VDH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0252	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY AT THE VILLAGE	4238 JAMES MADSON HIGHWAY FORK UNION, VA 23055

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 2/6/18 through 2/8/18. The facility was not in compliance with the Virginia Regulations for the Licensure of Nursing Facilities. The census in this 60 bed facility was 56 at the time of the survey. The survey sample consisted of 17 current Resident reviews and three closed record review.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Regulations for the Licensure of Nursing Facilities.	F 001		
	12 VAC 5-371-150 (B) (1) Cross Reference to F-578		12 VAC 5-371-150 (B)(1). Please cross reference to F-578	AOC 3/14/18
	12 VAC 5-371-220 (H) Cross Reference to F-580		12 VAC 5-371-220(H). Please cross reference to F-580	AOC 3/14/18
	12 VAC 5-371-370 (A) Cross Reference to F-584		12 VAC 5-371-370 (A). Please cross reference to F-584	AOC 3/14/18
	12 VAC 5-371-250 (G) Cross Reference to F-656		12 VAC 5-371-250 (G). Please cross reference to F-656	AOC 3/14/18
	12 VAC 5-371-250 (F) Cross Reference to F-657		12 VAC 5-371-250 (F). Please cross reference to F-657	AOC 3/14/18
	12 VAC 5-371-200 (B) (1) (ii) Cross Reference to F-658		12 VAC 5-371-200 (B)(1)(ii). Please cross reference to F-658	AOC 3/14/18
	12 VAC 5-371-220 (A) Cross Reference to F-687		12 VAC 5-371-220 (A). Please cross reference to F-687	AOC 3/14/18
	12 VAC 5-371-220 (B) Cross Reference to F-695		12 VAC 5-371-220 (B). Please cross reference to F-695	AOC 3/14/18
	12 VAC 5-371-270 (A) Cross Reference to F-745		12 VAC 5-371-270 (A). Please cross reference to F-745	AOC 3/14/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lisa Bethke | TITLE: Executive Director | (X6) DATE: 2-25-18

VDH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 001	Continued From Page 1	F 001		
	12 VAC 5-371-300 (H) Cross Reference to F-756		12 VAC 5-371-300 (H). Please cross reference to F-756.	AOC 3/14/18
	12 VAC 5-371-220 (B) Cross Reference to F-759		12 VAC 5-371-220 (B). Please cross reference to F-759.	AOC 3/14/18
	12 VAC 5-371-360 (E) Cross Reference to F-842		12 VAC 5-371-360 (E). Please cross reference to F842.	AOC 3/14/18
	12 VAC 5-371-180 (A) Cross Reference to F-880		12 VAC 5-371-180 (A). Please cross reference to F-880.	AOC 3/14/18

Envoy at the Village
Provider Number 495230

The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein.

To remain in compliance with all state and federal regulations, the center has taken or will take the actions set forth in this plan of correction. In addition, the following plan constitutes the center's allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated.

F578 AOC Date = 3/14/18

1. Physician orders obtained to discontinue the oral PRN dose of Haloperidol for Schizophrenia, Discontinue Haldol routine Haldol order for schizophrenia, Discontinue Ativan routine for agitation for Resident #4 . New physician order obtained for Haloperidol 2mg/ml injection (intramuscular) three times a day for schizophrenia and Ativan 2mg/ml injection (intramuscular) three times a day for seizure disorder for Resident #4. Resident # 4 continues to have the right to refuse respected. Medical Director assessed resident # 4 with no adverse effects noted from the doses of Haloperidol injection (intramuscular).
2. A quality review has been complete by DON/designee for current residents' medications for refusal of medications. Follow up based on findings.
3. Nursing staff re-educated on resident's rights of refusal of medication beginning on 2/9/18 and ongoing, along with Medical Director on 2/8/18 of expectations and resident rights. A quality review to be conducted by the DCS/Designee of five residents per week for three months, then monthly, for physician's orders that would not honor the resident's refusal of medications.
4. Results of the quality reviews to be reviewed at monthly QAPI meeting. Quality monitoring scheduled to be modified based on findings. The committee to recommend revisions to the plan as indicated to sustain substantial compliance.

F580 AOC Date = 3/14/18

1. Resident #160 no longer resides in facility.
2. A quality review of current resident's medical records has been completed by DON/designee to ensure current resident representatives have been notified of changes in conditions within the past 30 days.
3. Nurse staff re-education provided by DON/designee beginning 2/9/18 and ongoing regarding proper notification to resident representative of change in resident's condition. A quality review to be conducted by the DON/designee of five residents per week for three months, then monthly, to ensure appropriate notification of resident's representative of any change in the resident's condition.
4. Results of the quality reviews to be reviewed at monthly QAPI meeting. Quality monitoring scheduled to be modified based on findings. The committee to recommend revisions to the plan as indicated to sustain substantial compliance.

Envoy at the Village
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F584 AOC Date = 3/14/18

1. Wheelchair arm cushion of resident #41's wheelchair was replaced on 2/8/18.
2. A quality review has been completed on facility wheelchairs by the Director of Maintenance. Follow up repair based on findings.
3. Staff re-education on proper wheelchair condition and the ability to recognize when wheelchair is in need of repair and maintenance. A quality review to be conducted by the Director of Maintenance on the wheelchairs of five residents per week for three months, then monthly, to ensure wheelchairs are in appropriate condition/repair.
4. Results of the quality reviews to be reviewed at monthly QAPI meeting. Quality monitoring scheduled to be modified based on findings. The committee to recommend revisions to the plan as indicated to sustain substantial compliance.

F656 AOC Date = 3/14/18

1. Resident #49's care plan for wound care to right foot updated. Resident #40's communication ADL's, urinary incontinence, and pressure areas care plans updated. Resident #260's care plan for care and maintenance of a PICC (peripherally inserted central catheter) line updated.
2. A quality review has been completed by the Regional MDS Coordinator of current resident's care plans. Reviewed and followed up based on findings.
3. The MDS Coordinator and DON were re-educated by Regional DCS on the development and implementation of comprehensive care plans and care plan timing and revision. A quality review to be conducted by the Regional MDS Coordinator/designee of five residents per week for three months, then monthly, to ensure care plans are developed and implemented.
4. Results of the quality reviews to be reviewed at monthly QAPI meeting. Quality monitoring scheduled to be modified based on findings. The committee to recommend revisions to the plan as indicated to sustain substantial compliance.

F657 AOC Date = 3/14/18

1. Resident #35's wanderguard was removed from care plan. Resident #49's oxygen and pulse oximeter checks were removed from care plan. Resident #40's hospice services were removed from care plan.
2. A quality review of current resident's care plans for accuracy, timing and revision was conducted by Regional MDS Coordinator for accurately reflecting residents. Follow up based on findings.
3. The MDS Coordinator and DON were re-educated by Regional DCS on care plan accuracy, timing and revision on 2/14/18. A quality review to be conducted by the MDS Coordinator/designee of five residents per week for three months, then monthly, to ensure care plans are reviewed and revised in a timely manner.
4. Results of the quality reviews to be reviewed at monthly QAPI meeting. Quality monitoring scheduled to be modified based on findings. The committee to recommend revisions to the plan as indicated to sustain substantial compliance.

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F658 AOC Date = 3/14/18

1. Orders for Haloperidol were clarified by Medical Director and transcribed to the Medication Administration Record for Resident #4.
2. A quality review was completed by the DON/designee of current resident's orders compared to Medication Administration Record to ensure medications are being administered in accordance with physician orders.
3. Nurses were re-education by DON/designee beginning 2/9/18 and on going in regards to documentation on the Medication Administration Record. A quality review to be conducted by DON/designee of documentation on the Medication Administration Record of five residents per week for three months, then monthly, to ensure care plans are reviewed and revised in a timely manner.
4. Results of the quality reviews to be reviewed at monthly QAPI meeting. Quality monitoring scheduled to be modified based on findings. The committee to recommend revisions to the plan as indicated to sustain substantial compliance.

F687 AOC Date = 3/14/18

1. Obtained necessary documentation from Medical Director to secure diabetic shoes for Resident #59. Resident #59 has had an initial diabetic shoe sizing appointment.
2. A quality review was completed by Social Worker/designee of current resident's orders for specialty diabetic shoes to ensure orders have been obtained.
3. Social Worker re-educated by Executive Director on the 2/16/18 in regards to timely completion of physician orders. A quality review to be conducted by the Social Worker of five residents per week for three months, then monthly, to ensure resident orders for foot care are completed in a timely manner.
4. Results of the quality reviews to be reviewed at monthly QAPI meeting. Quality monitoring scheduled to be modified based on findings. The committee to recommend revisions to the plan as indicated to sustain substantial compliance.

F695 AOC Date = 3/14/18

1. A physician clarification order was obtained for Resident #25 for Oxygen.
2. A quality review has been completed by DON/designee for current residents who receive Oxygen for correct administration and documentation. Follow up based on findings.
3. Nursing staff re-educated by DON/designee beginning 2/9/18 and ongoing in regards to Oxygen orders, administration and documentation. A quality review to be conducted by DON/designee of Oxygen orders, administration and documentation of five residents per week for three months, then monthly, to ensure Oxygen is being administered as ordered.
4. Results of the quality reviews to be reviewed at monthly QAPI meeting. Quality monitoring scheduled to be modified based on findings. The committee to recommend revisions to the plan as indicated to sustain substantial compliance.

F745 AOC Date = 3/14/18

1. Obtained necessary documentation from Medical Director to secure diabetic shoes for Resident #59. Resident #59 has had an initial diabetic shoe sizing appointment.
2. A quality review was completed by Social Worker/designee of current resident's orders for assistive devices to ensure physician orders have been completed and followed.
3. Social Worker re-educated by Executive Director on the 2/16/18 in regards to timely completion of physician orders. A quality review to be conducted by the Social Worker of five residents per week for three months, then monthly, to ensure physician orders for assistive devices have been completed and followed in a timely manner.
4. Results of the quality reviews to be reviewed at monthly QAPI meeting. Quality monitoring scheduled to be modified based on findings. The committee to recommend revisions to the plan as indicated to sustain substantial compliance.

F756 AOC Date = 3/14/18

1. Physician orders obtained for Resident #4 for medication clarification. PRN Haloperidol discontinued per physician order.
2. A quality review has been completed by DON/designee for current residents who receive psychotropic medications to ensure no medication irregularity.
3. Nursing staff re-educated by representatives of the pharmacy management company beginning on 2/22/18 and ongoing in regards to medication irregularities and documentation. A quality review to be conducted by DON/designee of all current residents on psychotropic medications to ensure no medication irregularities and proper documentation of five residents per week for three months, then monthly, to ensure no medication irregularities.
4. Results of the quality reviews to be reviewed at monthly QAPI meeting. Quality monitoring scheduled to be modified based on findings. The committee to recommend revisions to the plan as indicated to sustain substantial compliance.

F758 AOC Date = 3/14/18

1. Physician orders obtained for Resident #4 for medication clarification. PRN Haloperidol discontinued per physician orders.
2. A quality review has been completed by DON/designee for current residents who receive psychotropic medications to ensure residents are free of unnecessary medications.
3. Nursing staff re-educated by DON/designee beginning on 2/9/18 and ongoing in regards to unnecessary medications. A quality review to be conducted by DON/designee of all current residents on psychotropic medications to ensure residents are free of unnecessary medications.
4. Results of the quality reviews to be reviewed at monthly QAPI meeting. Quality monitoring scheduled to be modified based on findings. The committee to recommend revisions to the plan as indicated to sustain substantial compliance.

Envoy at the Village
Provider Number 495230

F759 AOC Date = 3/14/18

1. Physician notified of Resident #14 not receiving Duloxetine per physician order. No adverse effects were noted. Physician notified of Resident #35 not receiving Ferrous Sulfate per physician orders.. No adverse effects were noted. Physician notified of Resident #40 receiving a lower dose of Singular. Resident # 40 receives Singular per physician order. No adverse effects were noted.
2. DON/designee completed med pass observations for medication administration accuracy with current licensed nursing staff.
3. Nursing staff re-educated by DON/designee and representatives of the pharmacy management company beginning on 2/22/18 and ongoing in regards to the five rights of medication administration and medication errors. A quality review to be conducted by DON/designee of one licensed nurse weekly for three month, then monthly, to ensure competency is maintained.
4. Results of the quality reviews to be reviewed at monthly QAPI meeting. Quality monitoring scheduled to be modified based on findings. The committee to recommend revisions to the plan as indicated to sustain substantial compliance.

F842 AOC Date = 3/14/18

1. Physician order obtained for Resident #25's Oxygen. Resident #4's Medication Administration Record was updated with accurate physician orders for Haloperidol.
2. A quality review has been completed by DON/designee for current residents receiving Oxygen to ensure an appropriate physician order has been obtained. A quality review has been completed by DON/designee for current residents to ensure their Medication Administration Record contains documentation for administration of medications that deviate from physician orders.
3. Nursing staff re-educated by DON/designee beginning on 2/9/18 and ongoing in regards to appropriate orders for Oxygen administration and documentation on Medication Administration Record regarding reasons for administration that deviate from physician orders. A quality review to be conducted weekly by DON/designee of five residents that have orders for Oxygen for three months, then monthly, to ensure current order for Oxygen administration. A quality review to be conducted weekly by DON/designee of five residents to ensure appropriate documentation on the Medication Administration Record for any instance of medication deviation that does not following prescribed orders.
4. Results of the quality reviews to be reviewed at monthly QAPI meeting. Quality monitoring scheduled to be modified based on findings. The committee to recommend revisions to the plan as indicated to sustain substantial compliance.

F880 AOC Date = 3/14/18

1. Resident #49's wound was assessed for signs and symptoms of infection. No signs and symptom of infection were noted.
2. A quality review was completed by DON/designee of current residents that have wounds for any signs and symptoms of infection. No signs and symptom of infection were noted. A quality

review was conducted for licensed nurses in regards to following infection control practices during dressing change.

3. Nursing staff re-educated by DON/designee beginning on 2/9/18 and ongoing in regards to proper hand washing associated with a dressing change. A quality review to be conducted weekly by DON/designee of five residents that have orders for dressing changes to ensure infection protocol adherence.
4. Results of the quality reviews to be reviewed at monthly QAPI meeting. Quality monitoring scheduled to be modified based on findings. The committee to recommend revisions to the plan as indicated to sustain substantial compliance.

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E 000	Initial Comments An unannounced Medicare/Medicaid standard survey was conducted 2/6/18 through 2/8/18. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with the Federal requirements for emergency preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/6/18 through 2/8/18. Two complaints were investigated. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 60 certified bed facility was 56 at the time of the survey. The survey sample consisted of 17 current Resident reviews and three closed record reviews.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §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. §483.10(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. §483.10(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	F 578		

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

Executive Director | 2-23-18

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 578	Continued From page 1	F 578		

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.
(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.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility failed for one of 20 residents in the survey sample (Resident # 4), to honor the resident's refusal of medications. Resident # 4 had a physician's order to administer an antipsychotic medication (Haloperidol) by means of an injection (intramuscular) if the oral form of Haloperidol was refused. Resident # 4 received the intramuscular form of Haloperidol 12 times between 10/1/17 and 12/31/17.

The findings were:

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F 578	Continued From page 2	F 578		

Resident # 4 in the survey sample, a 65 year-old female, was admitted to the facility on 8/22/14, and most recently readmitted on 4/26/17 with diagnoses that included anemia, hypertension, gastroesophageal reflux disease, renal insufficiency, diabetes mellitus, aphasia, Non-Alzheimer's dementia, seizure disorder, anxiety disorder, psychotic disorder, encephalopathy, generalized muscle weakness, and schizophrenia. According to the most recent Minimum Data Set, a Quarterly with an Assessment Reference Date of 11/3/17, the resident was assessed under Section C (Cognitive Patterns) as having severely impaired skills for daily decision making.

Review of the Physician's Order Form for the month of February 2018 revealed the following medication order, originally written on 4/26/17, and carried forward monthly:

Haloperidol Lactate 2mg/1ml (milligrams per milliliter) Oral. Give 0.5 ml by mouth every 4 hours as needed for schizophrenia.

The Physician's Order Form for the month of February 2018 also included the following medication order, originally written on 6/2/17, and carried forward monthly:

Haloperidol Lactate 0.2 ml (1 mg) Intramuscularly three times daily - Schizophrenia - Rotate Site - Administer if patient refused liquid.

NOTE: Haloperidol (Haldol) is an antipsychotic used in the treatment of psychotic disorders including chronic schizophrenia. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 579.

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F 578	Continued From page 3	F 578		

Review of the Medication Administration Records (MAR) for the months of October, November, and December 2017, and January 2018 revealed Resident # 4 received the intramuscular form of Haldol as follows:

10/8/17 - two times
10/10/17 - one time
10/14/17 - one time
10/17/17 - two times
10/22/17 - two times

The reverse side of the October MAR included the following notes for the administration of the intramuscular Haldol:

10/14/17 - 0600 (6:00 a.m.) - Haldol 2 mg - fighting, hitting
10/17/17 - Haldol .5 mg /1 ml vial = 0.2 ml R (right) gluteal - not effective
10/20/17 - Haldol
10/22/17 - Haldol 1 mg IM (intramuscular) due to refusal and spitting out oral Haldol (2p, 8p refused oral)

There were no administration notes for the use of the intramuscular Haldol on 10/8/17, and no entry on the face of the October MAR for the use of the intramuscular Haldol on 10/14/17.

11/1/17 - one time
11/4/17 - one time
11/25/17 - one time

There were no administration notes for the use of the intramuscular Haldol on 11/1/17, and 11/4/17. There was no entry on the face of the November MAR for the use of the intramuscular Haldol on

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F 578	Continued From page 4 11/25/17. The Interdisciplinary Progress (Nurses) Notes included the following entry regarding the use of the intramuscular Haldol on 11/25/17: 11/25/17 - 10:55 "...Resident medicated with PRN Haldol via flank...." 12/5/17 - one time There was an administration note for the use of the intramuscular Haldol on 12/5/17 that noted, "Haldol IM 0.2 ml Rt (right) buttock." During a meeting at approximately 3:30 p.m. on 2/8/18 that included the Administrator, Director of Nursing, Corporate Nurse Consultant, and the survey team, the findings regarding the use of PRN Haldol when the oral form of Haldol was refused, and the right of the resident to refuse medications was discussed.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of	F 580		

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treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and complaint investigation, the facility staff failed to notify the resident's representative of a change in condition for one of 20 residents in the survey sample. Resident #160's resident representative

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was not notified of a fall with injury.

The findings include:

Resident #160 was admitted to the facility on 2/11/13 with a re-admission on 5/29/17. Diagnoses for Resident #160 included end stage renal disease, below knee amputations, peripheral vascular disease, diabetes, anemia and heart disease. The minimum data set (MDS) dated 7/26/17 assessed Resident #160 with moderately impaired cognitive skills.

Resident #160's closed clinical record documented the resident rolled out of bed on 6/5/17. A communication form dated 6/5/17 at 1:00 a.m. documented, "Resident rolled OOB [out of bed]" and listed the resident experienced a "small abrasion to right elbow." This form documented the physician was notified of the fall on 6/5/17 at 4:00 a.m. The space on the form for notification to the family and/or resident representative was blank. The clinical record documented no evidence of notification to the resident's listed representative concerning the fall. Nursing notes dated 6/5/17 documented post-fall assessment of the resident but made no mention of any notification about the fall or injury.

On 2/8/18 at 4:00 p.m., the regional director of clinical services was interviewed about any notification to the resident's representative concerning the fall/injury. The regional director stated she reviewed the record and did not find any other information about notification but would continue to look.

On 2/8/18 at 4:45 p.m., the license practical nurse (LPN #2) caring for Resident #160 when he fell

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on 6/5/17 was interviewed by telephone. LPN #2 stated any notification to the family or representative would be documented on the communication form or in nursing notes.

These findings were reviewed with the administrator and director of nursing during a meeting on 2/8/18 at 3:50 p.m. There was no other information presented about notification to the resident's representative of the fall.

This was a complaint deficiency.

F 584 SS=D — Safe/Clean/Comfortable/Homelike Environment — CFR(s): 483.10(i)(1)-(7) — F 584

§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

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§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review, the facility staff failed to ensure a wheelchair was in good repair for one of 20 residents in the survey sample. The covering on the arm cushion of Resident #41's wheelchair was cracked with exposed foam.

The findings include:

Resident #41 was admitted to the facility on 11/25/12 with a re-admission on 4/25/15. Diagnoses for Resident #41 included seizures, high blood pressure, aphasia, dementia, hemiplegia and diabetes. The minimum data set (MDS) dated 1/2/18 assessed Resident #41 with short and long-term memory problems and moderately impaired cognitive skills.

On 2/6/18 at 3:06 p.m., Resident #41's wheelchair was observed. The covering on the left arm cushion was cracked along the outer

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F 584	Continued From page 9 edge with yellow foam visible. The covering to the cushion had multiple cracks causing a rough surface along the outer edge and top of the cushion. On 2/8/18 at 9:13 a.m., accompanied by the registered nurse (RN #3) caring for Resident #41, the wheelchair arm was observed in disrepair. RN #3 was interviewed at this time about the worn cushion. RN #3 stated the cushion needed replacement and had a rough surface. RN #3 stated the maintenance department was responsible for repairing wheelchairs and resident equipment after a work order was written. This finding was reviewed with the administrator and director of nursing during a meeting on 2/7/18 at 3:35 p.m.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		

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provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, facility staff failed to develop a CCP (comprehensive care plan) for three of 30 residents in the survey sample, Residents #49, #40 and #260.

1. Facility staff failed to include daily wound care to Resident #49's right foot in his CCP.

2. Facility staff failed to include interventions for the following areas triggered on Resident #40's most recent comprehensive assessment on her CCP; communication, ADL's (activities of daily living), urinary incontinence and pressure areas.

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3. Facility staff did not include interventions on Resident #260's CCP for care and maintenance of a PICC (peripherally inserted central catheter) line.

Findings included:

1. Facility staff failed to include daily wound care to Resident #49's right foot in his CCP.

Resident #49 was admitted to the facility on 12/26/2017 with diagnoses including, but not limited to: PVD (peripheral vascular disease), right foot ulcer, and rheumatoid arthritis.

Resident #49's most recent MDS (minimum data set) was his initial assessment with an ARD (assessment reference date) of 01/02/2018. Resident #49 was assessed as cognitively intact with a total cognitive score of 13 out of 15.

This surveyor observed RN #2 (registered nurse) perform wound care to Resident #49's right foot on 02/07/18 at 10:50 a.m. Resident #49's CCP was reviewed on 02/08/18 at 8:15 a.m. During the care plan review no focus areas or interventions were discovered for wound care or assessment of Resident #49's right foot ulcer.

The DON (director of nursing) was interviewed on 02/08/18 at 2:10 p.m. regarding Resident #49's wound care not being on his CCP. The DON stated regarding who updates the CCP, "Generally MDS or me. It is my goal for nursing to do it, but we haven't started that yet."

The Administrator was informed of the above findings during a meeting with the survey team on

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02/08/18 at approximately 3:45 p.m. No further information was received by the survey team prior to the exit conference on 02/08/18.

2. Facility staff failed to include interventions for the following areas triggered on Resident #40's most recent comprehensive assessment on her CCP; communication, ADL's (activities of daily living), urinary incontinence and pressure areas.

Resident #40 was originally admitted to the facility on 12/29/17 and readmitted on 01/11/18 with diagnoses including, but not limited to: Left Humeral Fracture, Respiratory Failure, Diabetes, COPD (chronic obstructive pulmonary disease), Hypertension, Anemia, CHF (congestive heart failure) and Depression.

Resident #40's most recent MDS was a 14-day comprehensive assessment with an ARD of 01/25/18. Resident #40 was assessed as cognitively intact with a total cognitive score of 13 out of 15.

Resident #40's admission MDS with an ARD of 12/31/17 included the following triggered CAAs (care area assessment); Communication, ADL's, Urinary Incontinence and Pressure Areas. The CCP was reviewed on 02/08/18 at 9:00 a.m. None of the above mentioned care areas were included on the care plan for Resident #40.

This surveyor and DON (director of nursing) reviewed Resident #40's care plan on 02/08/18 at 2:20 p.m. Regarding the missing care areas on the care plan the DON stated, "Good grief, they aren't there." Regarding who develops or updates resident CCP's the DON stated,

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"Generally MDS or me. It is my goal for nursing to do it, but we haven't started that yet."

The MDS nurse was interviewed on 02/08/18 at 2:30 p.m. regarding the missing areas on Resident #40's CCP. The MDS nurse stated, "I don't know why they aren't there. They should be. I will need to check in the computer and if they aren't there, then I will add them right now." At 2:40 p.m. the MDS nurse returned to this surveyor and stated, "They're not in there. I don't know. I must have gotten pulled away. They will be in there in the next fifteen minutes, rest assured."

The Administrator was informed of the above mentioned findings during a meeting with the survey team on 02/08/18 at 3:45 p.m. No further information was received by the survey team prior to the exit conference on 02/08/18.

3. Facility staff did not include interventions on Resident #260's CCP for care and maintenance of a PICC (peripherally inserted central catheter) line.

Resident #260 was originally admitted to the facility on 01/17/18 and readmitted on 01/25/18 with diagnoses including, but not limited to: PVD (peripheral vascular disease), right above knee amputation, Pneumonia, UTI (urinary tract infection), Dementia, Aphasia and Diabetes.

The most recent MDS was an initial assessment with an ARD of 02/01/18. Resident #260 was assessed as severely impaired in her cognitive status with a total cognitive score of six out of 15.

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An initial review of Resident #260's clinical record was conducted on 02/06/18 at 4:00 p.m. During this review Resident #260 was noted to have a PICC line and had been receiving IV (intravenous) abx (antibiotics) via her PICC line for Pneumonia.

Resident #260's CCP was reviewed on 02/08/18 at 9:30 a.m. During this review no focus area or interventions was located for use and care of a PICC line.

The DON (director of nursing) was interviewed on 02/08/18 at 2:10 p.m. regarding Resident #260's CCP. The DON stated regarding who develops and updates CCP, "Generally MDS or me. It is my goal for nursing to do it, but we haven't started that yet."

The Administrator was informed of the above mentioned findings during a meeting with the survey team on 02/08/18 at 3:45 p.m. No further information was received by the survey team prior to the exit conference on 02/08/18.

F 657 SS=D Care Plan Timing and Revision
CFR(s): 483.21(b)(2)(i)-(iii)

§483.21(b) Comprehensive Care Plans
§483.21(b)(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

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resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s).
An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, facility staff failed to review and revise a CCP (comprehensive care plan) for three of 20 residents in the survey sample, Residents #35, #49 and #40.

1. Facility staff failed to remove use of a wanderguard from Resident #35's CCP when the wanderguard was no longer in use by this resident.

2. Facility staff failed to remove oxygen and pulse oximeter checks from Resident #49's CCP. Resident #49 never received oxygen therapy.

3. Facility staff failed to remove hospice services from Resident #40's CCP. Resident #40 never received hospice services.

Findings included:

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1. Facility staff failed to remove use of a wanderguard from Resident #35's CCP when the wanderguard was no longer in use by this resident.

Resident #35 was originally admitted to the facility on 08/26/16 and readmitted on 09/14/17 with diagnoses including, but not limited to: Iron-deficiency Anemia, Osteoarthritis, Diabetes, Alzheimer's Disease, and CVA (cerebrovascular accident).

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/22/17. Resident #35 was assessed as moderately impaired in her cognitive status with a total cognitive score of 11 out of 15.

Resident #35's CCP was reviewed on 02/08/18 at 8:50 a.m. During this review an intervention was noted that stated, "...Personal wander prevention device-check for placement each shift and function daily. Date Initiated: 09/08/17..." Resident #35 had been observed several times throughout the survey conducted 02/06/18 through 02/08/18. A wanderguard was never noted on this resident.

The DON (director of nursing) was interviewed on 02/08/18 at 11:10 a.m. regarding Resident #35's use of a wanderguard. The DON stated, "I believe she had one at one time, but not now."

The DON approached this surveyor at approximately 2:10 p.m. on 02/08/18 and stated, "[Name] Resident #35 had a wanderguard before her last hospitalization, but it was not reordered on her readmission to the facility." Regarding

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who develops and updates CCP's the DON stated, "Generally MDS and me. It is my goal for nursing to do it, but we haven't started that yet."

The Administrator was informed of the above findings during a meeting with the survey team on 02/08/18 at approximately 3:45 p.m. No further information was received by the survey team prior to the exit conference on 02/08/18.

2. Facility staff failed to remove oxygen and pulse oximeter checks from Resident #49's CCP. Resident #49 never received oxygen therapy.

Resident #49 was admitted to the facility on 12/26/2017 with diagnoses including, but not limited to: PVD (peripheral vascular disease), right foot ulcer, and rheumatoid arthritis.

Resident #49's most recent MDS (minimum data set) was his initial assessment with an ARD (assessment reference date) of 01/02/2018. Resident #49 was assessed as cognitively intact with a total cognitive score of 13 out of 15.

Resident #49's CCP was reviewed on 02/08/18 at 8:15 a.m. During this review interventions were noted that stated, "...Administer oxygen as ordered...Monitor pulse ox as ordered..." No physician orders or use of oxygen and/or a pulse ox were noted in the clinical record.

The DON (director of nursing) was interviewed on 02/08/18 at 2:15 p.m. regarding Resident #49 and his use of oxygen or a pulse ox. The DON stated, "He has never been on it [oxygen]." Regarding who develops and updates CCP's the DON stated, "Generally MDS and me. It is my

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goal for nursing to do it, but we haven't started that yet."

The Administrator was informed of the above findings during a meeting with the survey team on 02/08/18 at approximately 3:45 p.m. No further information was received by the survey team prior to the exit conference on 02/08/18.

3. Facility staff failed to remove hospice services from Resident #40's CCP. Resident #40 never received hospice services.

Resident #40 was originally admitted to the facility on 12/29/17 and readmitted on 01/11/18 with diagnoses including, but not limited to: Left Humeral Fracture, Respiratory Failure, Diabetes, COPD (chronic obstructive pulmonary disease), Hypertension, Anemia, CHF (congestive heart failure) and Depression.

Resident #40's most recent MDS was a 14-day comprehensive assessment with an ARD of 01/25/18. Resident #40 was assessed as cognitively intact with a total cognitive score of 13 out of 15.

Resident #40's CCP was reviewed on 02/08/18 at 9:00 a.m. During this review an intervention was noted that stated, "...Facility to provide ADL [activities of daily living] care as needed and not provided by hospice staff..." Review of Resident #40's clinical record did not include any physician orders or notations of Resident #40 being on hospice services.

The DON (director of nursing) was interviewed on 02/08/18 at 2:20 p.m. regarding hospice services

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for Resident #40. The DON stated, "She is not on hospice. She has never been on hospice." Regarding who develops and updates CCP's the DON stated, "Generally MDS and me. It is my goal for nursing to do it, but we haven't started that yet."

The MDS nurse was interviewed on 02/08/18 at 2:30 p.m. regarding hospice services for Resident #40. The MDS nurse stated, "She isn't on hospice. We provide her ADL care. I will correct that."

The Administrator was informed of the above findings during a meeting with the survey team on 02/08/18 at approximately 3:45 p.m. No further information was received by the survey team prior to the exit conference on 02/08/18.

F 658 SS=D Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) — F 658

§483.21(b)(3) Comprehensive Care Plans
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility staff failed for one of 20 residents in the survey sample (Resident # 4), to follow professional standards of quality. 1a) Resident # 4 had an order for an antipsychotic (Haloperidol) to be administered three times a day if the resident refused the oral form of the medication. The order was changed by the nursing staff to an as needed (PRN) on the Medication Administration Record without

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physician approval. 1b) In addition, a Registered Nurse who administered medications, signed off on the Medication Administration Record as having administered the medication before it was administered.

The findings were:

1a. Resident # 4 in the survey sample, a 65 year-old female, was admitted to the facility on 8/22/14, and most recently readmitted on 4/26/17 with diagnoses that included anemia, hypertension, gastroesophageal reflux disease, renal insufficiency, diabetes mellitus, aphasia, Non-Alzheimer's dementia, seizure disorder, anxiety disorder, psychotic disorder, encephalopathy, generalized muscle weakness, and schizophrenia. According to the most recent Minimum Data Set, a Quarterly with an Assessment Reference Date of 11/3/17, the resident was assessed under Section C (Cognitive Patterns) as having severely impaired skills for daily decision making.

Review of the Physician's Order Form for the month of February 2018 revealed three orders for the use of Haloperidol. The first order for Haloperidol was originally written on 7/12/17, and carried forward monthly:

Haloperidol Lactate 2mg/1ml (milligrams per milliliter) Oral. 1 ml (2 mg) by mouth three times daily - Schizophrenia - If patient will not take liquid administer intramuscularly. The administration times for the scheduled oral Haldol were listed on the Medication Administration Record (MAR) as 6 AM, 2 PM, and 8 PM.

The second order for Haloperidol was originally

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written on 6/2/17, and carried forward monthly:

Haloperidol Lactate 0.2 ml (1 mg) Intramuscularly three times daily - Schizophrenia - Rotate Site - Administer if patient refused liquid. The administration times for the scheduled intramuscular Haldol were listed on the MAR as 9 AM, 2 PM, and 8 PM.

The third order for Haloperidol was originally written on 4/26/17, and carried forward monthly:

Haloperidol Lactate 2 mg/1 ml Oral. Give 0.5 ml by mouth every 4 hours as needed for schizophrenia.

NOTE: Haloperidol (Haldol) is an antipsychotic used in the treatment of psychotic disorders including chronic schizophrenia. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 579.

Review of the MAR for the month of October 2017 revealed the scheduled times for the intramuscular Haldol order were crossed out and the handwritten notation "PRN" was added. Entries on the October 2017 MAR indicated Resident # 4 received intramuscular Haldol as a PRN eight times; once on 10/10/17 and 10/14/17, and twice on 10/8/17, 10/17/17, and 10/22/17.

Review of the MAR for the month of November 2017 revealed the scheduled times for the intramuscular Haldol order were crossed out and the handwritten notation "PRN" was added. Entries on the November 2017 MAR and in the Interdisciplinary Progress (Nurses) Notes indicated Resident # 4 received intramuscular Haldol as a PRN three times; once on 11/1/17,

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11/4/17, and 11/25/17.

Review of the MAR for the month of December 2017 revealed the scheduled times for the intramuscular Haldol order were crossed out, but there was no handwritten "PRN" notation. One entry on the December 2017 MAR indicated Resident # 4 received intramuscular Haldol as a PRN once on, 12/5/17. .

Review of the MAR for the month of January 2018 revealed the scheduled times for the intramuscular Haldol order were crossed out, but there was no handwritten "PRN" notation. There were six entries on the MAR, two each for 1/1/18, 1/2/18, and 1/3/18. All six of the entries were circled. At approximately 10:30 a.m. on 2/7/18, LPN # 1 (Licensed Practical Nurse) was asked about the circled entries. LPN # 1 said, "The circles mean the medication was not given."

LPN # 1 was also asked about two other entries, one on 1/4/18, and 1/5/18, that were crossed out. "It looks like she (Resident # 4) was double dosed," LPN # 1 said. The LPN was unable to identify the initials of the staff member who signed the MAR on the two days in question.

Review of the MAR for the month of February 2018 revealed the scheduled times for the intramuscular Haldol order were crossed out, but there was no handwritten "PRN" notation, and no medications were signed off as having been given as of 2/7818, the date of record review.

A thorough review of Resident # 4's clinical record failed to reveal any documentation that the prescribing physician had changed the intramuscular Haldol to a PRN.

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During a meeting at approximately 3:30 p.m. on 2/8/18 that included the Administrator, Director of Nursing, Corporate Nurse Consultant, and the survey team, the findings regarding the staff changing the scheduled intramuscular Haldol to a PRN was discussed. The discussion also included the two crossed out entries dated 1/4/18 and 1/5/18.

The Potter-Perry Fundamentals of Nursing notes the following about physician's orders: "Nurses are responsible for performing all procedures correctly and exercising professional judgement as they carry out physicians' or health care providers' orders....Nurses follow physicians' or health care providers' orders unless they believe the orders are in error or are harmful to clients." (Ref. Potter-Perry Fundamentals of Nursing, 7th Edition, page 337.)

1b. At approximately 4:30 p.m. on 2/8/18, RN # 3 (Registered Nurse) came to the conference room and asked to speak to the surveyors. RN # 1 identified himself as the staff member who signed the MAR entries dated 1/4/18 and 1/5/18. Asked if he gave Resident # 4 the intramuscular Haldol, RN # 1 said, "No, I did not. I signed the MAR before I gave it, but then I did not give it." Asked if he was in the habit of signing off on the MAR before administering a medication, RN # 1 said, "Yes."

The Potter-Perry Fundamentals of Nursing notes the following about documenting the administration of medication: "After administering the medication, indicate which medications were given on the client's MAR...Nurses never

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F 658 SS=E	Continued From page 24 document that they have given a medication until they have actually given it." (Ref. Potter-Perry Fundamentals of Nursing, 7th Edition, page 709.) Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(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. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to provide specialty shoes as ordered by the physician for one of 20 residents in the survey sample. Resident #59 had been over six months without diabetic shoes ordered by the physician. The findings include: Resident #59 was admitted to the facility on 3/27/13 with diagnoses that included diabetes, diabetic neuropathy, cerebrovascular accident (stroke), anxiety and high blood pressure. The minimum data set (MDS) dated 1/17/18 assessed Resident #59 as cognitively intact. On 2/7/18 at 8:23 a.m., an interview was	F 658 F 687		

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conducted with Resident #59 concerning life in the facility. Resident #59 stated her physician ordered her special shoes but she never got them. The resident stated she had been without shoes for "quite awhile." Resident #59 stated her original shoes were lost at the facility and never found. The resident stated she was supposed to get new shoes ordered but had not been measured. The resident stated she currently wore slipper socks on her feet and was concerned because she still had not received her shoes. The resident had slipper socks on both feet at the time of the interview.

Resident #59's clinical record documented a current physician's order dated 8/1/17 for "diabetic shoes."

A nursing note dated 8/22/17 stated, "...Rsdt [Resident's] RP [responsible party] made aware Resdt's [resident's] black shoes lost. Writer looked [without] finding..." A social worker note dated 8/24/17 documented, "Dtr. [daughter] also concerned about missing black shoes. Staff have been searching rooms but have not found them... This writer researching if facility can purchase her a pair." A social worker note dated 8/25/17 documented, "The entire management team has searched the facility for Res [resident's] shoes today and haven't found them. They were last remembered being seen in the laundry room but no one seems to know where they went from there..." There was no further mention in the clinical record of the lost shoes or the order for "diabetic shoes."

Resident #59's plan of care (revised 9/9/17) documented the resident was at risk of injury due to poor safety awareness, pain and history of

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falls. Included in interventions to prevent injury and/or falls was, "Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in w/c [wheelchair]..."

On 2/7/18 at 2:03 p.m., the certified nurses' aide (CNA #1) caring for Resident #59 was interviewed about the resident's shoes. CNA #1 stated the resident used to have shoes but she did not know what happened to them. CNA #1 stated the resident now wore slipper socks each day.

On 2/7/18 at 2:05 p.m., the licensed practical nurse (LPN #1) caring for Resident #59 was interviewed about shoes/footwear. LPN #1 stated the resident's black shoes were lost months ago and were never found. LPN #1 stated there were discussions about who would pay for new shoes. LPN #1 stated the black shoes were "worn out" when they were lost but she did not know why the resident's shoes were not replaced. When asked about the current order for the resident to have diabetic shoes, LPN #1 stated the facility's social worker had more information about the diabetic shoes.

On 2/8/18 at 9:20 a.m., the social worker was interviewed about the order for Resident #59's diabetic shoes. The social worker stated the resident's original shoes were lost. The social worker stated the facility searched for the shoes but never found them. The social worker stated she called several places during September 2017 and October 2017 and she was not successful in finding a place that would come measure the resident for shoes. When asked about the resident going out of the facility to acquire the shoes, the social worker stated the local

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F 687	Continued From page 27 university hospital had a prosthetic/orthotic clinic that provided diabetic shoes per order. The social worker presented a copy of the request from the prosthetic/orthotic clinic dated 11/28/17 with attached paperwork required to order the shoes. The social worker presented another copy of the forms faxed 1/10/18 to the facility with a handwritten note on the first page stating, "2nd request - never got 1st request." The social worker stated forms had not been completed and sent to the orthotic clinic for Resident #59's diabetic shoes. The social worker had no explanation of why it had been over six months without any arrangements made or order completed for Resident #59's diabetic shoes. These finding were reviewed with the administrator and director of nursing during a meeting on 2/8/18 at 3:50 p.m.	F 687		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure oxygen was administered as ordered by the physician for one of 20 residents in the survey sample. Resident #25 was administered oxygen	F 695		

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at a rate between 3.5 and 4.0 lpm (liters per minute) when he was ordered 3.0 lpm.

The findings include:

Resident #25 was admitted to the facility on 11/27/17 with diagnoses that included COPD (chronic obstructive pulmonary disease), malnutrition and altered mental status. The minimum data set (MDS) dated 1/3/18 assessed Resident #25 as cognitively intact.

Resident #25 was observed on 2/6/18 at 4:00 p.m. in bed with oxygen administered from a concentrator at a rate between 3.5 lpm and 4.0 lpm. Resident #25 was observed again on 2/7/18 at 8:53 a.m. with his oxygen running between 3.5 lpm and 4.0 lpm.

Resident #25's clinical record documented no current physician's order for oxygen. The current physician order summary sheet signed by the physician on 2/2/18 included no orders for oxygen. The record documented a previous order dated 12/1/17 for oxygen to be administered continuously at 3 liters per minute. Resident #25's plan of care (revised 2/7/18) listed the resident had the potential for shortness of breath and ineffective breathing due to COPD. Interventions to maintain proper breathing included, "Oxygen as ordered..."

On 2/7/18 at 8:53 a.m., accompanied by the registered nurse (RN #3) caring for Resident #25, the oxygen was observed running at a rate between 3.5 lpm and 4.0 lpm from the concentrator. RN #3 was interviewed at this time about the ordered rate for the oxygen. RN #3 stated he thought after the resident went to a

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pulmonologist the oxygen was supposed to be set between 2.0 lpm and 3.0 lpm depending on how the resident was feeling. RN #3 stated he would look for an order for the oxygen.

On 2/7/18 at 1:49 p.m., RN #3 stated the resident had an order when he was admitted for oxygen to run at 3.0 lpm. RN #3 stated the order was not carried forward to the current list of physician orders.

These findings were reviewed with the administrator and director of nursing during a meeting on 2/7/18 at 3:35 p.m.

F 745 SS=E Provision of Medically Related Social Service CFR(s): 483.40(d) — F 745

§483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to provide medically needed social services for one of 20 residents in the survey sample. After Resident #59's shoes were lost in the facility, social services failed to take make arrangements for the resident to obtain physician ordered diabetic shoes. The resident had been over six months without shoes due to lack of interventions to utilize available orthotic services for measurements and ordering of customized shoes.

The findings include:

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Resident #59 was admitted to the facility on 3/27/13 with diagnoses that included diabetes, diabetic neuropathy, cerebrovascular accident (stroke), anxiety and high blood pressure. The minimum data set (MDS) dated 1/17/18 assessed Resident #59 as cognitively intact.

On 2/7/18 at 8:23 a.m., an interview was conducted with Resident #59 concerning life in the facility. Resident #59 stated her physician ordered her special shoes but she never got them. The resident stated she had been without shoes for "quite awhile." Resident #59 stated her original shoes were lost at the facility and never found. The resident stated she was supposed to get new shoes ordered but had not been measured. The resident stated she currently wore slipper socks on her feet and was concerned because she still had not received her shoes. The resident had slipper socks on both feet at the time of the interview.

Resident #59's clinical record documented a current physician's order dated 8/1/17 for "diabetic shoes."

A nursing note dated 8/22/17 stated, "...Rsdt [Resident's] RP [responsible party] made aware Resdt's [resident's] black shoes lost. Writer looked [without] finding..." A social worker note dated 8/24/17 documented, "Dtr. [daughter] also concerned about missing black shoes. Staff have been searching rooms but have not found them... This writer researching if facility can purchase her a pair." A social worker note dated 8/25/17 documented, "The entire management team has searched the facility for Res [resident's] shoes today and haven't found them. They were last remembered being seen in the laundry room but

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no one seems to know where they went from there..." There was no further mention in the clinical record of the lost shoes or the order for "diabetic shoes."

Resident #59's plan of care (revised 9/9/17) documented the resident was at risk of injury due to poor safety awareness, pain and history of falls. Included in interventions to prevent injury and/or falls was, "Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in w/c [wheelchair]..."

On 2/7/18 at 2:03 p.m., the certified nurses' aide (CNA #1) caring for Resident #59 was interviewed about the resident's shoes. CNA #1 stated the resident used to have shoes but she did not know what happened to them. CNA #1 stated the resident now wore slipper socks each day.

On 2/7/18 at 2:05 p.m., the licensed practical nurse (LPN #1) caring for Resident #59 was interviewed about shoes/footwear. LPN #1 stated the resident's black shoes were lost months ago and were never found. LPN #1 stated there were discussions about who would pay for new shoes. LPN #1 stated the black shoes were "worn out" when they were lost but she did not know why the resident's shoes were not replaced. When asked about the current order for the resident to have diabetic shoes, LPN #1 stated the facility's social worker had more information about the diabetic shoes.

On 2/8/18 at 9:20 a.m., the social worker was interviewed about the order for Resident #59's diabetic shoes. The social worker stated the resident's original shoes were lost. The social

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F 745	Continued From page 32 worker stated the facility searched for the shoes but never found them. The social worker stated she called several places during September 2017 and October 2017 and she was not successful in finding a place that would come measure the resident for shoes. When asked about the resident going out of the facility to acquire the shoes, the social worker stated the local university hospital had a prosthetic/orthotic clinic that provided diabetic shoes per order. The social worker presented a copy of the request from the prosthetic/orthotic clinic dated 11/28/17 with attached paperwork required to order the shoes. The social worker presented another copy of the forms faxed 1/10/18 to the facility with a handwritten note on the first page stating, "2nd request - never got 1st request." The social worker stated forms had not been completed and sent to the orthotic clinic for Resident #59's diabetic shoes. The social worker had no explanation of why it had been over six months without any arrangements made or order completed for Resident #59's diabetic shoes. These finding were reviewed with the administrator and director of nursing during a meeting on 2/8/18 at 3:50 p.m.	F 745		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756		

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§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility's consultant pharmacist failed, for one of 20 residents in the survey sample (Resident # 4), to identify a medication irregularity. Resident # 4 had a physician's order for a PRN (as needed) Oral antipsychotic medication (Haloperidol Lactate 2 milligrams per 1 milliliter) that exceeded 14 days in duration.

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The findings were:

Resident # 4 in the survey sample, a 65 year-old female, was admitted to the facility on 8/22/14, and most recently readmitted on 4/26/17 with diagnoses that included anemia, hypertension, gastroesophageal reflux disease, renal insufficiency, diabetes mellitus, aphasia, Non-Alzheimer's dementia, seizure disorder, anxiety disorder, psychotic disorder, encephalopathy, generalized muscle weakness, and schizophrenia. According to the most recent Minimum Data Set, a Quarterly with an Assessment Reference Date of 11/3/17, the resident was assessed under Section C (Cognitive Patterns) as having severely impaired skills for daily decision making.

Review of the Physician's Order Form for the month of February 2018 revealed the following medication order, originally written on 4/26/17, and carried forward monthly:

Haloperidol Lactate 2mg/1ml (milligrams per milliliter) Oral. Give 0.5 ml by mouth every 4 hours as needed for schizophrenia.

NOTE: Haloperidol (Haldol) is an antipsychotic used in the treatment of psychotic disorders including chronic schizophrenia. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 579.

Effective 11/28/17, PRN (as needed) orders for antipsychotic medications were limited to 14 days unless otherwise extended by the prescribing physician with appropriate supporting documentation. Ref. CFR 483.45(e)(4) and CFR

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F 756	Continued From page 35 483.45(e)(5). Review of Resident # 4's hard copy clinical record revealed the consultant pharmacist conducted monthly drug regimen reviews. However, there was no documentation to indicate the pharmacist identified the PRN order for Haloperidol as being out of the 14 day prescription range. During a meeting at approximately 3:30 p.m. on 2/8/18 that included the Administrator, Director of Nursing, Corporate Nurse Consultant, and the survey team, the findings regarding the use of PRN Haloperidol were discussed.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic	F 758		

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drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility failed, for one of 20 residents in the survey sample (Resident # 4), to ensure the resident was free of unnecessary medications. Resident # 4 had a physician's order for a PRN (as needed) Oral antipsychotic medication (Haloperidol Lactate 2 milligrams per 1 milliliter) that exceeded 14 days in duration

The findings were:

Resident # 4 in the survey sample, a 65 year-old

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female, was admitted to the facility on 8/22/14, and most recently readmitted on 4/26/17 with diagnoses that included anemia, hypertension, gastroesophageal reflux disease, renal insufficiency, diabetes mellitus, aphasia, Non-Alzheimer's dementia, seizure disorder, anxiety disorder, psychotic disorder, encephalopathy, generalized muscle weakness, and schizophrenia. According to the most recent Minimum Data Set, a Quarterly with an Assessment Reference Date of 11/3/17, the resident was assessed under Section C (Cognitive Patterns) as having severely impaired skills for daily decision making.

Review of the Physician's Order Form for the month of February 2018 revealed the following medication order, originally written on 4/26/17, and carried forward monthly:

Haloperidol Lactate 2mg/1ml (milligrams per milliliter) Oral. Give 0.5 ml by mouth every 4 hours as needed for schizophrenia.

NOTE: Haloperidol (Haldol) is an antipsychotic used in the treatment of psychotic disorders including chronic schizophrenia. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 579.

Effective 11/28/17, PRN (as needed) orders for antipsychotic medications were limited to 14 days unless otherwise extended by the prescribing physician with appropriate supporting documentation. Ref. CFR 483.45(e)(4) and CFR 483.45(e)(5).

A review of the Medication Administration Records (MAR) for the months of October,

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F 758	Continued From page 38 November, and December 2017, the month of January 2018, and the month of February 2018 as of 2/7/18, the date of record review, revealed the oral PRN Haloperidol was not used. A thorough review of Resident # 4's hard copy clinical record failed to identify any documentation from the ordering physician justifying the continued use of PRN Haloperidol beyond 14 days after 11/28/17, the date the 14 day limitation on PRN antipsychotic use became effective. During a meeting at approximately 3:30 p.m. on 2/8/18 that included the Administrator, Director of Nursing, Corporate Nurse Consultant, and the survey team, the findings regarding the use of PRN Haloperidol were discussed.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: During the medication pass and pour observation, staff interview, and clinical record review, facility staff failed to ensure a medication error rate of less than five percent. During the medication pass and pour observation conducted on 02/07/18 there were three noted medication errors out of 32 opportunities resulting in a medication error rate of 9.38%. These errors involved three out of 20 residents in the survey sample, Residents #14, #35 and #40.	F 759		

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1. Resident #14 received her Duloxetine during the morning medication administration instead of at bedtime as ordered by the physician.

2. Resident #35 received her Ferrous Sulfate (Iron) after breakfast instead of before breakfast as ordered by the physician.

3. Resident #40 received Singulair 10 mg (one tablet) during the morning medication administration instead of 20 mg (two tablets) as ordered by the physician.

Findings included:

1. Resident #14 received her Duloxetine during the morning medication administration instead of at bedtime as ordered by the physician.

Resident #14 was admitted to the facility on 10/02/17 with diagnoses including, but not limited to: Dementia, Hypertension, Depression and Glaucoma.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/01/17. Resident #14 was assessed as moderately impaired in her cognitive status with a total cognitive score of 11 out of 14.

Resident #14's medications were prepared and administered at 9:13 a.m. on 02/07/18 by LPN #1 (licensed practical nurse). During this administration Resident #14 received Duloxetine (Cymbalta) 60 mg (milligrams) by mouth. During the reconciliation the order read, "...Duloxetine HCL 60MG Take 1 [one] Cap [capsule] by mouth

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at bedtime for major depressive D/O [disorder]..."

LPN #1 was interviewed at 10:15 a.m. on 02/07/18 regarding the Duloxetine order. This surveyor and LPN #1 also reviewed Resident #14's current MAR (medication administration sheet) and current physician order. LPN #1 stated, "Oh my and I tried to be so careful. I will notify the doctor."

2. Resident #35 received her Ferrous Sulfate (Iron) after breakfast instead of before breakfast as ordered by the physician.

Resident #35 was originally admitted to the facility on 08/26/16 and readmitted on 09/14/17 with diagnoses including, but not limited to: Iron-deficiency Anemia, Osteoarthritis, Diabetes, Alzheimer's Disease, and CVA (cerebrovascular accident).

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/22/17. Resident #35 was assessed as moderately impaired in her cognitive status with a total cognitive score of 11 out of 15.

Resident #35's medications were prepared and administered at 9:25 a.m. on 02/07/18 by LPN #1 (licensed practical nurse). During this administration Resident #35 received Ferrous Sulfate 325 mg by mouth. During the reconciliation of Resident #35's morning medications at 10:08 a.m. a physician order was noted that stated, "...Ferrous Sulfate 325MG Tablet 1 [one] TAB [tablet] by mouth twice daily before meals for supplement..."

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Resident #35 received her morning dose of Ferrous Sulfate (Iron) at 9:25 a.m., approximately one to one and a half hours after breakfast had been served and consumed by this resident. LPN #1 was interviewed at 10:15 a.m. on 02/07/18 regarding Resident #35's Iron administration. LPN #1 stated, "I don't know why that is before meals. You don't give Iron on an empty stomach. I will get that clarified."

3. Resident #40 received Singulair 10 mg (one tablet) during the morning medication administration instead of 20 mg (two tablets) as ordered by the physician.

Resident #40 was originally admitted to the facility on 12/29/17 and readmitted on 01/11/18 with diagnoses including, but not limited to: Left Humeral Fracture, Respiratory Failure, Diabetes, COPD (chronic obstructive pulmonary disease), Hypertension, Anemia, CHF (congestive heart failure) and Depression.

Resident #40's most recent MDS was a 14-day comprehensive assessment with an ARD of 01/25/18. Resident #40 was assessed as cognitively intact with a total cognitive score of 13 out of 15.

Resident #40's medications were prepared and administered at 9:35 a.m. on 02/07/18 by LPN #1 (licensed practical nurse). During this administration Resident #40 received Singulair 10 mg by mouth. During the reconciliation of Resident #40's morning medications at 10:10 a.m. a physician order was noted that stated, "...Montelukast Sodium 10MG (Singulair) TABLET Take 2 [two] Tabs (20MG) by mouth every day..."

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LPN #1 was interviewed at 10:15 a.m. on 02/07/18 regarding Resident #40's Singulair. LPN #1 stated, "No I only gave one. I will give her another one now."

The Administrator and DON (director of nursing) were informed of the above information during a meeting with the survey team on 02/07/18 at approximately 3:35 p.m. No further information was received by the survey team prior to the exit conference on 02/08/18.

F 842 SS=D Resident Records - Identifiable Information
CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)

F 842

§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the

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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.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and

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(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for two of 20 residents in the survey sample. Resident #25's physician order summary sheet failed to include a current order for oxygen administration. Medication administration was inaccurately documented on Resident #4's medication administration record (MAR).

The findings include:

1. Resident #25's physician order summary sheet failed to include a current order for oxygen administration.

Resident #25 was admitted to the facility on 11/27/17 with diagnoses that included COPD (chronic obstructive pulmonary disease), malnutrition and altered mental status. The minimum data set (MDS) dated 1/3/18 assessed Resident #25 as cognitively intact.

Resident #25 was observed on 2/6/18 at 4:00 p.m. in bed with oxygen administered from a concentrator set between 3.5 lpm (liters per minute) and 4.0 lpm. Resident #25 was observed again on 2/7/18 at 8:53 a.m. with his oxygen running at a rate between 3.5 lpm and 4.0 lpm.

Resident #25's clinical record documented no current physician's order for oxygen. The current physician order summary sheet signed by the physician on 2/2/18 included no orders for oxygen. The record documented a previous

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order dated 12/1/17 for oxygen to be administered continuously at 3 liters per minute.

On 2/7/18 at 8:53 a.m., accompanied by the registered nurse (RN #3) caring for Resident #25, the oxygen was observed running at a rate between 3.5 lpm and 4.0 lpm from the concentrator. RN #3 was interviewed at this time about the ordered rate for the oxygen. RN #3 stated he thought after the resident went to a pulmonologist the oxygen was supposed to be set between 2.0 lpm and 3.0 lpm depending on how the resident was feeling. RN #3 stated he would look for an order for the oxygen.

On 2/7/18 at 1:49 p.m., RN #3 stated the resident had an order when he was admitted for oxygen to run at 3.0 lpm. RN #3 stated the order was not carried forward to the current list of physician orders.

These findings were reviewed with the administrator and director of nursing during a meeting on 2/7/18 at 3:35 p.m.

2. The facility staff failed to maintain complete and accurate Medication Administration Records for Resident # 4.

Resident # 4 in the survey sample, a 65 year-old female, was admitted to the facility on 8/22/14, and most recently readmitted on 4/26/17 with diagnoses that included anemia, hypertension, gastroesophageal reflux disease, renal insufficiency, diabetes mellitus, aphasia, Non-Alzheimer's dementia, seizure disorder, anxiety disorder, psychotic disorder, encephalopathy, generalized muscle weakness,

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and schizophrenia. According to the most recent Minimum Data Set, a Quarterly with an Assessment Reference Date of 11/3/17, the resident was assessed under Section C (Cognitive Patterns) as having severely impaired skills for daily decision making.

Review of the Physician's Order Form for the month of February 2018 revealed the following order for the use of Haloperidol, originally written on 6/2/17, and carried forward monthly:

Haloperidol Lactate 0.2 ml (1 mg) Intramuscularly three times daily - Schizophrenia - Rotate Site - Administer if patient refused liquid. The scheduled administration times were 9 a.m., 2 p.m., and 8 p.m. The scheduled times were crossed out and the handwritten notation "PRN" was added.

There was also an as needed order for Haloperidol was originally written on 4/26/17, and carried forward monthly:

Haloperidol Lactate 2 mg/1 ml Oral. Give 0.5 ml by mouth every 4 hours as needed for schizophrenia.

NOTE: Haloperidol (Haldol) is an antipsychotic used in the treatment of psychotic disorders including chronic schizophrenia. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 579.

Review of the October 2017 MAR revealed the intramuscular Haldol was three times with no explanation on the comments portion of the MAR as to the reason for the administration.

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F 842	Continued From page 47 According to the November 2017 MAR, the intramuscular Haldol was administered four times. Twice it was administered with no explanation on the comments portion of the MAR as to the reason for the administration. Once, the administration was documented on the comments portion of the MAR, but not on the front of the MAR. And once, the administration was documented in the Interdisciplinary Progress (Nurse) Notes, but not on the MAR. During a meeting at approximately 3:30 p.m. on 2/8/18 that included the Administrator, Director of Nursing, Corporate Nurse Consultant, and the survey team, the findings regarding the incomplete MAR entries was discussed.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		

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arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

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

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and

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transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, facility staff failed to follow infection control practices during a dressing change for one of 20 residents in the survey sample, Resident #49.

Facility staff failed to use proper hand washing during a dressing change for Resident #49. RN #2 used hand sanitizer at the beginning of the dressing change procedure and at no other time. She did not perform proper hand hygiene after removing the old dressing or at any time between glove changes. She was never observed washing her hands with soap and water. The work area was not cleaned with a disinfecting wipe prior to placing Resident #49's dressing change supplies onto clean paper towels.

Findings included:

Resident #49 was admitted to the facility on 12/26/2017 with diagnoses including, but not limited to: PVD (peripheral vascular disease), right foot ulcer, and rheumatoid arthritis.

Resident #49's most recent MDS (minimum data set) was his initial assessment with an ARD (assessment reference date) of 01/02/2018. Resident #49 was assessed as cognitively intact with a total cognitive score of 13 out of 15.

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Resident #49's clinical record was reviewed on 02/07/18 at 10:30 a.m. An order on the February POS (physician order sheet) stated, "...Iodoform...apply to area twice daily, clean are [sic] with wound cleanser and cover with gauze and kerlix..."

On 02/07/18 at 10:50 a.m. this surveyor observed RN #2 (registered nurse) perform a dressing change to Resident #49's right foot ulcer. RN #2 gathered her dressing change supplies from the dressing cart and placed them on top of clean paper towels on the resident's bedside table. RN #2 cleansed her hands with hand sanitizer and applied clean gloves. RN #2 removed the outer dressing from the resident's foot, (4x4's and kerlix), changed gloves, then removed the Iodoform gauze from the ulcer. She cleansed the perimeter of the ulcer with wound cleanser, changed gloves, applied Iodoform gauze to the ulcer using a sterile swab, applied clean 4x4's and kerlix. The resident tolerated the procedure with minimal discomfort. The ulcer was the approximate size of a 50-cent piece, pink and had a small amount of serous drainage on the old dressing.

A policy for dressing changes, to include hand washing, was requested during a meeting with the Administrator and DON (director of nursing) on 02/07/18 at approximately 3:35 p.m. A hand hygiene policy was received on 02/08/18 at approximately 9:30 a.m. A dressing change policy was received at 9:55 a.m.

The dressing change policy "Effective Date: 11/30/2014; Revision Date: 12/06/2017" stated, "Policy: A clean dressing will applied [sic] by a nurse to a wound as ordered to promote

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healing...Procedure: ...Place supplies on prepped work surface, Perform Hand Hygiene, Apply gloves, Remove and dispose of soiled dressing, Remove gloves, Perform hand hygiene, Apply gloves, Evaluate wound for type, color, amount of drainage, Cleanse wound as ordered, dispose of gauze, Remove gloves and perform hand hygiene, Apply treatment as order and clean dressing, Discard gloves and perform hand hygiene..."

Hand Hygiene as described in the facility policy, "Effective Date: 09/06/2016; Revision Date: 08/29/2017" stated, "Overview: The CDC [center for disease control] defines hand hygiene as cleaning your hands by using either handwashing (washing with soap and water), antiseptic hand wash, or antiseptic hand rubs (i.e. alcohol-based sanitizer including foam or gel). Purpose: To reduce the spread of germs in the healthcare setting. Process: Hand hygiene should performed: ...Before initiating a clean procedure...After contact with blood, body fluids, or excretions, mucous membranes, non-intact skin, or wound dressings...After glove removal..."

The DON was interviewed on 02/08/18 at 11:05 a.m. regarding Resident #49's dressing change procedure on 02/07/18 and on areas of the dressing change policy. The DON stated regarding a "prepped work surface, Clean the overside table with a Clorox wipe, place down a clean barrier, like a paper plate or wax paper. A paper towel is acceptable." Regarding hand hygiene, the DON stated, "At the start of the dressing change I would expect them to wash their hands with soap and water. Any other time during the dressing change hand sanitizer would be acceptable."

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RN #2 used hand sanitizer at the beginning of the dressing change procedure and at no other time. She did not perform proper hand hygiene after removing the old dressing or at any time between glove changes. She was never observed washing her hands with soap and water. The work area was not cleaned with a disinfecting wipe prior to placing Resident #49's dressing change supplies onto clean paper towels.

The Administrator was informed of the above findings during a meeting with the survey team on 02/08/18 at approximately 3:35 p.m. No further information was received prior to the exit conference on 02/08/18.