mental Status) of 1/15 indicating severe cognitive impairment. Resident # 47 required limited assistance of one staff person with activities of daily living for dressing, hygiene, bathing and toileting. She required minimal assistance of one staff person for transfer, ambulation, and bed mobility; Resident # 47 required total assistance of one staff person for eating and was coded as always continent of bowel and bladder.

On 1/24/2018 at 1:30 PM, Resident # 47 was observed sitting in the Day Room with 11 other residents. The television was on. No activities were going on.

On 1/24/2018 at 3:25 PM, Resident # 47 was observed sitting in the Day Room with 14 other residents. There were no Activities going on in Day Room on the 300 Unit or in the other Day Rooms.

On 01/25/18 at 04:29 PM, Resident # 47 was observed sitting in Day Room with 12 other residents. The TV was on in room. There were no activities being conducted.

On 1/26/2018 at 10:55 AM, Resident # 47 was observed sitting in the Day Room with 14 other residents. No activities were being conducted.

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Review of the Activities Progress Notes revealed three notes written on dates 6/13/17, 9/12/17 and 12/28/17. The note dated 6/13/17 stated Resident # 47 was "able to walk to and from activities. She does participate in group activities. She enjoys coloring and Move in Motion. She does have family support." The next two notes dated 9/12/17 and 12/28/17 stated "no changes made. Has family support."

Resident # 47 was not observed coloring or participating in any other activities during the survey. Observations revealed Activities did not occur as scheduled.

3. For Resident # 46, the facility staff failed to provide Activities during 3 days of survey 1/24-1/26/2018.

Resident # 46 was a 77-year-old female admitted to the facility on 5/31/2017 with the diagnoses of but not limited to: Anemia, Hypertension, Hyperlipidemia, Arthritis, Dementia and Alzheimer's Disease.

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12/4/2017. The MDS coded Resident # 46 with having severe cognitive impairment; Resident # 46 required total assistance of one staff person with all activities of daily living. Resident # 46 also was coded as always incontinent of bowel and had an indwelling catheter for bladder.

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On initial tour on 1/24/2018 at 9:30, Resident # 46 was observed to be lying in bed with the television on.

On 1/24/2018 at 1:30 PM, Resident # 46 was observed sitting in a wheelchair in the Day Room with 11 other residents. The television was on. No activities were going on.

On 1/24/2018 at 3:25 PM, Resident # 46 was observed sitting in a wheelchair in the Day Room with 14 other residents. There were no Activities going on in Day Room on the 300 Unit or in the other Day Rooms.

On 1/25/2018 at 10 AM, Resident # 46 was observed sitting in the Day Room with 14 other residents. No activities were being conducted.

On 1/25/2018 at 2:10 PM, Resident # 46 was observed sitting in the Day Room with 11 other residents. No activities were being conducted.

On 1/26/2018 at 10:55 AM, Resident # 46 was observed sitting in the Day Room with 14 other residents. No activities were being conducted.

Review of the clinical record revealed an Activity Evaluation dated 6/12/17 that documented Resident # 46 had interest in Group Activities, cards, games and religious activities. Observations revealed Resident # 46 did not participate in any activities and activities did not occur as scheduled.

Review of the care plan revealed no interventions for Activities for Resident #46.

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4. For Resident # 83, the facility staff failed to provide Activities during 3 days of survey 1/24-1/26/2018.

Resident #83 was a 58-year-old female admitted to the facility on 10/10/2017. Diagnoses included but were not limited to Vascular Dementia with behavioral disturbances, Diabetes and Complete Traumatic Amputation of left lower leg.

The most recent Minimum Data Set (MDS) assessment was an Admission Assessment with an Assessment Reference Date of 10/19/2017. The MDS coded Resident #83 as having a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment. Resident # 83 also was coded as requiring limited to total assistance of one staff member for Activities of Daily Living (ADLs). The only exception to this was eating, which the Resident was able to accomplish with only tray set up help. Resident # 83 was coded as always incontinent of bowel and bladder.

Resident # 83 was observed wheeling herself in the hallway during several observations during 1/24-1/26/2018. She also was observed to be sitting in the Day Room with other residents. The television was on.

On 1/26/2018 at 11 AM, an interview was conducted with Resident # 83 who stated there was "nothing to do" in the facility. Resident # 83 stated she would like to attend some Activities but there were not any going on.

Review of the Activities Progress Notes revealed

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F 679	Continued From page 49 only one Progress note written, dated 1/21/2018 and documented as a quarterly note. The note stated Resident # 83 was alert and oriented to herself and others. "Ambulated with wheelchair. Attends group activities, she is social. She has family support."	F 679		
	5. No meaningful activities were assessed for, nor planned for Resident #10.			

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Resident #10, was admitted to the facility on 5-20-17. Diagnoses included; left tibia fracture with surgical repair infection and revision of implanted device, hypertension, seizures, contractures, and congestive heart failure.

Resident #10's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1-17-18 was coded as an admission assessment. Resident #10 was coded as having a BIMS (brief interview of mental status) score of "13" out of a possible 15, or, mild to no cognitive impairment. Resident #10 was also coded as requiring extensive to total assistance of staff to perform activities of daily living, such as bed mobility, transferring, eating, locomotion, and toileting.

The care plan was reviewed and revealed no activity interventions for Resident #10.

The entire clinical record was reviewed, and no assessment of need, no activity attendance notes, nor meaningful Activities were planned for Resident #60.

On 1-25-18, 1-26-18, and 1-29-18, Resident #10 was observed at various times. No meaningful activities were attended by this Resident.

On 1-26-18 the Director of Nursing was interviewed, and stated the former activity director had resigned, and a new employee was responsible for activities. The DON stated this Resident had one quarterly note dated 1-21-19, but could find no activity assessments from a qualified activity professional in the clinical record. It was assumed the "2019" was intended to be

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2018, as this was the only January stay for this Resident in the facility.

On 1-26-18 the Administrator and DON were made aware of the staff failure to plan and document meaningful activities for Resident #10. No further information was provided by the facility.

6. No meaningful activities were assessed for, nor planned for Resident #60

Resident #60, was admitted to the facility on 12-6-17. Diagnoses included; stroke, diabetes, drug and alcohol abuse, high blood pressure and high cholesterol.

Resident #60's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12-15-17 was coded as a full admission assessment. Resident #60 was coded as having a BIMS (brief interview of mental status) score of "15" out of a possible 15, or cognitively intact. This was an error, as the Resident was not cognitively intact. Resident #60 was also coded as requiring extensive assistance of one staff member to perform activities of daily living, such as bed mobility, transferring, eating, locomotion, and toileting. Resident #60 was coded with one fall since admission, no floor mats used for falls, bed fast or wheel chair bound, at risk for falls, on depression medication, which increased the risk for falls. The Resident was assessed and coded on the MDS as always continent of bowel and bladder.

The care plan was reviewed and revealed no activity interventions for Resident #60.

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F 679	Continued From page 52 The entire clinical record was reviewed, and no assessment of need, no activity attendance notes, nor meaningful Activities were planned for Resident #60. On 1-24-18, 1-25-18, 1-26-18, and 1-29-18, Resident #60 was observed at various times. No meaningful activities were attended by this Resident. On 1-26-18 the Director of Nursing was interviewed, and stated the former activity director had resigned, and a new employee was responsible for activities. The DON stated this Resident had no activity assessments nor notes from a qualified activity professional in the clinical record. On 1-26-18 the Administrator and DON were made aware of the staff failure to plan and document meaningful activities for Resident #60. No further information was provided by the facility.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by:	F 684		3/5/18

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Based on staff interview, facility documentation review and clinical record review, the facility staff failed to provide diabetic management for one resident (Resident # 83) in a survey sample of 21 residents.

For Resident # 83, the facility staff failed to obtain Finger Stick Blood Sugars (FSBS) and administer Insulin as ordered by the physician.

Findings included:

Resident #83 was a 58-year-old female admitted to the facility on 10/10/2017. Diagnosis included but were not limited to Vascular Dementia with behavioral disturbances, Diabetes and Complete Traumatic Amputation of left lower leg.

The most recent Minimum Data Set (MDS) assessment was an Admission Assessment with an Assessment Reference Date of 10/19/2018. The MDS coded Resident #83 as having a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment. Resident # 83 was also coded as requiring limited to total assistance of one staff member for Activities of Daily Living (ADLs). The only exception to this was eating, which the Resident was able to accomplish with only tray set up help. Resident # 83 was coded as always incontinent of bowel and bladder.

Review of Resident # 83's comprehensive admission care plan developed 10/20/2017, upon the Resident's admission revealed a Diabetic Management care plan which included interventions to Notify physician of unstable blood sugar levels and Administer medications as ordered by the physician, see MARs."

F 684
1.The physician and family for resident□s #83 was made aware of the missing finger stick for blood sugars.

2.The facility has identified diabetic residents as having the potential to be affected by this alleged deficient practice. (MAR) medication administration records for diabetic residents who receive finger stick blood sugars for the current month were checked for omissions.

3. Licensed staff were in-serviced by DON (designee) on appropriate documentation of finger stick blood sugars and (MAR) medication administration record accuracy and the importance of blood sugar monitoring in the management of diabetic residents.

DON (designee) will audit Medication Administration Records to ensure proper documentation for blood sugar monitoring tests and/or the reason why held.

4. A weekly summary of audit results, will be reported to the Nursing Home Administrator by the DON.
DON to report a monthly summary to the QAPI committee for review until all medication administration thresholds are met.

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Review of the clinical record revealed that Resident # 83's orders had commenced from admission on 10/10/2017.

Review of the Physicians orders revealed the following orders:

Humulin 70/30 Give 20 units at supper order date 11/8/17.

FBS (Fasting Blood Sugar) and 4 PM BS (Blood Sugar) every day. Call if BS less than 60 or greater than 400.

The following are the FSBS results and insulin omitted recorded on the January 2018 MAR (Medication Administration Record) as documented by facility nursing staff:

1/11/18 at 4:30 p.m. - Blood sugar not documented.
1/15/18 at 4:30 p.m. - Blood sugar not documented.
1/16/18 at 6:30 a.m. - Blood sugar not documented.
1/24/18 at 6:30 a.m. - Blood sugar not documented.
1/24/18 at 4:30 p.m. - Blood sugar not documented.
1/25/18 at 6:30 a.m. - Blood sugar not documented.
1/25/18 at 4:30 p.m. - Blood sugar not documented.

1/24/18 at 5:00 p.m. - Humulin 70/30 Give 20 Units at Supper. Not documented.
1/25/18 at 5:00 p.m. - Humulin 70/30 Give 20 Units at Supper. Not documented.

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Review of the nursing progress notes revealed no documentation of explanations for the omissions of documentation of insulin administration and no explanation as to why the FSBSs were not attempted.

Medication Administration and Diabetic Management policies were reviewed, and stated that all FSBS and insulin administration must be "Documented in the nursing notes and on the MAR."

On 1/26/2018 at approximately 1:20 PM during the end of day debriefing, the Administrator and Director of Nursing (DON) were informed of the missing documentation of administration of medications and blood sugars for Resident #83. The DON stated she had identified problems with documentation of medications as an issue at the facility. The DON stated she had been working with the facility staff on improving the documentation of medications and treatments. The DON stated the facility used several Agency nurses who sometimes had difficulty with the electronic program to document on the MAR. The DON stated the expectation was for nurses to administer medications and treatments as ordered by the physician and to sign the MAR immediately after administering the medications. The DON stated that if it was not documented, it was not done. She could not explain why they were omitted, as no progress notes described the reason for the omissions.

On 1/26/2018 at approximately 1:30 PM, the DON stated the facility used "Med-Pass" for professional nursing guidance. The DON presented a copy of the Medication

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F 684	Continued From page 56 Administration Policy. Review of the facility policy on "Administering Medications" from Nursing Services Policy and Procedure Manual for Long-Term Care Revised December 2012 revealed on Page 5, Under Policy Interpretation and Implementation, under the Highlights: Timely Administration: "3. Medications must be administered in accordance with the orders, including any required time frame". On Page 6, "18. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose. 19. The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones. " On 1/29/218 at 2:10 PM, the Director of Nursing stated she did not find any documentation regarding the omissions on the MAR. Administration was informed of the findings on 1/26/2018, and 1/29/2018 at the end of day debriefing each day, the facility presented no further evidence.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 686		3/5/18

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F 686	Continued From page 57 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility documentation review the facility staff failed for 1 resident (Resident #66) of 21 residents in the survey sample to prevent and identify an unable to stage sacral pressure wound resulting in harm. Resident #66's sacral wound was first identified as unable to stage with 100% slough (dead tissue) present in the wound bed. The findings included: Resident #66, a 72 year old, was admitted to the facility on 4/11/16. Her diagnoses included multiple sclerosis, hypertension, anemia, and contractures. Her most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 12/19/17. She had a Brief Interview of Mental Status score of 15 indicating no cognitive impairment. She required extensive assistance with activities of daily living and was coded to be at risk to develop a pressure wound. On 1/24/18 at 10:30 a.m., an interview was conducted with Resident #66. She was lying in bed. She was observed to have a special air	F 686	F 686 1.Resident #66 sacral wound healed on 6/27/17 2.The facility has identified residents, at high risk for pressure sores per Braden scale, as having the potential to be affected by this alleged deficient practice. Residents were reviewed by the nurse management team to ensure all prevention measures were in place. 3.Skin assessments were completed on residents to ensure there were no unidentified skin issues. Any new high risk residents had appropriate interventions implemented to prevent development of pressure ulcers. Licensed staff were in-serviced by DON/designee on the principles of skin integrity, identification, prevention and treatment of pressure ulcers. including the completion of the ADL records to include ADL documentation and care of high risk residents with pressure sores. The Facility wound formulary was updated to include the treatment of High risk residents and unstageable and deep	

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mattress. Resident #66 was asked if she had a current wound. She stated that she did not have a wound currently, but used to have a wound on her backside. She stated that staff do not get her up in the geri chair anymore and she would like to get up.

A "Risk For Pressure Ulcers" assessment was completed on 4/4/17. Resident #66 scored a 15, indicating that she was at high risk for developing a wound.

A review of Resident #66's clinical record revealed an abrasion on the left buttock identified on 5/6/17 and an unable to stage sacral wound identified on 5/15/17.

Included in the clinical record was a form titled "Wound Assessment Report". The form was dated 5/15/17. The wound type was described as "Pressure Ulcer" and the date the wound was identified was 5/15/17. The "Assessment Occasion" was documented as "New Wound." The wound was staged as "Unstageable due to slough/eschar." The wound bed was described as "100% slough" and measured 0.5 cm (centimeter) X 0.5 cm x 0.

A fax communication form was also included in the record. The form was communication from the wound care nurse to the doctor. The form was dated 5/15/17 and read "Weekly Wound Update."
"New Sacrum 0.5 x 0.5 cm (centimeter) unstageable area (gray in color) Mepilex dsg (dressing) every 3 days + PRN (as needed). The MD (doctor) Response section read "noted" and included the doctor's signature.

F 686

tissue injury wounds.
DON/Designee will audit weekly Skin Assessments weekly to ensure there are no omitted or incomplete assessments and all identified skin issues have appropriate treatments and interventions in place.

4.The audit results will be reported to the monthly QAPI Committee until each threshold of the audit is met.

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On 1/26/18 at 12:13 p.m., an interview was conducted with the wound care nurse and Director of Nursing (DON). The wound care nurse stated that she found the sacral wound on 5/15/17 when she was changing the dressing for the left buttock wound during the 7-3 shift. She could not provide an exact time. She stated that the left buttock dressing was last changed three days earlier on 5/12/17. The Treatment Administration Record (TAR) for May 2017 was provided.

It was reviewed with the wound care nurse and the DON that the weekly skin checks had not been completed by a nurse in the month of May 2017. Skin checks were documented on the "Nursing Weekly Summary" form. Resident #66's record included a Nursing Weekly Summary dated 4/25/17 with no skin issues present and a Nursing Weekly Summary dated 5/30/17 that documented a sacral wound. During the interview, the DON stated that the weekly skin checks had not been completed.

At the conclusion of the interview, the wound care nurse and DON were asked to provide information regarding the wound prevention interventions that were in place prior to the identification of the sacral wound and to provide all information they wanted to discuss regarding the wound.

On 1/29/17 at 10:15 a.m. the DON provided the "Daily Care Check List" which was a document signed daily by the Certified Nursing Assistants (CNA). She stated that CNA D was Resident #66's usual CNA. The Daily Care Check List was signed as follows:

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5/12/17: 7-3= CNA D, 3-11= blank, 11-7= CNA B
5/13/17: no sheet provided
5/14/17: 7-3= CNA F, 3-11= CNA E, 11-7= CNA E
5/15/17: 7-3= CNA D

At this time, the DON stated that the facility completed pressure wound training in January 2017. She provided the training sign in sheets. She stated that all the CNAs that had signed off on the Daily Care Check Lists from 5/12/17 to 5/15/17 had received the training. The sign in sheets were reviewed in the presence of the DON. The signatures of CNA E and CNA F were not on the sign in sheets. The DON stated that CNA E was an agency nurse. The DON was asked to provide any training that CNA E would have received.

The "Employee In-Service/ Continuing Education Record" for CNA E was provided. It was documented that CNA E attended a 30 minute prevention of pressure ulcer training on 3/16/17. No pressure wound training documentation was provided for CNA F.

The CNAs also completed the "CNA ADL (Activities of Daily Living) Flow Record" each day. The activities of bladder function (brief change) and bathing were opportunities for the CNAs to view Resident #66's skin. The record was completed as follows:
1. Bladder Function (total number of voids)
5/12/17: 7-3= 2 voids, 3-11= blank, 11-7= blank
5/13/17: 7-3= 4 voids, 3-11= blank, 11-7= blank
5/14/17: 7-3= 2 voids, 3-11= blank, 11-7= blank
5/15/17: 7-3= 2 voids

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2. Bathing (How resident takes full body bath, gets in and out of tub, washes self)
5/12/17: 7-3= total dependence/ 1 person, 3-11= blank, 11-7= blank
5/13/17: 7-3= total dependence/ 1 person, 3-11= blank, 11-7= blank
5/14/17: 7-3= total dependence/ 1 person, 3-11= blank, 11-7= blank
5/15/17: 7-3= total dependence/ 1 person

According to the CNA ADL Flow Record for the month of May 2017, there was no documentation that any ADL care was provided for Resident #66 during the 3-11 or 11-7 shift on the days prior to the identification of the sacral wound (5/12/17-5/15/17).

On 1/29/18 at 4:25 p.m. the missing documentation on the CNA ADL Flow Record was reviewed with the DON. When asked if documentation on the Flow Record was supposed to be completed, the DON stated yes.

On 1/29/18 at 10:15 a.m., the DON and the wound care nurse were asked how long it took in hours for slough to develop in a wound. They did not give a time frame and stated that it depended on the individual's condition. When asked at what stage a wound should be found, the wound care nurse stated stage I.

At this time, the wound nurse also reviewed the wound prevention interventions that were in place for Resident #66 prior to the sacral wound identification. The wound care nurse stated that the standard pressure reducing mattress was in place, the same mattress that all residents in the facility used. She stated that Resident #66 was administered a daily multivitamin, she was turned

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and repositioned and incontinence care was provided.

It was reviewed with the DON and wound care nurse that Resident #66 was observed to currently use a specialty air mattress. The wound care nurse stated that the specialty air mattress was a pressure relieving mattress. The wound care nurse was asked why Resident #66 was not been on the specialty air mattress prior to the development of the sacral unable to stage wound, given that she had a history of wounds. The wound care nurse stated that at the time the specialty air mattresses were only being used for residents with wounds at stage 3 and 4. The DON stated that in September 2017, as part of an updated wound protocol, the facility began to use the specialty air mattress for residents who had the potential to develop a wound.

According to the physician orders, the specialty air mattress was first ordered for Resident #66 on 12/1/17 after the development of a deep tissue injury to the left buttock on 11/27/17. No information was provided indicating that the specialty air mattress was ordered at the time of the sacral wound identification on 5/15/17.

During the interview, the wound care nurse stated that Resident #66 did not want to get out of bed to participate in restorative activities and this contributed to the development of the wound. She was asked to provide documentation of the refusals. The "Nursing Restorative Treatment Plan" dated 4/24/17 was provided. The duration of treatment was four weeks, six times per day. The problem was positioning out of bed. An approach included "Transfer to gerichair via lift-position to maintain upright midline posture." It

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was documented that Resident #66 refused treatment on 4/29/17, 5/6/17, and 5/13/17. She refused restorative care on three occasions prior to the identification of the sacral wound.

As of 1/18/18, the facility had an order for Resident #66 to stay in bed to reduce the risk of pressure wound development. The order read "Resident may participate in Restorative Nsg (nursing) Program for position in bed in sidelying posture for pressure relief, pos (position) OOB (out of bed) 1 x weekly x 2 hrs (hours) in geri chair".

CNA D was interviewed on 1/29/18 at 10:45 a.m. CNA D was asked at what time in her shift she signed off on the Daily Care Check List. She stated that she usually signed towards the end of the shift. When asked what her signature meant, she stated it meant that she had completed her duties for the resident such as answering call bells and changing the resident. CNA D was asked what she was supposed to do if she found an issue with a resident's skin. She stated that she was supposed to report the issue to the nurse. When asked what types of skin issues she reported, CNA D stated she reported bruises, scratches and breakdown.

CNA D was asked if she regularly worked with Resident #66. CNA D stated yes. She stated that at the time Resident #66 developed the wounds, Resident #66 was getting up in the geri chair often and would want to stay up in the chair. CNA D stated that Resident #66 wasn't being changed as frequently because she wanted to stay in the chair rather than be in bed. CNA D stated that Resident #66 is changed more frequently now because she is in bed.

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The skin integrity care plan dated 4/21/16 was reviewed. The care plan read "(resident) is at risk for impaired skin integrity R/T (related to) Aging process and immobility. She is incontinent of bowels and bladder." The plan also read "5/17/17 sacral unstageable area." The approaches included: turn and reposition during rounds, assess the skin weekly, apply protective ointment after each brief change, observe bony prominences for redness, dietary to assess nutritional needs, observe fluid intake, position with pillow as needed.

The facility policy "Pressure Ulcer/Skin Breakdown- Clinical Protocol" was reviewed. The "Assessment and Recognition" section read "1. The nursing staff and Attending Physician will assess and document an individual's significant risk factors for developing pressure sores; for example, immobility, recent weight loss, and history of pressure ulcer(s)." The rest of the policy explained the physician's role in wound management.

In addition, the facility provided treatment protocols for wounds stage I-IV. No information was provide regarding unstageable wounds or deep tissue injuries.

Guidance on pressure wound staging provided by the National Pressure Ulcer Advisory Panel website located at www.NPUAP.com was accessed on 1/31/18 at 11:19 a.m..
"Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or

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F 686	Continued From page 65 eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed." Resident #66's sacrum was observed by the survey team on 1/25/18 at 9:15 a.m. The sacral wound was healed. Resident #66 stated that she did not have any pain. According to the wound care nurse, the sacral wound healed on 6/27/17. In summary, Resident #66's sacral pressure wound was not identified until it was unstageable. Weekly skin checks were not completed, CNAs did not document that they provided care for the resident, and a specialty air loss mattress was not used to aid in wound prevention for a resident who was assessed to be at high risk for wound development. On 1/26/18 and on 1/29/18, concern regarding Resident #66's sacral wound was discussed with the Administrator, DON and wound care nurse. The facility was given multiple opportunities to submit documentation regarding the sacral wound.	F 686		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(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. This REQUIREMENT is not met as evidenced by:	F 697		3/5/18

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Based on resident interview, staff interviews, and clinical record review, the facility staff failed to ensure that pain management was provided to two residents (Resident #21 and Resident #77) in a sample of 21 Residents.

1. For Resident #21, facility Staff failed to offer physician ordered topical cream and other, non-pharmacological, pain control interventions.

2. For Resident #77, the facility staff failed assess pain and failed to administer pain medication when the resident expressed that she was in pain.

The Findings Included:

1. For Resident #21, facility Staff failed to offer physician ordered topical cream and other, non-pharmacological, pain control interventions.

Resident #21's diagnoses included: Hypothyroidism, unspecified dementia without behavioral disturbances, major depressive disorder, Parkinson's Disease, other chronic pain, essential hypertension, chronic atrial fibrillation, Gastro-Esophageal Reflux Disease with esophagitis, Bilateral Primary Osteoarthritis of the knees, difficulty walking, and lack of coordination.

Resident #21's most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an ARD (Assessment Reference Date) of 11/09/17. The assessment coded Resident #21 with a BIMS (Brief Interview of Mental Status, an evaluation of cognitive status) score of 8, indicating Moderate Impairment.

The resident stated he had been getting the

F 697

F 697

1.Resident #21 and #77 had comprehensive pain evaluation completed to determine appropriate pain interventions.
Resident #21 had orders updated to include scheduled topical cream and PRN warm compresses to knees.
RN A for resident #77 was educated on the policy for pain assessment and the administration of PRN pain medications.

2.The facility has identified residents who report having pain per MDS, as having the potential to be affected by this alleged deficient practice.
Pain assessments were completed for those identified and medications reviewed with the physician to ensure they were provided pain management consistent with their goals.

3.Licensed staff were in-serviced by the DON/designee on the Pain assessment Policy & providing pain management to residents consistent with professional standards.

Residents who receive scheduled pain medications had orders updated to include the reassessment of pain approximately every 30-60 minutes post administration
Monitoring of pain assessments, medication administration and pain follow up will be completed weekly by DON (designee) Department heads will include resident interviews for pain on Guardian Angel rounds daily and will report

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cream regularly until about 3 months before our survey. The resident didn't specify whether he had specifically asked for the cream to be resumed.

"LPN C stated that non-pharmacologic interventions such as repositioning were offered, but stated that they were "usually not enough, he wants his medication"."

Pain assessments were only done per shift, which is documented on the MAR. There was no follow-up on specific pain interventions such as reassessment of pain 30 minutes after administration of medication. Staff stated that this was because the medications Resident #21 was receiving were scheduled, and only PRN medications got follow-up assessment.

On 1/24/18 at 10:05am, an interview was conducted with Resident #21. Resident #21 stated that he suffered from chronic pain to his legs and knees due to arthritis. Resident #21 stated that this pain was chronic and was what led him to retire from his job. When asked about how well his pain was managed, Resident #21 stated "not very well at all".

When asked to elaborate, Resident #21 stated that "they give me a pain pill, but it doesn't work." Resident #21 went on to state that he had spoken with his attending Physician several times, going back 3 months, explaining that his pain medication was not effective, but that no changes had yet been made. Resident #21 was asked if staff were prompt in bringing him his pain medication when he asked for it. Resident #21 stated that his medications were on a schedule.

concerns to the DON.

4.DON/Designee will bring audit results summary to the monthly QAPI meeting for review by Committee until thresholds for each portion of audit are met.

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Resident #21 stated that staff "used to bring me a cream for my knees" but had not done so in "months". When asked what non-pharmacologic treatments (treatments other than medications) if any had been helpful in treating his pain, Resident #21 stated that warm cloths applied to his knees helped. Resident #21 stated that staff did not offer this to him, that he applied his own warm washcloths when he wanted them.

On 1/25/18 at 9:29am, a brief interview was conducted with Licensed Practical Nurse (LPN) C. LPN C stated that Resident #21 had scheduled Tylenol (a Non-Steroidal Anti-Inflammatory Drug, or NSAID) available every 6 hours, and scheduled Tramadol (a narcotic pain killer) available every shift but did not have any PRN (used as-needed) pain medications. LPN C stated that non-pharmacologic interventions such as repositioning were offered, but stated that they were "usually not enough, he wants his medication". Review of Resident #21's Physician Orders showed Tylenol available every 6 hours and Tramadol available every 6 hours. The Physician Orders dated 3/02/17 also showed Myoflex Cream available to be used 3 times a day as needed for joint pain. Review of the TAR (treatment administration record) showed Myoflex cream was not used at any point between 1/1/18 and 1/26/18.

The issues with Resident #21's pain management were reviewed with the Administrator and Director of Nursing (DON) at the end of day meeting on 1/26/18. No further information was provided.

2. For Resident #77, the facility staff failed to assess pain and failed to administer pain

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medication when the resident expressed that she was in pain.

Resident #77, a 78 year old, was admitted to the facility on 7/16/15. Her diagnoses included chronic pain, dysphagia, breast cancer, cerebrovscular disease, and anxiety. Her most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 1/3/18. She was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment. She required limited assistance with activities of daily living. She was coded to have pain.

On 1/24/18 at 2:35 p.m., Registered Nurse A (RN A) and Licensed Practical Nurse C (LPN C) were at the nursing station. Resident #77 self propelled to the nursing station and told the nurses that she was in pain and wanted her pain medication. RN A told the resident that she needed to wait for her medication because it was not due yet. LPN C stated that she thought "they" were trying to wean the resident off pain medication. RN A told the resident that she had an order for tramadol and an order for Tylenol, but neither medication could be administered yet. Resident #77 continued to ask for the pain medication. LPN C told the resident that she last had her medication at 11:00 a.m. and could not have it again until 3:00 p.m. because it was scheduled to be given every 4 hours.

Resident #77 continued to ask for the pain medication. Neither nurse assessed Resident #77's pain level or location of the pain.

This surveyor was at the nursing desk reviewing Resident #77's clinical record at the time the

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interaction took place between Resident #77 and the nurses. According to the physician orders, Resident #77 had two orders for pain medication:
1. Acetaminophen 500 milligram, 1 tablet every 4 hours
2. Tramadol 50 milligram, 1 tablet every 8 hours prn (as needed) for mild to severe pain

The orders were reviewed with the nurses. They were asked why Resident #77 was asked to wait for pain medication when she had a prn Tramadol order. LPN C stated that the Tramadol could not be given with the Acetaminophen. LPN C was asked if the Tramadol could not be given with the Acetaminophen, under what situation would she ever give the Tramadol. LPN C then stated she could not give the Tramadol because the computer system would not let her. She stated that it was too close to the time that the Acetaminophen was to be administered. LPN C was asked to show this surveyor the pain medications in the computer. LPN C clicked through a few different computer screens. This surveyor stated that it looked as though the computer system allowed the administration of both pain medications. LPN C stated yes.

LPN C administered the scheduled Acetaminophen at 3:00 p.m.

Resident #77's care plan was reviewed. The care plan dated 7/18/17 read "(resident name) complains of Chronic Pain in her back, neck and generalized pain." The "Approaches" read Charge nurse will administer pain medications as ordered by physician, Evaluate nature of pain: location, duration, quality, toleration level, response to treatment, relief from medications, adverse reactions, etc., Have resident describe

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F 697	Continued From page 71 pain on scale of 1-10. The issue regarding the administration of Resident #77's pain medications was reviewed with the Director of Nursing and Administrator at the end of day meeting on 1/26/18.	F 697		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in	F 755		3/5/18

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order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review the facility staff failed for 1 resident (Resident #64) of 21 residents in the survey sample to ensure pharmacy recommendations were acted upon.

For Resident #64, the pharmacist recommended that the facility obtain a digoxin level nine times before the level was obtained.

The findings included:

Resident #64, a 72 year old, was admitted to the facility on 12/14/17. His diagnoses included diabetes, chronic kidney disease, pressure ulcer, and hypertension. The most recent Minimum Data Set assessment was an annual assessment with an assessment reference date of 12/19/17. He was coded with a Brief Interview of Mental Status score of 15 indicting no cognitive impairment. He required extensive assistance with activities of daily living.

The pharmacist completed the monthly Drug Regimen Review (DRR) form for Resident #64. The forms were filed in the resident record. In addition, the pharmacist provided the Director of Nursing (DON) with a print out of all the recommendations he made each month.

The following is a summary of the pharmacist recommendations for Resident #64:
1/31/17- digoxin level due (DON print out)
2/28/17- digoxin level due (DON print out)
3/28/17- digoxin ordered (DRR form)

F 755

F 755
1.Resident #64 has an order to obtain a Digoxin level every 6 month and has had a Digoxin level done.

2. Residents on Digoxin have the potential to be affected by practice. Pharmacy recommendations for last 30 days were reviewed for residents on Digoxin to ensure follow up completion.

Pharmacy Consultant inserviced the Don (designees) and the Administrator on the Policy for pharmacy recommendations and follow up.

3.DON/Designee will complete audit of pharmacy recommendations monthly to ensure pharmacy recommendations are acted upon timely. Findings of the audits will be reported to the Nursing Home Administrator.

4.DON will report any discrepancies of incomplete recommendations monthly from the monthly pharmacy report, to the QAPI committee until the threshold for completion of recommendations is met.

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F 755	Continued From page 73 4/24/17- digoxin level due (DRR form) 5/30/17- digoxin level due (DRR form) 6/29/17- digoxin level due (DRR form) 7/26/17- no digoxin level, written 3 times (DRR form) 8/26/17- digoxin level needed (DRR form) 9/29/17- suggest digoxin level for continuous Digitek use (DRR form) The digoxin level was ordered on 10/25/17. The level was reported on 10/30/17 as Low and signed by the physician. The issue was reviewed with the Director of Nursing on 1/29/18 at 3:50 p.m. She stated that the digoxin level kept falling off of the order sheet. She stated the first time it was drawn in 2017 was in October.	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be	F 757		3/5/18

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F 757	Continued From page 74 reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed for 1 resident (Resident #64) of 21 residents in the survey sample to ensure the resident was free from unnecessary medications. For Resident #64, Cardizem (blood pressure medication) was administered when it should have been held. The findings included: Resident #64, a 72 year old, was admitted to the facility on 12/14/17. His diagnoses included diabetes, chronic kidney disease, pressure ulcer, and hypertension. The most recent Minimum Data Set assessment was an annual assessment with an assessment reference date of 12/19/17. He was coded with a Brief Interview of Mental Status score of 15 indicting no cognitive impairment. He required extensive assistance with activities of daily living. Resident #64 had a physician order dated 12/14/17 for Cardizem 1 tab by mouth 3 times a day- check pulse before dosing, hold for pulse less than 60 and notify doctor. The January 2018 Medication Administration Record (MAR) was reviewed. On 1/3/18 at 8:00 p.m., the pulse was documented as 58. The medication was documented as having been	F 757	F757 1.The physician & family for resident # 64 was made aware of the medication error that led to the inaccurate dosing of the Cardizem. A medication error report was completed and filed in the DON office. 2.The facility has identified residents with medication parameters, as having the potential to be affected by this alleged deficient practice. MARS were reviewed for any other potential errors. 3.An audit of physician orders with parameters, was completed to ensure medications were given/held as ordered. Licensed nurses were in-serviced by (DON/consultant/designee) on the proper procedure to check physician orders during medication administration to ensure medications are given in accordance with specified parameters. DON (designee) will audit Medication Administration Records to ensure proper medication parameters have been followed. 4. DON to report a monthly summary to the QAPI committee for review until all medication administration thresholds are met.	

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F 757	Continued From page 75 administered. The medication should have been held according to the parameters in the order. The issue was reviewed with the DON on 1/29/18 at 3:55 p.m. The DON stated that the administration was an error.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a	F 758		3/5/18

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F 758	Continued From page 76 diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure the resident was free from un-necessary medications for two residents, (Resident #71 and Resident #15) in a survey sample of 21 residents. 1. Resident #71's Ativan PRN (as needed) antianxiety medication was administered without assessing the resident at the end of every 14 day continued use, and renewing the PRN order every 14 days. 2. For Resident #15, the facility staff failed to ensure the resident was free from unnecessary medications. The findings included: 1. Resident #71 was admitted to the facility on 7-25-15, and readmitted 2-7-17. Diagnoses	F 758	F 758 1.Resident #71 PRN Ativan was assessed for continued use by the Physician. The 4:04 AM and 9:23 PM time codes were deleted in resident #15 electronic medication administration record (MAR) Physician was called to re-assess the need for continued use and the medication order was clarified. 2. Any resident on a PRN psychotropic medication has the potential to be affected by the same practice. All residents, with PRN psychotropic medications, were assessed by their physician in conjunction with consultant pharmacy recommendations, to ensure PRN usage is limited and meets regulatory compliance.	

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included; Alzheimer's Dementia, left hip fracture with repair and dementia with behavioral disturbance, psychosis, anxiety, osteoporosis, and gastro-esophageal reflux disease.

Resident #71's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12-26-17 was coded as a quarterly assessment. Resident #71 was coded as having no BIMS (brief interview of mental status) score, or severe cognitive impairment. Resident #71 was also coded as requiring extensive to total assistance of one to two staff members to perform activities of daily living, such as bed mobility. The Resident exhibited no adverse behaviors. The Resident received routine and PRN antipsychotic medication.

On 1-26-18 at 11:25 a.m., Resident #71 was observed in the day room in a wheelchair, with a staff member sitting by her at the table, in preparation for lunch. A seat belt waist restraint was around the resident's lower waist. The restraint was around the back and underside of the wheelchair. No behaviors were observed.

Review of the clinical record revealed the resident had a physician's order for Ativan 0.5 mg (milligrams) by mouth every 6 hours as needed for agitation/restlessness. The Resident also had routine daily orders for remeron, mirtazipine, and risperdone antipsychotic medications.

Guidance for the administration of antipsychotic drugs is provided at www.nlm.nih.gov:

"Studies have shown that older adults with dementia (a brain disorder that affects the ability to remember, think clearly, communicate, and

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3. Licensed nurses were in-serviced by the Clinical Consultant re: Unnecessary Medication Regulation and current facility policy of the use of psychotropic medications.

A monthly Pharmacy meeting was initiated that includes the Medical Director, Consultant pharmacy, DON and other members of the IDT(Interdisciplinary Team). The meeting purpose is to review residents on psychotropic meds for PRN usage, appropriate diagnoses, targeted behaviors GDR, & side effects that may warrant medication changes.

DON/designee will audit new orders in the daily clinical meeting for all required order components that meet regulatory guidelines.

4. DON will report psychotropic compliance and improvement as per the monthly Pharmacy reports and monthly psychotropic meeting minutes.

A. The findings of the audits will be reported to the Nursing Home Administrator immediately when the policy is not adhered to.

B. Failure to adhere to the facility policy will be considered a violation. Violations will result in disciplinary action in accordance with the facility□s progressive disciplinary policy.

C. Reports of the findings from the

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F 758	Continued From page 78 perform daily activities and that may cause changes in mood and personality) who take antipsychotics (medications for mental illness) have an increased chance of death during treatment". Review of the care plan dated 1-20-18 revealed the following: " (name of resident)..... is receiving psychoactive drugs; risk of adverse side effects and increase in behaviors. She has a diagnosis of psychosis, depression, and anxiety. Interventions included: Evaluate medications quarterly and (PRN) as needed and review with representative. Review of physician order sheets revealed that the Resident was ordered to have as needed ativan on 3-1-17. Review of all physician progress notes in the clinical record revealed that neither the doctor, nor the Registered nurse practitioner, had reevaluated the Resident, and reordered the Ativan after each 14 day interval as required by regulation. On 1-26-18, the DON (director of nursing) was questioned about the physician reevaluation for PRN psychotropic drug continued use for Resident #71. She stated, "No, the reevals, and reordering have not been done." On 1-26-18 at 2:00 p.m., the DON and Administrator were notified of above findings. No further information was presented by the facility.	F 758	audits, along with any disciplinary action, if applicable, will be reported for 3 months by the Director of Nursing to the Quality Assurance committee consisting of the Director of Nursing, Medical Director, NHA, MDS coordinator, Pharmacy Consultant, Social Service Director and Dietary Manager on a monthly basis. Any trends or patterns identified will be addressed and revisions to the plan of action will be implemented.	

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2. For Resident # 15, the facility staff failed to ensure the resident was free from unnecessary medications, Lorazepam.

Resident # 15 was a 75 year old female admitted to the facility on 2/26/2016 with the diagnoses of, but not limited to, Diabetes, Anxiety disorder, Dementia without behavioral disturbance, Dysphagia and Cerebrovascular Disease.

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12/5/2017. The MDS coded Resident # 15 with a BIMS (Brief Interview for Mental Status) of 00/15 indicating severe cognitive impairment; Resident # 15 required total assistance of one staff person with all activities of daily living. Resident # 15 was also coded as always incontinent of bowel and bladder.

Review of the clinical record was conducted on 1/26/2018 and 1/29/2018.

Review of the Physicians orders revealed an order that was written on 3/3/2017 for Lorazepam 0.5 milligrams by mouth every 8 hours as needed for agitation.

Review of the January 2018 Medication Administration Record revealed the order for Lorazepam 0.5 milligrams by mouth every 8 hours as needed for agitation along with two time codes listed: 4:08 AM and 9:23 PM. Lorazepam was documented as having been administered twice in January 2018 on 1/5/2018 in the 9:23 PM slot and 1/28/2018 at 4:08 AM.

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F 758	Continued From page 80 Review of the Behavioral Health/ Sleep Disorder Physicians Progress Notes revealed notes written on 8/16/2017. There was no documentation about the as needed (PRN) order for Lorazepam and the indicated duration of the PRN order. On 1/29/2018 at 2:10 PM, an interview was conducted with the Director of Nursing (DON) who stated there should be a rationale for each medication and that the facility recently established new policies and procedures to address the new regulations regarding review of use of Psychotropic medications every 14 days. The DON stated the facility would utilize the Psychiatric Nurse Practitioner to make sure the residents were assessed properly every 14 days or according to the regulations. The DON stated she did not know why the Lorazepam was listed with the two times of 4:08 AM and 9:23 PM "because as needed medications are given when needed and the 8 hours would be calculated after the last administration." The DON stated those times listed did not reflect every 8 hours either and that the nurses and pharmacist should have caught the errors on the MAR. On 1/29/2018 during the end of debriefing, the Administrator and Director of Nursing were informed of the findings. No further information was provided.	F 758		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 760		3/5/18

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Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure five Residents were free from significant medication error (Residents #10, 29, 40, 83, and 47) in a survey sample of 21 Residents.

1. For Resident #10, the facility failed to administer anti seizure medication as ordered by a physician.

2. For Resident #29, the facility failed to administer insulin as ordered by a physician.

3. For Resident #40, the facility failed to administer anti seizure medication as ordered by a physician.

4. For Resident # 83, the facility staff failed to document the administration of Insulin for Diabetic Management and Anti-seizure medications.

5. For Resident # 47, the facility staff failed to document the administration of anti-seizure medications as ordered by the physician.

The findings included:

1. Resident #10, was admitted to the facility on 5-20-17. Diagnoses included; left tibia fracture with surgical repair infection and revision of implanted device, hypertension, seizures, contractures, and congestive heart failure.

Resident #10's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1-17-18 was coded as an admission assessment. Resident #10 was coded as having a BIMS (brief

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1.The physician & family for resident #10, #29, #40, #83, and #47 were made aware of the medication errors found in the medical record. Medication error reports were completed for each occurrence AND FILED IN DON OFFICE.

2.The facility has identified residents as having the potential to be affected by this alleged deficient practice. An audit of current Medication Administration and Treatment records were reviewed for errors and omissionS. Staff were educated as necessary and the physicians were made aware of the findings as needed.

3. Licensed staff were in-serviced by the Clinical Consultant on proper Medication Administration and the importance of appropriate documentation and (MAR) medication administration record accuracy.

DON/designee will audit Medication Administration Records to ensure proper medication documentation for medications as ordered.

4. A weekly summary of audit results, will be reported to the Nursing Home Administrator by the DON Administrator will sign following the review..
DON to report a monthly summary to the QAPI committee for review until all medication administration thresholds are met.

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interview of mental status) score of "13" out of a possible 15, or, mild to no cognitive impairment. Resident #10 was also coded as requiring extensive to total assistance of staff to perform activities of daily living, such as bed mobility, transferring, eating, locomotion, and toileting.

Review of Resident #10's clinical record revealed no evidence the following medication was administered on the days and times indicated:

1. Levetiracetam 1000 mg (milligram) twice daily at 8:00 a.m., and 8:00 p.m. (anti-seizure): 1-1-18 (8 a.m.),
1-12-18 (8 a.m.), 1-21-18 (8 a.m.), 1-24-18 (8 a.m.), and 1-26-18 (8 a.m.).

Valid physician's orders were evident for the medications in question. A thorough review of Resident #10's clinical record, including nursing progress notes, revealed no evidence he was away from the facility, nor refused the medication in question.

Review of the facility's policy entitled, "Medication Administration" revealed that all medications are to be given according to the prescriber's order and signed/documented by the administering individual as soon as the medication is given.

When interviewed on 1-26-18 at 4:00 p.m., the DON (director of nursing) stated that she had identified the failure of the staff to ensure medications and treatments were documented as being administered. The DON stated her expectation was for staff to administer medications and treatments per physician's orders and to document them as having been administered, immediately following

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F 760	Continued From page 83 administration. The administrator and DON were informed of the failure of the staff to ensure significant medications were administered and documented, on 1-26-18 at 4:00 p.m. No further information was provided by the facility. 2. Resident #29, was admitted to the facility on 9-12-16. Diagnoses included; hypertension, vascular dementia, stroke, diabetes, glaucoma, depression, high cholesterol, sleep apnea, gout, and gastro-esophageal reflux disease. Resident #29's most recent MDS (minimum data set) with an ARD (assessment reference date) of 11-20-17 was coded as a quarterly assessment. Resident #29 was coded as having a BIMS (brief interview of mental status) score of "15" out of a possible 15, or, no cognitive impairment. Resident #29 was also coded as requiring extensive to total assistance of staff to perform activities of daily living, such as bed mobility, transferring, eating, locomotion, and toileting. Review of Resident #29's clinical record revealed no evidence the following insulin order was administered on the days and times indicated: Novolog 100 unit/ml (milliliters) per sliding scale sub cutaneous injection insulin at 6:30 a.m., and 4:30 p.m., (diabetes): 1-1-18 (6:30 a.m.), 1-10-18 (6:30 a.m.), 1-14-18 (6:30 a.m.), 1-19-18 (6:30 a.m.), 1-24-18 (6:30 a.m.).	F 760		

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Valid physician's orders were evident for the medications and treatment in question. A thorough review of Resident #29's clinical record, including nursing progress notes, revealed no evidence she was away from the facility, nor refused the medications and treatment in question.

Review of the facility's policy entitled, "Medication Administration" revealed that all medications are to be given according to the prescriber's order and signed/documented by the administering individual as soon as the medication is given.

When interviewed on 1-26-18 at 4:00 p.m., the DON (director of nursing) stated that she had identified the failure of the staff to ensure medications and treatments were documented as being administered. The DON stated her expectation was for staff to administer medications and treatments per physician's orders and to document them as having been administered, immediately following administration.

The administrator and DON were informed of the failure of the staff to ensure significant medications were administered and documented, on 1-26-18 at 4:00 p.m. No further information was provided by the facility.

3. For Resident #40, the facility failed to administer anti seizure medication as ordered by a physician.

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Resident #40 was admitted to the facility on 12-09-16. Diagnoses included; Pneumonia, stroke, dysphagia, dementia, psychosis, gastrostomy.

Resident #40's most recent MDS (minimum data set) with an ARD (assessment reference date) of 11-17-17 was coded as a readmission assessment. Resident #40 was coded as having a BIMS (brief interview of mental status) score of "1" out of a possible 15, or, severe cognitive impairment. Resident #40 was also coded as requiring total assistance of staff to perform activities of daily living, such as bed mobility, transferring, eating, locomotion, and toileting.

Review of Resident #40's clinical record revealed no evidence the following two seizure medications were administered on the days and times indicated:

1. Levetiracetam 750 mg (milligram) twice daily at 8:00 a.m., and 8:00 p.m. (seizures): 1-3-18 (8 a.m.), 1-6-18
(8 p.m.), 1-7-18 (8 p.m.).

2. Valproic Acid 250 mg (milligram) twice daily at 8:00 a.m., and 8:00 p.m. (seizures): 1-3-18 (8 a.m.), 1-6-18
(8 p.m.), 1-7-18 (8 p.m.).

Valid physician's orders were evident for the medications in question. A thorough review of Resident #40's clinical record, including nursing progress notes, revealed no evidence he was away from the facility, nor refused the medications in question.

Review of the facility's policy entitled, "Medication

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Administration" revealed that all medications are to be given according to the prescriber's order and signed/documented by the administering individual as soon as the medication is given.

When interviewed on 1-26-18 at 4:00 p.m., the DON (director of nursing) stated that she had identified the failure of the staff to ensure medications were documented as being administered. The DON stated her expectation was for staff to administer medications and treatments per physician's orders and to document them as having been administered, immediately following administration.

The administrator and DON were informed of the failure of the staff to ensure significant medications were administered and documented, on 1-26-18 at 4:00 p.m. No further information was provided by the facility.

4. For Resident # 83, the facility staff failed to document the administration of Insulin for Diabetic Management and Anti-seizure medications as ordered by the physician.

Resident #83 was a 58 year old female admitted to the facility on 10/10/2017. Diagnosis included but were not limited to: Vascular Dementia with behavioral disturbances, Diabetes and Complete

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Traumatic Amputation of left lower leg.

The most recent Minimum Data Set (MDS) assessment, was an Admission Assessment with an Assessment Reference Date of 10/19/2018. The MDS coded Resident #83 as having a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment. Resident # 83 was also coded as requiring limited to total assistance of one staff member for Activities of Daily Living (ADLs). The only exception to this was eating, which the Resident was able to accomplish with only tray set up help. Resident # 83 was coded as always incontinent of bowel and bladder.

Review of Resident # 83's comprehensive admission care plan developed 10/20/2017, upon the Resident's admission revealed a Diabetic Management care plan which included interventions to Notify physician of unstable blood sugar levels and Administer medications as ordered by the physician, see MARs.

Review of the clinical record revealed that the Resident # 83's orders had commenced from admission on 10/10/2017. Review of the physician's order sheet, and Medication Administration Record (MAR) revealed the following orders for finger stick blood sugar (FSBS) checks, and Insulin which were not administered.

The following are the FSBS results and insulin omitted recorded on the MAR (Medication Administration Record) as documented by facility nursing staff:

1/11/18 at 4:30 p.m.- Blood sugar not

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documented.
1/15/18 at 4:30 p.m.- Blood sugar not documented.
1/16/18 at 6:30 a.m.- Blood sugar not documented.
1/24/18 at 6:30 a.m.- Blood sugar not documented .
1/24/18 at 4:30 p.m.- Blood sugar not documented.
1/25/18 at 6:30 a.m.- Blood sugar not documented.
1/25/18 at 4:30 p.m.- Blood sugar not documented.

1/24/18 at 5:00 p.m.- Humulin 70/30 Give 20 Units at Supper. Not documented.
1/25/18 at 5:00 p.m.- Humulin 70/30 Give 20 Units at Supper. Not documented.

Further review of the MAR revealed missing documentation of the anti-seizure medication Dilantin:

1/24/18 at 8:00 p.m.- Dilantin Extended CAP 100 milligrams by mouth every day. Not documented.
1/25/18 at 8:00 p.m.- Dilantin Extended CAP 100 milligrams by mouth every day. Not documented

Review of the nursing progress notes revealed no documentation of explanations for the omissions of documentation of insulin administration and no explanation as to why the FSBSs were not attempted. There was also no explanation about the omission of documentation of administration of Dilantin on those dates.

Medication Administration, and Diabetic Management policies were reviewed, and stated

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that all FSBS and insulin administration must be "Documented in the nursing notes and on the MAR."

Review of the facility policy on "Administering Medications" from Nursing Services Policy and Procedure Manual for Long-Term Care Revised December 2012 revealed on Page 5, Under Policy Interpretation and Implementation, under the Highlights: Timely Administration:
3. Medications must be administered in accordance with the orders, including any required time frame.
On Page 6,
18. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose.
19. The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones. "

Valid Physician's orders were evident for the medications and treatments not documented as having been administered.

An interview was conducted on 1/26/2018 with the Director of Nursing (DON) at approximately 1:00 p.m. The DON stated that if it was not documented, it was not done. She could not explain why they were omitted, as no progress notes described the reason for the omissions.

On 1/29/218 at 2:10 PM, the Director of Nursing stated she did not find any documentation regarding the omissions on the MAR.

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Administration was informed of the findings on 1/26/2018, and 1/29/2018 at the end of day debriefing each day, the facility presented no further evidence.

5. For Resident # 47, the facility staff failed to document the administration of anti-seizure medications as ordered by the physician.

Resident # 47 was an 81 year old female admitted to the facility originally on 8/20/2016 with the diagnoses of, but not limited to, Seizure Disorder, Major Depressive disorder, Dysphagia , PEG tube (Percutaneous Endoscopic Gastrostomy), GERD (Gastroesophageal Reflux Disease) and Cerebrovascular Disease.

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12/5/2017. The MDS coded Resident # 47 with a BIMS (Brief Interview for Mental Status) of 1/15 indicating severe cognitive impairment; Resident # 47 required limited assistance of one staff person with activities of daily living for dressing, hygiene, bathing and toileting and required minimal assistance of one staff person for transfer, ambulation, and bed mobility; Resident # 47 required total assistance of one staff person for eating and was also coded as always continent of bowel and bladder.

On 1/25/2018 at 9:30 AM, review of the clinical

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record was conducted.

Review of the Medication Administration Record (MAR) for December 2017 revealed missing documentation of medications:

Keppra 100 milligrams per milliliter oral solution , give 7.5 milliliters (750 milligrams) per PEG tube twice daily for seizures,
12/17/17 at 8 PM, 12/18/17 at 8 PM. 12/19/17 at 8 PM

Valproic Acid 250 milligrams per 5 milliliters solution (Depakene) give 10 milliliters (500 milligrams) per PEG tube twice daily for seizures.
12/17/17 at 8 PM, 12/18/17 at 8 PM. 12/19/17 at 8 PM

Increase Depakote dose to 250 milligrams per 5 milliliters three times a day-Valproic Acid 250 milligrams per 5 milliliters solution
12/25/2017 at 2 PM

Review of the Medication Administration Record (MAR) for January 2018 revealed missing documentation of medications:

Keppra 100 milligrams per milliliter oral solution , give 7.5 milliliters (750 milligrams) per PEG tube twice daily for seizures,
1/11/18 at 8 PM

Increase Depakote dose to 250 milligrams per 5 milliliters three times a day-Valproic Acid 250 milligrams per 5 milliliters solution (Depakene) give 10 milliliters (500 milligrams) per PEG tube three times per day for seizures.
1/11/18 at 8 PM

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On 1/25/2018 at 1:45 PM, an interview was conducted with LPN E (Licensed Practical Nurse A) who stated that nurses were expected to administer medications and treatments as ordered by the physician and document on the MAR and TAR at the time of administration.

On 1/26/2018 at approximately 1:20 PM during the end of day debriefing, the Administrator and Director of Nursing (DON) were informed of the missing documentation of administration of medications for Resident # 47. The DON stated she had identified problems with documentation of medications as an issue at the facility. The DON stated she had been working with the facility staff on improving the documentation of medications and treatments. The DON stated the since facility used several Agency nurses who sometimes had difficulty with the electronic program to document on the MAR. The DON stated the expectation was for nurses to administer medications and treatments as ordered by the physician and to sign the MAR immediately after administering the medications.

On 1/26/2018 at approximately 1:30 PM, the DON stated the facility used "Med-Pass" for professional nursing guidance. The DON presented a copy of the Medication Administration Policy.

Review of the facility policy on "Administering Medications" from Nursing Services Policy and Procedure Manual for Long-Term Care Revised December 2012 revealed on Page 5, Under Policy Interpretation and Implementation, under the Highlights: "Timely Administration:
3. Medications must be administered in accordance with the orders, including any

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F 760	Continued From page 93 required time frame." On Page 6, "18. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose. 19. The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones. " Valid Physician's orders were evident for the medications and treatments not documented as having been administered. During the end of day debriefing on 1/29/2018, the DON and Administrator again were informed of the findings. No further information was provided.	F 760		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(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	F 812		3/5/18

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F 812	Continued From page 94 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility staff failed to store and serve food in accordance with professional standards for food service safety. A fan with dust caked on the back of the frame was found blowing air over the area where dishes were washed and racked to dry. The findings included: An initial tour of the Kitchen was conducted on 1/24/18 at 9:06 am. During tour, it was observed that several wall-mounted fans were in use circulating air throughout the kitchen. One fan overlooking the dishwashing and drying area was observed to have thick dust caked on the rear of the housing covering the blades, in the air intake area. Inspection of the ice machine in the kitchen revealed that there was no air gap between the drainage pipe and floor drain. The far end of the drain pipe coming from the rear of the ice machine was resting inside the lip of the floor drain. The issues with the Kitchen were reviewed with the Kitchen Manager on 1/29/18 at approximately 10:50. The manager stated that a work order would be placed to have the fan cleaned. No further information was provided.	F 812	F 812 1- Fan has been cleaned. Ice machine air gas valve repair has been completed 2- Facility has identified all fans and ice machine drainage pipes are at risk. Audit conducted. 3- Dietary Manager or designee will do weekly sanitation inspection of the kitchen to include fans and checking ice machine drainage pipe. 4- Weekly inspection report that includes cleaning fans and proper placement of the ice machine drainage pipe will be reported to the monthly QAPI meeting	

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F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(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 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842		3/5/18

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F 842	Continued From page 96 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(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 observation, staff interview and clinical record review, the facility staff failed, for two residents (Residents #10, and #60) to maintain a complete and accurate clinical record in the survey sample of 21 residents. 1. No meaningful activity records existed in the clinical record for Resident #10. 2. No meaningful activity records existed in the clinical record for Resident #60.	F 842	F 842 1. Correction: An activity assessment was completed for R10 on 1/29/18 and reflects resident preferences. The care plan was updated on 2/13/18 to reflect person-centered activities. An activity assessment was completed for R60 on 12/11/17 and reflects resident preferences. The care plan was updated on 2/13/18 to reflect person-centered	

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The findings included:

1. Resident #10, was admitted to the facility on 5-20-17. Diagnoses included; left tibia fracture with surgical repair infection and revision of implanted device, hypertension, seizures, contractures, and congestive heart failure.

Resident #10's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1-17-18 was coded as an admission assessment. Resident #10 was coded as having a BIMS (brief interview of mental status) score of "13" out of a possible 15, or, mild to no cognitive impairment. Resident #10 was also coded as requiring extensive to total assistance of staff to perform activities of daily living, such as bed mobility, transferring, eating, locomotion, and toileting.

The care plan was reviewed and revealed no activities interventions for Resident #10.

The entire clinical record was reviewed, and no assessment of need, no activity attendance notes, nor meaningful Activities were planned for Resident #60.

On 1-25-18, 1-26-18, and 1-29-18, Resident #10 was observed. No meaningful activities were attended by this Resident.

On 1-26-18 the Director of Nursing (DON) was interviewed, and stated the former activity director had resigned, and a new employee was responsible for activities. The DON stated this Resident had one quarterly note dated 1-21-19, but could find no activity assessments from a qualified activity professional in the clinical record.

F 842

activities.
An activity participation record is being maintained for each resident to identify the activities that the resident participated in and the resident□s response.

2. Other Potential
Other residents in the facility have potentially been affected. A 100% audit will be completed to ensure that current residents have an activity assessment that identifies personal preference and activities that may be meaningful to the resident. An activity participation record will be completed and maintained for each resident to identify the resident□s participation and response to the activity.

3. System Change
The activity director participated in the 45-hour activity training program sponsored by Virginia Healthcare Association that ended on January 26, 2018. This program included education on completing activity assessments for resident preference and interests, establishing person centered activity care plans that identifies meaningful activities and documentation of resident□s participation and response to the activity.

The facility has adopted and initiated the use of an activity assessment and activity participation record to reflect resident preferences for meaningful activities and the resident□s response to the activities. Resident care plans will address person-centered and meaningful activities for each resident.

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F 842	Continued From page 98 It was assumed the "2019" was intended to be 2018, as this was the only January stay for this Resident in the facility. On 1-26-18 the Administrator and DON were made aware of the staff failure to plan and document meaningful activities for Resident #10. No further information was provided by the facility. 2. Resident #60, was admitted to the facility on 12-6-17. Diagnoses included; stroke, diabetes, drug and alcohol abuse, high blood pressure and high cholesterol. Resident #60's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12-15-17 was coded as a full admission assessment. Resident #60 was coded as having a BIMS (brief interview of mental status) score of "15" out of a possible 15, or cognitively intact. This was an error, as the Resident was not cognitively intact. Resident #60 was also coded as requiring extensive assistance of one staff member to perform activities of daily living, such as bed mobility, transferring, eating, locomotion, and toileting. Resident #60 was coded with one fall since admission, no floor mats used for falls, bed fast or wheel chair bound, at risk for falls, on depression medication, which increased the risk for falls. The Resident was assessed and coded on the MDS as always continent of bowel and bladder. The care plan was reviewed and revealed no activities interventions for Resident #60.	F 842	4. Monitoring The Director of Social Services will conduct a review of 3 residents each week x 6 weeks to monitor that the activity assessment has been completed, that the activity participation record is being completed and that the participation documents the resident□s response to the activity and that the resident□s plan of care addresses meaningful activities. Areas of identified opportunity will be discussed with the activity director and corrected as needed. Findings from the weekly audits will be reported to the administrator for tracking/trending of patterns and will be reported to the QAPI Committee.	

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F 842	Continued From page 99 The entire clinical record was reviewed, and no assessment of need, no activity attendance notes, nor meaningful Activities were planned for Resident #60. On 1-24-18, 1-25-18, 1-26-18, and 1-29-18, Resident #60 was observed. No meaningful activities were attended by this Resident. On 1-26-18 the Director of Nursing was interviewed, and stated the former activity director had resigned, and a new employee was responsible for activities. The DON stated this Resident had no activity assessments nor notes from a qualified activity professional in the clinical record. On 1-26-18 the Administrator and DON were made aware of the staff failure to plan and document meaningful activities for Resident #60. No further information was provided by the facility.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		3/5/18

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F 880	Continued From page 100	F 880		

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495375	A. BUILDING ____ B. WING ____	01/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPORIA MANOR LLC	200 WEAVER AVENUE EMPORIA, VA 23847

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F 880	Continued From page 101 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed for 1 resident (Resident #65) of 21 residents in the survey sample to practice appropriate hand washing prior to medication administration. And, the facility staff failed to have air gaps on the ice machines in the kitchen and on Unit 1. 1. For Resident #65, the facility staff failed to knock on the door, and or announce themselves prior to entering the bedroom. 2. The facility failed to have air gaps on the ice machines in the Kitchen and on Unit 1. The Findings included: Resident #65 was a 53 year old who was admitted to the facility on 2/5/13. Resident #65's diagnoses included Major Depressive Disorder, and Hypertension. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date	F 880	F 880 1.LPN A was educated on the hand washing policy and re: failure to properly wash her hands prior to administering medications to resident #65. Dishwasher air gap was repaired on the ice machines on Unit 1 and the kitchen. 2.All Ice machines were checked for air gaps and corrected as needed. 3.Staff were in-serviced by DON/Designee on the facility on Hand Washing Policy. Medication Administration competency will be completed by DON/designeeanagers, with each Licensed nurse, including agency staff, to ensure compliance with policy. DON/designee will complete med pass audits on all shifts 3 times per week to ensure compliance.	

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F 880	Continued From page 102 of 11/4/17, coded Resident #65 as sometimes being able to understand and be understood by others. On 1/24/18 at 9:00 A.M. an observation was conducted of the medication pass. Licensed Practical Nurse A was observed entering Resident #65's room in order to wash her hands. LPN A entered the bedroom without knocking or announcing herself to either Resident #65 or his roommate. LPN A quickly washed her hands for about 10 seconds. She then poured and administered Resident #65's medications. An interview was immediately conducted with LPN A. When asked why she didn't knock on the door or announce herself to the residents, she stated, "I don't have an explanation. I didn't knock before entering. It is important for respect and privacy." When asked why she only washed her hands for approximately 10 seconds, she stated, "I probably should have used the hand sanitizer. I know I didn't wash them long enough. We are supposed to sing the birthday song for 30 seconds." LPN A also stated that she was from an agency, and that it was her first day at the facility. On 1/29/18 at 1:12 P.M. an interview was conducted with the Director of Nursing (DON Administration B). When asked about her expectations regarding hand washing, she stated, "I expect them to wash hands according to CDC (Centers for Disease Control and Prevention) regulations." On 1/24/18 a review was conducted of facility documentation, revealing the Handwashing/Hand Hygiene policy dated August, 2015. It read,	F 880	Maintenance will audit the ice machines throughout the facility for the presence of air gaps .during his weekly inspections. 4 DON and maintenance will report audit findings to the QAPI committee until thresholds are met.	

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F 880	Continued From page 103	F 880		

"Vigorously lather hands with soap and rub together, creating friction to all surfaces, for a minimum of 20 seconds or longer under a moderate stream of running water, at a comfortable temperature."

No further information was received.

2. The facility failed to have air gaps on the ice machines in the Kitchen and on Unit 1.

An initial tour of the Kitchen was conducted on 1/24/18 at 9:06 am. During tour, it was observed that the ice machine in the kitchen had no air gap between the drainage pipe and floor drain. The far end of the drain pipe coming from the rear of the ice machine was resting inside the lip of the floor drain.
An inspection of the ice machines on each unit was conducted on 1/26/18 at approximately 10:30 am. The ice machine on Unit 1 was found to have no air gap between the drainage pipe from the ice machine and the floor drain. The drainage pipe from the ice machine was observed resting flush with the grate covering the floor drain.

The Administrator and DON were made aware of the issue at the end of day meeting on 1/26/18.