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	495192	A. BUILDING _____ B. WING _____	C 07/07/2017

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ENVOY OF LAWRENCEVILLE, LLC	1722 LAWRENCEVILLE PLANK ROAD LAWRENCEVILLE, VA 23868

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F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 7/5/17 through 7/7/17. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. Two complaints were investigated during the survey. The Life Safety Code survey/report will follow.

The census in this 77 certified bed facility was 77 at the time of the survey. The survey sample consisted of thirteen current resident reviews (Residents 1 through 13) and six closed record reviews (Residents 14 through 19).

F 159 SS=D 483.10(f)(10)(i)-(iv) FACILITY MANAGEMENT OF PERSONAL FUNDS — F 159

(f)(10)(i) ...If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section.

(f)(10)(ii) Deposit of Funds.
(A) In general: Except as set out in paragraph (f)(10)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.

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

Helene Molnar ED 7.25.17

A 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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(B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund.

(f)(10)(iii) Accounting and records.
(A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

(B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

(C)The individual financial record must be available to the resident through quarterly statements and upon request.

(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits-
(A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and

(B) That, if the amount in the account, in addition

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to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, facility document review and clinical record review, the facility staff failed to promptly provide requested cash from a resident account for one of 19 residents in the survey sample. It took four days for Resident #12 to obtain cash from her personal fund account maintained by the facility.

The findings include:

Resident #12 was admitted to the facility on 4/29/16 with diagnoses that included heart failure, diabetes, peripheral venous insufficiency and anxiety. The minimum data set (MDS) dated 5/7/17 assessed Resident #12 as cognitively intact.

A private interview was conducted on 7/6/17 at 11:00 a.m. with a group of cognitively intact residents about quality of life in the facility. When asked about any concerns with costs or payment for services, Resident #12 stated she had asked for four days in a row for $40 from her personal account and still had not received her money. Resident #12 stated she asked the office manager on Monday (7/3/17), Tuesday (7/4/17), Wednesday (7/5/17) and today (7/6/17) for $40 from her account. Resident #12 stated she was told that the facility had no cash available as the office manager had not been to the bank.

On 7/6/17 at 2:15 p.m. the office manager was interviewed about Resident #12's request for $40

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from her account. The office manager stated Resident #12 had a personal account at the facility and had a "small balance" in her account. The office manager stated on Monday (7/3/17) multiple residents requested cash from their accounts and she kept a limited amount of cash in the cash box. The office manager stated by the time Resident #12 requested her funds on 7/3/17 she did not have enough cash in the box to give her the requested $40. The office manager stated she was unable to go to the bank on Tuesday (7/4/17) as the bank was closed for the July 4th holiday. The office manager stated she did not go to the bank on Wednesday (7/5/17). When asked why the resident did not get her cash on Wednesday (7/5/17) the office manager stated because she did not go to the bank. The office manager stated, "I'm human. It slipped my mind." The office manager stated she thought the resident needed the cash for the weekend and did not need it immediately. When asked why the resident had not received her cash as of today (7/6/17) the office manager stated the resident had not come to her office for the money. When asked if the resident had to come again to her office to request the money the office manager stated, "She's [Resident #12] a walkie talkie. She [Resident #12] can come to me." When asked what she meant by a "walkie talkie," the office manager stated, "Those that can walk and talk." The office manager stated the residents that could "walk and talk" usually came to her for their money. The office manager stated she had the cash now in the cash box. The office manager stated, "She [Resident #12] can come get it [money] today."

On 7/6/17 at 2:50 p.m. the administrator was interviewed about Resident #12 waiting four days

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to get $40 from her personal account. The administrator stated the cash may have been depleted from the cash box on Monday (7/3/17) and Tuesday (7/4/17) was a holiday but the resident should have been able to get her money on Wednesday (7/5/17). The administrator stated she would have expected the office manager to respond to Resident #12's request for money as soon as possible. The administrator stated when and what the resident needed the money for was irrelevant and the resident should be able to access their cash when requested.

The facility's policy titled Resident Trust Fund - Banking Hours (effective 11/30/14) stated, "During the established 'banking hours' that fall within regular business working hours, request for both cash withdrawals from the Receptionist and check withdrawals from the Business Office Manager will be honored."

These findings were reviewed with the administrator and director of nursing during a meeting on 7/7/17 at 11:00 a.m.

F 241 SS=D 483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY — F 241

(a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview and clinical record review, the facility staff failed to promote the dignity and respect of one of 19

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residents in the survey sample. During an interview about resident fund accessibility, Resident #12 was referred to by a staff member as a "walkie talkie." In addition, after four verbal requests from Resident #12 for cash from her personal account, facility staff took no initiative to ensure the resident received her requested money.

The findings include:

Resident #12 was admitted to the facility on 4/29/16 with diagnoses that included heart failure, diabetes, peripheral venous insufficiency and anxiety. The minimum data set (MDS) dated 5/7/17 assessed Resident #12 as cognitively intact.

A private interview was conducted on 7/6/17 at 11:00 a.m. with a group of cognitively intact residents about quality of life in the facility. When asked about any concerns with costs or payment for services, Resident #12 stated she had asked for four days in a row for $40 from her personal account and still had not received her money. Resident #12 stated she asked the office manager on Monday (7/3/17), Tuesday (7/4/17), Wednesday (7/5/17) and today (7/6/17) for $40 from her account. Resident #12 stated she was told that the facility had no cash available as the office manager had not been to the bank.

On 7/6/17 at 2:15 p.m. the office manager was interviewed about Resident #12's request for $40 from her account. The office manager stated Resident #12 had a personal account at the facility and had a "small balance" in her account. The office manager stated on Monday (7/3/17) multiple residents requested cash from their

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accounts and she kept a limited amount of cash in the cash box. The office manager stated by the time Resident #12 requested her funds on 7/3/17 she did not have enough cash in the box to give her the requested $40. The office manager stated she was unable to go to the bank on Tuesday (7/4/17) as the bank was closed for the July 4th holiday. The office manager stated she did not go to the bank on Wednesday (7/5/17). When asked why the resident did not get her cash on Wednesday (7/5/17) the office manager stated because she did not go to the bank. The office manager stated, "I'm human. It slipped my mind." The office manager stated she thought the resident needed the cash for the weekend and did not need it immediately. When asked why the resident had not received her cash as of today (7/6/17) the office manager stated the resident had not come to her office for the money. When asked if the resident had to come again to her office to request the money the office manager stated, "She's [Resident #12] a walkie talkie. She [Resident #12] can come to me." When asked what she meant by a "walkie talkie," the office manager stated, "Those that can walk and talk." The office manager stated the residents that could "walk and talk" usually came to her for their money. The office manager stated she had the cash now in the cash box. The office manager stated, "She [Resident #12] can come get it [money] today."

On 7/6/17 at 2:50 p.m. the administrator was interviewed about the office manager's reference to Resident #12 as a "walkie talkie" and lack of initiative to get Resident #12 the requested cash. The administrator stated it was certainly not appropriate to refer to Resident #12 as a "walkie talkie" or any label. The administrator stated the

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F 241	Continued From page 7 cash may have been depleted from the cash box on Monday (7/3/17) and Tuesday (7/4/17) was a holiday but the resident should have been able to get her money on Wednesday (7/5/17). The administrator stated she would have expected the office manager to respond to Resident #12's request for money as soon as possible. The administrator stated when and what the resident needed the money for was irrelevant and the resident should be able to access their cash when requested. On 7/6/17 at 3:50 p.m. the administrator stated she talked with the office manager about the interview regarding Resident #12. The administrator stated the office manager's casual response to the cash request and reference to the resident as a "walkie talkie" were "completely unacceptable." These findings were reviewed with the administrator and director of nursing during a meeting on 7/7/17 at 11:00 a.m.	F 241		
F 252 SS=E	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §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- (i)(1) A safe, clean, comfortable, and homelike	F 252		

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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.
This REQUIREMENT is not met as evidenced by:
Based on observations, clinical record review, and staff interview, the facility staff failed to maintain the facility in a clean, comfortable, and homelike environment. The facility staff also failed for two of 19 residents (Residents # 10 and 13) to maintain their rooms and personal equipment in a clean and safe manner. There were deep gouges in the wall behind Resident # 10's bed, and the resident's wheelchair was in disrepair. In Resident # 13's room, the Venetian blinds were broken.

The findings include:

1. During the General Observations Tour of the facility at 7:50 a.m. on 7/7/17, the following conditions were noted:

On the West Unit:

The Nurses Station counter top was chipped and had sharp edges in the area where residents and visitors stand to speak with nursing staff behind the counter.

The floor tile was chipped at the tread of the rear

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exit door.
The veneer on many of the doors on the unit were scratched, had deep gouges, or were splintered, particularly at the hinge edge of the doors. Included were the Shower Room door, the Fire Doors to the 200 Unit, and the Therapy Room door. Specific resident room doors included rooms 208, 210, 211, 212, 213, 214, 215, 300, 301, 302, 303, 304, and 309.

On the East Unit:

The work surface at the Nurses Station had a large area that was chipped off. On the front of the Nurses Station, an end cap was missing from one of the safety bumpers, exposing a sharp edge.

The veneer on many of the doors on the unit were scratched, had deep gouges, or were splintered, particularly at the hinge edge of the doors. Included were the Fire Doors on the "E" Wing, the Whirlpool/Shower Room door, and the Restorative Dining Room door. Specific resident rooms door included rooms 100, 101, 102, 103, 104, 105, 106, 107, 108, 111, 113, 114, 115, 116, 118, 119, 200, 201, 203, 204, and 207. In addition, the kick plates on rooms 104, 105, and 204 were broken.

In the Restorative Dining Room, there was missing floor tile at the Patio exit door, the door frame was corroded at the door tread, and there was approximately 18 inches of weather stripping missing at the bottom the door frame. A patched area near the door was unfinished and in need of additional repair. There were deep gouges in the wall under on set of windows.

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The hand rails throughout the facility were in need of refinishing. In some areas, the finish was worn down to the bare wood.

At 9:45 a.m. on 7/7/17, the Maintenance Director was interviewed regarding the maintenance of the building. Asked if he had a punch list of repairs that needed to be made, the Maintenance Director showed the surveyor a handful of note papers that he said were things that needed to be done. The Maintenance Director said he worked alone in the building, although he did have an individual that works about 20 hours a week to help him.

The observations were discussed with the Administrator and the Director of Nursing during a meeting at 11:00 a.m. on 7/7/17 with the survey team.

2. Resident #10's wheelchair was in disrepair and the wall behind the resident's bed was damaged.

Resident #10 was admitted to the facility on 6/10/16 with a re-admission on 9/7/16. Diagnoses for Resident #10 included chronic kidney disease, dementia and peripheral vascular disease. The minimum data set (MDS) dated 6/6/17 assessed Resident #10 with moderately impaired cognitive skills.

On 7/5/17 at 11:15 a.m. Resident #10 was observed seated in his wheelchair in his room. The covering on the left arm rest cushion of the resident's wheelchair was cracked and worn. The end of the support rod under the left arm rest on the wheelchair had an orange piece of foam taped on the end of the rod. The foam was torn and exposed the end of the arm rest support rod.

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This support rod was missing a protective cap. The wall behind the head of Resident #10's bed was damaged. There were at least twelve vertical scraped streaks approximately six to twelve inches in length with scraped, missing paint. In some places the drywall covering was scraped and hanging from the wall.

On 7/6/17 at 8:40 a.m. accompanied by licensed practical nurse (LPN) #3, Resident #10's wheelchair and damaged wall were observed. LPN #3 was interviewed at this time about the worn left arm rest cushion and the support rod missing an end cap. LPN #3 stated she was not sure who covered the wheelchair support rod with the orange foam. LPN #3 stated she thought the wall was on a list of needed repairs waiting to be completed by maintenance. LPN #3 stated she thought the wall was damaged from moving the resident's bed up and down. On 7/6/17 at 9:00 a.m. LPN #3 stated someone from the therapy department had taped the orange foam cushion to the wheelchair support rod. LPN #3 stated a work order had not yet been written to repair the chair.

On 7/6/17 at 9:10 a.m. the maintenance director was interviewed about Resident #10's wheelchair and damaged wall. The maintenance director stated the damaged wall had been on a repair list for "about a month." The maintenance director stated they were trying to work on the worst rooms first. The maintenance director stated he was not aware that Resident #10's wheelchair was in disrepair and a work order had not been entered to replace the missing end cap.

These findings were reviewed with the administrator and director of nursing during a

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F 252	Continued From page 12 meeting on 7/6/17 at 1:30 p.m.	F 252		

3. Resident #13's Venetian blinds were broken and missing a section on the bottom right side of the blinds.

On 7/7/17 at approximately 8:28 a.m.,while in the resident's room for an interview, this Surveyor observed the Venetian blind, hanging at the window, in need of repair. The bottom section of the Venetian blind was missing a section and this Surveyor could see to the outside of the window through the broken section of the blind. Resident #13 was interviewed and asked about the Venetian blind and how long the blind had been broken. Resident #13 stated, "It's been like that for a while. I just don't pay no attention to it now."

On 7/7/17 at approximately 11:15 a.m., during the meeting with the administrator and the director of nursing the above findings were mentioned.

F 278 SS=D 483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED — F 278

(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.

(h) Coordination
A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

(i) Certification

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(1) A registered nurse must sign and certify that the assessment is completed.

(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

(j) Penalty for Falsification
(1) Under Medicare and Medicaid, an individual who willfully and knowingly-

(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility staff failed for one of 19 residents in the survey sample (Resident # 9) to ensure a complete and accurate Minimum Data Set. Resident # 9 had a Significant Change Minimum Data Set with inaccurate information at Section K (Swallowing/Nutritional Status).

The findings were:

Resident # 9 in the survey sample, a 93 year-old female, was admitted to the facility on 2/25/15 and most recently readmitted on 10/19/16 with

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F 278	Continued From page 14	F 278		

diagnoses that included asthma, dysphagia, pneumonia, generalized muscle weakness, gastroesophageal reflux disease, osteoporosis, dementia, depressive disorder, anemia, hypertension, hyperlipidemia, cardiomegaly, and Alzheimer's Disease. According to the most recent Minimum Data Set (MDS), a Significant Change with an Assessment Reference Date of 6/2/17, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 3 out of 15.

Under Section K (Swallowing/Nutritional Status), at Item K0200-b, the resident's weight was listed as 106 pounds. At Item K0300, Weight Loss, the resident was assessed as not having a weight loss of 5% or more in the last month or a loss of 10% or more in the last 6 months.

Review of Resident # 9's weight record revealed her weight six months earlier, on 12/1/16, was 118 pounds. Compared with her weight of 106 pounds listed on the 6/2/17 MDS, the resident lost 12 pounds, for a 10.2% weight loss.

At approximately 3:00 p.m. on 7/5/17, LPN # 1 (Licensed Practical Nurse), one of the facility's MDS Coordinators, was asked about the omission of Resident # 9's 10% weight loss from the Significant Change MDS of 6/1/17. LPN # 1 said she would check on it and get back to the surveyor.

At 3:35 p.m. on 7/5/17, LPN # 1 returned to the surveyor and said, "She (Resident # 9) did have a 10% weight loss. We did not code that (on the MDS)."

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F 278	Continued From page 15 The findings were discussed with the Administrator and Director of Nursing during a meeting with the survey team at 4:00 p.m. on 7/6/17.	F 278		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 279		

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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, the facility staff failed to develop a comprehensive care plan for two of 19 residents in the survey sample, Resident #4 and #6.

1. Resident #4 did not have a care plan (CP) developed for Dehydration and Fluid Maintenance.

2. Resident #6 did not have a care plan (CP) developed for Dental, Pressure Ulcer,

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Communication, and Antiplatelets.

The findings include:

1. Resident #4 did not have a care plan (CP) developed for Dehydration and Fluid Maintenance.

Resident #4 was originally admitted to the facility on 2/13/15 and readmitted on 4/17/17, with but not limited to, the following diagnoses: diabetes type two (2), dysphagia, hypertension, glaucoma, and non-toxic goiter. The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/19/17 was a significant change assessment. The resident was assessed as being an eleven (11) for cognitive impairments meaning moderately impaired.

On 7/6/17 at approximately 8:30 a.m., Resident #4's significant change assessment was reviewed. Under Section V. Care Area Assessment, Dehydration and Fluid Maintenance triggered on the assessment and was checked off for care planning. A CP initiated on 9/28/15 and updated on 5/1/17 was reviewed in the electronic clinical records. The CP did not address the CAA triggered for Dehydration and Fluid Maintenance.

On 7/6/17 at approximately 8:52 a.m., the MDS Coordinator, who was a registered nurse and will be identified as RN#1, was interviewed regarding the missing CP for Dehydration and Fluid Maintenance. RN #1 reviewed the CP and stated, "I will talk with MDS and see what I can find out."

On 7/6/17 at approximately 10:10 a.m., the MDS Coordinator, who was a licensed practical nurse and will be identified as LPN #1 approached this

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Surveyor and stated, "[Resident named] was not care planned for Dehydration and Fluid Maintenance. I was going to go back and do it but I didn't."

On 7/6/17 at approximately 4:15 p.m., during the end of the day meeting with the administrator and the director of nursing the above findings were mentioned.

2. Resident #6 did not have a care plan developed regarding dental care, pressure ulcer prevention, communication or antiplatelet use.

Resident #6 was admitted to the facility on 5/8/17 with diagnoses that included hemiplegia, cerebrovascular accident (stroke), neuromuscular bladder dysfunction with urine retention and high blood pressure. The minimum data set (MDS) dated 6/12/17 assessed Resident #6 with moderately impaired cognitive skills.

Resident #6's admission MDS dated 5/21/17 documented communication, dental care and pressure sores as triggered care areas requiring the development of a comprehensive care plan. The care area assessment summary indicated the facility would develop a care plan for communication, dental and pressure sore prevention.

Resident #6's clinical record documented a physician orders dated 5/9/17 for the antiplatelet medications Clopidogrel Bisulfate (Plavix) 75 mg (milligrams) and Aspirin 81 mg to be administered each day due to history of stroke.

Resident #6's care plan (revised 5/16/17) included no problems goals and/or interventions

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regarding communication, dental care, pressure sore prevention or antiplatelet use.

On 7/6/17 at 8:50 a.m. the registered nurse responsible for care plan development (RN #1) was interviewed about the missing care areas on Resident #6's plan. After reviewing the care plan RN #1 stated she did not find entries on Resident #6's care plan for dental, pressure sore prevention, communication or Plavix/aspirin use. RN #1 stated the resident did not have a pressure sore but interventions were in place for prevention. RN #1 stated she did not know why the triggered care areas were left off the care plan.

The Nursing 2017 Drug Handbook on pages 371 through 373 describes Plavix as an antiplatelet medication used to reduce blood clots in patients with heart disease documented by a recent stroke, heart attack or peripheral arterial disease. This reference lists bleeding as a possible adverse effect and states Plavix use along with aspirin may increase the risk of gastrointestinal bleeding. This reference on pages 164 and 165 describes aspirin as a non-steroidal anti-inflammatory drug (NSAID) used to reduce the risk of recurrent transient ischemic attacks, stroke or death in at risk patients. (1)

These findings were reviewed with the administrator and director of nursing during a meeting on 7/6/17 at 1:30 p.m.

(1) Rader, Janet, Dorothy Terry and Leigh Ann Trujillo. Nursing 2017 Drug Handbook. Philadelphia: Wolters Kluwer, 2017.

F 309 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES F 309

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483.24 Quality of life
Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:

(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on observations, clinical record review,

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and staff interview, the facility staff failed for one of 19 residents in the survey sample (Resident # 11) to follow physician's orders for the administration of an anticonvulsant. During the medication pass and pour observation, Lamotrigine was not available for administration to Resident # 11, which resulted in the resident missing a dose of medication ordered for seizures.

The findings were:

Resident # 11 in the survey sample, a 75 year-old male, was admitted to the facility on 4/13/17, with diagnoses that included cerebral infarction, aphasia, generalized muscle weakness, right spastic hemiplegia, deep vein thrombosis, hypertension, diabetes mellitus, obesity, cognitive communication deficit, and seizure disorder. According to the most recent Minimum Data Set, a Medicare 5-Day with an Assessment Reference Date of 6/14/17, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 3 out of 15.

During the medication pass and pour observation at 7:40 a.m. on 7/6/17, LPN # 2 (Licensed Practical Nurse) prepared seven medications for administration to Resident # 11. After preparing the medications, LPN # 2 stated that the resident was out of Lamotrigine and that she would notify the pharmacy.

NOTE: Lamotrigine (Lamictal) is an anticonvulsant used in the treatment of seizures. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 678.

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During reconciliation of the medications ordered and administered to Resident # 11, the following medication order was noted.

4/19/17 - Lamotrigine Tablet 100 mg (milligrams). Give 1 tablet by mouth two times a day for seizure activity.

The times noted for administration were 0800 (8:00 a.m.) and 1700 (5:00 p.m.).

Review of the Progress (Nurses) Notes in Resident # 11's Electronic Health (Clinical) Record revealed the following entries:

7/6/17 - 7:47 a.m. "Medication (Lamotrigine) on order."

7/6/17 - 2:17 p.m. "Resident Lamotrigine 100 mg was sent to backup pharmacy [name of pharmacy] by [name of facility pharmacy provider]. Notified Dr, [name] and orders were given to administer medication on next scheduled dose at 5:00 p.m. today."

At 2:20 p.m. on 7/6/17, LPN # 2 told the surveyor, "The pharmacy sent 1 (one) pill. I spoke to the doctor and he said to give it at 5:00 p.m." LPN # 2 went on to indicate that a full order of Lamotrigine would be arriving with the regular medication delivery scheduled for that evening.

The findings were discussed with the Administrator and Director of Nursing during a meeting with the survey team at 4:00 p.m. on 7/6/17.

F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		

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(e) Incontinence.
(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.

(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-

(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;

(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and

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

(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff

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interview and clinical record review, the facility staff failed to ensure a properly functioning urinary catheter for one of 19 residents in the survey sample. Urine failed to drain from Resident #6's suprapubic catheter due to an improperly positioned drainage bag.

The findings include:

Resident #6 was admitted to the facility on 5/8/17 with diagnoses that included hemiplegia, cerebrovascular accident (stroke), neuromuscular bladder dysfunction with urine retention and high blood pressure. The minimum data set (MDS) dated 6/12/17 assessed Resident #6 with moderately impaired cognitive skills.

Resident #6's clinical record documented a physician's order dated 5/10/17 for use of a suprapubic catheter due to urine retention associated with neuromuscular dysfunction of the bladder. An order was documented dated 5/10/17 to change the catheter bag and/or catheter monthly or as needed for leakage.

A change in condition form dated 6/14/17 at 11:20 p.m. documented, "suprapubic catheter non functioning. Painful urination through penis." A nursing note dated 6/15/17 at 12:12 a.m. documented, "Resident was sent to [hospital] due to pain during urination and non functioning catheter per [physician]." A nursing note dated 6/15/17 at 2:41 a.m. stated, "Resident returned to [facility] from [hospital] with the following instructions...When changing leg bag, ensure he [the] bag is replaced in proper direction. End with stopcock for emptying bag goes at bottom, end with open tube is conntected [connected] to catheter for drainage." (sic)

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Resident #6's emergency room report dated 6/15/17 documented the resident presented to the emergency room due to a suprapubic catheter that was not draining with reports of urine leaking from his penis and abdominal pain. The emergency room report documented the physician's examination as, "Abdomen/GI [gastrointestinal]: Inspection: distension, that is mild, suprapubic catheter inplace [in place] drainage bag placed upside down no drainage in bag, Palpation...moderate abdominal tenderness, in the suprapubic area...bladder is distended, tender to palpation...suprapubic catheter in place. Urine is clear." The emergency room report stated action taken due to non-functioning catheter, "changed leg bag to upright proper position and suprapubic catheter draining clear urine without difficulty." The resident was discharged back to the facility with written instructions stating, "when changing leg bag, ensure the bag is replaced in proper direction. end with stopcock for emptying bag goes at bottom, end with open tube is conntected [connected] to catheter for drainage." (sic)

On 7/5/17 at 2:15 p.m. Resident #6 was interviewed about the drainage problem with his catheter on 6/14/17. Resident #6 stated he had to go to the emergency room because there was no urine draining from his catheter. Resident #6 stated he always wore a leg bag and the catheter and bag had been changed on the day shift on 6/14/17. Resident #6 stated during the evening on 6/14/17 his abdomen started feeling "full" and his bladder was pulsating "like a toothache." Resident #6 stated the hospital told him the drainage bag was not put on right and that was why the urine was not draining in the bag.

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Resident #6 stated once they changed the bag around at the hospital he had no further problems.

On 7/5/17 at 2:30 p.m. the licensed practical nurse (LPN #2) caring for Resident #6 during the day on 6/14/17 was interviewed about Resident #6's suprapubic catheter not draining. LPN #2 stated the resident's catheter and bag were changed on 6/14/17. LPN #2 stated she got the assistant director of nursing (ADON) to help her because she had never changed a suprapubic catheter before. LPN #2 stated she got urine return after changing the catheter so she knew the catheter was in the bladder. LPN #2 stated she did not know what happened to make the catheter not drain. LPN #2 stated she was not at the facility when the resident was sent to the emergency room. LPN #2 stated she thought there was a problem with the clamp and was not sure if it happened when someone was emptying the catheter bag. LPN #2 stated the aides emptied catheters during the shift as needed. LPN #2 stated she left that evening not aware of any issues with the catheter or the drainage bag.

On 7/5/17 at 2:45 p.m. the director of nursing (DON) was interviewed about Resident #6's improperly positioned catheter bag. The DON stated the catheter was not draining and the resident went to the emergency room and returned. The DON stated the stopcock on the drainage bag was closed and the urine was not draining into the bag. The DON stated she did not know how the bag could have been improperly positioned.

On 7/5/17 at 3:40 p.m. the certified nurses' aide (CNA #2) caring for Resident #6 on the evening

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of 6/14/17 was interviewed about the catheter. CNA #2 stated she usually checked several times during a shift to see if the urine needed to be drained from the resident's leg bag. CNA #2 stated she did not remember the exact time but "later in the evening" on 6/14/17 she noticed there was no urine in the bag and urine was coming out of Resident #6's penis. CNA #2 stated the resident reported to her that his brief was wet. CNA #2 stated she did not move or remove the bag and immediately reported to the nurse that Resident #6 was wet and had no urine in the collection bag.

The LPN caring for Resident #6 on the evening of 6/14/17 was not available for interview.

On 7/6/17 at 7:40 a.m. the assistant director of nursing (RN #2) that helped LPN #2 change the catheter on 6/14/17 was interviewed. RN #2 stated LPN #2 had not changed a suprapubic catheter before so she assisted her with the process. RN #2 stated the catheter was replaced without problem. RN #2 stated the catheter and bag were changed and she left the facility about 5:00 p.m. or 5:30 p.m. on 6/14/17 and was not aware of a problem. RN #2 stated she did not know how the bag got placed wrong.

Nursing notes on 6/14/17 made no mention the catheter or the catheter bag was changed.

On 7/6/17 at 9:40 a.m. with the resident's permission and accompanied by CNA #1, Resident #6's catheter bag was inspected. The resident had a leg collection bag held in place on his left thigh with two adjustable straps. A blue stopcock was at the bottom of the bag with the top of the bag connected to the drainage tubing.

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CNA #1 detached the bottom strap and turned the blue stopcock located at the bottom of the collection bag and drained the collected urine into a container for disposable. CNA #1 closed the stopcock and re-attached the leg strap.

On 7/6/17 at 10:35 a.m. the DON was interviewed again about Resident #6's improperly placed catheter drainage bag. The DON stated she did know how the bag could have been inverted. When asked if she or anyone called the emergency room to discuss the issue the DON stated, "No." The DON stated, "I don't know what happened."

The Lippincott Manual of Nursing Practice 10th edition on page 777 states catheterization may be done to relieve acute or chronic urinary retention and documents, "Suprapubic catheterization establishes drainage from the bladder by introducing a catheter percutaneously or by an incision through the anterior abdominal wall into the bladder." (1)

These findings were reviewed with the administrator and director of nursing during a meeting on 7/6/17 at 1:30 p.m.

(1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.

F 425 SS=D 483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH F 425

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and

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biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by:
Based on observations, clinical record review, and staff interview, the facility staff failed for one of 19 residents in the survey sample (Resident # 11) to ensure medications were available for administration. During the medication pass and pour observation, Lamotrigine was not available for administration to Resident # 11.

The findings were:

Resident # 11 in the survey sample, a 75 year-old male, was admitted to the facility on 4/13/17, with diagnoses that included cerebral infarction, aphasia, generalized muscle weakness, right spastic hemiplegia, deep vein thrombosis, hypertension, diabetes mellitus, obesity, cognitive communication deficit, and seizure disorder. According to the most recent Minimum Data Set, a Medicare 5-Day with an Assessment Reference Date of 6/14/17, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 3 out of 15.

During the medication pass and pour observation at 7:40 a.m. on 7/6/17, LPN # 2 (Licensed Practical Nurse) prepared seven medications for administration to Resident # 11. After preparing the medications, LPN # 2 stated that the resident

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F 425	Continued From page 30 was out of Lamotrigine and that she would notify the pharmacy. At approximately 2:30 p.m. on 7/6/17, LPN # 2 advised the surveyor that one dose of Lamotrigine was sent by the pharmacy to the facility's local backup pharmacy and that it would be administered at the next scheduled administration time. NOTE: Lamotrigine (Lamictal) is an anticonvulsant used in the treatment of seizures. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 678. The findings were discussed with the Administrator and Director of Nursing during a meeting with the survey team at 4:00 p.m. on 7/6/17.	F 425		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);	F 441		

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(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.

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

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(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observations, staff interview, and review of facility policy and procedure, the facility staff failed to maintain acceptable handwashing practices. During the observation of the medication pass and pour, the staff member administering medications failed to wash hands following resident contact during the administration of medications.

The findings were:

At approximately 7:40 a.m. on 7/6/17, a medication pass and pour observation was initiated on the West Unit. The staff member passing medications, later identified as LPN # 2 (Licensed Practical Nurse), was in the middle of passing medications to a resident when the observation started. When LPN # 2 finished passing medications to the resident, she returned to the medication cart and moved to another resident. LPN # 2 did not wash her hands after completing the medication pass or before starting to pass medications to another resident.

LPN # 2 prepared medications for the next resident and then entered the resident's room. LPN # 2 gave a small cup containing medications to the resident and then handed him his water container to use when he took his medications.

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After returning the resident's water container to his overbed table, LPN # 2 returned to her medication cart and moved on to the next resident. LPN # 2 did not wash her hands after completing the medication pass or before starting to pass medications to the next resident.

After preparing the medications for the next resident, LPN # 2 entered the resident's room. LPN # 2 gave a small cup containing medications to the resident and then handed the resident her water container to use when she took her medications. After returning the resident's water container to her overbed table, LPN # 2 returned to her medication cart and moved on to the next resident. LPN # 2 did not wash her hands after completing the medication pass or before starting to pass medications to the next resident. At that point, the medication pass and pour observation was ended.

Review of the facility's Policies and Procedures for Handwashing, effective 9/6/16, noted the following:

"Hand hygiene should be performed:
Before and after patient care.
After contact with inanimate objects (including medical equipment) in the immediate patient vicinity."

The Potter-Perry Fundamentals of Nursing notes the following regarding the administration of medications:

" 7. Prepare medications:
a. Perform hand hygiene.
l. Dispose of soiled supplies, and perform hand hygiene."

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(Ref. Fundamentals of Nursing, Potter-Perry, 7th Edition, 2009, pages 719-722.)

The findings were discussed with the Administrator and Director of Nursing during a meeting with the survey team at 4:00 p.m. on 7/6/17, and again at 11:00 a.m. on 7/7/17..

This is a complaint deficiency

F 465 SS=D 483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON — F 465

(i) Other Environmental Conditions

The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents.
This REQUIREMENT is not met as evidenced by:
Based on observations and staff interviews, the facility staff failed to maintain two water fountains, which were accessible to the residents, staff, and the general public, in working condition. According to staff, the water fountains were turned off due to residents with fluid restrictions.

The findings were:

During the General Observations Tour of the facility at 7:50 a.m. on 7/7/17, the water fountain

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across from the Nurses Stations on the West Unit was covered with a sign reading "DO NOT USE." LPN # 2 (Licensed Practical Nurse), who was seated at the Nurses Station was asked if the water fountain was broken. LPN # 1, who was also at the Nurses Station responded, "It's not broken, it's turned off. We have residents on fluid restriction."

On the East Unit, there was also a water fountain located across from the Nurses Station. When the surveyor tried to use the water fountain, it did not work. A CNA (Certified Nursing Assistant) who was nearby, was asked about the water fountain. The CNA indicated the fountain had been turned off.

During an interview at 9:45 a.m. on 7/7/17, the Maintenance Director was asked about the water fountains. "They've been turned off for quite a while," he said. "I can't remember if it was the DON (Director of Nursing) or the Administrator who had them turned off. It's due to residents on fluid restrictions."

During a meeting at 11:00 a.m. on 7/7/17 with the Administrator, the DON, and the survey team, the water fountains were discussed. "I've been here a year and a half," the Administrator said, "and they were off when I got here." The DON said she had been at the facility for two years and the water fountains were off when she got here. During the discussion, the Administrator and DON both agreed that residents on fluid restriction had the right to be noncompliant. "They could just as easily get water to drink from the lavatory sink in their room if they wanted," the Administrator said.

F 465

F 514 483.70(i)(1)(5) RES

F 514

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F 514 SS=D	Continued From page 36 RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514		

(i) Medical records.
(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-

(i) Complete;

(ii) Accurately documented;

(iii) Readily accessible; and

(iv) Systematically organized

(5) The medical record must contain-

(i) Sufficient information to identify the resident;

(ii) A record of the resident's assessments;

(iii) The comprehensive plan of care and services provided;

(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

(v) Physician's, nurse's, and other licensed professional's progress notes; and

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure an

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accurate clinical record for one of 19 residents in the survey sample. Resident #3's current physician orders documented a duplicate order for Vitamin B12.

The findings include:

Resident #3 was admitted to the facility on 12/22/14 with diagnoses that included difficulty swallowing, rheumatoid arthritis, vitamin B deficiency, ischemic heart disease, atrial fibrillation, diabetes and depression. The minimum data set (MDS) dated 4/18/17 assessed Resident #3 with moderately impaired cognitive skills.

Resident #3's clinical record documented duplicate active physician orders for Vitamin B12. The record documented a physician's order dated 9/16/15 for Vitamin B12 1000 mcg (micrograms) to be administered each day as a supplement. The record also documented a physician's order dated 9/29/15 for Vitamin B12 500 mcg two tablets to be given each day as a supplement.

On 7/6/17 at 8:45 a.m. the licensed practical nurse unit manager (LPN #3) was interviewed about the duplicate orders for Resident #3. LPN #3 stated nurses entered the orders into the computer system. LPN #3 stated they found duplicate orders "from time to time." LPN #3 stated the resident was administered the Vitamin B12 only once daily and she would have to get the duplicate removed from the active orders.

This finding was reviewed with the administrator and director of nursing during a meeting on 7/6/17 at 1:30 p.m.

Preparation and submission of the plan of correction does not constitute and admission, or agreement by the provider of the truth or the facts alleged or the correctness of the conclusion set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of the requirement under State and Federal Law.

Helene Molnar 7.19.17

Plan of Correction

F 159: Facility Management of Personal Funds

1. Discussion and reeducation was conducted with Executive Director (ED), Business Office Manager (BOM) and Regional Director of Business Office Services (RDBOS) on July 12, 2017 regarding importance of prompt access to resident trust account funds for all residents.

2. Any residents who have trust accounts could potentially be affected.

3. Reeducation on importance of prompt access to resident trust accounts funds for all residents.

4. ED and BOM will meet weekly to ensure residents have access to funds in a timely manner.

5. ED and BOM are in the process of increasing the on-site resident trust cash box amount to ensure availability up resident request. Resident trust box will become the HR Manager's responsibility effective Aug. 1st 2017. ED will poll random residents monthly for three months, then quarterly, to ensure continued access to funds. The ED or designee will complete Quality Monitoring once a week for 4 weeks to ensure compliance, then monthly, then quarterly. Thereafter, Quality Monitoring schedule to be modified bases on findings of Quality Reviews. The results of the Quality Monitoring will be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for review, analysis, and further recommendations.

Date of Compliance: 8/7/17

Helene Molnar 7/19/17

Plan of Correction

F 241: Dignity and Respect of Individuality

1. Discussion and reeducation was conducted with Executive Director (ED), Business Office Manager (BOM) and Regional Director of Business Office Services (RDBOS) regarding communication skills.

2. Any residents have the potential to be affected.

3. Reeducation was conducted with ED, BOM and RDBOS regarding treating all residents with dignity and respect of individuality.

4. Staff members will be in-serviced quarterly regarding the importance of dignity and respect for individuality.

5. ED will speak with residents monthly for three months, then quarterly to ensure that all residents' needs are met with dignity and respect. ED will ask to attend monthly Resident Council Meetings. to address any concerns that residents may have. The ED or designee will complete Quality Monitoring once a week for 4 weeks to ensure compliance, then monthly, then quarterly. Thereafter, Quality Monitoring schedule to be modified bases on findings of Quality Reviews. The results of the Quality Monitoring will be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for review, analysis, and further recommendations.

Date of Compliance: August 7, 2017

Helene Molnar 7.19.17

Plan of Correction

F 252: Safe/ Clean/ Comfortable/ Home-like Environment

1. Gather estimates to contract facility-wide repair of walls, doors and floors. Gather estimates to contract replacement of countertops for both nurse's stations. Broken blinds replaced.

2. Any residents have the potential to be affected.

3. Executive Director (ED) will re-educate staff at monthly staff meeting, regarding the importance of timely reports to the Maintenance Director, of all needed in-house repairs. Wheelchairs in disrepair will be taken out of service and replaced. Physical plant repairs will be contracted out, to ensure timely repairs of walls, doors and floors. Handrails throughout the facility will be refinished by September 2017.

4. ED and Maintenance Director will do weekly rounds, to audit the physical plant and ensure that all issues are addressed in a timely manner.

5. ED and Maintenance Director will meet daily, to discuss each days itinerary. Audits will be conducted weekly for three months, then monthly, to ensure that progress is continual. The ED or designee will complete Quality Monitoring once a week for 4 weeks to ensure compliance, then monthly, then quarterly. Thereafter, Quality Monitoring schedule to be modified bases on findings of Quality Reviews. The results of the Quality Monitoring will be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for review, analysis, and further recommendations.

Date of Compliance: August 7, 2017

Helene Molnar 7.19.17

Plan of Correction

F 278 Assessment Accuracy/Coordination/Certified

1. Resident # 9 whom was not coded correctly for Section K of the MDS for weight loss of 10% a modification was done to correct this omission.

2. Residents with weight loss have the potential to be affected.

3. All sections of the MDS will be reviewed by the IDT (Inter Disciplinary Team) member assigned for each section of the MDS. Once these steps are completed then MDS will be verified for any potential flagged areas and MDS to review again before submission.

4. The IDT will be in-serviced by the MDS on the importance of correct data entry and where to collect the information for the assessment.

5. Audit tool will be used to conduct a review of completed assessments of section K. . The ED or designee will complete Quality Monitoring once a week for 4 weeks to ensure compliance, then monthly, then quarterly. Thereafter, Quality Monitoring schedule to be modified bases on findings of Quality Reviews. The results of the Quality Monitoring will be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for review, analysis, and further recommendations.

Date of Compliance: August 7, 2017

Helene Molnar 7-19-17

Plan of Correction:

F 279: Develop Comprehensive Care Plans

1. Resident #4: Resident's care plan was updated to reflect potential dehydration/ fluid imbalance related to applicable diagnosis.

   Resident #6: Resident's care plan was updated to reflect the potential for pressure ulcers, potential communication deficits, potential for dental care, and receiving the antiplatelet medication- Plavix.

2. Residents with diagnoses similar to Resident #4 or Resident #6 have the potential to be affected.

3. Care Plan audit will be performed for any residents receiving the antiplatelet medication, Plavix, to ensure it is and continues to be care planned for risk of bleeding/ bruising.

4. The IDT will help to monitor care plans by open discussions of any residents that are started on or admitted with antiplatelet medications

5. IDT and Care Plan Team will (a) conduct daily review of new orders, new admissions, and nurse's notes during the morning meeting every day, and as needed; (b) conduct weekly care plan meetings; and (c) weekly review of care plans for continued compliance. MDS will also report to QAPI monthly with any updates or requests/recommendations for changes. The ED or designee will complete Quality Monitoring once a week for 4 weeks to ensure compliance, then monthly, then quarterly. Thereafter, Quality Monitoring schedule to be modified bases on findings of Quality Reviews. The results of the Quality Monitoring will be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for review, analysis, and further recommendations.

Date of Compliance: August 7, 2017

Helene Molnar 7.19.17

Plan of Correction

F309: Provide Care/ Services for Highest Well-being

1. When the nurse #2 noticed that the medication was not available she immediately called the pharmacy to request unavailable medication. Medication was sent to the local back-up pharmacy and medication was administered the same day.

2. Any residents who receive medications have the potential to be affected.

3. Licensed staff will be educated on the new facility process to weekly validate that residents have sufficient meds for the next 7 days, they will document their findings on a Quality Monitoring tool and request re-order from pharmacy. These tools will be submitted to the DCS.

4. The ADCS will monitor West Wing nurse's station; the Unit Manager will monitor East Wing nurses station for compliance through use of a Quality Monitoring tool.

5. The Director of Clinical Services or designee to complete Quality monitoring 3 times per week for 4 weeks to ensure compliance, then weekly for one month then quarterly. Thereafter Quality Monitoring schedule to be modified bases on findings of Quality Reviews. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for review, analysis, and further recommendations.

Date of Compliance: August 7, 2017

Helene Molnar 7.19.17

Plan of Correction

F315: No Catheter, Prevent UTI, Restore Bladder.

1. Resident #6 Foley Cather was inspected for proper placement and drainage.

2. Any residents who have an indwelling catheter have the potential to be affected.

3. Licensed nurses and CNA will be re-educated by the ADCS on how to properly maintain a Foley catheter drainage bag. When doing end of shift report nurses will do walking rounds to assure that catheters are functioning properly.

4. For residents with indwelling catheters the ADCS will complete a quality monitor tool to ensure that catheters are functioning/draining properly.

5. The Director of Clinical Services or designee to complete Quality monitoring 3 times per week for 4 weeks to ensure compliance, then weekly for one month then quarterly. Thereafter Quality Monitoring schedule to be modified bases on findings of Quality Reviews. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for review, analysis, and further recommendations.

Date of Compliance: August 7, 2017

Helene Molnar 7.19.17

Plan of Correction

F425: Pharmaceutical Service/ Accurate Procedures/ RPH:

1. When the nurse #2 noticed that the medication was not available she immediately called the pharmacy to request unavailable medication. Medication was sent to the local back-up pharmacy and medication was administered the same day.

2. Any residents who receive medications have the potential to be affected.

3. Licensed staff will be educated on the new facility process to weekly validate that residents have sufficient meds for the next 7 days, they will document their findings on a Quality Monitoring tool and request re-order from pharmacy. These tools will be submitted to the DCS.

4. The ADCS will monitor West Wing nurse's station; the Unit Manager will monitor East Wing nurses station for compliance through use of a Quality Monitoring tool.

5. The Director of Clinical Services or designee to complete Quality monitoring 3 times per week for 4 weeks to ensure compliance, then weekly for one month then quarterly. Thereafter Quality Monitoring schedule to be modified bases on findings of Quality Reviews. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for review, analysis, and further recommendations.

Date of Compliance: August 7, 2017

Helene Molnar 7.19.17

Plan of Correction

F441: Infection Control/ Prevent Spread/ Linens

1. The licensed nurse was reeducated on proper handwashing procedure.
2. Any residents who receive medication have the potential to be affected.
3. The licensed nurses were reeducated by the DCS on proper handwashing.
4. The ADCS (or designee) will conduct random medication pass observations. The Director of Clinical Services or designee to conduct random observation of LPN and a Quality Monitor tool will be completed.
5. The Director of Clinical Services or designee to complete Quality monitoring 3 times per week for 4 weeks to ensure compliance, then weekly for one month then quarterly. Thereafter Quality Monitoring schedule to be modified based on findings of Quality Reviews. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for review, analysis, and further recommendations.

Date of Compliance: August 7, 2017

dHelene Molnar 7.19.17

Plan of Correction

F 465: Safe/ Functional/ Sanitary/ Comfortable Environment

1. Two of the three water fountains in the facility have been out of service for eight years. They will be put back into service, unless they are deemed unsafe or irreparable. If unsafe or irreparable, they will either be removed entirely or replaced with new fountains.

2. Any residents could potentially be affected.

3. Maintenance Director will determine if water fountains are safe and working properly. If not, they will be removed or replaced.

4. Executive Director (ED) and Maintenance Director will review status of water fountains by July 31st, 2017, and will determine how best to proceed.

5. ED and Maintenance Director will determine if water fountains are working properly and safely. If not, they will either be replaced or removed entirely. The ED or designee will complete Quality Monitoring once a week for 4 weeks to ensure compliance, then monthly, then quarterly. Thereafter, Quality Monitoring schedule to be modified bases on findings of Quality Reviews. The results of the Quality Monitoring will be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meeting for review, analysis, and further recommendations.

Date of Compliance: August 7, 2017

dHelene Molnar 7.19.17

Plan of Correction

F514: Resident Records Complete/ Accurate/ Accessible

1. The duplicate medication order was immediately removed from the POS.

2. Any residents who receive medications have the ability to be affected.

3. Monthly review of POS' to be done by the night shift nurses.

4. Nurses on night shift will do a monthly check of all POS to ensure that orders are not being duplicated. For those resident's who are newly admitted to the facility the Clinical team, consisting of the DCS, ADCS and Unit Manager will review all new orders for accuracy during the Clinical Start-up meeting." The ADCS will monitor West Wing nurse's station; the Unit Manager will monitor East Wing nurses station for compliance.

5. The Director of Clinical Services or designee to do a monthly review of POS' and complete a Quality Monitor to be performed monthly x 3 months to assure compliance with accurateness of physician order sheets then quarterly thereafter. Quality Monitoring schedule to be modified based on findings of Quality Reviews. The results of Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations. To be completed November 1, 2017.

Date of Compliance: August 7, 2017

Helene Molnar 7.19.17