STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT RURAL RETREAT	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/31/17 through 11/2/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 116 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents 1 through 21) and 4 closed record reviews (Residents 22 through 25).	F 000	This plan of correction constitutes our credible allegation of compliance. Preparation and/or execution of this plan of correction do not constitute admission or agreement by the provider of the conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state laws.	
F 155 SS=D	483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES 483.10 (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. (g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F 155	F 155 Right to Refuse; Formulate Advance Directives **Criteria 1:** Resident #2 DDNR order was corrected with initiation of new DDNR order per resident's wishes on October 31, 2017. On October 31, 2017, Social Services audited all resident's charts verifying DDNR orders; no additional errors were found. **Criteria 2:** Advance Directives/DDNR orders for admissions, readmissions, and residents with changes in condition will be reviewed weekly	

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

Executive Director 11-24-17

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

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F 155	Continued From page 1 (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. 483.24 (a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to accurately complete a DDNR (Durable Do Not Resuscitate) order form for 1 of 25 Residents, Resident #2. The findings included:	F 155	by social services director or designee for accuracy and corrections will be made per resident/RP's wishes. **Criteria 3:** DON or designee will provide education to social services and nursing staff by November 30, 2017 and during new hire orientation thereafter regarding accuracy and completion of Advance Directives to include DDNR orders. Social services will do a review/audit of Advance Directives/DDNR orders weekly for admissions, readmissions, and residents with changes in condition to ensure accuracy. **Criteria 4:** Results of audits will be presented to ED or designee weekly by DON/social services director. ED or designee will present results to facility QA committee monthly for further intervention or recommendation as necessary. **Criteria 5:** December 16, 2017	

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F 155	Continued From page 2 Section 1 and 2 of the Residents DDNR order form had not been completed. The record review revealed that Resident #2 had been admitted to the facility 01/04/2017. Diagnoses included, but were not limited to, anxiety, seizures, congestive heart failure, and bipolar disorder. Section C (cognitive status) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 09/05/2017 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. The clinical record included a DDNR order form from the Virginia Department of Health dated 04/17/2017 section 1 and 2 of this form had been left blank. Under section 1 the DDNR read in part, "I further certify [must check 1 or 2]: 1. The patient is CAPABLE of making an informed decision... 2. The patient is INCAPABLE of making an informed decision..." The boxes beside #1 and #2 had been left blank. Section 2 read "If you checked 2 above, check A, B, or C below:" The three boxes below had also been left blank. The clinical record also included a physicians telephone order dated 04/17/2017 indicating the Residents code status was a DNR (do not resuscitate).	F 155		

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F 155	Continued From page 3 On 10/31/2017 at approximately 10:50 a.m. the unit manager was asked about the DDNR. The administrative staff were notified of the missing information on the DDNR during a meeting with the survey team on 10/31/2017 at approximately 2:45 p.m. On 11/01/2017 at approximately 1:20 p.m. the administrative staff verbalized to the surveyor that a 100% audit had been completed at the facility regarding DDNR's and no further issues were identified. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 155		
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes 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. (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. §483.70	F 164	**F 164** Personal **Privacy**/Confidentiality of Records **Criteria 1:** On November 1, 2017, DON provided education to nurses of Residents #19, #21, and #17 on regarding the proper utilization of the privacy screen option on the medication cart computers. **Criteria 2:** DON or designee will observe a sample of nurses weekly during medication pass to ensure privacy screen option on medication cart computer is being utilized properly.	

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F 164	Continued From page 4 (i) Medical records. (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 by and in compliance with 45 CFR 164.512. 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 protect the private health care information for 3 of 25 Residents, Residents #19, #21, and #17. The findings included. 1. For Resident #19, the facility staff failed to secure the Residents medical record. The electronic health record was left open and in the hallway unattended exposing the Residents private health information.	F 164	**Criteria 3:** DON or designee will provide education by November 30, 2017 to nursing staff regarding privacy of records to include utilization of the privacy screen. DON or designee will monitor/observe a sample weekly to ensure utilization of privacy screen on computers. **Criteria 4:** Results of audits will be presented to ED or designee weekly by DON or designee. ED or designee will present results to facility QA committee monthly for further intervention or recommendation as necessary. **Criteria 5:** December 16, 2017	

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F 164	Continued From page 5 The record review revealed that Resident #19 had been admitted to the facility 10/11/2017. Diagnoses included, but were not limited to, diabetes, heart failure, hypothyroidism, and cerebral ischemia. Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/17/2017 included a BIMS (brief interview for mental status) summary score of 13 out of a possible 15 points. Section I (active diagnoses) included the diagnosis of diabetes. On 11/01/2017 at approximately 8:00 a.m. two surveyors observed a medication cart on the east wing. On top of this medication cart was a computer that the nursing staff would use during their medication pass. This computer had been left open and the surveyors were able to read Resident #19's private health care information. The nursing staff was not in the immediate vicinity of this medication cart. The surveyors were able to observe numerous Residents in the hallway as well as various staff. When LPN (licensed practical nurse) #3 returned to the medication cart the surveyor asked her if she usually left the computer open. To which LPN #3 replied she did not. The administrative staff were notified of the above during a meeting with the survey team on 11/01/17 at approximately 4:35 p.m. The facility provided the survey team with a copy of a document titled "Internet, E-Mail and Computer Usage Policy." This document read in part "Use of Company computers, networks...may	F 164		

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F 164	Continued From page 6	F 164		

be revoked at any time for inappropriate conduct carried out on such systems, including, but not limited to...Failing to log off any secure, controlled-access computer or other form of electronic data system to which you are assigned, if you leave such computer or system unattended..."

No further information regarding this issue was provided to the survey team prior to the exit conference.

2. For Resident #21, the facility staff failed to secure the Residents medical record. The electronic health record was left open and in the hallway unattended exposing the Residents private health information.

The record review revealed that Resident #21 had been admitted to the facility 06/03/2017. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, dementia, depressive disorder, and congestive heart failure.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 09/18/2017 included a BIMS (brief interview for mental status) summary score of 5 out of a possible 15 points.

On 11/01/2017 at approximately 8:10 a.m. two surveyors observed a medication cart on the west wing. On top of this medication cart was a computer that the nursing staff would use during their medication pass. This computer had been left open and the surveyors were able to read Resident #21's private health care information. The nursing staff was not in the immediate vicinity

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F 164	Continued From page 7 of this medication cart. The surveyors were able to observe numerous Residents in the hallway as well as various staff. When LPN (licensed practical nurse) #4 returned to the medication cart the surveyor asked her if she usually left the computer open. To which LPN #4 replied "Yes it will go off by itself." The administrative staff were notified of the above during a meeting with the survey team on 11/01/17 at approximately 4:35 p.m. The facility provided the survey team with a copy of a document titled "Internet, E-Mail and Computer Usage Policy." This document read in part "Use of Company computers, networks...may be revoked at any time for inappropriate conduct carried out on such systems, including, but not limited to...Failing to log off any secure, controlled-access computer or other form of electronic data system to which you are assigned, if you leave such computer or system unattended..." No further information regarding this issue was provided to the survey team prior to the exit conference. 3. The facility failed to protect the private health care information for Resident #17. Resident #17 was originally admitted to the facility on 5/20/17 with a readmission date of 8/23/17. Diagnoses included but not limited to: dysphagia, heart failure, enterocolitis due to clostridium difficile, and hypokalemia. The most recent MDS (minimum data set) was a quarterly assessment with an ARD of (assessment reference date) of 10/13/17. It was documented that Resident # 17	F 164		

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F 164	Continued From page 8 had a cognitive score of 12 out of 15 indicating moderate cognitive impairment. On 11/1/17 at 8:57 a.m., RN (registered nurse) # 2 was administering medications to Resident #17. After preparing the medication, RN # 2 locked the medication cart and proceeded to enter Resident # 17's room. RN#2 did not log off of the computer prior to entering the room and Resident # 17's information was not protected. Also noted on the medication cart was an empty medicine bottle that contained information for Resident #17 which was left unprotected. On 11/1/17 at 4:31 p.m. the DON (director of nursing), ADON (assistant director of nursing), Adm (administrator), nurse consultant, regional MDS consultant, and regional director of operations were made aware of the above findings. Per the facility "internet, e-mail and computer usage policy" which according to the DON is also the facility standard of practice, "failing to log off any secure, controlled-access computer or other form of electronic data system to which you are assigned, if you leave such computer or system unattended" is inappropriate conduct. No further information regarding this issue was provided to the survey team prior to the exit conference on 11/2/17 at 5:15 p.m.	F 164		
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey	F 167		

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F 167	Continued From page 9 of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to post signage that directed the public of where to obtain the past 3 years of survey results in an area that was readily accessible to all who entered the facility to review. The findings included: The survey team, which consisted of 5 surveyors, entered the facility on 10/31/17 for an annual Medicare/Medicaid survey. Observations were made to locate the signage that directed the public of where the past 3 years of survey results	F 167	F 167 Right to Survey Results - Readily Available **Criteria 1:** On November 2, 2017, the survey results book was relocated to table in front lobby and signage stating "for any additional information regarding the past 3 years of surveys, please see the receptionist" were posted near the location of the survey results binder as well as in the front lobby window to ensure accessibility. **Criteria 2:** No other resident risk posed related to alleged deficient practice. **Criteria 3:** ED or designee will send notification to all residents/RPs to include the following: 1. most recent survey results, 2. Location of signage, and 3. Location of results as part of resident council. ED or designee will monitor monthly to ensure posting of results during administrative rounds. DON or designee will provide education to staff by November 30, 2017 regarding location of survey results.	

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F 167	Continued From page 10 could be found. These observations were made from 10/31/17 through 11/2/17. On 11/2/17 at approximately 12:30 pm, the surveyor notified the administrator that there was no signage in the front lobby that directed anyone interested in reviewing these survey results of where they were located. There was also no signage that directed the public of where to obtain the past 3 years of survey results if they were wanting to be reviewed. There was a black notebook on a small table to the right of the front doors that had a cover page on the front of it stating "SURVEY RESULTS". At approximately 1 pm, the administrator asked the surveyor to come to the nursing units and see if the signage there would be ok. The surveyor noted a laminated page at the West nurses' station that read in part " ...Survey Results are located in the front lobby". The administrator and surveyor went to the East nurses' station and no signage could be found. The administrator stated, "They don't have a bulletin board like the other nurses' station has. I will take care of this immediately." No further information was provided to the surveyor prior to the exit conference on 11/2/17.	F 167	**Criteria 4:** ED will present results of monitoring monthly to facility QA committee for further intervention or recommendation as necessary. **Criteria 5:** December 16, 2017	
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 241	F 241 Dignity and Respect of Individuality **Criteria 1:** On November 2, 2017, LPN #1 was educated on importance of knocking and introducing one's self prior to entering resident's room by DON.	

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F 241	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to knock on the door or announce themselves when entering the room of 1 of 25 residents (Resident #12). The findings included: The facility staff failed to knock on the door or announce themselves before entering Resident #12's room. The surveyor reviewed Resident #12's clinical record on 10/31/17 and 11/1/17. Resident #12 was admitted to the facility 3/10/17 and readmitted 6/16/17 with diagnoses that included but not limited to urine retention, urinary tract infection, peripheral vascular disease, deep tissue injury, atrial fibrillation, hyperlipidemia, cerebral infarction, dysphagia, hemiplegia, hypertension, Vitamin D deficiency, Vitamin B12 deficiency, constipation, chronic pain, pneumonia, and severe sepsis with septic shock. Resident #12's significant change in minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/24/17 assessed the resident with short term memory problems, long term memory problems, and severely impaired cognitive skills for daily decision making. Section G Functional Status assessed Resident #12 to require extensive assistance of 2 staff for bed mobility and assessed the resident with an impairment on one side that involved both extremities. The surveyor and licensed practical nurse observed Resident #12 on 10/31/17 at 10:14 a.m.	F 241	**Criteria 2:** DON educated staff on November 2, 2017 on importance of knocking and introducing self prior to entering resident's room. **Criteria 3:** DON or designee will provide education to staff regarding dignity and respect of residents by November 30, 2017 and during new hire orientation thereafter. Nursing admin or designee will monitor a sample of staff weekly to ensure accuracy. **Criteria 4:** This education and audit will be presented to ED weekly by DON or designee. Results of audits will be presented and reviewed by facility QA committee monthly for further intervention or recommendation as necessary. **Criteria 5:** December 16, 2017	

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F 241	Continued From page 12 when the surveyor asked L.P.N. #1 to check the resident's Foley catheter. L.P.N. #1 entered Resident #12's room without knocking or announcing herself and went directly to the left side of the bed to check the Foley catheter. The surveyor observed wound care on 11/01/17 at 1:40 p.m. with licensed practical nurse #1 providing the wound care and certified nursing assistant #3 assisting in the care. L.P.N. #1 had gathered the wound care supplies from the treatment cart and along with C.N.A. #1 entered the resident's room without knocking or announcing themselves and proceeded to provide wound care to Resident #12. The surveyor informed the administrative staff of the above failure to knock on Resident #12's door before entering in the end of the day meeting on 11/2/17 at 12:18 p.m. No further information was provided prior to the exit conference on 11/2/17.	F 241		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, facility	F 246	F 246 Reasonable Accommodation of Needs/Preferences **Criteria 1:** Care plan for Resident #6 was updated to reflect that resident does not utilize call bell, but instead yells out when something is needed. **Criteria 2:** During weekly checks of ambassador room assignments, department managers or designees will monitor for proper location of call bells and will be corrected if deemed necessary.	

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F 246	Continued From page 13 staff failed to ensure call bells were accessible to 2 of 25 residents in the survey sample (Resident # 6 and Resident # 10). Findings included: 1. Facility staff failed to ensure that call bells were accessible to Resident #6. Resident # 6 was originally admitted to the facility on 2/16/15 with a readmission date of 12/15/16. Diagnoses included but not limited to: chronic diastolic congestive heart failure, hypothyroidism, chronic kidney disease stage 3, and hypertension. The most recent MDS (minimum data set) assessment was quarterly assessment with an ARD (assessment reference date) of 10/13/17. Facility staff documented Resident # 6's cognitive status was severely impaired with a cognitive score of 6 out of 15. The clinical record for Resident #6 was reviewed on 10/31/17 at 9:30 a.m. According to the most recent quarterly MDS assessment with an ARD of 10/13/17, the facility staff had documented Resident # 6 requires extensive assist of 2 persons with bed mobility. A review of the current plan of care for Resident #6 had "call light within reach" as an intervention listed in problem areas that included but not limited to: risk of urinary tract infection due to incontinence, self-care deficit requires assistance with ADL's (activities of daily living) related to generalized weakness and debility, resident does have a history of cva (cerebrovascular accident), and at risk for pain related to multiple chronic disease processes, resident has a diagnosis of chronic pain. On 10/31/17 at 12:15 p.m., Resident # 6 was	F 246	**Criteria 3:** DON or designee will provide education to facility staff regarding proper location of call bells and resident respect and dignity by November 30, 2017. Department managers or designees will do weekly checks of ambassador room assignments to ensure accuracy. **Criteria 4:** Department managers or designees will present audit results to ED weekly. Results of audits will be presented and reviewed by facility QA committee monthly for further intervention or recommendation as necessary. **Criteria 5:** December 16, 2017	

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observed lying in bed. Her call bell was observed hanging down on the left side of the bed near the floor out of the reach of the resident.

On 11/1/17 at 8:10 a.m., Resident # 6 was observed lying in bed asleep. Her call bell was observed hanging down the left side of her bed on the floor.

On 11/1/17 at 11:35 a.m., surveyor went into room to talk with Resident #6 after she received patient care. The call bell was observed hanging down the left side of the bed near the floor out of Resident # 6's reach.

On 11/1/17 at 1:59 p.m., Resident # 6 was observed lying in bed with her call bell hanging down the left side of her bed near the floor out of her reach.

On 11/2/17 at 7:55 a.m., Resident # 6 was observed by the surveyor lying in bed asleep. Call bell was observed hanging down the left side of the bed on the floor out of her reach.

On 11/2/17 at 12:18 p.m., the administrator, DON (director of nursing), ADON (assistant director of nursing), consultant nurse, regional MDS consultant, and regional director of operations were made aware of the above findings.

No further information regarding this issue was provided to the survey team prior to the exit conference on 11/2/17 at 5:15 p.m.

2. Facility staff failed to ensure that call bells were accessible to Resident #10.

Resident #10 was originally admitted to the facility

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on 2/10/15 with a readmission date of 9/12/15. Diagnoses included but not limited to: major depressive disorder, multiple sclerosis, hyperlipidemia, and constipation. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 10/13/17. Facility staff documented Resident # 10's cognitive status was moderately impaired with a cognitive score of 11 out of 15.

The clinical record for Resident # 10 was reviewed on 10/31/17 at 2:00 p.m. According to the most recent quarterly MDS assessment with an ARD of 10/31/17, the facility staff had documented that Resident # 10 required extensive assistance of 2 persons with bed mobility. A review of the current plan of care for Resident #10 listed "call light within reach" listed as an intervention listed in problem areas that included but not limited to: self-care deficit, risk for and/or complaints of pain related to multiple chronic disease processes including diagnosis of neuropathy, chronic pain, multiple sclerosis and muscle spasms, and history of frequent urinary tract infections.

On 10/31/17 at 7:45 a.m., during the initial tour, Resident # 10 was observed lying in bed with her call bell out of reach hanging down the right side of the bed.

On 10/31/17 at 10:55 a.m., Resident # 10 was observed in bed attempting to dress herself. The call bell was observed out of Resident # 10's reach hanging down the right side of the bed.

On 11/1/17 at 9:25 a.m., Resident # 10 was observed in bed with the call bell hanging down the right side of the bed near the floor. The call

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F 246	Continued From page 16 bell was not within reach of the resident. On 11/1/17 at 9:45 a.m., Resident # 10 was observed in bed with call bell hanging down the right side of the bed on the floor. Call bell was not within reach of the resident. On 11/2/17 at 7:55 a.m., Resident # 10 was observed in bed with the call bell hanging down the right side of the bed near the floor. The call bell was not within reach of the resident. On 11/2/17 at 12:18 p.m., the administrator, DON (director of nursing), ADON (assistant director of nursing), consultant nurse, regional MDS consultant, and regional director of operations were made aware of the above findings. No further information regarding this issue was provided to the survey team prior to the exit conference on 11/2/17 at 5:15 p.m.	F 246		
F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; 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 ensure 2 of 25 residents' adaptive equipment was clean and sanitary (Resident #1 and Resident #14). The findings included:	F 253	F 253 Housekeeping and Maintenance Services **Criteria 1:** On November 2, 2017, Resident #1 wheelchair and Resident #14 wheelchair cushion were cleaned by nursing staff. **Criteria 2:** Nursing admin developed a cleaning schedule to be utilized by the nursing staff on night shift. During weekly checks of ambassador room assignments, department managers or designees will monitor adaptive equipment for cleanliness and will be corrected if deemed necessary.	

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F 253	Continued From page 17 1. The facility staff failed to ensure Resident #1's wheelchair was clean and sanitary. The surveyor reviewed Resident #1's clinical record on 10/31/17 and 11/1/17. Resident #1 was admitted to the facility 1/20/17 with diagnoses that included but not limited to chronic obstructive pulmonary disease, urinary tract infection, chronic pain, depressive episodes, hyperlipidemia, constipation, hypertension, type 2 diabetes mellitus, Vitamin D deficiency, seizures, periodic headaches, and anxiety. Resident #1's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/24/17 assessed the resident with a BIMS (brief interview for mental status) as 11 out of 15. Section G Functional Status assessed the resident's mobility status required a walker or a wheelchair. The surveyor observed the resident on 10/31/17 at 12:35 p.m. eating lunch in the dining room. Resident #1 was sitting in a wheelchair. The surveyor sat to the left of the resident and observed where the spokes connected to a black plastic material, this area had a whitish appearance in the corners. The surveyor observed Resident #1 during the day on 10/31/17 and 11/1/17. The same whitish material was observed again during an interview with the resident on 11/1/17 at 8:50 a.m. The resident was asked if the wheelchair was cleaned by staff. Resident #1 stated she didn't know. "Go ask them." The surveyor interviewed the director of nursing on 11/1/17 at 1:11 p.m. The DON stated housekeeping was responsible for cleaning	F 253	**Criteria 3:** DON or designee will provide education to facility staff regarding cleaning and sanitation of adaptive equipment to include cleaning schedule by November 30, 2017. Department managers or designees will do weekly checks of ambassador room assignments to ensure accuracy. **Criteria 4:** Department managers or designees will present audit results to ED weekly. Results of audits will be presented and reviewed by facility QA committee monthly for further intervention or recommendation as necessary. **Criteria 5:** December 16, 2017	

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F 253	Continued From page 18 resident care equipment and then stated "she might have to get back with me on that." The surveyor requested the facility policy on cleaning resident equipment from the director of nursing. The surveyor interviewed the director of housekeeping other #7 on 11/1/17 at 3:00 p.m. The surveyor asked what department was responsible for the cleaning of resident equipment-wheelchairs, Geri chairs, cushions. Other #7 stated nursing was responsible for cleaning equipment and housekeeping was responsible for resident rooms. The surveyor reviewed the facility policy titled "Cleaning and Disinfection of Environmental Surfaces" on 11/1/17. The policy read in part "Policy Statement Resident-care equipment, including reusable items and durable medical equipment, will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA (occupational safety and health administration) Bloodborne Pathogens Standard." The policy was not specific as to which department was responsible for the cleaning of resident care equipment. The surveyor informed the administrative staff of the above concern on 11/2/17 at 12:18 p.m. No further information was provided prior to the exit conference on 11/2/17. 2. The facility staff failed to ensure Resident #14's wheelchair cushion was clean and sanitary. The surveyor reviewed Resident #14's clinical record 10/31/17 and 11/1/17. Resident #14 was admitted to the facility 1/10/17 with diagnoses that	F 253		

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F 253	Continued From page 19 included but not limited to epilepsy, spastic quadriplegic cerebral palsy, unspecified psychosis, hyperlipidemia, anxiety, gout, Vitamin B deficiency, Vitamin D deficiency, edema, constipation, knee contracture, and unspecified osteoarthritis. Resident #14's quarterly MDS (minimum data set) assessment with an assessment reference date (ARD) of 11/2/17 assessed the resident with a BIMS (brief interview for mental status) of 13 out of 15. Section G Functional Status was marked that Resident #14 normally used a wheelchair for mobility. Resident #14's current comprehensive care plan with the problem onset of potential for skin breakdown dated 1/24/17 included the following approaches to care: Pressure relieving devices/equipment as needed. The surveyor observed Resident #14 on 10/31/17 at 12:34 p.m. in the dining room. The resident was sitting in a wheelchair with a cushion underneath him. On the left side of the wheelchair cushion, the surveyor noticed a white material on the left side. The surveyor asked registered nurse #2 who was sitting at the table how often resident's equipment was cleaned and when Resident #14's cushion was last cleaned. R.N. #1 stated "Not cleaned in the last 3 days evidently." The surveyor interviewed the director of nursing on 11/1/17 at 1:11 p.m. The DON stated housekeeping was responsible for cleaning resident care equipment then stated "she might have to get back with me on that." The surveyor requested the facility policy on cleaning resident	F 253		

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F 253	Continued From page 20 equipment from the director of nursing. The surveyor interviewed the director of housekeeping other #7 on 11/1/17 at 3:00 p.m. The surveyor asked what department was responsible for the cleaning of resident equipment-wheelchairs, Geri chairs, cushions. Other #7 stated nursing was responsible for cleaning equipment and housekeeping was responsible for resident rooms. The surveyor reviewed the facility policy titled "Cleaning and Disinfection of Environmental Surfaces" on 11/1/17. The policy read in part "Policy Statement Resident-care equipment, including reusable items and durable medical equipment, will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA (occupational safety and health administration) Bloodborne Pathogens Standard." The policy was not specific as to which department was responsible for the cleaning of resident care equipment. The surveyor informed the administrative staff of the above concern on 11/2/17 at 12:18 p.m. No further information was provided prior to the exit conference on 11/2/17.	F 253		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate	F 278	F 278 Assessment Accuracy/Coordination/Certified **Criteria 1:** Resident is over the age of 65. On November 2, 2017, Resident #10 RP was notified and gave consent for vaccine to be administered.	

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F 278	Continued From page 21 participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure an accurate MDS for 1 of 25 residents in the survey sample, Resident # 10. The findings included: The facility staff inaccurately coded a pneumococcal vaccine as being up to date on the MDS for Resident # 10.	F 278	**Criteria 2:** MDS assessments will be reviewed by MDS coordinator for accuracy and will be corrected if deemed necessary. **Criteria 3:** DON or designee will provide education to MDS coordinators and nursing staff regarding MDS accuracy and completion of assessments by November 30, 2017. MDS will do a review/audit of admissions, readmissions, and residents with changes in condition sample weekly to ensure accuracy. **Criteria 4:** MDS coordinator will review results of audits to ED weekly. ED will present results of audits to facility QA committee monthly and reviewed for further intervention or recommendation as necessary. **Criteria 5:** December 16, 2017	

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F 278	Continued From page 22 Resident # 10 was originally admitted to the facility on 2/10/15 with a readmission date of 9/12/15. Diagnoses included but not limited to: dementia, multiple sclerosis, major depressive disorder, polyneuropathy, and hyperlipidemia. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 10/13/17. The facility staff coded Resident # 10's cognitive status as 11 out of 15 indicating moderate impairment. Resident # 10 was also coded on the MDS as having a BIMS (Brief Interview for Mental Status) score of 11 out of a possible 15. The clinical record was reviewed on 10/31/17 at 2:00 p.m by the surveyor. The signed physician's orders dated 10/7/17 had orders that stated "may have pneumovax 0.5 cc upon admission and every 5 years (unless otherwise indicated or received in the last 5 years)." Upon review of the face sheet it was noted that Resident # 10 last received a pneumococcal vaccine on 10/12/12. In Section O of the quarterly MDS with an ARD of 10/13/17, specifically O0300A, the question reads "is the pneumococcal vaccination up to date?" The facility staff coded "yes." On 10/31/17 at 2:48 p.m., the survey team met with the administrator and the DON (director of nursing) and made them aware of these findings. Surveyor asked DON who monitors and keeps up with the facility vaccinations. DON stated "to be completely honest I had a notebook on my desk doing audits on the vaccines and then you guys walked in and it got pushed to the side." DON stated that she would follow up on the situation. On 11/2/17 at 8:55 a.m. DON reported to	F 278		

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F 278	Continued From page 23 surveyor that the facility was contacting the family representative for Resident # 10 to obtain consent to administer the pneumonia vaccine. On 11/2/17 at 3:42 p.m. DON verbally reported to surveyor that the family representative for Resident # 10 had given consent and that the facility would administer the pneumococcal vaccine to Resident # 10. No further information regarding this issue was reported to the survey team prior to the exit conference on 11/2/17 at 5:15 p.m.	F 278		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan	F 280	F 280 Right to Participate Planning Care - Revise CP **Criteria 1:** On November 2, 2017, Resident #13s care plan was updated. Also on November 2, 2017, non-pharmacological special requirement was added for all pain and anxiety medications to be completed prior to administration of medication. **Criteria 2:** DON and nursing admin added special requirement for non-pharmacological interventions for pain and anxiety medications to be completed prior to administration of medication.	

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F 280	Continued From page 24 of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 280	**Criteria 3:** DON or designee will provide education to facility staff regarding care plan updates and non-pharmacological interventions by November 30, 2017. DON or designee will conduct an audit weekly to ensure special requirements for non-pharmacological interventions are added to admissions, readmissions, and residents with changes in condition. **Criteria 4:** DON or designee will review results of audits to ED weekly. ED or designee will present results of audits to facility QA committee monthly to be reviewed for further intervention or recommendation as necessary. **Criteria 5:** December 16, 2017	

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F 280	Continued From page 25 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to review and revise the CCP (Comprehensive Care Plan) for 2 of 17 residents in the survey sample (Residents #13 and #19). The findings included: 1. The facility staff failed to review and revise the CCP (Comprehensive Care Plan) for Resident #13's refusal of care. Resident #13 was admitted to the facility on 1/19/17 with the following diagnoses of, but not limited to Alzheimer's Disease, high blood pressure, Parkinson's Disease, heart failure, dementia and diabetes. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/10/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 3 out of a possible score of 15. Resident #13 also was coded as requiring	F 280		

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F 280	Continued From page 26 assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing. The clinical record was reviewed by the surveyor on 11/1 and 11/2/17. During this review, the surveyor noted in the nurses' notes dated and timed for 10/6/17 at 2:55 am which stated " ...Did refuse medications and to have blood sugar obtained ..." On 10/5/17 at 9:25 pm another nurses' note stated " ...Patient refused medications and care ..." The surveyor continued to note further documentation throughout Resident #13's clinical record of the resident refusing care and medications on different episodes. The surveyor also reviewed the resident's MAR (Medication Administration Record) for the month of October, 2017 and it was noted that there was documentation made by the nursing staff as to the resident refusing to take his medications and/or having his blood sugar obtained. These refusals were noted to be on different days and times for the month that was reviewed. On 11/2/17 at 2 pm, the director of nursing (DON) was notified of the above documented findings by the surveyor. The DON read over the resident's CCP and stated," I know that he does refuse care or his meds (medications) a lot and you are exactly right, it is not on his care plan." No further information was provided to the surveyor prior to the exit conference on 11/2/17 at 5:15 pm. 2. The facility staff failed to review and revise the CCP (Comprehensive Care Plan) for	F 280		

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F 280	Continued From page 27 Resident #19 in regards in having non-pharmacological interventions of pain that were appropriate for this resident. Resident #19 was admitted to the facility on 10/11/17 with the following diagnoses of, but not limited to atrial fibrillation, heart failure, high blood pressure, diabetes, thyroid disorder, other fractures, stroke, muscle weakness and Cirrhosis. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/17/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. Resident #19 was also coded as requiring extensive assistance of 2 staff members for dressing and personal hygiene and being totally dependent on 1 staff member for bathing. The surveyor conducted a review of Resident #19's clinical record on 11/2/17. The surveyor noted that the resident had a physician order for "Tramadol HCL 50 mg (milligram) Take one by mouth every 8 hours as needed for pain. (sic)". The surveyor also reviewed the resident's CCP. During this review, the surveyor noted that the resident had been care planned for pain which stated the following under Problem/Need: "I am at risk for pain r/t (related to) ...Rheumatoid Arthritis, Fracture right femoral, Fractured left tibular (sic)". The following interventions/approaches were noted as follows: " "Call light within reach " Medications as ordered by the physician " Labs as ordered, report results to MD (medical doctor) " Document effectiveness of any prns (as needed medications) administrated " Document and alert MD to any significant	F 280		

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F 280	Continued From page 28 changes related to pain " Assistive devices as ordered " Pain assessment on admission, and as directed by facility " Encourage/escort me out of my for room activities (sic)." The surveyor also noted the following care planed for Resident #19 under "Diversional activity deficit": "Problem/Need Due to my 2 broken legs I am in constant pain I do not wish to attend group activities I prefer to read & concentrate on therapy & getting well (sic)." The following interventions/approaches were noted as follows: " "Place activity calendar in each room, on bulletin board and in activity room " Staff to address resident by name at all times " Staff to introduce themselves to resident with each contact " Provide one-on-one visits in quiet location when resident is unable to tolerate group activities setting " If resident is reluctant to attend activities with others, visit and discuss to identify reasons " Provide structured activity program for intellectual stimulation " Provide brief activities for resident" On 11/2/17 at approximately 3 pm, the director of nursing (DON) was asked by the surveyor to read the resident's care plan for pain and activities for Resident #19. The DON read over the care plan in these areas and stated "These two don't match. In the pain area, the resident says she doesn't want to leave her room and in another area the resident is care planned for attending and encouraging group activities." No further information was provided to the	F 280		

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F 280	Continued From page 29 surveyor prior to the exit conference on 11/2/17 at 5:15 pm.	F 280	F 281 Services Provided Meet Professional Standards	
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: 2. The facility staff failed to follow standards of professional practice for Resident #23 for medication administration. The facility staff failed to obtain an apical pulse prior to the administration of the medication Digoxin. The clinical record of Resident #23 was reviewed 11/2/17. Resident #23 was admitted to the facility 8/14/17 with diagnoses that included but not limited to hypokalemia, unspecified atrial fibrillation, pleural effusion, hyperlipidemia, hypertension, unspecified dementia without behavioral disturbances, adult failure to thrive, anemia, acute kidney failure, chronic kidney disease, and dysphagia. Resident #23's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/20/17 assessed the resident with a BIMS (brief interview for mental status) as 09 out of 15. Resident #23's August 2017 and September 2017 physician orders read "Digoxin 125 mcg	F 281	**Criteria 1:** On November 2, 2017, wound nurse assessed area to right lower buttock, applied barrier cream and wrote communication to physician. On November 3, 2017 physician also assessed area and determined that area was blanchable and to continue applying barrier cream as ordered. **Criteria 2:** Audit was conducted by DON on November 17, 2017 for every resident receiving Digoxin to ensure special requirement or fixed parameter was in place and for accurate completion. Skin assessment/check schedule was created and will be monitored for completion and accuracy. **Criteria 3:** DON or designee will provide education by November 30, 2017 to nursing staff regarding standards of practice for medication administration and accurately performing a nursing skin assessment/check. DON or	

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F 281	Continued From page 30 (micrograms) by mouth daily." A review of the electronic medication administration record (eMAR) for August 2017 and September 2017 found that there was no documentation showing that staff had obtained Resident #23's apical pulse prior to administration of the digoxin. The director of nursing (DON) was asked what the standard of practice was before administering the drug digoxin. The DON stated hold the drug if the apical pulse was less than 60. "We learned that in school." The surveyor asked for the facility standards for administering medications. The DON stated the standards of practice for the administration of Digoxin was the facility policy. The director of nursing provided the surveyor the facility policy for administering medications on 11/1/17 at 1:15 p.m. The policy read "If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication shall contact the resident's Attending Physician or the facility's Medical Director to discuss the concerns." According to the facility drug handbook, Wolters Kluwer, 2018 Nursing Drug Handbook, 38th edition, pages 457-459, digoxin is a cardiac glycoside and anti-dysrhythmic medication which increases cardiac output and decreases heart rate. Before giving the drug, take apical-radial pulse for 1 minute. Record and notify prescriber of significant changes (sudden increase or decrease in pulse rate, pulse deficit, irregular	F 281	designee will review/audit all new admissions, readmissions, and residents with changes in condition related to Digoxin to ensure accuracy and completion of special requirement or fixed parameter. All residents are at risk by the above mentioned alleged deficient practice. Skin assessment/check schedule was created and will be monitored weekly by DON or designee for completion and accuracy. **Criteria 4:** DON or designee will review results of audits with ED. ED or designee will present audits to facility QA committee monthly to be reviewed for further intervention or recommendation as necessary. **Criteria 5:** December 16, 2017	

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F 281	Continued From page 31 beats and, particularly, regularization of a previously irregular rhythm). Potter and Perry's, Fundamentals of Nursing, 6th edition (pg. 643) states, "Apical pulse less than 60 beats/min (bradycardia). Assess for the presence of factors that may alter heart rate (e.g., digoxin or other cardiac medications. It may be necessary to withhold prescribed medications until the physician can evaluate the need to adjust the dose." The surveyor informed the administrative staff on 11/2/17 at 12:18 p.m. of the concern with no apical pulses prior to the administration of Digoxin on Resident #23. No further information was provided by the facility prior to the exit on 11/2/17. Based on observation, resident interview, staff interview, facility, document review, and clinical record review, the facility staff failed to follow standards of professional practice for 2 of 25 residents in the survey sample, Resident # 6 and Resident # 23. Findings included: 1. Facility staff failed to identify and assess an open area to right lower buttock and assess pain and implement interventions for Resident # 6. Resident # 6 was originally admitted to the facility on 2/16/15 with a readmission date of 12/15/16. Diagnoses included but not limited to: chronic diastolic congestive heart failure, hypothyroidism, chronic kidney disease stage 3, and hypertension. The most recent MDS (minimum data set) assessment was a quarterly	F 281		

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assessment with an ARD (assessment reference date) of 10/13/17. The facility staff documented Resident # 6's cognitive status was severely impaired with a cognitive score of 6 out of 15.

The clinical record for Resident #6 was reviewed on 10/31/17 at 9:30 a.m. Upon review of the most recent MDS with an ARD of 10/13/17 it was documented by the facility staff in section M0150 that Resident #6 was at risk for developing pressure ulcers. Section M1040 H. facility staff documented that Resident # 6 had moisture associated skin damage. In section M1200 facility staff documented pressure reducing device for bed and applications of ointments/medications other than to feet as skin and ulcer treatments.

On 11/1/17 at 11:13 a.m., Resident # 6 was observed by the surveyor lying in her bed flat on her back.

On 11/1/17 at 11:15 a.m., LPN (licensed practical nurse) #1 was preparing to provide treatment to Resident #6's buttocks. LPN #1 tells surveyor "she usually gets Greer's goo but we are out of it and waiting on it to come from the pharmacy in Richmond." I have an order to use house barrier cream until it comes in." LPN #1 states she gets MASD (moisture associated skin damage) a lot because she is non-compliant with turning. Surveyor asked LPN #1 if Resident # 6 was able to turn herself? LPN #1 stated "no."

On 11/1/17 at 11:19 a.m., LPN #1 assisted by CNA #1 (certified nursing assistant) began to administer treatment to Resident # 6's buttocks. When CNA #1 touched Resident # 6 on her right thigh to assist her in turning, Resident #6 stated "ooh my butt." CNA #1 along with LPN #1 turned

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F 281	Continued From page 33 Resident # 6 on her left side. LPN #1 began to wash Resident #6's bottom with soap and water. Resident # 6 flinched as soon as her buttocks were touched by the treatment nurse. Resident # 6 stated "it's hurting my butt." LPN#1 continued to wash Resident #6's buttocks but started patting the area instead of washing in circular motion. Resident # 6 then stated "she's hurting me." Surveyor observed areas on the buttocks of Resident # 6 as follows: red area on right lower buttock in the fold, one open area right upper buttock, small open area in the crease in between both buttocks and 2 open areas on left buttock. There was redness noted to bilateral buttocks. LPN #1 pressed an area on the left buttock to show that the area was blanchable. LPN #1 then applied Derma Septin house barrier cream to Resident #6's buttocks. Resident #6 stated "that hurts" during the application of the Derma Septin. The facility staff did not stop at any time during the procedure to assess Resident # 6 for pain or provide interventions. LPN#1 and CNA #1 assisted Resident #6 with turning to her left side and a pillow was placed on the right side of her back. On 11/1/17 at 12:15 p.m. the survey interviewed LPN # 1 regarding Resident #6's pain during the treatment. LPN #1 stated that Resident #6 "always complains of pain." "She's one that if you just touch her she will say it hurts so you don't know if it's her or if it's in her mind." The survey team asked the LPN #1 what you are supposed to do if a resident complains of pain? LPN #1 stated that "you notify the doctor that the resident needs to be reassessed for their pain meds." The survey team asked LPN #1 why she did not stop to assess the resident during the treatment when	F 281		

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she complained of pain? LPN #1 stated that she did not know that she could stop while the surveyors were watching. The DON was in the meeting with the LPN #1 and told LPN #1 "this is a lesson learned, when a resident complains of pain, you stop and reassess."

On 11/2/17 at 10:30 a.m. 3 surveyors observed incontinence care of Resident #6 after consent was given by the resident. LPN #1verbally informed surveyors that Resident #6 had been premedicated with Lortab and topical Lidocaine. LPN #1 made surveyors aware that the Greer's goo was now in the facility to be applied as ordered. LPN #1 assessed resident's pain level prior to initiating treatment and Resident #6 denied having pain. Resident #6 was turned on her left side with assist of 2 persons, LPN #1 and CNA #3. When CNA #3 touched Resident #6's bottom to wash her bottom Resident #6 flinched and stated "it hurts." The facility staff stopped to assess resident and asked Resident #6 if she wished for them to continue treatment. Resident # 6 stated "try to." When CNA #3 continued to wash the area to the buttocks, Resident # 6 flinched again and stated "it hurts in that spot." Facility staff stopped treatment and assessed the resident. CNA #3 touched an area on Resident #6's bottom and asked "is this where it hurts?" Resident #6 stated "no." CNA #3 touched another area on Resident # 6's bottom and asked "is this where it hurts?" Resident #6 stated "no." CNA #3 touched a different area on Resident #6's buttocks and Resident # 6 immediately flinched and stated "yes." The facility staff stopped to assess the resident and asked the resident if she wished for them to continue treatment. Resident #6 stated "yes." LPN #1 was asked by surveyors how the area to Resident #6's buttocks looked in

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F 281	Continued From page 35 comparison to yesterday? LPN #1 stated that the areas on Resident #6's bottom looked better than yesterday. LPN#1 stated "they were more red yesterday." LPN #1 applied Greer's Goo to Resident #6's bottom and Resident #6 flinched during application. LPN #1 asked Resident #6 if she wanted her to stop and Resident # 6 stated "no." LPN #1 then stated that the area to the right lower buttock in the fold was new and that she did not see it yesterday. LPN #1 changed gloves, sanitized her hands and donned new gloves. LPN #1 attempted to touch the area to see if the area blanched, but Resident #6 flinched and complained of pain. LPN #1 stated that she will use house barrier cream on the area and notify the doctor that the area needs to be assessed. LPN # 1 placed Derma Septin to the area on the right lower buttock in the fold. The area to Resident # 6's right lower buttock was observed by the surveyor on 11/1/17 during treatment. On 11/2/17 at 11:50 a.m., the survey team conducted an interview with CNA #1 who was the CNA assisting the treatment nurse with wound care on 11/1/17 at 11:19 a.m., CNA #1 was asked about the areas on Resident #6's buttocks. CNA#1 did report that she saw the area on Resident #6's right lower buttock. The survey team asked CNA #1 if the area was open. CNA # 1 stated "honestly I can't say if it was open or not." Surveyor then asked CNA # 1 about Resident #6's pain level during the treatment on 11/1/17 at 11:15 a.m. CNA #1 stated "even before you touch her she will say you are hurting her." "I think it's just from memory." Surveyor asked CNA#1 what she would do if she was washing a resident and they complained of pain? CNA # 1 stated that she would report it to the nurse. CNA #1 stated that "LPN # 1 stops." The surveyor then	F 281		

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F 281	Continued From page 36 asked CNA # 1 "that's not what happened yesterday is it?" CNA # 1 stated "no." According to the current physician's orders for November 2017, Resident # 6 had current orders that stated "masd to bilateral buttocks, clean with soap and water, pat dry, apply greers goo with every incontinent episode until resolved." The facility provided the surveyor with the documentation of the assessments of the areas to Resident #6's buttocks since treatment was initiated. In a note dated 7/14/2017 at 4:22 p.m., the note that stated "new order for treatment to buttocks and bilateral thighs and sacrum, cleanse, apply house barrier cream bid (two times daily) and with each brief change due to severe moisture associated skin damage." A note that was written on 7/20/17 at 10:09 AM that was a late entry for 7/19/2017 stated "this nurse was notified by nursing staff regarding resident's MASD to buttocks/sacrum worsening. Upon assessment resident was observed to have several small excoriated areas that were noted to have large amount of redness that was blanchable upon assessment. No s/s (signs or symptoms) of infection noted upon assessment. Resident did not express any pain during assessment or wound care treatment. Encouraged resident to limit time in w/c (wheelchair) during day and to off-load and reposition while in bed to help prevent further injury and promote healing. Resident also has air-overlay to mattress to help with pressure relief and promote wound healing Resident is observed to have adequate nutrition at this time to aide in wound healing as well. N.O. (new order) from MD (medical doctor) to clean with soap and water and	F 281		

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F 281	Continued From page 37 apply Greer's goo with every incont. (incontinent) episode until resolved. Will continue to monitor for any acute changes." A note written on 7/31/2017 at 1:38 PM stated "remains on skilled for nursing and rehab alert to person confused to time and place feeds self appetite varies up with lift sits in wheelchair no voiced complaints offered incont (incontinent) of bladder and bowels buttocks healing." A note written on 8/10/2017 at 1:15 PM stated "remains skilled for nursing and rehab alert to person confused to time and place can make her needs known skin warm and dry color good no voiced complaints offered po (by mouth) fluids encouraged abd (abdomen) soft bowel sounds x4 no cough lungs clear x4 uses nasal 02 at 2 liters incontinent of bladder and bowels bottom cont's (continues) to heal." The surveyor reviewed the weekly skin assessments that was provided by the facility a weekly skin assessment dated 8/4/17 was reviewed and read under comments "tx (treatment) current to buttocks, 8/11/17 under comments "tx current on sacrum and buttocks",8/19/17 under comments "tx current on sacrum and buttocks",8/25/17 under comments " tx current to buttocks areas", 9/1/17 under comments " tx current to buttocks areas",9/8/17 under comments "tx current to buttocks", 9/16/17 under comments "tx current to buttocks", 9/22/17 under comments " current tx to buttocks and peri groin", 9/29/17 under comments "tx current to buttocks and peri groin", 10/14/17 under comments "tx current to buttocks and peri groin" and 10/27/17 under comments "tx current to buttocks and peri groin."	F 281		

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F 281	Continued From page 38 Per the facility "Pressure Ulcer Risk Assessment Policy", "Skin will be assessed for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated." The policy also states "staff will perform routine skin inspections (with daily care)." "Nurses are to be notified to inspect the skin if changes are identified." "Nurses will conduct skin assessments at least weekly to identify changes." Per the facility "Wound Care Policy" under documentation it stated "The following information should be recorded in the resident's medical record 1. The type of wound care given. 2. The date and time the wound care was given. 3. The position in which the resident was placed. 4. The name and title of the individual performing wound care. 5. Any change in the resident's condition. 6. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. 7. How the resident tolerated the procedure. 8. Any problems or complaints made by the resident related to the procedure. 9. If the resident refused the treatment and the reason(s) why. 10. The signature and title of the person recording the data." On 11/2/17 at 12:18 p.m. the DON, ADON (assistant director of nursing), administrator, consultant nurse, regional mds consultant, and regional operations manager were made aware of the above findings. The DON made the survey team aware at this time that the facility policies were also the facility standard of practice.	F 281		

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F 281	Continued From page 39 No further information regarding this issue was presented to the survey team prior to the exit conference on 11/2/17 at 5:15 p.m.	F 281		
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards	F 309	F 309 Provide Care/Services for Highest Well Being **Criteria 1:** On November 2, 2017, non-pharmacological special requirement was added for all pain and anxiety medications to be completed prior to administration of medication. On October 31, 2017, DON presented survey team with copy of 72 hour BM report with written interventions that were put in place for Resident #4. On November 1, 2017, physician for Resident #5 was notified regarding lab drawn on incorrect date, physician stated that lab obtained on October 24th was sufficient to discontinue order for the 21st. On November 1, 2017, clarification order received for Resident #12 NPO except for honey thick liquids per ST recommendations. On November 1, 2017 order obtained for Resident #6 to obtain and apply EMLA cream 30 minutes prior to wound treatment.	

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F 309	Continued From page 40 of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: 3. For Resident #2, the facility staff failed to provide any non-pharmacological interventions prior to administering pain medication and failed to follow the bowel protocol. The record review revealed that Resident #2 had been admitted to the facility 01/04/2017. Diagnoses included, but were not limited to, anxiety, hypertension, seizures, congestive heart failure, and bipolar disorder. Section C (cognitive status) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 09/05/2017 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section H (bladder and bowel) was coded to indicate the Resident was always continent of bladder and occasionally incontinent of bowel. Section I (active diagnoses) included constipation. Section J (health conditions) was coded to indicate the Resident had received pain medication but had not received any non-medication interventions. The Residents CCP (comprehensive care plan) included the problems area at risk for constipation interventions included initiate standing order for constipation on the third day of no bowel movement and at risk for pain. A review of the Residents current orders revealed that Resident #2 was receiving miralax powder 17 grams every morning for slow transit constipation.	F 309	**Criteria 2:** Nursing staff will monitor BM reports daily and follow bowel protocol according to the standing orders. Physician orders will be reviewed as part of monthly review to ensure accuracy of current orders. Orders will be clarified and MD notified of any medication errors. Special requirement for non-pharmacological interventions were added on November 2, 2017 for pain and anxiety medications to be completed prior to administration of medication. **Criteria 3:** DON or designee will provide education to nursing staff by November 30, 2017 in regard to importance of CNA documentation of bowel movements, nurse monitoring of BM reports, and process of utilizing bowel protocol from physician standing orders. DON or designee will provide education by November 30, 2017 to nursing staff on the eight rights of medication administration, order clarification, and physician notification. DON or designee will	

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F 309	Continued From page 41 Resident #2 was receiving colace 100 mg twice a day up until 10/24/2017 for constipation when it was changed to senna 8.6 mg two tablets by mouth once daily. A review of the Residents BM (bowel movement) records for October revealed that the Resident was coded as having a BM on 10/02/2017 and again on 10/20/2017. The surveyor interviewed Resident #2 on 10/31/2017 at approximately 12:50 p.m. Resident #2 verbalized to the surveyor that her bowels did not move like they should. The facility had standing orders regarding "Constipation: These are the steps to follow in the order given: If no bowel movement in 3 days. 1. MOM (milk of magnesia) 30 cc PO (by mouth) QD (everyday) PRN (as needed) for constipation-if no results within 8-12 hours, do Suppository. 2. Biscadoly 10mg suppository (Ducolax) 1 PR (per rectum) QD PRN for constipation if no results within 8-12 hours do enema. 3. If no results from #1 or #2 administer fleets enema X1 not (notify) MD (medical doctor)." The facility did not provide the surveyor with any information indicating the standing order protocol had been followed. During a meeting with the survey team on 10/31/2017 at approximately 2:45 p.m. the administrative team were notified of the concerns regarding Resident #2's BM's the DON (director of nursing) verbalized to the survey team that the Resident self-initiated going to the bathroom and that the staff monitored the Residents bowel	F 309	monitor BM reports to identify residents for whom interventions may need to be initiated and document follow-up has been completed daily. DON or designee will then verify that the resident is no longer being identified on the report. Supervisor will review order entry on new orders followed by the ADON/DON review of orders, corrections to be documented daily. Audits will be conducted for 30 days. **Criteria 4:** DON or designee will review results of audits with ED. ED or designee will present audits to facility QA committee monthly to be reviewed for further intervention or recommendation as necessary. **Criteria 5:** December 16, 2017	

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F 309	Continued From page 42 sounds. The DON also stated it appeared as if there had been a malfunction in their computer system. Resident #2 had been prescribed the pain medications norco 5/325 mg one every 6 hours as needed for pain and percocet 5/325 mg one every 6 hours as needed for pain. Per the eMAR (electronic medication administration record) Resident #2 had received the norco 31 times in October and the percocet 7 times. The surveyor was unable to locate any information to indicate the Resident had been offered any non-pharmacological interventions prior to administering the pain medications. The administrative team was asked about any non pharmacological interventions prior to administering the pain medications during a meeting with the survey team on 10/31/2017 at approximately 2:45 p.m. No further information regarding either one of these issues was provided to the survey team prior to the exit conference. 4. For Resident #4, the facility failed to follow the Residents bowel protocol. The record review revealed that Resident #4 had been admitted to the facility 02/04/2016. Diagnoses included, but were not limited to, dementia with behavioral disturbances, Alzheimer's disease, diabetes, hypertension, and hypothyroidism. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of	F 309		

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F 309	Continued From page 43 09/05/2017 was coded 1/1/3 to indicate the Resident had problems with long and short term memory and was severely impaired in cognitive skills for daily decision making. Section H (bladder and bowel) was coded to indicate the Resident was always incontinent of bladder and bowel. A review of the Residents BM (bowel movement) sheets for 09/30-10/31/2017 revealed that Resident #4 had a BM on 10/20/2017 but did not have another BM until 10/26/2017. The facility had standing orders regarding "Constipation: These are the steps to follow in the order given: If no bowel movement in 3 days. 1. MOM (milk of magnesia) 30 cc PO (by mouth) QD (everyday) PRN (as needed) for constipation-if no results within 8-12 hours, do Suppository. 2. Biscadoly 10mg suppository (Ducolax) 1 PR (per rectum) QD PRN for constipation if no results within 8-12 hours do enema. 3. If no results from #1 or #2 administer fleets enema X1 not (notify) MD (medical doctor)." The DON (director of nursing) provided the surveyor with documentation to indicate the facility had provided the Resident with MOM on 10/24/2017. However, when the Resident did not have a BM within 8-12 hours (see above standing orders) the bowel protocol was not followed. The administrative staff were notified of the issue regarding the Residents BM's and the bowel protocol during a meeting with the survey team on 10/31/2017 at approximately 2:45 p.m. No further information regarding this issue was	F 309		

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F 309	Continued From page 44 provided to the survey team prior to the exit conference. 5. The facility staff failed to provide the highest practical well-being for Resident #5. Resident #5 was admitted to the facility on 2/1/17 with the following diagnoses of, but not limited to anemia, high blood pressure, anxiety disorder, depression, end stage renal disease, spinal stenosis and low back pain. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/8/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. Resident #5 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and total dependence of 1 staff member for bathing. The surveyor conducted a review of Resident #5's clinical record on 10/31/17 and 11/1/17. It was noted by the surveyor that on 9/19/17 the following physician order was noted " ...Mucinex q 12 hours x (times) 3 days, Lactulose 15 gram po (by mouth) x 2 days ..." The surveyor reviewed the resident's MAR (Medication Administration Record) for the month of September, 2017. The surveyor noted the following documentation on the MAR: "Mucinex ER (extended release) 600 mg (milligram) by mouth every 12 hours for 3 days for cough." The medication was documented as being given on 9/20/17, 9/21/17 and 9/22/17 at 9 am, 1 pm and 5 pm. "Lactulose 20 GM/30 ML (gramper milliliter) 15 GM by mouth every 12 hours x 2 days" was also noted on the resident's MAR for September, 2017. The staff documented that this medication was given to the resident on 9/20/17 at 9 am and again at 9 pm.	F 309		

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F 309	Continued From page 45 On 11/1/17 at 8:50 am, the surveyor notified the director of nursing (DON) of the above documented findings. The DON stated "Let me look and see how the Mucinex was ordered but the Lactulose was just done wrong." Also during the clinical record review, the surveyor noted that Resident #5 was given "Cyclobenzaprine 5 mg by mouth three times a day as needed for pain/muscle spasms". On the MAR, the staff documented that this medication was given to the resident on 9/12/17 at 4:20 am, 9/14/17 at 2:29 pm, 9/17/17 at 10:57 pm, 9/18/17 at 9:37 am and 9/19/17 at 9:43 am. The surveyor reviewed the nurses' notes of Resident #5 for the above documented dates and times that the Cyclobenzaprine was given. There were no non-pharmacological interventions documented as being used before the administration of the "prn" (as needed) Cyclobenzaprine dose on these dates and times by the staff. On 11/1/17 at 9:20 am, the surveyor notified the assistant director of nursing of the above documented findings. The assistant director of nursing stated "You are right. They didn't document any interventions." At 4:35 pm, the administrative team was notified of the above documented findings by the surveyor. No further information was provided to the surveyor prior to the exit conference on 11/2/17 at 5:15 pm. 6. The facility staff failed to follow the bowel	F 309		

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F 309	Continued From page 46 regimen when Resident #13 had no bowel movements for 3 days. Resident #13 was admitted to the facility on 1/19/17 with the following diagnoses of, but not limited to Alzheimer's Disease, high blood pressure, Parkinson's Disease, heart failure, dementia and diabetes. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/10/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 3 out of a possible score of 15. Resident #13 also was coded as requiring assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing. The clinical record was reviewed by the surveyor on 11/1 and 11/2/17. During this review, the surveyor noted that the resident had no bowel movements documented for 10/12 17 through 10/15/17 and 10/17/17 through 10/21/17. On 11/1/17 at 4:35 pm, the administrative team was notified of the above documented findings by the surveyor. The surveyor requested a copy of the facility's standing orders for bowel regimens. On 11/2/17 at 2:30 pm, the surveyor received a copy of the standing orders for Resident #13. The following was noted on the standing orders under the section of "GI problems": "Constipation: These are the steps to follow in the order given: If no bowel movement in 3 days. 1. MOM 30 cc po (by mouth) QD (every day) PRN (as needed) for constipation-If no results within 8-12 hours do suppository. 2. Bisacodyl 10 mg suppository (Dulcolax) 1 PR (per rectum) QD for constipation. If no results	F 309		

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F 309	Continued From page 47 within 8-12 hours do enema. 3. If no results from #1 or #2 administer fleets enema X1 not (sic) MD." No further information was provided to the surveyor prior to the exit conference on 11/2/17 at 5:15 pm. 7. The facility staff failed to document non-pharmacological interventions prior to the administration of a pain medication for Resident #19. Resident #19 was admitted to the facility on 10/11/17 with the following diagnoses of, but not limited to atrial fibrillation, heart failure, high blood pressure, diabetes, thyroid disorder, other fractures, stroke, muscle weakness and Cirrhosis. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/17/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. Resident #19 was also coded as requiring extensive assistance of 2 staff members for dressing and personal hygiene and being totally dependent on 1 staff member for bathing. The clinical record of Resident #19 was performed by the surveyor on 11/2/17. During this review, the surveyor reviewed the resident's MAR (Medication Administration Record) for the month of October, 2017. The surveyor noted that Resident #19 was given "Tramadol 50 mg (milligram) Take one by (sic) every 8 hours as needed for pain". On the MAR, the staff documented that this medication was given to the resident on 10/13/17 at 8:28 am, 10/15/17 at 11:38 am, 10/18/17 at 9:38 pm, 10/20/17 at 12:54	F 309		

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F 309	Continued From page 48 am, 10/22/17 at 2:16 am, 10/26/17 at 1:23 am, 10/27/17 at 12:12 am, 10/27/17 at 10:27 pm, 10/30/17 at 11:54 pm and 10/31/17 at 11:41 pm. The surveyor reviewed the nurses' notes for Resident #19 on the above dates and times that the "PRN" pain medication, Tramadol was given. There was no documentation of non-pharmacological interventions being used prior to the administration of this pain medication. At approximately 2 pm, the director of nursing was notified of the above documented findings by the surveyor. No further information was provided to the surveyor prior to the exit conference on 11/2/17 at 5:15 pm. 8. The facility staff failed to administer the medication Topamax as ordered by the physician for Resident #1. The surveyor reviewed Resident #1's clinical record on 10/31/17 and 11/1/17. Resident #1 was admitted to the facility 1/20/17 with diagnoses that included but not limited to chronic obstructive pulmonary disease, urinary tract infection, chronic pain, depressive episodes, hyperlipidemia, constipation, hypertension, type 2 diabetes mellitus, Vitamin D deficiency, seizures, periodic headaches, and anxiety. Resident #1's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/24/17 assessed the resident with a BIMS (brief interview for mental status) as 11 out of 15.	F 309		

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F 309	Continued From page 49 A physician order dated 9/7/17 at 3:00 p.m. read "?(increase) Neurontin to 400 mg (milligrams) ? (one) po (by mouth) q (every) 8 hrs (hours). ?Topamax to 100 mg in am (morning) & 150 mg at night x 1 wk (week) then 150 mg ? po bid (twice a day) thereafter." The surveyor reviewed the September 2017 electronic medication administration records on 11/1/17. There were two (2) entries for the night time dose of Topamax. The first entry read "Topamax 100 mg Take 1 tablet at bedtime with 50 mg for total of 150 mg x 1 week. Order Date: 9/07/17 Start Date: 9/08/17 Stop Date: 9/15/17" and the second entry read "Topamax 50 mg Take one by mouth at bedtime with 100 mg for a total of 150 mg x 1 week. Order Date: 9/07/17 Start Date: 9/07/17 Stop Date: 9/14/17. The surveyor reviewed the September 2017 eMAR. Topamax 100 mg was administered at 10:00 p.m. from 9/8/17 through 9/15/17 for a total of 8 doses-not 7 doses or 1 week as ordered. Topamax 50 mg was administered at 10:00 p.m. from 9/7/17 through 9/14/17 for a total of 8 doses-not 7 doses or 1 week as ordered. The surveyor informed the administrative staff of the physician order for Topamax not followed in the end of the day meeting on 11/1/17 at 4:31 p.m. Upon reviewing the September 2017 eMAR, the regional minimum data set registered nurse stated the resident received too many of the Topamax. No further information was provided prior to the exit conference on 11/2/17.	F 309		

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F 309	Continued From page 50 9. The facility staff failed to administer Cipro and Amoxicillin as ordered by the physician and failed to ensure the correct order for consistency of fluids was placed in Resident #12's cooler. The surveyor reviewed Resident #12's clinical record on 10/31/17 and 11/1/17. Resident #12 was admitted to the facility 3/10/17 and readmitted 6/16/17 with diagnoses that included but not limited to urine retention, urinary tract infection, peripheral vascular disease, deep tissue injury, atrial fibrillation, hyperlipidemia, cerebral infarction, dysphagia, hemiplegia, hypertension, Vitamin D deficiency, Vitamin B12 deficiency, constipation, chronic pain, pneumonia, and severe sepsis with septic shock. Resident #12's significant change in minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/24/17 assessed the resident with short term memory problems, long term memory problems, and severely impaired cognitive skills for daily decision making. Section G Functional Status assessed Resident #12 to require extensive assistance of 2 staff for bed mobility and assessed the resident with an impairment on one side that involved both extremities. (a). Resident #12 had a physician order dated 9/30/17 that read "1. Stop Invanz. 2. Start Amoxicillin suspension 500 mgs (milligrams) q (every) 12 hours per PEG (tube in the stomach that delivers food, medicines, or fluids) x 10 days for UTI (urinary tract infection)." The surveyor reviewed the September 2017 and October 2017 electronic medication administration record on 11/1/17. The order for	F 309		

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F 309	Continued From page 51 Amoxicillin had been entered onto the September 2017 eMAR with an order date of 9/30/17 and a start date of 10/1/17. The surveyor reviewed the October 2017 eMAR. The entry on 1/1/17 at 9:00 a.m. had a "star" in the box. The next entry at 9:00 p.m. had a "N". Resident #12 had been sent to the emergency room on 10/1/17 and returned on 10/2/17 at 1238 a.m. Resident #12 then received 18 doses of Amoxicillin from 10/2/17 at 9:00 a.m. through 10/10/17 at 9:00 p.m. However, the physician order was for 10 days-not 9 days as administered. The surveyor requested the contents of the stat box from the director of nursing and the pharmacy manifest for Amoxicillin on 11/1/17. The stat box list was reviewed on 11/2/17 with the director of nursing. Amoxicillin 250 mg capsule was in the stat box. The DON stated for Resident #12 the order was for the suspension and that was not in the stat box. The pharmacy manifest for Amoxicillin was reviewed on 11/2/17. The manifest read "Amoxicillin Sus (suspension) 250 mg/5 ml (milliliter) ***Sent 100 ml on 10-2-17 per AJR***." The manifest did not have a time stamp." The surveyor informed the administrative staff of the above medication (Amoxicillin) not being administered for 10 days as ordered in the end of the day meeting. The regional minimum data set registered nurse stated Resident #12 didn't get enough of the medication after reviewing the September and October 2017 eMARs. No further information was provided prior to the exit conference on 11/2/17. (b). Resident #12 had a physician order dated	F 309		

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F 309	Continued From page 52 10/9/17 that read in part "Cipro 500 mg (milligram) per peg q (every) 12 ° (hour) x 7 days." The surveyor reviewed the September 2017 electronic medication administration records. An entry on the September 2017 eMARs read "Ciprofloxacin 500 mg (milligrams) per peg q (every) 12 hours for 7 days. Order Date: 10/09/17 Start Date: 10/09/17 Discontinue Date: 10/16/17." Resident #12 received Cipro 500 mg beginning on 9/9/17 at 9:00 p.m. through 9/16/17 at 9:00 p.m. for a total of fifteen (15) doses- one dose too many. The surveyor informed the administrative staff of the above medication Cipro not administered for 7days as ordered in the end of the day meeting. The regional minimum data set registered nurse stated Resident #12 received an additional dose of Cipro after reviewing the September 2017 eMARs. No further information was provided prior to the exit conference on 11/2/17. (c). The facility staff failed to ensure the physician order for the consistency of Resident #12's liquids was accurate. The liquid placed in Resident #12's bedside cooler was not what the physician ordered. Resident #12 had orders dated 10/18/17 that read in part "NPO (nothing by mouth) except for nectar thick liquids-mouth care 4 times daily." The surveyor observed Resident #12 on 10/31/17	F 309		

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F 309	Continued From page 53 at 10:05 a.m. On the over the bed table was a cooler with melted ice. The cooler contained 4 (four) honey thickened waters and one (1) sweetened tea honey consistency. The surveyor checked the cooler again on 10/31/17 at 12:50 p.m. The cooler was filled with ice and 3(three) honey thickened waters and 1 (one) honey thickened tea. The surveyor interviewed licensed practical nurse #2 on 10/31/17 at 12:50 p.m. L.P.N. #2 agreed the honey thickened water and tea were in the cooler and stated he would check the order for accuracy. After checking the order, L.P.N. #2 stated Resident #12 should have nectar thick liquids-not honey. The surveyor interviewed the district dietary manager other #5 on 11/1/17 at 9:14 a.m. Other #5 stated the coolers in the resident's rooms are done by nursing staff-not dietary staff. The surveyor informed the administrative staff of the above concern during an end of the day meeting on 11/1/17 at 4:31 p.m. No further information was provided prior to the exit conference on 11/2/17. 10. The facility staff failed to follow the bowel protocol for Resident #14. The surveyor reviewed Resident #14's clinical record 10/31/17 and 11/1/17. Resident #14 was admitted to the facility 1/10/17 with diagnoses that included but not limited to epilepsy, spastic quadriplegic cerebral palsy, unspecified psychosis, hyperlipidemia, anxiety, gout, Vitamin	F 309		

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F 309	Continued From page 54 B deficiency, Vitamin D deficiency, edema, constipation, knee contracture, and unspecified osteoarthritis. Resident #14's quarterly MDS (minimum data set) assessment with an assessment reference date (ARD) of 11/2/17 assessed the resident with a BIMS (brief interview for mental status) of 13 out of 15. Section G Functional Status was marked that Resident #14 normally used a wheelchair for mobility. Section H Bladder and Bowel assessed the resident to always be incontinent of bowel. Resident #14's current comprehensive care plan included the problem of potential fluid volume deficit secondary to constipation dated 1/24/17. Approaches: Monitor & document BM's (bowel movements) daily. The surveyor reviewed Resident #14's "BM Details Roster" from 9/30/17 through 10/30/17. Resident #14 did not have a bowel movement from 10/3/17 through 10/8/17. Resident #14 had bowel movements on 10/2/17 and 10/9/17. Resident #14 had no documented bowel movements from 10/26/17 through 10/29/17. The facility had standing orders regarding "Constipation: These are the steps to follow in the order given: If no bowel movement in 3 days. 1. MOM (milk of magnesia) 30 cc PO (by mouth) QD (everyday) PRN (as needed) for constipation-if no results within 8-12 hours, do Suppository. 2. Bisacodyl 10mg suppository (Ducolax) 1 PR (per rectum) QD PRN for constipation if no results within 8-12 hours do enema. 3. If no results from #1 or #2 administer fleets	F 309		

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F 309	Continued From page 55 enema X1 not (notify) MD (medical doctor)." The surveyor reviewed Resident #14's September 2017 and October 2017 electronic medication administration records. There was no documentation that the first order of the standing orders was implemented. MOM should have been administered on 10/6/17 when the resident did not have a bowel movement from 10/3/17 through 10/8/17. The October 2017 eMAR had no documentation of MOM administration on 10/6/17. The surveyor informed the administrative staff of the above concern on 11/2/17 at 12:18 p.m. No further information was provided prior to the exit conference on 11/2/17. Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to ensure the highest practical well-being for 10 of 25 residents in the survey sample, Resident # 6, Resident # 17, Resident #2, Resident#4, Resident #5, Resident #13, Resident #19, Resident #1, Resident #12, and Resident # 14. The findings included: 1. Facility staff failed to assess pain and provide interventions for pain relief for Resident #6. Resident # 6 was originally admitted to the facility on 2/16/15 with a readmission date of 12/15/16. Diagnoses included but not limited to: chronic diastolic congestive heart failure, hypothyroidism, chronic kidney disease stage 3, and hypertension. The most recent MDS (minimum	F 309		

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data set) assessment was quarterly assessment with an ARD (assessment reference date) of 10/13/17. Facility staff documented Resident # 6's cognitive status was severely impaired with a cognitive score of 6 out of 15.

The clinical record for Resident #6 was reviewed on 10/31/17 at 9:30 a.m. Upon review of the most recent MDS with an ARD of 10/13/17, the facility staff documented in section M0150 that Resident #6 was at risk for developing pressure ulcers. Section M1040 H., the facility staff documented that Resident # 6 had moisture associated skin damage. In section M1200, the facility staff documented pressure reducing device for bed and applications of ointments/medications other than to feet as skin and ulcer treatments.

On 11/1/17 at 11:13 a.m., Resident # 6 was observed lying in her bed flat on her back.

On 11/1/17 at 11:15 a.m., LPN #1 was preparing to provide treatment to Resident #6's buttocks. LPN #1 tells surveyor "she usually gets Greer's goo but we are out of it and waiting on it to come from the pharmacy in Richmond." "I have an order to use house barrier cream until it comes in." LPN #1 states she gets MASD (moisture associated skin damage) a lot because she is non-compliant with turning." Surveyor asked LPN #1 if Resident # 6 was able to turn herself? LPN #1 states "no."

On 11/1/17 at 11:19 a.m., LPN #1 assisted by CNA # 1 (certified nursing assistant) began to administer treatment to Resident # 6's buttocks. When CNA #1 touched Resident # 6 on her right thigh to assist her in turning Resident #6 stated "ooh my butt." CNA #1 along with LPN #1 turned

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Resident # 6 on her left side. LPN #1 began to wash Resident #6's bottom with soap and water. Resident # 6 flinched as soon as her buttocks were touched by the LPN #1. Resident # 6 stated "it's hurting my butt." LPN #1 continued to wash Resident #6's buttocks but started patting the area instead of washing in circular motion. Resident # 6 then stated "she's hurting me." Surveyor observed areas on the buttocks of Resident # 6 as follows: a red area on right lower buttock in the fold, one open area right upper buttock, small open area in the crease in between both buttocks and 2 open areas on left buttock. There was redness noted to bilateral buttocks. LPN #1 pressed an area on the left buttock to show that the area was blanchable. LPN #1 then applied Derma Septin house barrier cream to Resident #6's buttocks. Resident #6 stated "that hurts" during the application of the Derma Septin.

The facility staff did not stop at any time during the procedure to assess Resident # 6 for pain or provide interventions. LPN #1 and CNA #1 assisted Resident #6 with turning to her left side and a pillow was placed on the right side of her back.

On 11/1/17 at 12:15 p.m., the survey team interviewed LPN #1 regarding Resident #6's pain during the treatment. LPN #1 stated that Resident #6 "always complains of pain." "She's one that if you just touch her she will say it hurts so you don't know if it's her or if it's in her mind." Survey team asked the LPN # 1 what you are supposed to do if a resident complains of pain? LPN #1 stated that "you notify the doctor that the resident needs to be reassessed for their pain meds." Survey team asked the LPN #1 why she did not stop to assess the resident during the treatment

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F 309	Continued From page 58 when she complained of pain? LPN #1 stated that she did not know that she could stop while the surveyors were watching. DON (director of nursing) was in the meeting with the LPN #1 and told LPN #1 "this is a lesson learned, when a resident complains of pain, you stop and reassess." On 11/2/17 at 10:30 a.m., 3 surveyors observed incontinence care of Resident #6 after consent was given by the resident. LPN #1 verbally informed surveyors that Resident #6 had been premedicated with Lortab and topical Lidocaine. LPN #1 made surveyors aware that the Greer's goo was now in the facility to be applied as ordered. LPN #1 assessed resident pain level prior to initiating treatment and Resident #6 denied having pain. Resident #6 was turned on her left side with assist of 2 persons treatment nurse and CNA #3. When CNA #3 touched Resident #6's bottom to wash her bottom Resident #6 flinched and stated "it hurts." The facility staff stopped to assess resident and asked Resident #6 if she wished for them to continue treatment. Resident # 6 stated "try to." When CNA #3 continued to wash the area to the buttocks Resident # 6 flinched again and stated "it hurts in that spot." The facility staff stopped treatment and assessed the resident. CNA #3 touched an area on Resident #6's bottom and asked "is this where it hurts?" Resident #6 stated "no." CNA # 3 touched another area on Resident # 6's bottom and asked "is this where it hurts?" Resident #6 stated "no." CNA # 3 touched a different area on Resident #6's buttocks and resident # 6 immediately flinched and stated "yes. The facility staff stopped to assess the resident and asked Resident #6 if she wished for them to continue treatment. Resident #6 stated "yes."	F 309		

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F 309	Continued From page 59 LPN #1 was asked by surveyors how the area to Resident #6's buttocks looked in comparison to yesterday? LPN #1 stated that the areas on Resident #6's bottom looked better than yesterday. LPN #1 stated "they were more red yesterday." LPN #1 applied Greer's Goo to Resident #6's bottom and Resident #6 flinched during application. LPN #1 asked Resident #6 if she wanted her to stop and Resident # 6 stated "no." LPN #1 then stated that the area to the right lower buttock in the fold was new and that she did not see it yesterday. LPN #1 changed gloves, sanitized her hands and donned new gloves. LPN #1 attempted to touch the area to see if the area blanched, but resident flinched and complained of pain. LPN #1 stated that she will use house barrier cream on the area and notify the doctor that the area needs to be assessed. LPN #1 placed Derma Septin to the area on the right lower buttock in the fold. The area to Resident # 6's right lower buttock was noted by surveyor on 11/1/17 during treatment. On 11/2/17 at 11:50 a.m., the survey team conducted an interview with CNA #1 who was the CNA assisting LPN #1 with wound care on 11/1/17 at 11:19 a.m., CNA #1 was asked about the areas on Resident #6's buttocks. CNA# 1 did report that she saw the area on Resident #6's right lower buttock. Survey team asked CNA # 1 if the area was open. CNA # 1 stated "honestly I can't say if it was open or not." Surveyor then asked CNA # 1 about Resident #6's pain level during the treatment on 11/1/17 at 11:15 a.m., CNA # 1 stated "even before you touch her she will say you are hurting her." "I think it's just from memory." Surveyor asked CNA# 1 what she would do if she was washing a resident and they complained of pain? CNA # 1 stated that	F 309		

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F 309	Continued From page 60 she would report it to the nurse. CNA #1 stated that "normally LPN #1 stops." Surveyor then asked CNA # 1 "that's not what happened yesterday is it?" CNA # 1 stated "no." On 11/2/17 at 12:18 p.m., the DON, ADON (assistant director of nursing), administrator, consultant nurse, regional mds consultant, regional operations manager was made aware of the above findings. The facility staff requested that surveyors speak with Resident #6 again because of the cognitive status of the resident and her frequent complaints of pain. On 11/2/17 at 12:25 p.m., 2 surveyors and RN# 1 went in and spoke with Resident # 6. Surveyor asked Resident # 6 if she remembered receiving treatment to her buttocks on 11/1/17 and Resident # 6 stated "yes." The surveyor then asked Resident #6 if she remembered receiving treatment to her buttocks on 11/2/17 and Resident # 6stated "yes." The surveyor then stated to Resident #6 "I noticed that you were having pain while they were treating your bottom, would you have preferred for the staff to stop while you were hurting or keep going?" Resident # 6 stated "rather they keep going." Surveyor then asked Resident # 6 "when you complained of pain and the staff stopped and gave you a break before they continued did that make it better?" Resident #6 stated "yeah." On 11/2/17 at 12: 32 p.m., the DON, ADON, and administrator were made aware of the details of the conversation held with Resident #6. No further information was provided to the survey team prior to the exit conference on 11/2/17 at 5:15pm	F 309		

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F 309	Continued From page 61 2. Facility staff failed to follow physician's orders for nectar thickened liquids for Resident #17. Resident #17 was originally admitted to the facility on 5/20/17 with a readmission date of 8/23/17. Diagnoses included but not limited to: dysphagia, heart failure, enterocolitis due to clostridium difficile, and hypokalemia. The most recent MDS (minimum data set) was a quarterly assessment with an ARD of (assessment reference date) of 10/13/17. It was documented that Resident # 17 had a cognitive score of 12 out of 15 indicating moderate cognitive impairment. On 11/1/17 at 8:57 a.m., RN # 2 was administering medications to Resident #17. After preparing the medication RN #2 poured regular water in a cup, locked the medication cart. RN # 2 stated "now she is on thickened liquids, but she can have regular water when I am with her." RN #2 proceeded into Resident #17's room and administered medications followed by the regular water. The clinical record for Resident #17 was reviewed on 11/2/17 at 8:03 a.m. According to the current physician's order Resident #17 is to have nectar thick liquids. Upon review of the most recent MDS with an ARD of 10/13/17 in section K specifically K0510 Nutritional Approaches, the facility staff documented a check mark under C. mechanically altered diet- required change in texture of food or liquids (e.g., pureed food, thickened liquids). A review of Resident # 17's current plan of care had "diet and/or liquid consistency per MD orders as an intervention for the problem area potential for aspiration due to diagnosis of dysphagia.	F 309		

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F 309	Continued From page 62 On 11/2/17 at 8:21 a.m., the surveyor spoke with the DON (director of nursing) regarding the issue stated above. On 11/2/17 at 10:05 a.m., the DON reported to the survey team that when Resident #17 was readmitted to the facility the free water stopped. The DON stated "she is on thickened liquids and should not have gotten her meds with water." No further information regarding this issue was provided to the survey team prior to the exit conference on 11/2/17 at 5:15 p.m.	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: 5. The facility staff failed to ensure Resident #3 received sufficient baths/showers to provide good personal hygiene. Resident #3 was admitted to the facility on 5/30/16. Her diagnoses include but are not limited to high blood pressure, hypothyroidism, urinary tract infection, anxiety and alzheimer's disease. Resident #3's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 10/5/17 assessed her to understand and could be understood. She was assessed to have as cognitive status of 4 out of 15. Her assessment revealed in section G, she needed assistance with daily activities of living.	F 312	F 312 ADL Care Provided for Dependent Residents **Criteria 1:** Resident #10 stated that she would like to have a shower on November 1, 2017. DON confirmed that resident #10 did receive a shower the evening of November 1, 2017. **Criteria 2:** A facility wide ADL care audit was completed by ED for additional residents on November 1, 2017. DON developed new plan utilizing shower aides, giving showers 6 days per week. Since November 13, 2017, daily shower audits are conducted by DON or designee to ensure showers offered and weekly notes inputted.	

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F 312	Continued From page 63 Review of Resident #3's current comprehensive care plan revealed under problem/need the following: "Requires assistance is for ADL's related to generalized weakness, debility and cognitive loss." Resident #3's activity of daily living sheet revealed her bathing record. The record revealed she was not getting showers or daily bed bath from 9/21/17 through 10/4/17. On 9/20/17 the record revealed she had a shower and the next shower was on 10/4/17. She had a bed bath on 9/22/17, 9/23/17 and 9/28/17. On 11/1/17, the administrator, director of nurses and director of nurses were informed of Resident #3's lack of baths/showers. No further information related to the baths or showers was provided by the facility staff. Based on Resident interview, staff interview, and clinical record review, the facility staff failed to provide necessary ADL (activities of daily living) care for 3 of 25 Residents in regards to showers. Residents #4, #8, and #3. The findings included. 1. For Resident #4, the facility failed to provide assistance with showers/bathing. The record review revealed that Resident #4 had been admitted to the facility 02/04/2016. Diagnoses included, but were not limited to, dementia with behavioral disturbances, Alzheimer's disease, diabetes, hypertension, and	F 312	**Criteria 3:** DON or designee will in-service nursing staff by November 30, 2017 regarding ADL care including bathing/shower care and documentation. DON or designee will audit daily ADL care for a minimum of 5 times a week for 90 days. **Criteria 4:** DON or designee will review results of audits with ED. ED or designee will present audits to facility QA committee monthly to be reviewed for further intervention or recommendation as necessary. **Criteria 5:** December 16, 2017	

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F 312	Continued From page 64 hypothyroidism. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 09/05/2017 was coded 1/1/3 to indicate the Resident had problems with long and short term memory and was severely impaired in cognitive skills for daily decision making. Section G (functional status) was coded 3/2 for personal hygiene and bathing to indicate the Resident required extensive assistance of one person to perform these tasks. A review of the Residents bath sheets for 09/30-10/31/2017 revealed that Resident #4 had only received a shower on 10/04, 10/10, 10/14, and 10/19/2017. The Resident appeared clean and well-groomed at the time of the survey. The administrative staff was notified on 10/31/2017 at approximately 2:45 p.m. that the Resident had only had 4 baths for the month of October 2017. The DON (director of nursing) verbalized to the survey team that she had just revamped the bath team, hired a new person, and that they would now have staff available to give showers 6 days a week. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #8, the facility failed to provide the Resident with assistance with showers/bathing. The record review revealed that Resident #8 had been admitted to the facility 02/08/2015.	F 312		

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F 312	Continued From page 65 Diagnoses included, but were not limited to, dementia, hypertension, constipation, age related osteoporosis, anxiety disorder, and malignant neoplasm. Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/18/2017 included a BIMS (brief interview for mental status) summary score of 4 out of a possible 15 points. Section G (functional status) was coded 3/2 for personal hygiene and 4/2 for bathing to indicate the Resident required extensive assistance of one person for personal hygiene and was totally dependent on one person for bathing. A review of the facility concern log revealed a concern with the Resident regarding showers/baths. For the month of 09/2017 that facility had documented that the Resident had received 4 showers-09/05, 09/11, 09/19, and 09/26. For the month of October 2017 the facility had documented that the Resident had received 5 showers 10/09, 10/10, 10/19, 10/20, and 10/25. On 10/31/2017 at approximately 12:35 p.m. the surveyor spoke with non-staff person #1. Non staff person #1 stated she did not bathe this Resident as the staff would not let her. Non staff person #1 stated the Resident had gone 9 days one time without a bath. The facility was made aware of the issue regarding the Residents showers on 10/31/2017 at approximately 2:45 p.m. The DON (director of nursing) verbalized to the survey team that she	F 312		

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F 312	Continued From page 66 had just revamped the bath team, hired a new person, and that they would now have staff available to give showers 6 days a week. No further information regarding this issue was provided to the survey team prior to the exit conference. 3. The facility staff failed to provide 2 showers per week in addition to bed baths to Resident #6. Resident # 6 was originally admitted to the facility on 2/16/15 with a readmission date of 12/15/16. Diagnoses included but not limited to: chronic diastolic congestive heart failure, hypothyroidism, chronic kidney disease stage 3, and hypertension. The most recent MDS (minimum data set) assessment was quarterly assessment with an ARD (assessment reference date) of 10/13/17. Facility staff documented Resident # 6's cognitive status was severely impaired with a cognitive score of 6 out of 15. The clinical record for Resident #6 was reviewed on 10/31/17 at 9:30 a.m., Upon review of the most recent MDS with an ARD of 10/13/17, the facility staff documented in section G specifically G0120 that Resident # 6 required total assistance with bathing with the support of 2 or more persons to physically assist. A review of the facility "hygiene, bath, skin check roster" revealed that the facility staff had documented that Resident #6 refused a shower on 10/4/17, received a shower on 10/15/17, received a shower on 10/19/17. No further information was documented in the clinical record regarding resident receiving showers.	F 312		

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F 312	Continued From page 67 On 10/31/17 at 2:48 p.m., the facility staff was made aware of the above findings. The survey team spoke with the DON (director of nursing) regarding this resident not receiving 2 showers weekly. DON stated that she was aware of the issue and that one of the aides that usually did the showers for the residents got injured and could not work. The facility has hired a new person to administer showers and that they facility would be administering showers 6 days weekly once the new hire comes on board. On 11/1/17 at 11:09 a.m., the DON (director of nursing) made surveyor aware that she could not locate any other documentation in the clinical record regarding the resident receiving 2 showers weekly. No further information regarding this issue was presented to the survey team prior to the exit conference on 11/2/17 at 5:15 p.m. 4. The facility staff failed to administer 2 showers weekly in addition to bed baths for Resident #10. Resident # 10 was originally admitted to the facility on 2/10/15 with a readmission date of 9/12/15. Diagnoses included but not limited to: dementia, multiple sclerosis, major depressive disorder, polyneuropathy, and hyperlipidemia. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 10/13/17. The facility staff coded Resident # 10's cognitive status as 11 out of 15 indicating moderate impairment. The clinical record was reviewed on 10/31/17 at	F 312		

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F 312	Continued From page 68 2:00 p.m. The most recent MDS with an ARD of 10/31/17 was reviewed specifically section G. In section G0120 the facility staff documented that Resident #10 required total assistance with bathing with the support of one person to assist physically. Upon review of the facility" hygiene, bath, skin check roster" it was documented that Resident #10 received a shower on 10/4/17, on 10/19/17 beside bath day it was documented that a partial bath was given, on 10/19/17 beside bath day it was documented that the resident received a complete bed bath, on 10/20/17 beside bath day it was documented that Resident #10 received a shower.10/23/17 beside bath day facility documented that Resident #10 received a partial bath, 10/25/17 beside bath day facility documented that Resident #10 received a shower. On 11/1/17 at 9:45 a.m. LPN #1 and CNA# 2 in to assist Resident # 10 and apply treatment as ordered. Resident #10 stated "I thought I was going to take me a shower." LPN #1 stated to Resident #10 "I think today is your make up shower day" Resident #10 then stated "I'd really like to get my hair washed" LPN #1 then told Resident #10 "we will get you cleaned up until then" On 11/1/17 at 11:32 a.m., the survey team spoke with the DON (director of nursing) regarding this resident not receiving 2 showers weekly. DON stated that she was aware of the issue and that one of the aids that usually did the showers for the residents got injured and could not work. The facility has hired a new person to administer	F 312		

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F 312	Continued From page 69 showers and that they facility would be administering showers 6 days weekly once the new hire comes on board. On 11/1/17 at 2:45 pm surveyor observed Resident # 10 in wheelchair in activity room. Resident # 10 was dressed in the same clothing that she had been dressed in at 9:45 a.m. Surveyor discreetly asked Resident# 10 if she had received a shower? Resident # 10 stated "no." On 11/1/17 at 4:40 pm Resident # 10 was observed in her room in her wheelchair. Resident # 10 was still dressed in the same clothing that was put on her at 9:45 a.m. Surveyor asked Resident #10 if she had received a shower? Resident # 10 stated "no." On 11/1/17 at 11:09 a.m. the DON (director of nursing) made surveyor aware that she could not locate any other documentation in the clinical record regarding the resident receiving 2 showers weekly. On 11/1/17 at 4:31 p.m., the facility staff spoke with DON, ADON (assistant director of nursing, consultant nurse, regional MDS consultant, and regional director of operations and made them aware of Resident # 10 requesting a shower and not receiving one. On 11/2/17 at 9:50 a.m. DON verbally informed the surveyor that Resident # 10 had received a shower on the evening of 11/1/17. No further information regarding this issue was presented to the survey team prior to the exit	F 312		

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F 312	Continued From page 70 conference on 11/2/17 at 5:15 p.m.	F 312		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review facility staff failed to identify and treat open area to skin for 1 of 25 residents in the survey sample, Resident # 6. The findings included: The facility staff failed to identify and treat open area to right lower buttock for Resident #6. Resident # 6 was originally admitted to the facility on 2/16/15 with a readmission date of 12/15/16. Diagnoses included but not limited to: chronic diastolic congestive heart failure, hypothyroidism,	F 314	F 314 Treatment/SVCS to Prevent/Heal Pressure Sores **Criteria 1:** On November 2, 2017, wound nurse assessed area to right lower buttock, applied barrier cream and wrote communication to physician. On November 3, 2017 physician also assessed area and determined that area was blanchable and to continue applying barrier cream as ordered. **Criteria 2:** Skin assessment/check schedule was created and will be monitored weekly by DON or designee for completion and accuracy. **Criteria 3:** DON or designee will provide education to nursing staff by November 30, 2017 regarding accurately performing a nursing skin assessment/check and protocol. A sample of skin assessments/checks will be audited weekly to ensure accuracy and adequate completion by DON or designee.	

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F 314	Continued From page 71 chronic kidney disease stage 3, and hypertension. The most recent MDS (minimum data set) assessment was quarterly assessment with an ARD (assessment reference date) of 10/13/17. Facility staff documented Resident # 6's cognitive status was severely impaired with a cognitive score of 6 out of 15. The clinical record for Resident #6 was reviewed on 10/31/17 at 9:30 a.m. Upon review of the most recent MDS with an ARD of 10/13/17, the facility staff documented in section M0150 that Resident #6 was at risk for developing pressure ulcers. Section M1040 H., the facility staff documented that Resident # 6 had moisture associated skin damage. In section M1200 facility staff documented pressure reducing device for bed and applications of ointments/medications other than to feet as skin and ulcer treatments. On 11/1/17 at 11:13 a.m., Resident # 6 was observed lying in her bed flat on her back. On 11/1/17 at 11:15 a.m., LPN (licensed practical nurse) #1 was preparing to provide treatment to Resident #6's buttocks. LPN #1 tells the surveyor "she usually gets Greer's goo but we are out of it and waiting on it to come from the pharmacy in Richmond." "I have an order to use house barrier cream until it comes in." LPN #1 stated she gets MASD (moisture associated skin damage) a lot because she is non-compliant with turning." Surveyor asked LPN #1 if Resident # 6 was able to turn herself? LPN #1 stated "no." On 11/1/17 at 11:19 a.m., LPN #1 assisted by CNA (certified nursing assistant) #1 (certified nursing assistant) began to administer treatment to Resident # 6's buttocks. When CNA #1	F 314	**Criteria 4:** DON or designee will review results of audits with ED. ED or designee will present audits to facility QA committee monthly to be reviewed for further intervention or recommendation as necessary. **Criteria 5:** December 16, 2017	

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F 314	Continued From page 72 touched Resident # 6 on her right thigh to assist her in turning Resident #6 stated "ooh my butt." CNA#1 along with LPN #1 turned Resident # 6 on her left side. LPN #1 began to wash Resident #6's bottom with soap and water. Resident # 6 flinched as soon as her buttocks were touched by the LPN #1. Resident # 6 stated "it's hurting my butt." LPN #1 continued to wash Resident #6's buttocks but started patting the area instead of washing in circular motion. Resident # 6 then stated "she's hurting me." The surveyor observed areas on the buttocks of Resident # 6 as follows: red area on right lower buttock in the fold, one open area right upper buttock, small open area in the crease in between both buttocks and 2 open areas on left buttock. There was redness noted to bilateral buttocks. LPN #1 pressed an area on the left buttock to show that the area was blanchable. LPN #1 then applied Derma Septin house barrier cream to Resident #6's buttocks. Resident #6 stated "that hurts" during the application of the Derma Septin. The facility staff did not stop at any time during the procedure to assess Resident # 6 for pain or provide interventions. LPN #1 and CNA # 1 assisted Resident #6 with turning to her left side and a pillow was placed on the right side of her back. On 11/1/17 at 12:15 p.m., the survey team interviewed LPN #1 regarding Resident #6's pain during the treatment. LPN #1 stated that Resident #6 "always complains of pain." "She's one that if you just touch her she will say it hurts so you don't know if it's her or if it's in her mind." Survey team asked the LPN #1 what you are supposed to do if a resident complains of pain? LPN #1 stated that "you notify the doctor that the resident	F 314		

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F 314	Continued From page 73 needs to be reassessed for their pain meds." Survey team asked LPN #1 why she did not stop to assess the resident during the treatment when she complained of pain? LPN # 1 stated that she did not know that she could stop while the surveyors were watching. The DON (director of nursing) was in the meeting with the LPN # 1 and told LPN #1 "this is a lesson learned, when a resident complains of pain, you stop and reassess." On 11/2/17 at 10:30 a.m., 3 surveyors observed incontinence care of Resident #6 after consent was given by the resident. LPN #1 verbally informed surveyors that Resident #6 had been pre medicated with Lortab and topical Lidocaine. LPN #1 made surveyors aware that the Greer's goo was now in the facility to be applied as ordered. LPN #1 assessed Resident # 6's pain level prior to initiating treatment and Resident #6 denied having pain. Resident #6 was turned on her left side with assist of 2 persons' treatment nurse and CNA # 3. When CNA # 3 touched Resident #6's bottom to wash her bottom Resident #6 flinched and stated "it hurts." The facility staff stopped to assess and asked Resident #6 if she wished for them to continue treatment. Resident # 6 stated "try to." When CNA # 3 continued to wash the area to the buttocks Resident # 6 flinched again and stated "it hurts in that spot." The facility staff stopped treatment and assessed the resident. CNA # 3 touched an area on Resident #6's bottom and asked "is this where it hurts?" Resident #6 stated "no." CNA # 3 touched another area on Resident # 6's bottom and asked "is this where it hurts?" Resident #6 stated "no." CNA # 3 touched a different area on Resident #6's buttocks and resident # 6 immediately flinched and stated "yes.	F 314		

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F 314	Continued From page 74 The facility staff stopped to assess the resident and asked the resident if she wished for them to continue treatment. Resident #6 stated "yes." LPN # 1 was asked by surveyors how the area to Resident #6's buttocks looked in comparison to yesterday? LPN #1 stated that the areas on Resident #6's bottom looked better than yesterday. LPN # 1 stated "they were more red yesterday." LPN #1 applied Greer's Goo to Resident #6's bottom and Resident #6 flinched during application. LPN #1 asked Resident #6 if she wanted her to stop and Resident # 6 stated "no." LPN #1 then stated that the area to the right lower buttock in the fold was new and that she did not see it yesterday. LPN #1 changed gloves, sanitized her hands and donned new gloves. LPN # 1 attempted to touch the area to see if the area blanched, but Resident # 6 flinched and complained of pain. LPN #1 stated that she will use house barrier cream on the area and notify the doctor that the area needs to be assessed. LPN # 1 placed Derma Septin to the area on the right lower buttock in the fold. The area to Resident # 6's right lower buttock was noted by surveyor on 11/1/17 during treatment. On 11/2/17 at 11:50 a.m., the survey team conducted an interview with CNA #1 who was the CNA assisting the LPN #1 with wound care on 11/1/17 at 11:19 a.m., CNA # 1 was asked about the areas on Resident #6's buttocks. CNA# 1 reported that she saw the area on Resident #6's right lower buttock. Survey team asked CNA #1 if the area was open. CNA #1 stated "honestly I can't say if it was open or not." Per the facility "Pressure Ulcer Risk Assessment Policy", "Skin will be assessed for the presence of developing pressure ulcers on a weekly basis or	F 314		

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more frequently if indicated." The policy also states "staff will perform routine skin inspections (with daily care)." "Nurses are to be notified to inspect the skin if changes are identified." "Nurses will conduct skin assessments at least weekly to identify changes."

Per the facility "Wound Care Policy", "The following information should be recorded in the resident's medical record.
1. The type of wound care given.
2. The date and time the wound care was given.
3. The position in which the resident was placed.
4. The name and title of the individual performing wound care.
5. Any change in the resident's condition.
6. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound.
7. How the resident tolerated the procedure.
8. Any problems or complaints made by the resident related to the procedure.
9. If the resident refused the treatment and the reason(s) why.
10. The signature and title of the person recording the data."

On 11/2/17 at 12:18 p.m., the DON, ADON (assistant director of nursing/, administrator, consultant nurse, regional MDS consultant, and regional operations manager were made aware of the above findings. The DON made the survey team aware at this time that the facility policies were also the facility standard of practice.

No further information regarding this issue was presented to the survey team prior to the exit

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F 314	Continued From page 76 conference on 11/2/17 at 5:15 p.m.	F 314	F 315 No Catheter, Prevent UTI, Restore Bladder	
F 315 SS=E	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal	F 315	**Criteria 1:** DON provided education to LPN #1 and CNA #10 on November 1, 2017 regarding proper personal care. Clarification order obtained on November 1, 2017 for Resident #10 to have an 18 French with 5 mL balloon foley catheter due to leakage. **Criteria 2:** Residents with current catheters were reviewed by nursing admin on November 1, 2017 to ensure proper anchor devices were in place. **Criteria 3:** DON or designee will provide education for nursing staff by November 30, 2017 regarding anchoring of tubing related to catheter, processing of physician orders, and personal care. Audit of residents with catheters will be conducted weekly to include admissions, readmissions, and residents with a change in condition requiring a foley catheter by DON or designee to ensure proper orders and anchoring devices are in place.	

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F 315	Continued From page 77 bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document and clinical record review, the facility staff failed to ensure 4 of 25 residents received appropriate care and treatment in regards to Foley catheter care (Residents #19, #10, #20 and #12). The findings included: 1. Resident #19 was admitted to the facility on 10/11/17 with the following diagnoses of, but not limited to atrial fibrillation, heart failure, high blood pressure, diabetes, thyroid disorder, other fractures, stroke, muscle weakness and Cirrhosis. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/17/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. Resident #19 was also coded as requiring extensive assistance of 2 staff members for dressing and personal hygiene and being totally dependent on 1 staff member for bathing. On 11/2/17 at 8:30 am, the surveyor and licensed practical nurse (LPN) #1 went into Resident #19's room. The surveyor asked LPN #1 to look at the size of the Foley catheter that the resident had. LPN #1 looked at the catheter and stated "It is an 18 French catheter with a 10 cc balloon." The surveyor conducted a review of Resident #19's clinical record on 11/2/17. On the resident's MAR (Medication Administration for the month of October, 2017, the following order was noted: "Change 16 FR (French) Foley catheter and fig	F 315	**Criteria 4:** DON or deslgnee will review results of audits with ED. ED or designee will present audits to facility QA committee monthly to be reviewed for further intervention or recommendation as necessary. **Criteria 5:** December 16, 2017	

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leaf bag every 30 days." The order date was documented as 10/18/17 and the start date was documented as 11/10/17 on the MAR.

The surveyor reviewed all the supplemental orders and monthly physician order sheets and an order for the Foley catheter was not found by the surveyor.

At approximately 2 pm on 11/2/17, the surveyor notified the director of nursing of the above documented findings. The director of nursing reviewed the resident's MAR and supplemental orders and stated "I can't find any orders for the Foley catheter either."

No further information was provided to the surveyor prior to the exit conference on 11/2/17 at 5:15 pm.

2. For Resident # 10 the facility staff failed to provide appropriate catheter care, and ensure that the correct size foley was inserted into the bladder for Resident #10.

Resident # 10 was originally admitted to the facility on 2/10/15 with a readmission date of 9/12/15. Diagnoses included but not limited to: dementia, multiple sclerosis, major depressive disorder, polyneuropathy, and hyperlipidemia. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 10/13/17. The facility staff coded Resident # 10's cognitive status as 11 out of 15 indicating moderate impairment.

The clinical record was reviewed on 10/31/17 at 2:00 p.m. The most recent MDS with an ARD of 10/31/17 was reviewed specifically section H. In H0100A facility staff documented that Resident #

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F 315	Continued From page 79 10 had an indwelling catheter. Upon review of the current physician's orders for Resident # 10 that was signed by the physician on 10/7/17 had orders that stated "change foley catheter every 3 weeks with 16F (French) 10 cc balloon. Change catheter collection bag with every foley change." "May remove foley catheter with 16F 10 cc balloon if removed or leaking." "ensure foley cath securing device present" "foley catheter care every shift" "foley BSD bag is placed properly at bedside or on w/c and not touching floor" "foley cath cover in place for dignity". On 11/1/17 at 9:25 a.m., the surveyor observed Resident #10 tugging on foley catheter tubing. Catheter tubing was not secured and catheter was positioned upward which would have urine flow back into the bladder. On 11/1/17 at 9:45 a.m., LPN (licensed practical nurse) # 1 and CNA (certified nursing assistant) # 2 in to assist Resident # 10 and apply treatment as ordered. Resident #10 stated "I thought I was going to take me a shower." LPN #1 stated to Resident #10 "I think today is your make up shower day" Resident #10 then stated "I'd really like to get my hair washed" LPN # 1 then told Resident #10 "we will get you cleaned up until then." Resident was noted to have #18 French foley catheter with a 5 cc bulb inserted into the bladder. Catheter was positioned upward. No leg strap was in place. LPN #1 requested that CNA # 2 get a leg strap for the foley catheter. LPN #1 placed leg strap on the left leg of Resident #10 and secured the foley catheter to the leg strap. After the application of the leg strap, the foley catheter was still positioned upward so that the urine	F 315		

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F 315	Continued From page 80 would flow back into the bladder. The resident was turned toward her right side with the assistance of the LPN #1 and CNA # 2. Resident #10 was noted to have had a bowel movement at the time of care. Initially treatment nurse started cleaning Resident #10's buttocks after the bowel movement. Resident #10 was turned and CNA # 2 washed vaginal area. While washing vaginal area stool was noted on the wash cloth. CNA # 2 turned Resident #10 again with the assistance of the LPN #1 and cleaned the stool from Resident #10's buttocks and perineal area. CNA # 2 and LPN #1 applied a pull up incontinent brief on Resident # 10 assisted her in putting on her shirt, pants, and shoes, and got Resident #10 out of bed with the mechanical stand up lift and placed in the wheelchair. Privacy cover was noted to be in place on foley catheter bag. During the procedure the facility staff did not change the water in between washing the buttocks with the bowel movement and the vaginal area. They facility staff also did not perform catheter care during the procedure. Per the facility policy for giving a bed bath which according to the DON (director of nursing) is also the facility standard of practice, it is documented under care of the perineum to "always wash the anal area last to avoid contaminating the urinary tract with fecal matter." Per the facility policy on "Urinary Catheter Care" which according to the DON is also the facility standard of practice, 3. Under the heading for maintaining unobstructed urine flow states "the urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing	F 315		

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F 315	Continued From page 81 back into the urinary bladder." Under changing catheters, it is documented under 2. "ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh.)" On 11/1/17 at 4:28 p.m., the DON and administrator were made aware of the above findings. No further information regarding this issue was presented to the survey team prior to the exit conference on 11/2/17 at 5:15 p.m. 3. The facility staff failed to ensure that Resident # 20 had the correct size catheter and bulb inserted into the bladder. Resident #20 was originally admitted to the facility on 10/24/15 with a readmission date of 5/27/16. Diagnoses included but not limited to: quadriplegia, neuromuscular dysfunction of the bladder, urinary tract infection, major depressive disorder and chronic pain syndrome. The most recent MDS (minimum data set) was a quarterly MDS assessment with an ARD (assessment reference date) of 10/23/17. The facility staff had Resident #20 documented as cognitively intact with a cognitive score of 15 out of 15. The clinical record for Resident #20 was reviewed on 11/2/17 at 9:35 a.m. Upon review of the most recent quarterly MDS with an ARD of 10/23/17 specifically section H. In H0100 facility staff documented that Resident #20 had an indwelling catheter. A review of the current physician's orders revealed that Resident # 20 had orders for #18 Fr foley with 10 cc balloon.	F 315		

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F 315	Continued From page 82 On 11/2/17 at 9:50 a.m. surveyor spoke with Resident # 20 per request of the resident. Resident #20 gave consent for surveyor to look at her catheter. Resident # 20 was noted to have had an 18 Fr catheter with a 5 cc balloon inserted into the bladder. A leg strap was in place however it was soiled and loose on Resident # 20's leg. Per the facility policy on "Urinary Catheter Care" which according to the DON is also the facility standard of practice," Under changing catheters it is documented under 2. "ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh.)" On 11/2/17 4:28 p.m., at the DON, ADON (assistant director of nursing), administrator, consultant nurse, regional MDS consultant, and regional operations manager were made aware of the above findings. No further information regarding this issue was presented to the survey team prior to the exit conference on 11/2/17 at 5:15 p.m. 4. The facility staff failed to anchor Resident #12's indwelling Foley catheter. The surveyor reviewed Resident #12's clinical record on 10/31/17 and 11/1/17. Resident #12 was admitted to the facility 3/10/17 and readmitted 6/16/17 with diagnoses that included but not limited to urine retention, urinary tract infection, peripheral vascular disease, deep tissue injury, atrial fibrillation, hyperlipidemia, cerebral infarction, dysphagia, hemiplegia, hypertension, Vitamin D deficiency, Vitamin B12	F 315		

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deficiency, constipation, chronic pain, pneumonia, and severe sepsis with septic shock.

Resident #12's significant change in minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/24/17 assessed the resident with short term memory problems, long term memory problems, and severely impaired cognitive skills for daily decision making. Section G Functional Status assessed Resident #12 to require extensive assistance of 2 staff for bed mobility and assessed the resident with an impairment on one side that involved both extremities.

A telephone order dated 10/18/17 read in part "Foley cath (catheter) 16F (French) 5 cc (cubic centimeters) chg (change) every 30 days."

The surveyor and the wound care nurse licensed practical nurse #1 observed Resident #12's Foley catheter 10/31/17 at 10:40 a.m. Resident #12's Foley catheter bag was positioned on the right side of the bed. L.P.N. #1 was asked to check for size and anchorage. The Foley size was correct; however, the Foley catheter tubing was not anchored to the resident's thigh. L.P.N. #1 stated the strap may have been soiled.

The surveyor requested the facility policy on catheter care from the director of nursing on 11/02/17 at 9:00 a.m. and was provided the policy at 9:13 a.m.

The policy titled "Catheter Care, Urinary" read in part "Changing Catheters 2. Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped

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F 315	Continued From page 84 to the resident's inner thigh." The surveyor informed the administrative staff of the above issue with regards to Resident #12's Foley catheter tubing not anchored on 11/2/17 at 12:18 p.m. No further information was provided prior to the exit conference on 11/2/17.	F 315	F 328 Treatment/Care for Special Needs **Criteria 1:** On November 1, 2017, filters were cleaned and sanitized for Residents #1 and #12.	
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia,	F 328	**Criteria 2:** On November 7, 2017, central supply personnel cleaned and sanitized all filters and added to weekly change out schedule. **Criteria 3:** DON or designee will provide education to nursing staff by November 30, 2017 regarding cleaning and sanitation of oxygen concentrator filters. DON or designee will conduct random sample audit weekly to ensure proper change out of tubing as well as proper cleaning of filters. **Criteria 4:** DON or designee will review results of audits with ED. ED or designee will present audits to facility QA committee monthly to be reviewed for further intervention or recommendation as necessary. **Criteria 5:** December 16, 2017	

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F 328	Continued From page 85 diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to ensure oxygen equipment was maintained in a clean and sanitary condition for 2 of 25 residents (Resident #1 and Resident #12). The findings included: 1. The facility staff failed to ensure the oxygen	F 328		

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F 328	Continued From page 86 filter was clean and sanitary for Resident #1. The surveyor reviewed Resident #1's clinical record on 10/31/17 and 11/1/17. Resident #1 was admitted to the facility 1/20/17 with diagnoses that included but not limited to chronic obstructive pulmonary disease, urinary tract infection, chronic pain, depressive episodes, hyperlipidemia, constipation, hypertension, type 2 diabetes mellitus, Vitamin D deficiency, seizures, periodic headaches, and anxiety. Resident #1's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/24/17 assessed the resident with a BIMS (brief interview for mental status) as 11 out of 15. Section O Special Treatments, Procedures and Programs was marked for oxygen use. Resident #1's current comprehensive care plan dated 2/3/17 read "COPD (chronic obstructive pulmonary disease). Approaches: O2 per order. Change O2 tubing every week. O2 sats per order." The October 2017 physician orders read "Apply 2 liters of O2 (oxygen) at bedtime." The surveyor and registered nurse #2 observed Resident #1's oxygen concentrator on 10/31/17 at 2:50 p.m. The oxygen concentrator was not in use. R.N. #2 stated Resident #1 used oxygen at bedtime. The surveyor asked R.N. #2 to check the filter and the tubing. R.N. #2 removed the filter from the back of the oxygen concentrator and said "Clean on one side-dirty on the other." The filter had an accumulation of whitish gray material on one side. R.N. #2 stated she would take care of the issue. R.N. #2 stated the tubing	F 328		

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F 328	Continued From page 87 and filter are usually changed out every Tuesday. No date was observed on the tubing. The surveyor requested the facility policy on 11/1/17 at 1:00 p.m. from the director of nursing. The policy titled "Departmental (Respiratory Therapy) Prevention of Infection" read in part "9. Check filters once weekly while they are in continuous use. Discard filters or sterilize them between uses for different residents." The surveyor informed the administrative staff of the above concern during an end of the day meeting on 11/1/17 at 4:31 p.m. No further information was provided prior to the exit conference on 11/2/17. 2. The facility staff failed to ensure Resident #12's oxygen filter was clean and sanitary and failed to document when the oxygen tubing was changed. The surveyor reviewed Resident #12's clinical record on 10/31/17 and 11/1/17. Resident #12 was admitted to the facility 3/10/17 and readmitted 6/16/17 with diagnoses that included but not limited to urine retention, urinary tract infection, peripheral vascular disease, deep tissue injury, atrial fibrillation, hyperlipidemia, cerebral infarction, dysphagia, hemiplegia, hypertension, Vitamin D deficiency, Vitamin B12 deficiency, constipation, chronic pain, pneumonia, and severe sepsis with septic shock. Resident #12's significant change in minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/24/17 assessed the resident with short term memory problems, long	F 328		

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F 328	Continued From page 88 term memory problems, and severely impaired cognitive skills for daily decision making. Section O-Special Treatments, Procedures, and programs was marked for oxygen therapy. Resident #12's current comprehensive care plan dated 10/30/17 read "I have a dx (diagnosis) of COPD and am risk of shortness of breath and other respiratory complications. Approaches: O2 as needed change tubing weekly. Resident #12's October 2017 physician orders read in part "O2 at 2L/Min (liters per minute) via nasal cannula as needed at bedtime for COPD (chronic obstructive pulmonary disease)." The surveyor and licensed practical nurse #2 observed Resident #12 in bed on 10/31/17 at 10:05 a.m. The oxygen concentrator at the bedside read that the resident was receiving 2 liters of oxygen via nasal cannula. The surveyor asked how often tubing was changed and filters cleaned. L.P.N. #2 stated weekly and the tubing should have been changed Monday night and the filter cleaned. L.P.N. #2 checked the filter. The filter contained a lot of whitish gray material and no date on the tubing. L.P.N. #2 stated last night was Monday. It should have been changed and cleaned. The surveyor reviewed the October 2017 electronic medication administration records (eMARs). There was no entry for tubing change weekly. The two entries pertaining to oxygen were 1. O2 @ 2lpm (liters per minute) via n/c (nasal cannula) to maintain sats (saturation levels) above 90 percent. 2. O2 at @L/Min via nasal cannula as needed at bedtime for COPD.	F 328		

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F 328	Continued From page 89 The surveyor requested the facility policy on 11/1/17 at 1:00 p.m. from the director of nursing. The policy titled "Departmental (Respiratory Therapy) Prevention of Infection" read in part "9. Check filters once weekly while they are in continuous use. Discard filters or sterilize them between uses for different residents." The surveyor informed the administrative staff of the above concern during an end of the day meeting on 11/1/17 at 4:31 p.m. No further information was provided prior to the exit conference on 11/2/17.	F 328		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F 329	F 329 Drug Regimen is Free From Unnecessary Drugs **Criteria 1:** On November 2, 2017, non-pharmacological special requirement was added for all pain and anxiety medications to be completed prior to administration of medication. **Criteria 2:** DON and nursing admin added special requirement for non-pharmacological interventions for pain and anxiety medications to be completed prior to administration of medication. **Criteria 3:** DON or designee will provide education to facility staff regarding care plan updates and	

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F 329	Continued From page 90 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to provide non-pharmacological interventions prior to the administration of Ativan to 1 of 25 residents (Resident #5). The findings included: The facility staff failed to provide non-pharmacological interventions prior to the administration of Ativan to Resident #5. Resident #5 was admitted to the facility on 2/1/17 with the following diagnoses of, but not limited to anemia, high blood pressure, anxiety disorder, depression, end stage renal disease, spinal stenosis and low back pain. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/8/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a	F 329	non-pharmacological interventions by November 30, 2017. DON or designee will conduct an audit weekly to ensure special requirements for non-pharmacological interventions are added to admissions, readmissions, and residents with changes in condition. **Criteria 4:** DON or designee will review results of audits to ED weekly. ED or designee will present results of audits to facility QA committee monthly to be reviewed for further intervention or recommendation as necessary. **Criteria 5:** December 16, 2017	

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F 329	Continued From page 91 possible score of 15. Resident #5 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and total dependence of 1 staff member for bathing. During the review of the October, 2017, the MAR (Medication Administration Record) of Resident #5, the surveyor noted that the resident was given "Ativan 1 mg (milligram) every 8 hours as needed for anxiety by mouth". The resident was given the Ativan on the following dates and times, as documented on the MAR, "10/1/17 at 5:45 pm, 10/3/17 at 9:54 am, 10/7/17 at 5:35 pm, 10/18/17 at 12:45 pm and 10/20/17 at 11:42 am. The surveyor reviewed the nurses' notes of Resident #5 for the above documented dates and times that the Ativan was given. There were no non-pharmacological interventions documented as being used before the administration of the "prn" (as needed) Ativan dose on these dates and times by the staff. On 11/1/17 at 9:20 am, the surveyor notified the assistant director of nursing of the above documented findings. The assistant director of nursing stated "You are right. They didn't document any interventions." At 4:35 pm, the administrative team was notified of the above documented findings by the surveyor. No further information was provided to the surveyor prior to the exit conference on 11/2/17.	F 329		
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332		

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F 332	Continued From page 92 (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and during a medication pass and pour observation, the facility failed to ensure a medication error rate of less than 5%. There were 3 errors in 35 opportunities for a medication error rate of 8.5%. These medication errors affected Residents #16 and #17. The findings included. 1. For Resident #16, the facility staff failed to administer the Residents voltaren as ordered by the physician and administered one drop of thera tears into both eyes when the physician order called for two drops. The record review revealed that Resident #16 had been admitted to the facility 10/20/2017. Diagnoses included, but were not limited to, insomnia, diabetes, congestive heart failure, and chronic kidney disease. There was no completed MDS (minimum data set) assessment on this Resident. However, the Resident was alert and orientated. On 11/01/2017 at approximately 8:33 a.m. the surveyor observed LPN (licensed practical nurse) #3 prepare and administer Resident #16's morning medications. When preparing the Residents medications LPN #3 verbalized to the	F 332	F 332 Free of Medication Error Rates of 5% of More **Criteria 1:** Expired Vancomycin was properly disposed of on November 1, 2017 by nursing admin and Voltaren was obtained from pharmacy on November 2, 2017. Vancomycin was obtained from pharmacy on evening of November 1, 2017 to be administered. **Criteria 2:** Nursing admin looked through medications located in medication rooms to ensure meds were not expired on the evening of November 1, 2017. Pharmacy consultant to conduct medication pass reviews for nurses two times monthly. **Criteria 3:** Pharmacy consultant/DON or designee will provide education to nursing staff regarding administration rights. Pharmacy consultant will conduct monthly medication cart/pass audits.	

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F 332	Continued From page 93 surveyor that they did not have the Residents voltaren cream and she would need to notify the pharmacy. After preparing the Residents medications LPN #3 entered the Residents room and administered the Residents by mouth medications after administering these medications LPN #3 proceeded to administer the Residents eye drops. LPN #3 was observed by the surveyor to place one drop of the thera tears in each of the Residents eyes. After leaving the room the surveyor confirmed with LPN #3 that she had placed one drop in each of the Residents eyes. A review of the Residents clinical record revealed that the Resident should have received two drops of the thera tears in each eye. The voltaren that had been omitted was ordered to be administered four times daily. LPN #3 approached the surveyor on 11/01/2017 at approximately 11:00 a.m. and stated she had contacted the pharmacy regarding the voltaren and had been told the pharmacy did not have a current order for the voltaren. The administrative staff were notified of the omission of the voltaren and that the Resident had only received one eye drop when the physician ordered called for two drops during a meeting with the survey team on 11/01/2017 at approximately 4:35 p.m. The facility policy/procedure titled "Administering Medications" read in part "...Medications must be administered in accordance with the orders..." No further information regarding this issue was provided to the survey team prior to the exit	F 332	**Criteria 4:** DON or designee will review results of audits to ED weekly. ED or designee will present results of audits to facility QA committee monthly to be reviewed for further intervention or recommendation as necessary. **Criteria 5:** December 16, 2017	

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F 332	Continued From page 94 conference. 2. Facility staff attempted to administer expired Vancomycin to Resident # 17. Resident #17 was originally admitted to the facility on 5/20/17 with a readmission date of 8/23/17. Diagnoses included but not limited to: dysphagia, heart failure, enterocolitis due to clostridium difficile, and hypokalemia. The most recent MDS (minimum data set) was a quarterly assessment with an ARD of (assessment reference date) of 10/13/17. It is documented that Resident # 17 has a cognitive score of 12 out of 15 indicating moderate cognitive impairment. On 11/1/17 at 8:57 a.m. RN (registered nurse) # 2 was administering medications to Resident #17. Resident # 17 has a current order for Vancomycin 125 mg/2.5 ml (125 milligrams in 2.5 milliliters) by mouth four times daily. RN # 2 retrieved the medication from the refrigerator in the medication room. RN # 2 showed surveyor the bottle and stated "it's enough for the dose, she gets 2.5 mls." Surveyor noted a sticker on the bottle of Vancomycin was written to state "discard after 10/31/17." RN # 2 prepared 2.5 ml of the ordered Vancomycin and took the medication in the room to administer to Resident # 17. Surveyor called RN # 2 out of the room before administering any medication and advised her that she could not administer the medication to the resident because of the discard after 10/31/17 sticker on it. RN # 2 discarded the medication and stated that she would have to order the medication from the pharmacy. On 11/1/17 at 4:28 p.m. the DON (director of nursing), ADON (assistant director of nursing), Adm (administrator), nurse consultant, regional	F 332		

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F 332	Continued From page 95 MDS consultant, and regional director of operations were made aware of the above findings. No further information regarding this issue was provided to the survey team prior to the exit conference on 11/2/17 at 5:15 p.m.	F 332		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and	F 334	F 334 Influenza and Pneumococcal Immunizations **Criteria 1:** Resident is over the age of 65. On November 2, 2017, Resident #10 RP was notified and gave consent for vaccine to be administered. **Criteria 2:** MDS assessments will be reviewed by MDS coordinator for accuracy and will be corrected if deemed necessary. **Criteria 3:** DON or designee will provide education to MDS coordinators and nursing staff regarding MDS accuracy and completion of assessments by November 30, 2017. MDS or designee will do a review/audit of admissions, readmissions, and residents with changes in condition sample weekly to ensure accuracy.	

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F 334	Continued From page 96 (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff	F 334	**Criteria 4:** MDS coordinator will review results of audits to ED weekly. ED will present results of audits to facility QA committee monthly and reviewed for further intervention or recommendation as necessary. **Criteria 5:** December 16, 2017	

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F 334	Continued From page 97 failed to ensure that pneumococcal vaccination status was up to date for 1 of 25 residents in the survey sample, Resident # 10. Findings included: Facility staff failed to ensure that the pneumonia vaccine for Resident # 10 was up to date. Resident # 10 was originally admitted to the facility on 2/10/15 with a readmission date of 9/12/15. Diagnoses included but not limited to: dementia, multiple sclerosis, major depressive disorder, polyneuropathy, and hyperlipidemia. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 10/13/17. The facility staff coded Resident # 10's cognitive status as 11 out of 15 indicating moderate impairment. The clinical record was reviewed on 10/31/17 at 2:00 p.m. The signed physician's orders dated 10/7/17 had orders that stated "may have pneumovax 0.5 cc upon admission and every 5 years (unless otherwise indicated or received in the last 5 years)." Upon review of the face sheet it was noted that Resident # 10 last received a pneumococcal vaccine on 10/12/12. According to the physician's order, Resident #10's pneumococcal vaccination status was out of date as of 10/13/17. Further review of the clinical record did not reveal any documented indications to prevent Resident # 10 from receiving a pneumococcal vaccine. On 10/31/17 at 2:48 p.m., the survey team met with the administrator and the DON (director of nursing) and made them aware of the findings. Surveyor asked DON who monitors and keeps up	F 334		

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F 334	Continued From page 98 with the facility vaccinations. DON stated "to be completely honest I had a notebook on my desk doing audits on the vaccines and then you guys walked in and it got pushed to the side." DON stated that she would follow up on the situation. On 11/2/17 at 8:55 a.m., DON reported to surveyor that the facility was contacting the family representative for Resident # 10 to obtain consent to administer the pneumonia vaccine. On 11/7/17 at 3:42 p.m., DON verbally reported to surveyor that the family representative for Resident # 10 had given consent and that the facility would administer the pneumococcal vaccine to Resident # 10. No further information regarding this issue was reported to the survey team prior to the exit conference on 11/2/17 at 5:15 p.m.	F 334		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 371	F 371 Food Procure, Store/Prepare/Serve - Sanitary **Criteria 1:** On October 31, 2017, dietary manager discarded all opened and undated food items and hairnets firmly in place. **Criteria 2:** All residents are at risk by the above mentioned alleged deficient practice. Procedure on proper food storage to include proper labeling and dating will be reviewed by dietary staff.	

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F 371	Continued From page 99 (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to label and date opened items of food, failed to record tray line temperatures and failed to ensure hair nets firmly secured loose strands of employee's hair. The findings included: The surveyor toured the kitchen on 10/31/17 beginning at 7:46 a.m. with other #3. The surveyor observed a pitcher of unsweetened tea dated 10/27/17 and a pitcher of red Kool-Aid dated 10/26/17 in the reach in refrigerator. Other #3 was asked what was the facility policy for discarding food and drinks. Other #3 stated staff should discard after three (3) days. Also in the reach in refrigerator was a 5lb (pound) carton of sour cream dated 10/20/17. Other #3 stated the sour cream should be discarded after 7 days. The surveyor and other #3 checked the walk-in refrigerator. A 5lb carton of pimento cheese spread was dated 10/20/17, a 5lb carton of pimento cheese was opened and dated 9/30/17, and a 5lb carton of cottage cheese was opened and dated 10/1/17. A gallon of 2% milk was opened but not dated. An opened bag of	F 371	**Criteria 3:** Dietary manager or designee provided education to staff regarding labeling, storage procedures, tray line temps, and proper fit of hairnets on November 2, 2017. Manager or designee will audit the refrigerators, freezers, and temp logs daily to ensure all food items are in proper date range and tray line temps all complete and accurate with follow up no less than 5 days per week for 8 weeks. **Criteria 4:** Dietary manager will review results of audits to ED weekly. ED will present results of audits to facility QA committee monthly and reviewed for further intervention or recommendation as necessary. **Criteria 5:** December 16, 2017	

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F 371	Continued From page 100 shredded iceberg lettuce had no date when opened. The surveyor observed some of the shredded lettuce was dark green and looked "wilted". In the walk-in freezer, the surveyor observed an opened bag of rolls without a date. The surveyor was joined by the dietary manager other #1 for the remainder of the kitchen tour. In the dry storage area, a box of thickener was observed open to the air and without a date anywhere on the bag or box when opened. The dietary manager stated the box should be labeled and the bag secured when opened. During the tour of the kitchen, the surveyor observed three employees wearing hairnets (other #1, other #2, and other #4). The hair was not fully contained in the hair net. Each of the employees had hair dangling from underneath the hair net. The dietary manager other #1 stated the facility might need to use a different kind of hairnet. The surveyor and the dietary manager reviewed the tray line temperatures. In the month of October 2017, there were no recorded temperatures for the dinner meal on 10/20/17 and 10/26/17 and there were no recorded temperatures for breakfast or lunch on 10/6/17. The dietary manager stated she would follow-up with the cook. The surveyor informed the administrator and the director of nursing of the kitchen concerns during an end of the day meeting on 10/31/17 at 2:48 p.m. The surveyor requested the facility policy on storage of food.	F 371		

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F 371	Continued From page 101 The facility policy titled "Food and Supply Storage Procedures-Continued" was reviewed 11/1/17. The policy read in part "Discard leftovers not utilized within 48 hours." No further information was provided prior to the exit conference on 11/2/17.	F 371		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, facility document review, and clinical record review, the facility failed to ensure physician ordered medications were available for administration for 3 of 25 Residents, Residents #16, #9, and #3. The findings included. 1. For Resident #16, the facility failed to ensure the Residents voltaren and the narcotic norco were available for administration.	F 425	F 425 Pharmaceutical SVC-Accurate Procedures, RPH **Criteria 1:** RP and physicians were notified for all missed doses. Tylenol had been given to resident #16 on October 31, 2017 when Norco was unavailable and was documented. Medications were all obtained prior to exit on November 2, 2017. **Criteria 2:** A medication availability audit was completed by nursing admin for other residents and no additional issues were noted on November 2, 2017. **Criteria 3:** DON or designee will educate clinical staff regarding medication administration and management by November 30, 2017. DON or designee will audit medication availability daily at least 5 times a week for a minimum of 90 days.	

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F 425	Continued From page 102 The record review revealed that Resident #16 had been admitted to the facility 10/20/2017. Diagnoses included, but were not limited to, insomnia, diabetes, congestive heart failure, and chronic kidney disease. There was no completed MDS (minimum data set) assessment on this Resident. However, the Resident was alert and orientated. On 11/01/2017 at approximately 8:33 a.m. the surveyor observed LPN (licensed practical nurse) #3 prepare and administer Resident #16's morning medications. When preparing the Residents medications LPN #3 verbalized to the surveyor that they did not have the Residents voltaren cream and she would need to notify the pharmacy. Upon entering the Residents room Resident #16 verbalized that she had not received her narcotic pain medication that morning but had been given tylenol instead. A review of the Residents clinical record indicated that Resident #16 had physicians orders for- 1. Norco 5/325 take 1 by mouth every 6 hours daily for pain. 2. Voltaren gel apply to affected areas four times daily. A review of the Residents clinical record revealed that on 10/31/2017 at 12:00 a.m. and 12:00 p.m. and on 11/01/2017 at 6:00 a.m. the facility nursing staff had documented that the Residents norco was not available for administration. On 11/01/2017 at approximately 11:00 a.m. LPN #3 approached the surveyor and stated she had contacted the pharmacy regarding the voltaren and had been told the pharmacy did not have a	F 425	**Criteria 4:** DON or designee will review results of audits to ED weekly. ED or designee will present results of audits to facility QA committee monthly to be reviewed for further intervention or recommendation as necessary. **Criteria 5:** December 16, 2017	

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F 425	Continued From page 103 current order for the voltaren. On 11/01/2017 at approximately 2:40 p.m. the surveyor spoke with pharmacist #1 via phone. Pharmacist #1 verbalized to the surveyor that no voltaren had ever been sent to the facility for this Resident and that an order for the Residents voltaren came over the fax machine for the first time today. On 11/01/2017 at approximately 2:50 p.m. the surveyor asked LPN #3 where she had obtained the voltaren previously for Resident #16. LPN #3 verbalized to the surveyor that there was some in the bottom of the medication cart and she guessed they just assumed it belonged to Resident #16. On 11/02/2017 at approximately 8:00 a.m. the surveyor spoke with Resident #16 regarding the voltaren. Resident #16 verbalized to the surveyor that the facility had put some medication on her lower back and shoulders. On 11/01/2017 at approximately 1:35 p.m. the DON (director of nursing) was asked if they had a backup pharmacy. The DON verbalized that there was a local pharmacy they could use. The facility policy/procedure titled "Administering Medications" read in part "...Medications must be administered in accordance with the orders..." The administrative staff were made aware of the issues regarding the Residents narcotic pain medication norco and voltaren during a meeting with the survey team on 11/01/2017 at approximately 4:35 p.m.	F 425		

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F 425	Continued From page 104 No further information regarding this issue was provided to the survey team prior to the exit conference. 2. The facility staff failed to ensure that Resident #9 had an antibiotic, Invanz, available for administration. Resident #9 was admitted to the facility on 3/7/17 with the diagnoses of, but not limited to high blood pressure, neurogenic bladder, Urinary Tract Infection, Alzheimer's Disease, dementia, anxiety disorder and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/23/17 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #9 was also coded requiring extensive assistance of 1 staff member for dressing and personal hygiene and total dependence of 1 staff member for bathing. The surveyor conducted a review of Resident #9's clinical record on 11/1/17. During this review, the surveyor noted a physician order dated for 9/28/17 for the following: "Invanz 850 mg (milligram) Intramuscularly once daily for 5 days". The surveyor also reviewed the resident's MAR (Medication Administration Record) for the month of Administration Details which stated " ...pharmacy notified states it would be here tonight". This medication was noted to had been administrated on 9/29/17 for the first dose and was to be administrated once a day for 5 days. On 11/2/17 at approximately 1:40 pm, the director of nursing was notified of the above documented findings. The director of nursing stated "I don't know why we didn't have the dose of the antibiotic to give to the resident. It was a regular scheduled	F 425		

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F 425	Continued From page 105 medication and I would think the pharmacy would send all the doses since it was just for 5 days." No further information was provided to the surveyor prior to the exit conference on 11/2/17 at 5:15 pm. 3. The facility staff failed to have the medication Ativan 0.5 mg give one half tab 0.25 mg (for anxiety) available for administration on 10/11/17 at 9:00 pm. Resident #3 was admitted to the facility on 5/30/16. Her diagnoses include but are not limited to high blood pressure, hypothyroidism, urinary tract infection, anxiety and Alzheimer's disease. Resident #3's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 10/5/17 assessed her to understand and could be understood. She was assessed to have as cognitive status of 4 out of 15. Her assessment revealed in section G, she needed assistance with daily activities of living. The physician order sheet dated 7/1/17 contained an order for: "Ativan 0.5 mg take one half tab (0.25mg) by mouth every night at bedtime." Resident #3's electronic medication administration record (eMARs) was reviewed. The eMAR also contained the order: "Ativan 0.5 mg take one half tab (0.25mg) by mouth every night at bedtime." The medication Ativan was not available for administration by the staff on 10/11/17 during the medication pass observation. The Cubex (the facility medication dispensing system), was checked for the Ativan.	F 425		

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F 425	Continued From page 106 On the administration record the following note was written: 10:28 pm, 10/11/17 (scheduled: 9:00pm, 10/11/17; Ativan 0.5 mg tablet) Ativan 0.5 mg take one half tab (0.25mg tablet) ...scheduled for 10/11/2017 9:00 pm unavailable. MD and pharmacy aware via telephone conversation due to requires code for Cubex." On 11/1/17 at 1:15 pm, the directors of nurses was asked to look at the administration record note for the Ativan that was not available on 10/11/17. After she looked she said, that looks right to me. However, the medication was unavailable for administration on 10/11/17 at 9:00pm, and there was no documentation made by the nurse placing the medication on hold until it was available. During the end of the day meeting on 11/1/17, the administrator and the director of nurses were informed of the medication not being available. No further information was provided by the facility related to the Ativan being unavailable for administration.	F 425		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff,	F 441	F 441 Infection Control, Prevent Spread, Linens **Criteria 1:** On November 2, 2017, LPN #1 was educated by DON regarding hand hygiene and proper infection control practices. On November 1, 2017, LPN #5 was educated by DON regarding infection control during medication pass.	

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F 441	Continued From page 107 volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (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	F 441	**Criteria 2:** All residents are at risk by the above mentioned alleged deficient practice. Brief education was provided to staff on November 2, 2017 regarding infection control practices and hand hygiene. **Criteria 3:** DON or designee will provide comprehensive infection control education will be provided to facility staff by November 30, 2017 to include tracking of infections and hand washing. Pharmacy consultant will conduct monthly medication cart/pass audits. **Criteria 4:** DON or designee will review results of audits to ED weekly. ED or designee will present results of audits to facility QA committee monthly to be reviewed for further intervention or recommendation as necessary. **Criteria 5:** December 16, 2017	

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F 441	Continued From page 108 (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to follow infection control guidelines for 3 of 25 residents (Resident #12, Resident #18, and Resident #17). The findings included: 1. The facility staff failed to perform hand hygiene when going from dirty to a clean area and failed to clean scissors after the scissors were used to remove a bandage from Resident #12's calf. The surveyor reviewed Resident #12's clinical record on 10/31/17 and 11/1/17. Resident #12 was admitted to the facility 3/10/17 and readmitted 6/16/17 with diagnoses that included but not limited to urine retention, urinary tract infection, peripheral vascular disease, deep tissue injury, atrial fibrillation, hyperlipidemia, cerebral infarction, dysphagia, hemiplegia, hypertension, Vitamin D deficiency, Vitamin B12	F 441		

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F 441	Continued From page 109 deficiency, constipation, chronic pain, pneumonia, and severe sepsis with septic shock. Resident #12's significant change in minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/24/17 assessed the resident with short term memory problems, long term memory problems, and severely impaired cognitive skills for daily decision making. Section G Functional Status assessed Resident #12 to require extensive assistance of 2 staff for bed mobility and assessed the resident with an impairment on one side that involved both extremities. The surveyor observed wound care on 11/01/17 at 1:40 p.m. with licensed practical nurse #1 providing the wound care and certified nursing assistant #3 assisting in the care. L.P.N. #1 had gathered the wound care supplies from the treatment cart and along with C.N.A. #1 entered the resident's room without knocking or announcing themselves and proceeded to provide wound care to Resident #12. L.P.N. #1 placed a barrier on the over the bed table. The over the bed table was not cleaned prior to the placement of the barrier. The first area of treatment was the right buttock. L.P.N. #1 applied gloves. L.P.N. #1 applied Dakin's solution on a 4 x 4 and cleaned the right buttock. L.P.N. #1 removed her gloves and applied a pair of new gloves. The surveyor observed no hand hygiene. L.P.N. #1 then applied a dated foam dressing. L.P.N. #1 removed her gloves and washed her hands. L.P.N. #1 applied new gloves, checked the size of Resident #12's Foley catheter and removed her gloves. L.P.N. #1 then cleaned her hands with hand sanitizer. L.P.N. #1	F 441		

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F 441	Continued From page 110 applied gloves and cleaned Resident #12's left heel with Betadine swabs three times. Gloves removed and hands were washed. L.P.N. #1 pulled her scissors from her pocket. Gloves applied and L.P.N. #1 cut the bandage from Resident #12's left calf. The scissors were returned to the clean barrier. No cleaning of the scissors was observed before or after they were used. L.P.N. #1 removed her gloves and applied a new pair of gloves. The surveyor did not observe L.P.N. #1 perform hand hygiene. L.P.N. #1 proceeded to clean the area on the calf with Dakin's solution and then removed gloves. No hand hygiene was observed. L.P.N. #1 donned a new pair of gloves and applied xeroform gauze, 4 x 4 and kerlix to the left calf wound. L.P.N. #1 carried soiled dressings to the trash can located on the treatment cart located in the hall and placed the uncleaned scissors in the cart. The surveyor requested the facility policy on dressing changes from the director of nursing on 11/1/17. The surveyor interviewed the assistant director of nursing on 11/2/17 at 8:00 a.m. During the interview, the ADON was asked when should scissors be cleaned. The ADON stated before they were used and after. The ADON stated the procedure had been reviewed with the wound care nurse previously. The ADON was also asked when should one wash hands. The ADON stated after glove removal. The surveyor interviewed L.P.N. #1 on 11/2/17 at 9:30 a.m. about the wound care observation on 11/1/17. L.P.N. #1 stated she thought she had washed her hands after she had removed her gloves. L.P.N. #1 stated she knew to clean her	F 441		

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F 441	Continued From page 111 scissors but she didn't. The surveyor reviewed the facility policy titled "Dressing, Dry/Clean" on 11/2/17. The policy read in part "Steps in the Procedure 6. Put on clean gloves. Loosen tape and remove soiled dressing. 7. Pull glove over dressing and discard into plastic or biohazard bag. 8. Wash and dry hands thoroughly. 13. Put on clean gloves." The surveyor informed the administrative staff of the above concern during Resident #12's wound care observation in the end of the day meeting on 11/2/17 at 12:18 p.m. No further information was provided prior to the exit conference on 11/2/17. 2. For Resident #18, the facility staff failed to perform any hand hygiene after using her bare hands to wipe her nose with a tissue and before administering insulin. The record review revealed that Resident #18 had been admitted to the facility 08/15/2015. Diagnoses included, but were not limited to, diabetes, bipolar disorder, hypertension, and hypothyroidism. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 09/05/2017 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. On 11/01/2017 at approximately 8:05 a.m. two surveyors approached LPN (licensed practical nurse) #5. LPN #5 was observed by the surveyors to be using her bare hands and a	F 441		

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F 441	Continued From page 112	F 441		

tissue to wipe her nose. LPN #5 was observed by the surveyors to throw the tissue she had used to wipe her nose in the trash bin on the medication cart. Without performing any hand hygiene LPN #5 began preparing Resident #18's insulin for administration. After preparing the insulin LPN #5 applied a pair of gloves and entered the Residents room and administered the Residents insulin into the Residents abdomen. After administering the insulin LPN #5 removed her gloves and washed her hands.

After exiting the Residents room, the surveyor asked LPN #5 about wiping her nose and the lack of any hand hygiene. LPN #5 verbalized to the surveyors that she didn't realize she had wiped her nose.

The facility policy titled "Administering Medications" read in part "...Staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable..."

Per the CDC (centers for disease control) website accessed 11/03/2017.
https://www.cdc.gov/handhygiene/download/hand_hygiene_core.pdf
"...Healthcare workers should wash hands with soap and water when hands are visibly dirty, contaminated or soiled and use an alcohol-based handrub when hands are not visibly soiled to reduce bacterial counts. Hand hygiene is indicated before: patient contact, donning gloves..."

On 11/02/2017 at approximately 7:55 a.m. the surveyor interviewed the designated infection

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F 441	Continued From page 113 control nurse/ADON (assistant director of nursing). When asked if LPN #5 should have completed any hand hygiene after wiping her nose and before preparing and administering insulin the ADON replied Yes, she should have washed her hands. The administrative team were made aware of the infection control issue regarding LPN #5 and Resident #18 during a meeting with the survey team on 11/01/2017 at approximately 4:35 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 3. Facility staff failed to follow infection control guidelines for clostridium difficile for Resident #17. Resident #17 was originally admitted to the facility on 5/20/17 with a readmission date of 8/23/17. Diagnoses included but not limited to: dysphagia, heart failure, enterocolitis due to clostridium difficile, and hypokalemia. The most recent MDS (minimum data set) was a quarterly assessment with an ARD of (assessment reference date) of 10/13/17. It is documented that Resident # 17 has a cognitive score of 12 out of 15 indicating moderate cognitive impairment. On 11/1/17 at 8:57 a.m., RN (registered nurse) # 2 was administering medications to Resident #17. After preparing the medication RN # 2 sanitized her hands and donned gloves and entered Resident #17's room and administered medications to Resident #17. RN # 2 removed her gloves and washed her hands prior to leaving the room.	F 441		

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F 441	Continued From page 114 On 11/1/17 at 9:25 a.m., surveyor checked the isolation cart that was placed outside Resident # 17's room and there were no isolation gowns in the cart. On 11/1/17 at 9:30 a.m., surveyor spoke with RN#2 . Surveyor asked RN# 2 why she did not wear an isolation gown when entering Resident # 17's room? RN # 2 stated that she was told that Resident #17 has on a brief and that the c diff (clostridium difficile) was contained, and if staff washes their hands before and after contact with Resident #17 they didn't need to gown and glove. RN# 2stated "She (Resident #17) comes out to activities and everything." On 11/1/17 at 2:48 p.m., DON (director of nursing) and administrator were made aware of the above findings. Per the Clostridium difficile facility policy which per the DON is also the facility standard of practice under contact precautions it states under 10. "Residents with diarrhea associated with C. difficile (i.e., residents who are colonized and symptomatic) will be placed on Contact Precautions. Healthcare workers and visitors will wear gloves and gowns when entering the room of a resident with C. difficile infection." No further information regarding this issue was presented to the survey team prior to the exit conference on 11/2/17 at 5:15 p.m.	F 441		
F 502 SS=E	483.50(a)(1) ADMINISTRATION (a) Laboratory Services (1) The facility must provide or obtain laboratory	F 502	F 502 Administration **Criteria 1:** Resident #2 order obtained on November 1, 2017 for BMP to be obtained on next lab day. Resident #4 physician was notified and provider discontinued order on November 2, 2017.	

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F 502	Continued From page 115 services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain physician ordered lab tests for 4 of 25 Residents, Residents #2, #4, #23, and #11. The findings included. 1. For Resident #2, the facility staff failed to obtain a BMP (basic metabolic panel) lab test. The record review revealed that Resident #2 had been admitted to the facility 01/04/2017. Diagnoses included, but were not limited to, anxiety, seizures, congestive heart failure, and bipolar disorder. Section C (cognitive status) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 09/05/2017 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. The clinical record included a physicians telephone order dated 07/14/2017 for a BMP to be obtained. When reviewing the clinical record the surveyor was unable to find the results for this BMP. On 10/31/2017 at approximately 10:30 a.m. RN (registered nurse) #1 was asked about the missing BMP.	F 502	**Criteria 2:** Labs to be drawn on November 1, 2017 were reviewed and audited by nursing admin to ensure completion, documentation, and results obtained from lab. **Criteria 3:** DON or designee will educate licensed clinical staff regarding obtaining ordered labs and reporting results to provider by November 30, 2017. DON or designee will utilize a daily lab book audit tool to include result status and reporting compliance for a minimum of 90 days. **Criteria 4:** DON or designee will review results of audits to ED weekly. ED or designee will present results of audits to facility QA committee monthly to be reviewed for further intervention or recommendation as necessary. **Criteria 5:** December 16, 2017	

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F 502	Continued From page 116 On 11/01/2017 at approximately 1:20 p.m. the DON (director of nursing) verbalized to the survey team that they had not obtained the BMP. The administrative staff were notified of the missing BMP during a meeting with the survey team on 11/01/2017 at approximately 4:35 p.m. No further information regarding the missing BMP was shared with the survey team prior to the exit conference. 2. For Resident #4, the facility failed to obtain the physician ordered laboratory tests CBC (complete blood count), CMP (comprehensive metabolic panel), and TSH (thyroid stimulating hormone). The record review revealed that Resident #4 had been admitted to the facility 02/04/2016. Diagnoses included, but were not limited to, dementia with behavioral disturbances, Alzheimer's disease, diabetes, hypertension, and hypothyroidism. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 09/05/2017 was coded 1/1/3 to indicate the Resident had problems with long and short term memory and was severely impaired in cognitive skills for daily decision making. Resident #4's clinical record included a physicians telephone order dated 07/03/2017 for a CBC, CMP, and TSH to be obtained. During the clinical record review the surveyor was unable to find the results for these lab tests.	F 502		

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F 502	Continued From page 117 The DON (director of nursing) was asked about the missing lab tests on 11/01/2017 at approximately 9:55 a.m. During a meeting with the administrative team on 11/02/2017 at approximately 4:35 p.m. the DON verbalized to the survey team that the lab was unable to find any results for these lab tests. No further information regarding the missing lab tests was provided to the survey team prior to the exit conference. 3. The facility staff failed to obtain a Vitamin D level and a Vitamin B12 level for Resident #23. The clinical record of Resident #23 was reviewed 11/2/17. Resident #23 was admitted to the facility 8/14/17 with diagnoses that included but not limited to hypokalemia, unspecified atrial fibrillation, pleural effusion, hyperlipidemia, hypertension, unspecified dementia without behavioral disturbances, adult failure to thrive, anemia, acute kidney failure, chronic kidney disease, and dysphagia. Resident #23's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/20/17 assessed the resident with a BIMS (brief interview for mental status) as 09 out of 15. The clinical record contained a telephone order dated 9/21/17 that read "1. D/C (discontinue) Vitamin D & B12 level ordered for 9/20/17. 2. Vitamin D & B12 level on 9/26/17." The surveyor reviewed the laboratory section of the clinical record but found no results for a Vitamin D level or a Vitamin B12 level completed	F 502		

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F 502	Continued From page 118 on 9/26/17. The surveyor informed the director of nursing that there were no results for the Vitamin D level and the Vitamin B12 level ordered for 9/26/17 in the clinical record on 11/2/17 at 10:00 a.m. The director of nursing informed the surveyor 11/2/17 at 10:30 a.m. that the Vitamin D level and the Vitamin B12 level ordered for 9/26/17 had not been obtained. The surveyor informed the administrative staff of the above concern during a meeting on 11/2/17 at 12:18 p.m. No further information was provided prior to the exit conference on 11/2/17. 4. For Resident #11 the facility staff failed to obtain physician ordered laboratory test, TSH (Thyroid Stimulating Hormone). Resident #11 was admitted to the facility on 3/3/16 and readmitted on 6/2/17. Resident #11's diagnoses include but are not limited to: elevated blood pressure, urinary retention, thyroid disorder, depression, chronic pain, and anemia. A review of Resident #11's clinical record revealed on the most recent minimum data set (MDS) with an assessment reference date of 8/09/17, the facility staff assessed the resident to understand and usually to be understood and as a 12 for his cognitive status. On 7/27/17, a review of Resident #11's clinical record revealed that the physician had given an order for the laboratory test, TSH on 9/5/17 to be drawn the next lab day 9/7/17.	F 502		

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F 502	Continued From page 119 A review of Resident 11's electronic clinical record and hard chart for the results of the lab tests completion. However, the results were not found in the record. On 11/1/17 at 1:15 pm, the directors of nurses was asked to assist in locating the labs. After looking she stated to the surveyor, "didn't have one for that date (9/7/17) I can't fix that". On 11/1/17 at approximately 5:25 pm, during a meeting with the administrator and the director of nurses, the missing lab results were discussed. Prior to exit no further information was provided to the surveyor related to the lab that was not obtained.	F 502		
F 504 SS=D	483.50(a)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN (a) Laboratory Services (2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain a physician order prior to obtaining a laboratory test for 2 of 25 residents in the survey sample (Resident #5 and Resident #23). The findings included:	F 504	F 504 Lab SVCS Only When Ordered by Physician **Criteria 1:** Physician notifications were completed on both residents #5 and #23. **Criteria 2:** Labs to be drawn on November 1, 2017 were reviewed and audited by nursing admin to ensure completion, documentation, and results obtained from lab. **Criteria 3:** DON or designee will educate licensed clinical staff regarding obtaining ordered labs and reporting results to provider by November 30, 2017. DON or designee will utilize a daily lab book audit tool to include result status and reporting compliance for a minimum of 90 days.	

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F 504	Continued From page 120 1. The facility staff failed to obtain a physician order prior to obtaining a laboratory test for Resident #5. Resident #5 was admitted to the facility on 2/1/17 with the following diagnoses of, but not limited to anemia, high blood pressure, anxiety disorder, depression, end stage renal disease, spinal stenosis and low back pain. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/8/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a possible score of 15. Resident #5 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and total dependence of 1 staff member for bathing. The surveyor conducted a review of Resident #5's clinical record on 10/31/17 and 11/1/17. It was noted by the surveyor that on 9/19/17 the physician had ordered "K+ (Potassium) lab in 2 days". The surveyor could not find the results for a K+ level drawn on 9/21/17. Instead it was noted that on a laboratory result of a K+ level dated as being obtained on 9/24/17. The director of nursing (DON) was notified of the above documented findings by the surveyor on 11/1/17 at 9:10 am. The DON stated "Let me go and check the logs and call the lab." At 4:35 pm, the administrative team was notified of the above documented findings by the surveyor. The DON provided a copy of a physician order dated for 11/1/17 which stated the following: "D/C K+ order to be drawn on 10/21 draw on 10/24." The surveyor was also provided a copy of a nurses' note dated and times for	F 504	**Criteria 4:** DON or designee will review results of audits to ED weekly. ED or designee will present results of audits to facility QA committee monthly to be reviewed for further intervention or recommendation as necessary. **Criteria 5:** December 16, 2017	

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F 504	Continued From page 121 11/1/17 at 10:03 am which stated "spoke with Dr. ____ (name of doctor) reported that K level to be drawn on 10/21 was drawn on 10/24. Per MD (medical doctor) K+ drawn on 10/24 was sufficient. Order to dc (discontinue)10/21 lab and draw K 10/24 received. (sic)" No further information was provided to the surveyor prior to the exit conference on 11/2/17. 2. The facility staff obtained a CBC (complete blood count) and a BMP (basic metabolic panel) on 8/22/17 prior to obtaining the physician order. The clinical record of Resident #23 was reviewed 11/2/17. Resident #23 was admitted to the facility 8/14/17 with diagnoses that included but not limited to hypokalemia, unspecified atrial fibrillation, pleural effusion, hyperlipidemia, hypertension, unspecified dementia without behavioral disturbances, adult failure to thrive, anemia, acute kidney failure, chronic kidney disease, and dysphagia. Resident #23's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/20/17 assessed the resident with a BIMS (brief interview for mental status) as 09 out of 15. The laboratory section of the clinical record contained the results of a CBC and a BMP dated 8/22/17. The surveyor was unable to locate a physician order for the BMP and CBC obtained 8/22/17. The surveyor informed the director of nursing that an order for the CBC and BMP obtained 8/22/17	F 504		

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F 504	Continued From page 122 could not be located in the clinical record on 11/2/17 at 10:00 a.m. The director of nursing informed the surveyor 11/2/17 at 10:30 a.m. that the CBC and BMP obtained on 8/22/17 was done without a physician order. The surveyor informed the administrative staff of the above concern during a meeting on 11/2/17 at 12:18 p.m. No further information was provided prior to the exit conference on 11/2/17.	F 504		
F 507 SS=D	483.50(a)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS (a) Laboratory Services (2) The facility must- (iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure physician ordered laboratory results were in the clinical record for 1 of 25 residents (Resident #14). The findings included: The facility staff failed to ensure the final results of a Phenobarbital level obtained in January 2017 were in Resident #14's clinical record.	F 507	F 507 Lab Reports in Record - Lab Name/Address **Criteria 1:** Results were obtained from laboratory on November 1, 2017 for Resident #14 and was reviewed by physician with no new orders obtained. **Criteria 2:** Labs to be drawn on November 1, 2017 were reviewed by nursing admin to ensure completion, documentation, and results obtained from lab. **Criteria 3:** DON or designee will educate licensed clinical staff regarding obtaining ordered labs and reporting results to provider by November 30, 2017. DON or designee will utilize a daily lab book audit tool to include result status and reporting compliance for a minimum of 90 days.	

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F 507	Continued From page 123 The surveyor reviewed Resident #14's clinical record 10/31/17 and 11/1/17. Resident #14 was admitted to the facility 1/10/17 with diagnoses that included but not limited to epilepsy, spastic quadriplegic cerebral palsy, unspecified psychosis, hyperlipidemia, anxiety, gout, Vitamin B deficiency, Vitamin D deficiency, edema, constipation, knee contracture, and unspecified osteoarthritis. Resident #14's quarterly MDS (minimum data set) assessment with an assessment reference date (ARD) of 11/2/17 assessed the resident with a BIMS (brief interview for mental status) of 13 out of 15. An order dated 1/13/17 read "FLP (fasting lipid panel), CMP (comprehensive metabolic panel), TSH (thyroid stimulating hormone), phenobarbital level next Tuesday- ?(Increased) cholesterol, HTN (hypertension), seizures." The surveyor reviewed the laboratory section for the results of the ordered laboratory tests. All were there except the phenobarbital level. The "Laboratory Report" dated 1/18/17 1145 read "Ordered: PHENO Pending: PHENO." The laboratory report had been initialed and dated by registered nurse #4 with the notation "Received 1-19-17." The surveyor reviewed each page of the laboratory section and was unable to locate the results of the phenobarbital level. The surveyor informed the administrative staff in the end of the day meeting on 11/1/7 at 5:15 p.m. On 11/2/17, the director of nursing provided the	F 507	**Criteria 4:** DON or designee will review results of audits to ED weekly. ED or designee will present results of audits to facility QA committee monthly to be reviewed for further intervention or recommendation as necessary. **Criteria 5:** December 16, 2017	

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F 507	Continued From page 124 results of the phenobarbital level obtained on 1/18/17. The DON was asked where the results were located. The DON stated the staff called the lab for the results. When asked if the MD (medical doctor) had been notified, the DON stated she would inform the MD. "The lab result was within normal limits-a 15 I believe." The facility policy titled "Charting and Documentation" was reviewed. The policy read in part "1. All observations, medications administered, services performed, etc., must be documented in the resident's clinical records." No further information was provided prior to the exit conference on 11/2/17.	F 507		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F 514	**F 514** Res Records - Complete/Accurate/Accessible **Criteria 1:** Facility staff was unable to provide any additional information for alleged deficient practice. **Criteria 2:** Nursing staff educated on implementation and documentation of bowel protocol. Nursing admin or designee monitoring BM report daily since November 2, 2017 to ensure completion and effectiveness of interventions.	

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F 514	Continued From page 125 (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, facility document review, and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for 3 of 25 residents (Resident #14, Resident #13, and Resident #6). The findings included: 1. The facility staff failed to document the administration of MOM (milk of magnesia) to Resident #14 on the October electronic medication administration records (eMARs) The surveyor reviewed Resident #14's clinical record 10/31/17 and 11/1/17. Resident #14 was admitted to the facility 1/10/17 with diagnoses that included but not limited to epilepsy, spastic quadriplegic cerebral palsy, unspecified psychosis, hyperlipidemia, anxiety, gout, Vitamin B deficiency, Vitamin D deficiency, edema, constipation, knee contracture, and unspecified osteoarthritis. Resident #14's quarterly MDS (minimum data	F 514	**Criteria 3:** DON or designee will provide education by November 30, 2017 to nursing staff regarding documentation to ensure an accurate clinical record. DON or designee will provide education to nursing staff by November 30, 2017 in regard to importance of CNA documentation of bowel movements, nurse monitoring of BM reports, and process of utilizing bowel protocol from physician standing orders. DON or designee will provide education by November 30, 2017 to nursing staff on the eight rights of medication administration, order clarification, and physician notification. DON or designee will monitor BM reports to identify residents for whom interventions may need to be initiated and document follow-up has been completed daily. DON or designee will then verify that the resident is no longer being identified on the report. Supervisor will review order entry on new orders followed by the ADON/DON review of orders, corrections to be documented daily. Audits will be conducted for 30 days.	

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F 514	Continued From page 126 set) assessment with an assessment reference date (ARD) of 11/2/17 assessed the resident with a BIMS (brief interview for mental status) of 13 out of 15. A review of the October 2017 BM (bowel movements) Details Roster was completed 11/1/7. The detailed report did not have a bowel movement documented for Resident #14 from 10/3/17 through 10/8/17 for a total of 6 days and no documentation of a BM from 10/26/17 through 10/29/17 -a total of 4 days. The surveyor reviewed the October 2017 eMAR. There was no documentation that any interventions had been offered between 10/3/17 and 10/8/17 or from 10/26/17 through 10/29/17 on the October 2017 eMAR. The director of nursing was informed there was no evidence interventions had been done for Resident #14's 6 days and 4 days without a bowel movement in October 2017. The DON provided the "No BM Report." The "No BM Report" was reviewed. Next to Resident #14's name, MOM was written that it was given at 0600 10/7/17 and MOM given on 10/29/17. However, the medication MOM was not charted on the October 2017 eMAR. When asked if the MOM should be charted on the eMAR, the DON stated she "pleaded the 5th." The facility policy titled "Administering Medications" was reviewed 11/2/17. The policy read in part "20. As required or indicated for a medication, the individual administering the medication will record in the resident's medical record: a. The date and time the medication was administered.; f. any results achieved and when	F 514	**Criteria 4:** DON or designee will review results of audits to ED weekly. ED or designee will present results of audits to facility QA committee monthly to be reviewed for further intervention or recommendation as necessary. **Criteria 5:** December 16, 2017	

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F 514	Continued From page 127 those results were observed." No further information was provided prior to the exit conference on 11/2/17. 2. The facility staff failed to maintain a complete and accurate clinical record for Resident #13. Resident #13 was admitted to the facility on 1/19/17 with the following diagnoses of, but not limited to Alzheimer's Disease, high blood pressure, Parkinson's Disease, heart failure, dementia and diabetes. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/10/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 3 out of a possible score of 15. Resident #13 also was coded as requiring assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing. The clinical record was reviewed by the surveyor on 11/1 and 11/2/17. The MAR (Medication Administration Record) for the month of October, 2017 was also reviewed by the surveyor. On the MAR under 10/1/17 at 6:45 am, the staff documented "Y" which represents the staff noted Resident #13 to exhibit behaviors during that shift. The surveyor reviewed the nurses' notes and there was no documentation of behaviors noted for this date and time. Under 10/6/17 at 6:45 am, the surveyor noted the staff documented "N" which represents the resident did not exhibit behaviors during that shift. The surveyor noted the following documentation in the nurses' notes for 10/6/17 2:55 am which stated " ...has been yelling, cursing and grabbing". The director of nursing was notified of the above	F 514		

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F 514	Continued From page 128 documented findings on 11/2/17 at approximately 2:30 pm in the conference room by the surveyor. The surveyor showed the director of nursing the documentation on the MAR and in the nurses' notes for the above dates and times. The director of nursing stated "In these examples, the staff did not accurately document either in the nurses' notes or on the MAR for these dates". No further information was provided to the surveyor prior to the exit conference on 11/2/17 at 5:15 pm. 3. Facility staff failed to appropriately document pain medication for Resident # 6. Resident # 6 was originally admitted to the facility on 2/16/15 with a readmission date of 12/15/16. Diagnoses included but not limited to: chronic diastolic congestive heart failure, hypothyroidism, chronic kidney disease stage 3, and hypertension. The most recent MDS (minimum data set) assessment was quarterly assessment with an ARD (assessment reference date) of 10/13/17. Facility staff documented Resident # 6's cognitive status was severely impaired with a cognitive score of 6 out of 15. The clinical record for Resident #6 was reviewed on 10/31/17 at 9:30 a.m. Upon review of the most recent MDS with an ARD of 10/13/17 it was documented by the facility staff in section M0150 that Resident #6 was at risk for developing pressure ulcers. Section M1040 H. facility staff documented that Resident # 6 had moisture associated skin damage. In section M1200 facility staff documented pressure reducing device for bed and applications of ointments/medications other than to feet as skin and ulcer treatments.	F 514		

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F 514	Continued From page 129 On 11/1/17 at 11:13 a.m. Resident # 6 was observed lying in her bed flat on her back. On 11/1/17 at 11:15 a.m. LPN (licensed practical nurse) #1 was preparing to provide treatment to Resident #6's buttocks. LPN #1 tells surveyor "she usually gets Greer's goo but we are out of it and waiting on it to come from the pharmacy in Richmond.' "I have an order to use house barrier cream until it comes in." LPN #1 stated she gets MASD (moisture associated skin damage) a lot because she is non-compliant with turning. Surveyor asked LPN #1 if Resident # 6 was able to turn herself? LPN #1 stated "no." On 11/1/17 at 11:19 a.m. treatment nurse assisted by CNA # 1 (certified nursing assistant) began to administer treatment to Resident # 6's buttocks. When CNA # 1 touched Resident # 6 on her right thigh to assist her in turning Resident #6 stated "ooh my butt." CNA #1 along with LPN #1 turned Resident # 6 on her left side. LPN #1 began to wash Resident #6's bottom with soap and water. Resident # 6 flinched as soon as her buttocks was touched by the treatment nurse. Resident # 6 stated "it's hurting my butt." LPN #1 continued to wash Resident #6's buttocks but started patting the area instead of washing in circular motion. Resident # 6 then stated "she's hurting me." Surveyor observed areas on the buttocks of Resident # 6 red area on right lower buttock in the fold, one open area right upper buttock, small open area in the crease in between both buttocks and 2 open areas on left buttock. There was redness noted to bilateral buttocks. LPN #1 pressed an area on the left buttock to show that the area was blanchable. LPN #1 then applied Derma Septin house barrier cream to Resident #6's buttocks. Resident #6 stated "that	F 514		

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F 514	Continued From page 130 hurts" during the application of the Derma Septin. Facility staff did not stop at any time during the procedure to assess Resident # 6 for pain or provide interventions. LPN #1 and CNA # 1 assisted Resident #6 with turning to her left side and a pillow was placed on the right side of her back. On 11/1/17 at 11:25 a.m. surveyor reviewed the EMAR (electronic medication administration record) to assess if Resident # 6 had been premedicated prior to care to her buttocks. No documentation was noted to support that Resident #6 had been premedicated prior to care to her buttocks. Surveyor spoke with LPN # 4 and asked if Resident # 6 could have something for pain. LPN #4 stated "I gave her something." Surveyor told LPN# that she did not see any documentation of pain medications being given on 11/1/17. LPN#4 stated "I know I gave it to her, I gave it to her around 10:00." LPN# 4 stated that she would show surveyor where she gave the medication. Upon review of the EMAR there was no documentation that pain medication had been administered to Resident #6. Surveyor requested to see documentation of the med administration on the controlled substance log. Surveyor observed the controlled substance log for Resident # 6 for Lortab 5-325 mg give one by mouth every 6 hours as needed for pain had the count listed at 11. Upon counting the Lortab 5-325 mg in the lock narcotic drawer for Resident #6 the count was 10 tablets. LPN# 4 signed the controlled substance sign out log at that time in front of surveyor that 1 tab was administered to Resident # 6 at 10:00 a.m. On 11/1/17 at 12:10 p.m. the EMAR was	F 514		

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F 514	Continued From page 131 reviewed and it is documented that Resident #6 received Lortab 5-325 mg at 11:47 a.m. Per the facility policy for administering medication which according to the DON is also the facility standard of practice, it is documented as number 20. "As required or indicated for medication, the individual administering the medication will record in resident's medical record: a. The date and time the medication was administered. b. The dosage; c. The route of administration; d. The injection site (if applicable) e. Any complaints or symptoms for which the drug was administered; f. Any results achieved and when those results were observed; and g. The signature and title of the person administering the drug. On 11/1/17 at 2:48 p.m. DON (director of nursing), Administrator, ADON (assistant director of nursing), consultant nurse, regional MDS consultant, and regional operations manager were made aware of the above findings. No further information regarding the above findings was presented to the survey team prior to the exit conference on 11/2/17 at 5:15 p.m.	F 514		