STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495233	A. BUILDING _____ B. WING _____	06/29/2017

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FAUQUIER HEALTH REHABILITATION & NURSING CENTER	360 HOSPITAL DRIVE WARRENTON, VA 20186

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 6/27/17 through 6/29/17. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 113 certified bed facility was 105 at the time of the survey. The survey sample consisted of 23 current Resident reviews (Residents #1 through #18, and #25 through #29) and 6 closed record reviews (Residents #19 through #24).	F 000		
F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to	F 157		8/13/17

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

Electronically Signed | 07/21/2017

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F 157	Continued From page 1 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). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to immediately notify the responsible party of clinical changes for one of 29 residents in the survey sample, Resident #6. The facility staff failed to immediately (within 24 hours) notify the responsible party when Resident #6 developed a wound. The findings include:	F 157	1. RP of Resident #6 was notified of change in skin condition on 5/28/17 by licensed nurse, including treatment plan in place. Facility reviewed contact information with RP and next of kin with family on 5/28/17 for clinical record update. 2. All residents have the potential to be affected by this deficient practice.	

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F 157	Continued From page 2 Resident #6 was admitted to the facility on 4/27/17, readmitted on 5/12/17 and readmitted on 6/21/17 with diagnoses that included, but were not limited to: stroke, sepsis (a blood stream infection), high blood pressure, abrasion of the penis, diabetes, urinary retention, chronic kidney disease, BPH (benign prostatic hyperplasia - an enlarged prostate gland), and difficulty swallowing. Resident #6's most recent MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 5/19/17. Resident #6 is coded as scoring a two out of a possible 15 on the BIMS (brief interview for mental status) in Section C, Cognitive Patterns, indicating that Resident #6 was severely cognitively impaired in daily decision making. In Section G, Functional Status, Resident #6 was coded as being totally dependent of two people for bed mobility and transfers. Resident #6 was further coded as being totally dependent of one person for toilet use. In Section M, Skin Conditions, Resident #6 was coded as having one unstageable (1) [pressure injury] that was not present on admission on 5/12/17. A review of Resident #6's clinical record revealed, in part, a nursing progress note that documented the following; "5/19/2017 Late Entry Effective Date: 5/19/2017 8:32 PM. Health Status Note. Note Text: The tip/head of penis noted with bleeding and some localized ischemic necrosis from indwelling Foley cath. MD (medical doctor) notified and per wound protocol N/O (new order) started. Cleanse Tip/head of Penis with NS (normal saline), pat dry and apply Triple antibiotic ointment Q shift, every shift for Local Ischemic	F 157	3. Social Services and clinical team, which includes RN Care Managers, Director of Nursing (DON), Therapy Director, and Dietary Manager, will be educated on facility policy on "Notification of Change," which includes notifying MD/RP of changes in resident condition. Facility will send all residents and/or their RPs a letter to verify contact information for facility records. Facility will verify contact information upon admission, during quarterly care conferences, and as provided by residents or RP. Care manager or designee will review 24 hour report to ensure MD/RP are notified on residents identified with a change in condition. 4. DON or designee will audit 25% of 24 hour reports on weekly basis for 30 days, then 10% for 60 days. Issues identified will be corrected immediately. A summary of audit findings and corrective action will be reviewed and addressed by the Quality Assurance Performance Improvement (QAPI) committee for further guidance and instruction.	

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Necrosis. MD and wound Nurse to assess later."

Further review of Resident #6's clinical record revealed, in part, the following nursing progress note; "5/28/17 Pt (patient) son came in to visit.... Pt son who is also his RP was informed about the ulcer on the tip his (sic) penis and the tx (treatment) in place."

There was no further evidence in Resident #6's clinical record that any facility staff member had attempted to contact Resident #6's RP.

On 6/29/17 at approximately 10:00 a.m. a meeting was conducted with ASM #1, the administrator and ASM #2, the director of nursing. At this time ASM #1 and ASM #2 were made aware of the above concern. ASM #1 and ASM #2 were asked if they were aware of the circumstances why Resident #6's RP was not notified about the wound. ASM #1 stated that there was an error made when the son's phone number was written down and was not working. When asked what else was done to attempt to notify Resident #6's family member ASM #1 was unable to say. At this time a policy was requested regarding notification.

On 6/29/17 at approximately 10:15 a.m. an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 was asked under what circumstances she would call a resident's RP. LPN #5 stated she would call for any change in medical condition, a fall, an incident and wounds. When asked what she would do if she was unable to reach the responsible party, LPN #5 stated, "I would try to contact the second contact on the list and if still unable to get in touch

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with an RP I would ask social services to get involved."

On 6/29/17 at 10:30 a.m. an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked when she would notify a resident's RP. LPN #2 stated, "Any medical change, laboratory results, a change of condition and any incidents." When asked what she would do if she was unable to reach the RP, LPN #2 stated, "I would try a second emergency contact number and if I was still unable to reach the RP then I would contact the social worker and ask her to help get in touch with the RP. She (the social worker) functions as a liaison with family and is our support person."

A review of the facility policy titled "Notification of Change" revealed, in part, the following documentation; "Description and Purpose: To provide guidelines for when staff should notify resident, resident's physician, and or responsible party when a change occurs. Policy: The facility will immediately inform the resident and consult with the resident's physician, and if known, notify the resident's legal representative or an appropriate family member when there is a change in the resident's condition. Guidelines: Notification of change shall include: 2. Clinical complications may include but are not limited to, conditions such as the development of a stage II pressure sore..... Procedure: 2. If the change is of a clinical nature, the licensed nurse will fully describe the situation, document an assessment of the resident's response/current health status, and describe the staff's interventions to treat the situation. The documentation is to be specific to the situation. 3. Nursing staff will notify the physician and responsible party or family member

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F 157	Continued From page 5 of the resident's health condition. a) Documentation of notification will be made in nursing notes. b) Documentation of notification (including all attempts) will be made on the 24 hour report form. 4. If the staff is unable to contact the physician or resident's responsible party or family, documentation of all attempts will be noted in the nursing notes. Documentation will include: a. contact person b. time (s) of attempted contact c. if message was left (and with whom) d. method of contact. No further information was provided prior to the end of the survey process. 1. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. This information was obtained from the website: https://www.npuap.org/national-pressure-ulcer-advisory-panel-npuap-announces-a-change-in-terminology-from-pressure-ulcer-to-pressure-injury-and-updates-the-stages-of-pressure-injury/	F 157		
F 164 SS=D	PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS CFR(s): 483.10(h)(1)(3)(i); 483.70(i)(2) 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 164		8/13/17

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F 164	Continued From page 6 (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, family interview, staff interview, clinical record review and facility document review, it was determined	F 164	1. Res. #10 was made aware that privacy will be maintained during care. CNA #6 was re-educated on providing privacy	

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F 164	Continued From page 7 that the facility staff failed to provide Personal privacy for one of 29 residents in the survey sample; Residents #10. The facility staff failed to close the door to Resident #10's room during incontinent care. The facility staff pulled Resident #10's privacy curtain but left a ten inch gap on the side of the bed by the door that someone could look through. The findings include: Resident #10 was admitted to the facility on 2/29/08 and most recently readmitted on 3/13/17 with the diagnoses of but not limited to: altered mental status, diabetes, bipolar, chronic kidney disease, human immunodeficiency virus, acidosis, chronic pain syndrome, delusional disorder, adrenal gland disorder, glaucoma, stage 4 breast cancer with metastasis, deafness, and blindness. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/28/17. Resident #10 was coded as being cognitively intact, scoring a 15 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring limited to extensive assistance for transfers; supervision to limited assistance for ambulation; supervision for hygiene; limited assistance for bathing; independent for eating; and as generally continent of bowel and bladder, with incontinence at times. On 6/28/17 at 7:50 a.m., incontinent care was	F 164	during care on 6/28/17. 2. All residents have the potential to be affected by this deficient practice. 3. All nursing staff will be educated on providing privacy to residents while giving care, ensuring privacy curtains and/or room doors are closed to allow for privacy. 4. DON or designee will conduct rounds daily M-F for 4 weeks, then on a weekly basis for 60 days. Any issues will be immediately corrected and staff re-educated or counseled as necessary. Results of rounds and corrective action will be reviewed and addressed by the QAPI committee for any further guidance and instruction.	

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observed on Resident #10 being performed by CNA #6 (Certified Nursing Assistant). Resident #10 was in the bed closest to the door to the room. The curtain was pulled mostly around, but there was a gap of several inches (approximately 10 inches) between the edge of the curtain and the wall next to the door, leaving a gap that someone could look through to see the resident receiving care. The door to the room was left open.

On 6/28/17 at 1:41 p.m., in an interview with CNA #6, she stated that she did not close the door because it slipped her mind to do so, that she was in a rush.

On 6/29/17 at 10:15 a.m., OSM (Other Staff Member) #14, the director of social services, assisted this surveyor with communicating with Resident #10. OSM #14 signed into the resident's hand questions regarding the door being open during care. The resident responded verbally that she would want the door closed.

A review of the facility policy, "Nursing" documented, "It is the policy of this facility that all residents be treated fairly and with kindness, respect, and dignity.....5. Residents will be examined and treated in a manner that maintains the privacy of their bodies. A closed door or drawn curtain shields the resident from passers-by. People not involved in the car {sic} of the resident shall not be present without the resident's consent while they are being examined or treated. Staff members will KNOCK before entering the resident's room. 6. Privacy for the resident's body will be maintained while toileting, bathing and other activities or personal hygiene, except as needed for the resident's safety and

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F 164	Continued From page 9 assistance..." On 6/28/17 at 6:00 p.m., the Administrator (ASM #1 - Administrative Staff Member), the DON (Director of Nursing - ASM #2) and the care manager, (RN - Registered Nurse #2) were made aware of the findings. No further information was provided by the end of the survey.	F 164		
F 247 SS=D	RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE CFR(s): 483.10(e)(6) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide notice of a room change for two of 29 residents in the survey sample, Resident #25 and #6. 1. The facility staff failed to notify Resident #25 of a room change in a timely manner and failed to allow the resident to view the new room and meet her roommate prior to the room change. 2. The facility staff failed to notify the responsible party when Resident #6 was moved from one room in the facility to another and failed to provide documentation that Resident #6 and the new roommate were agreeable to the room change.	F 247	1. Resident #6 was interviewed about his room placement on 7/21/17. Resident #6 stated he has adjusted to his room and does not wish to move rooms at this time. Resident #25 was moved to a private room on 6/30/17. Resident #25 stated she has adjusted to her room and does not wish to move at this time when interviewed by social services on 7/4/2017. 2. All residents have the potential to be affected by this deficient practice. 3. The social service director, social service coordinator, and interdisciplinary team (IDT) will be educated on "Room	8/13/17

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F 247	Continued From page 10 The findings include: 1. Resident #25 was admitted to the facility on 10/27/16 with diagnoses that included but were not limited to: rheumatoid arthritis, osteomyelitis, right ankle and foot PVD (peripheral vascular disease), and anxiety disorder. Resident #25's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 5/6/17. Resident #25 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #25 was coded as requiring total dependence on two or more staff with transfers, dressing, locomotion on and off the unit, and toileting. Resident #25 was coded as requiring extensive assistance from staff with bed mobility. Review of Resident #25's clinical record revealed a note from the social worker dated 4/4/17. The note documented that the resident was to be moved to the 400 hall due to long term care status. The note documented that the resident was notified the day of the transfer and that the Resident agreed to the room change. The note also documented that the Resident didn't see the point in moving because she was going to be discharged soon. The note failed to document if the resident was able to meet her roommate or view her new room prior to the room change. On 6/28/17 at 9:11 a.m., an interview was conducted with Resident #25. Resident #25 stated that a few months ago she had to change her room because her insurance switched to private pay, but she did not want to be separated	F 247	Change" policy, to ensure residents are provided notice of room change request and reason for room change. The education will also include notification to the RP of resident room change. All residents will be given the opportunity to see the new room and meet their potential room mate when a room change is being considered. Social service director or designee will review room change requests with the IDT during daily stand up meetings. Social service director or designee will document room change notice provided to the resident and RP, and will monitor and document the residents' adjustment to their new room. 4. The Administrator or designee will audit 50% of room changes for 30 days, then 25% for 60 days to ensure proper notification and authorizations were made. Any issues will be address and staff will be re-educated or counseled as necessary. The results of the audit will be presented to the QAPI committee for further guidance or instruction.	

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from her roommate. Resident #25 stated that the social worker came in one day and told her that she was switching room's right after lunch. Resident #25 stated that there was no discussion about the room change. When asked if she told the social worker that she did not want to move, Resident #25 stated, "I didn't know I had the choice." Resident #25 stated that she was not able to see her new room or meet her roommate before transferring to a different room. Resident #25 stated she received little notice before switching rooms.

On 6/29/17 at 12:00 p.m., an interview was conducted with OSM (other staff member) #14, the Director of Social Services regarding reasons for resident room changes. OSM #14 stated that residents would change rooms if there was a conflict with roommates, an outbreak of some type of infection, or if several rooms contained one person; the facility would try to pair the residents of the same gender, to make room for additional residents. OSM #14 stated that if a resident was a fall risk, she may also move the resident closer to the nursing station. When asked if the facility ever moved a resident based on their insurance status i.e. going from skilled to long term care, OSM #14 stated that the facility would move the resident during this time because the long term care side of the facility is more "home-like." OSM #14 stated that the skilled hallway is also closer to therapy and is easier for skilled residents to get to. When asked if the facility was dually certified, OSM #14 stated, "Yes." When asked about the process of transferring a resident to a new room, OSM #14 stated that the room change would first be discussed in the morning meeting with administrative staff and then the resident or

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responsible party would be informed of the room change. OSM #14 stated that once the resident or responsible party is made aware and agrees to the room change, she would assist the residents and their belongings to the new room. When asked if the resident is able to view their new room or meet their new roommate prior to agreeing to the room change, OSM #14 stated, "It varies, unless the resident asks ahead of time." When asked if resident's have a choice as to whether or not they change rooms, OSM #14 stated that residents can decline the room changes if they want. OSM #14 stated, "I have residents all the time that don't want to change rooms." When asked if residents are made aware that they have the choice to decline room changes, OSM #14 stated that residents should be aware. When asked why Resident #25 was moved from the 300 hall to the 400 hall, OSM #14 stated that she was told by the administrative staff that she was to move Resident #25. OSM #14 stated that same day she made the resident aware of the room change and she seemed to be agreeable with the move. When asked if Resident #25 was able to view her new room or meet her roommate prior to agreeing to the transfer, OSM #14 stated that she did not assist the resident to do that because the resident did not ask. When asked why Resident #25 had to move, OSM #14 stated, "I think she was interjecting herself into her roommate's care." When asked if the reason Resident #25 moved to a new room was documented, OSM #14 stated that she was not sure.

On 6/29/17 at 12:18 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator. When asked some of the reasons why a resident would be

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moved to a new room, ASM #1 stated that a resident would be moved if the resident requested a room change, roommate compatibility issues, or for medical isolation due to an infection. When asked if the facility was dually certified, ASM #1 stated that it was. When asked if it was ever ok to move a resident to a different room because they came off skilled services to long term care, ASM #1 stated that was not ok.

On 6/29/17 at 12:29 p.m., ASM (administrative staff member) #1, the administrator was made aware of the above concerns.

Facility policy titled, "Resident Room Changes/Transfers" documents in part, the following:
"Procedure:
1. Rooms are assigned according to:
a. Level of care required
b. Infection control needs
c. Mental Status
d. Resident and or responsible party wishes
e. Room/bed availability
2. Room changes are made for the following reasons:
a. Isolation
b. Incapability with roommates-one roommate requests the change
c. Resident or responsible party wishes
3. All needs and requests for room changes will be handled by the social worker, admissions, and nursing.
4. The resident and responsible party will be given a 30 day notice before the change of room, unless the safety and health of resident warrants a move or a resident and family wish to move sooner...

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6. The social worker will obtain the resident and family authorization for the room change by obtaining verbal consent and documenting this in the resident's record. In cases involving the safety and health of the resident, consent will not be required in order to protect the resident or another resident.
7. The social worker will make every effort to introduce the residents to each other before the room change, and orient resident and family to the room before the transfer.
8. The social worker will monitor and assess the need for social service intervention in the adjustment period of the roommates..."

No further information was presented prior to exit.

2. The facility staff failed to notify the responsible party when Resident #6 was moved from one room in the facility to another and failed to provide documentation that Resident #6 and the new roommate were agreeable to the room change.

Resident #6 was admitted to the facility on 4/27/17, readmitted on 5/12/17 and readmitted on 6/21/17 with diagnoses that included, but were not limited to: stroke, sepsis (a blood stream infection), high blood pressure, abrasion of the penis, diabetes, urinary retention, chronic kidney disease, BPH (benign prostatic hyperplasia - an enlarged prostate gland), and difficulty swallowing.

Resident #6's most recent MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 5/19/17. Resident #6 was coded as scoring a two out of a possible 15 on the BIMS (brief interview for mental status) in Section C, Cognitive Patterns,

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indicating that Resident #6 was severely cognitively impaired in daily decision making.

A review of Resident #6's clinical record revealed, in part, the following nursing progress note dated 6/24/17, "Patient moved to Room (room #)."

Further review of Resident #6's clinical record did not reveal any further documentation by nursing or by the social worker regarding the room change.

On 6/28/17 at 3:30 p.m. an interview was conducted with LPN (licensed practical nurse) #3, the social worker. LPN #3 was asked to describe her role. LPN #3 stated, "I advocate for the patient, families and the doctors. I let them know what's going on and address grievances, FRIs (facility reported incidences). I also do D/C (discharge) planning and order the DME (durable medical equipment)." LPN #3 was asked about the room change process for residents'. LPN #3 stated that it depended on the competency level of the resident involved. When asked if she would contact the RP (responsible party), LPN #3 stated, "We try to as common courtesy, it is not required." When asked why Resident #6 had a room change, LPN #3 stated she did not know why. LPN #3 was asked to describe the process followed for a resident room change. LPN #3 stated, "I go to the resident, contact the RP and make a note. We don't take them (the residents) ahead of the time, and don't usually introduce them to their new roommate. I go back to see they are doing." When asked if she documented the interactions and her observations, LPN #3 stated, "Sometimes, but not 100%." When asked if she had any documentation regarding the room change for Resident #6 on 6/24/17. LPN #3

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F 247	Continued From page 16 stated that she did not. On 6/29/17 at approximately 10:00 a.m. a meeting was conducted with ASM #1, the administrator and ASM #2, the director of nursing. At this time ASM #1 and ASM #2 were made aware of the above concern. ASM #1 and ASM #2 were asked if they were aware of the circumstances why Resident #6 was moved from one room to another, both stated they were not. At this time a policy was requested regarding room changes. On 6/29/17 at approximately 10:15 a.m. an interview was conducted with LPN #5. LPN #5 was asked about process for moving a resident from one room to another. LPN #5 stated, "You can't just change a resident's room. You have to go through a chain of command, you have to notify the family and get permission first. Prior to moving the resident you should introduce them to the new roommate." The facility staff member responsible for admissions was on vacation during the survey process and could not be interviewed. No further information was provided prior to the end of the survey process.	F 247		
F 278 SS=E	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination	F 278		8/13/17

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F 278	Continued From page 17 A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to complete an accurate MDS (minimum data set) assessment for four of 29 residents in the survey sample, Resident #8, #13, #3, and #11. 1. The facility staff failed to document the correct	F 278	1. A height was obtained for Resident #8 and a modified Minimum Data Set (MDS) assessment with the Assessment Reference Date (ARD) of 2/15/17 will be completed by correction date. For Resident #13, Section J of the quarterly MDS assessment with the ARD date of 2/8/17 will be modified to include	

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F 278	Continued From page 18 height on Resident #8's annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 2/15/17. 2. The facility staff failed to accurately record that Resident # 13 had a fall on 1/27/17 in section J for her quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 2/8/17. 3 a. The facility staff failed to code the use of psychoactive medications on Resident #3's quarterly MDS (minimum data set) assessment with an ARD of 6/4/17. 3 b. The facility staff coded Resident #3 as having received restorative nursing on the annual assessment with an ARD of 3/4/17 when she had not received restorative nursing and did not have a program in place. The facility staff also coded Resident #3 as receiving restorative nursing on the quarterly assessment with an ARD of 6/4/17, when she did not have a restorative nursing program in place. 4. The facility staff incorrectly coded Resident #11 as receiving an anticoagulation (a blood thinner) medication, an antibiotic (to treat infection) and a diuretic (to reduce fluid in the body) on the quarterly MDS (minimum data set) with an ARD (assessment reference date) of 5/19/17. Resident #11 had not received any of those medications during the seven day look back period for that assessment. The findings include:	F 278	resident's fall on 1/27/17. Resident #3s quarterly MDS assessment with an ARD of 6/4/17 will be modified to include psychoactive medications. Resident #3 annual MDS assessment with an ARD of 3/4/17 and quarterly MDS assessment with an ARD of 6/4/17 will be modified to reflect a restorative nursing program (RNP) was not in place. Resident #11 quarterly MDS assessment with an ARD of 5/19/17 will be modified to include the correct medications received during the seven day look back period for that assessment. 2. All residents have the potential to be affected by this deficient practice. 3. MDS, RN #1 will be re-educated on resources and references, including the RAI (Resident Assessment Instrument) Manual 3.0, for the completion of MDS assessments so they accurately reflect the resident's status. 4. MDS, RN#2 or designee will audit 25% of MDSs completed by MDS, RN#1 on a weekly basis for 30 days, then 10% weekly for 60 days, to ensure MDSs assessments accurately reflect the resident's status. Issues identified will be corrected, with corrective action, such as modification, staff re-education or counseling. A summary of the audits will be reviewed and addressed by the QAPI committee for guidance and instruction.	

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1. The facility staff failed to document the correct height on Resident #8's annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 2/15/17.

Resident #8 was admitted to the facility on 6/2/17 with diagnoses that included but were not limited to: non-infective gastroenteritis, colitis, cerebral palsy, high blood pressure, constipation, and chronic lower back pain. Resident #8's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 6/7/17. Resident #8 was coded as being severely cognitively impaired in the ability to make daily decisions scoring 00 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #8 was coded in Section K0200, "Height and Weight" as having a height of 69 inches.

Review of Resident #8's annual MDS assessment with an ARD date of 2/15/17, revealed Resident #8 was coded in Section K0200, "Height and Weight," as having a height of 64 inches.

Review of Resident #8's height on the vital sign tab of the POC (point click care) documented Resident #8 as having a height of 69 inches. No other heights were found in the clinical record.

On 6/29/17 at 10:38 a.m., an interview was conducted with RN (registered nurse) #1, the MDS nurse. When asked the process for coding heights on the MDS, RN #1 stated the advanced certified nursing assistant (CNA) usually takes the heights of the residents and enters them into the computer system under the vital sign tab of the POC. RN #1 will then use this information to

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complete the MDS assessment. When asked about the discrepancy between Resident #8's two heights on the annual MDS assessment with an ARD date of 2/15/17 and the quarterly MDS assessment with an ARD of 6/7/17, RN #1 stated, "I think that was a coding issue." When asked which MDS assessment had the coding issue, RN #1 looked at the vital sign tab in the computer and stated that the resident was documented as being 69 inches not 64 inches. RN #1 could not determine where the 64 inches had come from. RN #1 stated that she uses the RAI (Resident Assessment Instrument) manual when completing the MDS assessments.

On 6/29/17 at 4:50 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit.

According to the RAI 3.0 manual,

"Height and weight measurements assist staff with assessing the resident ' s nutrition and hydration status by providing a mechanism for monitoring stability of weight over a period of time. The measurement of weight is one guide for determining nutritional status.

Steps for Assessment for K0200A, Height
1. On admission, measure and record height in inches.
2. Measure height consistently over time in accordance with the facility policy and procedure, which should reflect current standards of practice (shoes off, etc.).
3. For subsequent assessments, check the medical record. If the last height recorded was

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more than one year ago, measure and record the resident's height again.

Coding Instructions for K0200A, Height
·Record height to the nearest whole inch.
·Use mathematical rounding (i.e., if height measurement is X.5 inches or greater, round height upward to the nearest whole inch. If height measurement number is X.1 to X.4 inches, round down to the nearest whole inch). For example, a height of 62.5 inches would be rounded to 63 inches and a height of 62.4 inches would be rounded to 62 inches."

2. The facility staff failed to accurately record that Resident # 13 had a fall on 1/27/17 in section J for her quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 2/8/17.

Resident # 13 was admitted to the facility on 5/2/16 and most recently readmitted on 2/1/17 with diagnoses that included, but were not limited to: atrial fibrillation (1), depression, Alzheimer's disease (2), arthritis, and chronic obstructive pulmonary disease (3). Resident # 13's most recent MDS was an annual assessment with an ARD of 5/2/17. Resident # 13 was coded as scoring 15 out of a possible 15 on the BIMS (Brief Interview for Mental Status) indicating that Resident #13 was cognitively intact.

Review of Resident # 13's quarterly MDS assessment with an ARD of 2/8/17 revealed in Section J1800: (Any Falls since Admission/Entry or Reentry or Prior Assessment...) Resident #13 was coded as having 0 (zero) falls since the last MDS assessment.

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A review of Resident #13's clinical record revealed that Resident #13 had one documented fall dated 1/27/17 since her last MDS assessment.

During an interview on 6/29/17 at 10:05 a.m. with RN (registered nurse) # 1, the MDS coordinator, Resident # 13's quarterly assessment was reviewed. RN # 1 stated that the fall should have been on the quarterly MDS. When asked what reference she (RN # 1) uses to complete the MDS assessments, RN # 1 stated, "The RAI (resident assessment instrument) manual and also in the MDS software we use there is a tab one can click on for guidance."

During an interview on 6/29/17 at approximately 3:00 p.m. with ASM (Administrative staff member) # 1, the administrator, this concern was shared.

The RAI manual revealed, in part, the following documentation regarding the coding of falls:

J1800: Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA [Omnibus Budget Reconciliation Act] or Scheduled PPS [Prospective Payment Systems]), whichever is more recent (cont.)

Planning for Care:

Identification of residents who are at high risk of falling is a top priority for care planning. A previous fall is the most important predictor of risk for future falls.
Falls may be an indicator of functional decline and development of other serious conditions such as delirium, adverse drug reactions, dehydration,

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and infections.
External risk factors include medication side effects, use of appliances and restraints, and environmental conditions.
A fall should stimulate evaluation of the resident's need for rehabilitation, ambulation aids, modification of the physical environment, or additional monitoring (e.g., toileting, to avoid incontinence).

Steps for Assessment:

1. If this is the first assessment (A0310E = 1), review the medical record for the time period from the admission date to the ARD.

2. If this is not the first assessment (A0310E = 0), the review period is from the day after the ARD of the last MDS assessment to the ARD of the current assessment.

3. Review all available sources for any fall since the last assessment, no matter whether it occurred while out in the community, in an acute hospital, or in the nursing home. Include medical records generated in any health care setting since last assessment.

4. Review nursing home incident reports, fall logs and the medical record (physician, nursing, therapy, and nursing assistant notes).

5. Ask the resident and family about falls during the look-back period. Resident and family reports of falls should be captured here whether or not these incidents are documented in the medical record.

Coding Instructions:

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Code 0, no: if the resident has not had any fall since the last assessment. Skip to Swallowing Disorder item (K0100).
Code 1, yes: if the resident has fallen since the last assessment. Continue to Number of Falls since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS) item (J1900), whichever is more recent.

Examples:

1. An incident report describes an event in which Mr. S. was walking down the hall and appeared to slip on a wet spot on the floor. He lost his balance and bumped into the wall, but was able to grab onto the hand rail and steady himself.

Coding: J1800 would be coded 1, yes.
Rationale: An intercepted fall is considered a fall.

No further information was provided prior to exit.

References:

(1) Atrial Fibrillation: An arrhythmia is a problem with the speed or rhythm of the heartbeat. Atrial fibrillation (AF) is the most common type of arrhythmia. The cause is a disorder in the heart's electrical system. This information was obtained from the website:
https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=Atrial+Fibrillation&commit=Search

(2) Alzheimer's Disease: Alzheimer disease (AD) is a degenerative disease of the brain that causes gradual loss of memory, judgment, and the ability to function socially. This information was

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obtained from the website: https://rarediseases.info.nih.gov/diseases/10254/alzheimer-disease

(3) COPD - chronic obstructive pulmonary disease: A type of lung disease marked by permanent damage to tissues in the lungs, making it hard to breathe. This information was obtained from the website: www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0022631/

3 a. The facility staff failed to accurately code the use of psychoactive medications on Resident #3's quarterly MDS (minimum data set) assessment with an ARD of 6/4/17.

Resident #3 was admitted to the facility on 6/22/09 with a recent readmission on 12/20/16, with diagnoses that included but were not limited to: end stage renal disease requiring hemodialysis (a procedure used in toxic conditions and renal failure, in which wastes and impurities are removed from the blood by a special machine (1)), high blood pressure, dementia, stroke, depression, anxiety, and diabetes.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD of 6/4/17, coded the resident as having both short and long term memory difficulties and as being moderately impaired to make daily cognitive decisions. Resident #3 was coded as requiring extensive assistance of one or more staff members for dressing; as dependent of one or more staff members for transfers, moving in the bed, moving on the unit, toileting needs and

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bathing. The resident was coded as being independent in eating after set up assistance was provided.

The review of the quarterly MDS with an ARD of 6/4/17 revealed documented in Section N - Medications that the resident had received two days of an antipsychotic medication, seven days of an antianxiety medication, and no days of an antidepressant medication during the seven days prior to the assessment reference date of 6/4/17.

Review of the MAR (medication administration record) for May 2017 documented, "Seroquel (an antipsychotic medication used to treat schizophrenia and bipolar disorder (2)) 25 MG (milligrams); Give 12.5 mg by mouth one time a day every Tue (Tuesday), Thu (Thursday), Sat (Saturday) for anxiety, administer prior to dialysis on Tuesday, Thursday, and Saturday." The MAR documented that the resident received the Seroquel on 5/30/17.

The June 2017 MAR documented, "Seroquel 25 MG; Give 12.5 mg by mouth one time a day every Tue, Thu, Sat for anxiety, administer prior to dialysis on Tuesday, Thursday, and Saturday." The MAR documented that the resident received the Seroquel on 6/1/17 and 6/3/17.

This equals a total of three times during the seven day look back period of 5/29 through 6/4/17, not two days as coded on the quarterly MDS with an ARD of 6/4/17.

Review of the MAR (medication administration record) for May 2017 documented, "Ativan (used to treat anxiety (3)) 1 MG (milligram); give 1 MG by mouth one time a day every Mon (Monday)

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Wed (Wednesday) and Fri (Friday) for 30 minutes prior to pick up for dialysis at 7:00 a.m." The MAR documented that the resident received it on 5/29/17 (Monday) and 5/31/17 (Wednesday).

The June 2017 MAR documented, "Ativan 1 MG; give 1 MG by mouth one time a day every Mon, Wed, and Fri for 30 minutes prior to pick up for dialysis at 7:00 a.m." The MAR documented that the resident received it on 6/2/17.

This equals a total of three times during the seven day look back period of 5/29 through 6/4/17, not seven days as coded on the quarterly MDS with an ARD of 6/4/17.

The May 2017 MAR documented, "Bupropion HCL (hydrochloride) (an antidepressant used to treat depression (4)), Give 37.5 mg by mouth one time a day for depression." The MAR documented that the resident received it on 5/29/17 through 6/4/17.

This equals a total of seven times during the seven day look back period of 5/29 through 6/4/17, not zero days as coded on the quarterly MDS with an ARD of 6/4/17.

An interview was conducted with RN (registered nurse) #1, the MDS coordinator, on 6/29/17 at 10:10 a.m. The MARs and Section N of the quarterly MDS with an ARD of 6/4/17 were reviewed with RN #1. RN #1 stated, "I guess I wasn't paying attention, they (medications) are coded incorrectly." When asked what reference is used to complete an MDS assessment, RN #1 stated, "The RAI (Resident Assessment Instrument) manual."

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The RAI manual October 2016:
Coding Instructions
N0410A-G: Code medications according to the pharmacological classification, not how they are being used.
N0410A, Antipsychotic: Record the number of days an antipsychotic medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
N0410B, Antianxiety: Record the number of days an anxiolytic medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
October 2016 Page N-5
N0410C, Antidepressant: Record the number of days an antidepressant medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).

The administrator and Director of Nursing were made aware of the above findings on 6/29/17 at 1:15 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 266.
(2) This information was obtained from the following website:
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011909/?report=details
(3) This information was obtained from the following website:
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH

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T0010988/?report=details.
(4) This information was obtained from the following website:
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009361/?report=details

3 b. The facility staff coded Resident #3 as having received restorative nursing on the annual assessment with an ARD of 3/4/17 when she had not received restorative nursing and did not have a program in place. The facility staff also coded Resident #3 as receiving restorative nursing on the quarterly assessment with an ARD of 6/4/17 when she did not have a restorative nursing program in place.

The annual MDS assessment with an ARD of 3/4/17, coded the resident in Section O - Special Treatments, Procedures, and Programs, as having received a Restorative Nursing Program of five days of passive range of motion, four days of dressing and/or grooming and five days of eating and/or swallowing.

The quarterly MDS assessment with an ARD of 6/4/17, coded the resident in Section O - Special Treatments, Procedures, and Programs, as having received a Restorative Nursing Program of seven days of passive range of motion, six days of active range of motion, seven days of bed mobility and six days of dressing and/or grooming.

Review of the clinical record did not evidence any documentation of a Restorative Nursing Program.

Review of Resident #3's comprehensive care plan dated 5/22/12, with revised on date of

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6/27/17, did not evidence any documentation of a Restorative Nursing Program.

On 6/29/17 at 10:10 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked to present documentation of the restorative program for Resident #3.

On 6/29/17 at 2:20 p.m. RN #1 presented a document titled, "Nursing Rehabilitation/Restorative Care" for Resident #3 that was dated 11/8/12.

On 6/29/17 at 2:20 p.m. an interview was conducted with ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and RN (registered nurse) #1, the MDS coordinator. A request was made again for documentation of the Restorative Nursing Program for Resident #3. When asked who oversees the restorative nursing program, RN #1 stated, "I do not oversee this program at this point." The director of nursing, ASM #2 stated, "I thought that the MDS nurse oversaw this." The administrator, ASM #1 stated, "We don't have any other documentation to provide to you other than the document of 11/8/12." ASM #1, ASM #2 and RN #1 were made aware of the concern at this time.

No further information was provided prior to exit.

RAI Manual October 2016:
Steps for Assessment
1. Review the restorative nursing program notes and/or flow sheets in the medical record.
2. For the 7-day look-back period, enter the number of days on which the technique, training or skill practice was performed for a total of at

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least 15 minutes during the 24-hour period.
3. The following criteria for restorative nursing programs must be met in order to code O0500:

" Measureable objective and interventions must be documented in the care plan and in the medical record. If a restorative nursing program is in place when a care plan is being revised, it is appropriate to reassess progress, goals, and duration/frequency as part of the care planning process. Good clinical practice would indicate that the results of this reassessment should be documented in the resident's medical record.
" Evidence of periodic evaluation by the licensed nurse must be present in the resident's medical record. When not contraindicated by state practice act provisions, a progress note written by the restorative aide and countersigned by a licensed nurse is sufficient to document the restorative nursing program once the purpose and objectives of treatment have been established.

4. The facility staff incorrectly coded Resident #11 as receiving an anticoagulation (a blood thinner) medication, an antibiotic (to treat infection) and a diuretic (to reduce fluid in the body) on the quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 5/19/17. Resident #11 had not received any of those medications during the seven day look back period for that assessment.

Resident #11 was admitted to the facility on 6/5/13 with a readmission on 11/9/16 with diagnoses that included, but were not limited to: high blood pressure, high lipid level in the blood, depression, anxiety, atrial fibrillation (an irregular

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heart beat), stroke and macular degeneration (a condition of the eye that causes blindness).

Resident #11's most recent comprehensive MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 11/16/16. Resident #11 was coded as scoring a five out of a possible 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired for cognition.

Further review of Resident #11's MDS assessments revealed a quarterly assessment with an ARD of 5/19/17. Section N, Medications of this MDS assessment coded Resident #11 as receiving an antidepressant, an anticoagulant and an antibiotic for seven of the seven look back days.

A review of Resident #11's physician order summary report did not reveal any orders for an antidepressant, an anticoagulant or an antibiotic during May 2017.

Further review of Resident #11's clinical record did not provide evidence that she had received any of the coded medications during the month of May 2017.

On 6/28/17 at 2:20 p.m. an interview was conducted with RN (registered nurse) #1, an MDS coordinator. RN #1 was asked where she obtained her information to complete the quarterly MDS assessment with an ARD of 5/19/17. RN #1 stated she obtained the information from the PCC (point click care) electronic medical record, progress notes and the documented ADLs (activities of daily living). RN #1 further stated that she would take the "hard" chart (paper copy)

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F 278	Continued From page 33 and review to look at all the information available. RN #1 was asked to review Section N, Medications of Resident #11's quarterly MDS with an ARD of 5/19/17. RN #1 was asked to state where she obtained the information that Resident #11 had received an antidepressant, an anticoagulant or an antibiotic during the seven day look back period. RN #1 stated that she would have to do some research. On 6/29/17 at 11:50 a.m. RN #1 stated that Resident #11's MDS with an ARD of 5/19/17 was incorrectly coded on Section N, Medications. RN #1 stated that Resident #11 had not received an antidepressant, an anticoagulant or an antibiotic during the month of May 2017. RN #1 was asked what guidance she used to complete the MDS assessments. RN #1 stated that she used the RAI (resident assessment instrument) manual as guidance. On 6/29/17 at 1:15 p.m. ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above findings. No further information was provided prior to the end of the survey process.	F 278		
F 279 SS=E	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 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.	F 279		8/13/17

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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 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.

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F 279	Continued From page 35 (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 observations, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to develop a comprehensive care plan for six or 29 residents in the survey sample, Resident #23, #4, #6, #11, #5, and #17. 1. The facility staff failed to develop an interim care plan 48 hours after Resident #23's admission on 2/21/17, and failed to develop an comprehensive care plan 7 days after the completion of the comprehensive MDS (minimum data set) assessment with and ARD (assessment reference date) of 2/28/17. 2. The facility staff failed to develop a care plan for psychoactive medications, as triggered on the CAA (care area assessments) of Resident #4's significant change MDS (minimum data set) with and ARD of 2/13/17. 3. The facility staff failed to develop a comprehensive care plan for the triggered care areas of cognitive loss, communication, pressure ulcer, and psychotropic drug use in Section V -	F 279	1. A comprehensive care plan will be completed on Residents # 4, #6, #11, #5, and #17, including all areas triggered on the Care Area Assessments (CAAs) and significant change MDS for each residents. Resident #23 was discharged from facility on 5/23/2017. 2. All residents will be reviewed to ensure each resident's care plan is reviewed and revised with a comprehensive care plan that reflects their medical, nursing, mental, and psychosocial needs. 3. Care managers, MDS RNs, and the clinical team will be re-educated on the development and completion of care plans, including interim, comprehensive, and significant changes in resident condition that requires care plan interventions. The DON or designee will review new admissions and residents identified with a change in condition M-F in clinical stand up to ensure care plans are in place, reviewed, and revised as	

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F 279	Continued From page 36 Care Area Assessment (CAA), on Resident #6's admission comprehensive MDS (minimum data set) assessment with an ARD (assessment reference date) of 5/19/17. 4. The facility staff failed to develop a comprehensive care plan for the triggered care areas of cognitive loss, communication, urinary incontinence, nutritional status, pressure ulcer, and psychotropic drug use in Section V - Care Area Assessment (CAA), on Resident #11's admission comprehensive MDS with an ARD of 11/16/16. 5. The facility staff failed to develop a comprehensive care plan for Resident #5 for the triggered areas in section V on the CAA summary of the 6/2/17 Admission/5-day MDS assessment. 6. The facility staff failed to develop a comprehensive care plan for Resident #17 for the triggered areas in section V on the CAA summary of the 6/6/17 significant change MDS assessment. The findings include: 1. The facility staff failed to develop an interim care plan 48 hours after Resident #23's admission on 2/21/17, and failed to develop an comprehensive care plan 7 days after the completion of the comprehensive MDS (minimum data set) assessment with and ARD (assessment reference date) of 2/28/17. Resident #23 was admitted to the facility on 2/21/17 with diagnoses that included but were not limited to: displaced intertrochanteric fracture of	F 279	needed. MDS RN or designee will review residents requiring comprehensive care plans, as triggered by the CAAs. 4. DON or designee will audit 10% of care plans weekly for 30 days, then monthly for 60 days to ensure care plans are implemented, reviewed, or revised as indicated. Issues identified will be corrected, with staff re-education or counseling as needed. The results of audits will be reviewed by the QAPI committee for guidance and further instruction.	

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the left femur, high blood pressure, vascular dementia without behavioral disturbance, non-traumatic intracranial hemorrhage, anxiety disorder and major depressive disorder. Resident #23's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 5/15/17. Resident #23 was coded as severely cognitively impaired in the ability to make daily decisions scoring 99 out of 15 on the BIMS (Brief interview for Mental Status) exam. Resident #23 was coded as requiring extensive assistance from two plus persons with transfers; extensive assistance from one person with dressing, and personal hygiene, and total dependence on staff with bathing.

Review of Resident #23's comprehensive admission MDS (minimum data set) assessment revealed that this was completed on 2/28/17.

Review of Resident #23's clinical record revealed that the comprehensive care plan was not put into place until 3/14/17.

Review of Resident #23's clinical record revealed that there was no evidence of an interim care plan.

On 6/29/17 at 3:20 p.m., an interview was conducted with LPN (licensed practical nurse) #2, Resident #23's nurse. When asked who was responsible for creating the interim and comprehensive care plan, LPN #2 stated that the unit care manager was responsible. LPN #2 confirmed that she could not find an interim care plan and that the comprehensive care plan was not created until 3/14/17.

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On 6/29/17 at approximately 3:40 p.m., an interview was conducted with RN (registered nurse) #2, the care manager. When asked when the interim care plan should be created, RN #2 stated the interim care plan should be created 24 hours after the Resident is admitted to the facility. When asked what type of items are on the interim care plan, RN #2 stated that areas like falls, code status, pain and skin were all on the interim care plan. When asked when the comprehensive care plan should be created, RN #2 stated that the comprehensive care plan was created 21 days after admission. RN #2 stated that the care managers were responsible for creating the comprehensive assessment.

On 6/29/17 at approximately 4 p.m., an interview was conducted with RN # 4, the care manager. When asked when the interim care plan should be created, RN #4 stated that the interim care plan is created immediately after the resident is admitted. When asked what types of areas are put onto the interim care plan, RN #4 stated that areas such as falls, wounds, and infections are placed on the interim care plans. When asked when the comprehensive care plans are created, RN #4 stated that the comprehensive care plans are created 21 days after admission. When asked if she could find an interim care plan for Resident #23, RN #4 stated that there was not a care plan and that it should have been created. RN #4 stated that there was a lot of time from when the resident was admitted to a care plan being put into place on 3/14/17.

On 6/29/17 at 4:50 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above findings.

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F 279	Continued From page 39 The facility policy titled, "Assessment and Care of Patient/Resident through the Care Plan," documents in part, the following: "A comprehensive assessment care plan is developed for each resident that includes measurable objectives and time tables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. All residents on admission must have an assessment completed by a Licensed Nurse within twenty four hours of admission. From this process of an assessment, an Interim Care plan is created and used until the completion of a comprehensive MDS." No further information was presented prior to exit. 2. The facility staff failed to develop a care plan for psychoactive medications, as triggered on the CAA (care area assessments) in Section V of Resident #4's significant change MDS (minimum data set) with and ARD of 2/13/17. Resident #4 was admitted to the facility on 4/1/09, and most recently readmitted on 2/2/17 with diagnoses including, but not limited to: history of a stroke, dementia with behaviors, and anxiety. On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 5/16/17, Resident #4 was coded as having both short term and long term memory deficits, and as being moderately impaired for making daily decisions. She was coded as having received psychoactive medications on all seven days of the look back period.	F 279		

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A review of the significant change MDS for Resident #4, with an assessment reference date of 2/13/17, revealed that the resident was coded as having received psychoactive medications for six of the seven days of the look back period. This review revealed that the CAA (care area assessment) in section V triggered psychoactive medications as an area to be addressed in the comprehensive care plan. The box indicating whether or not the CAA trigger was to be care planned had a check mark in it.

A review of Resident #4's comprehensive care plan dated 10/21/15 and updated on 5/19/17 failed to reveal goals or interventions related to psychoactive medication use.

On 12/28/17 at 5:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, RN (registered nurse) #2, a care manager, and RN #8 were informed of these concerns.

On 6/29/17 at 8:00 a.m., RN #2 was interviewed. She stated that developing the comprehensive care plan from the CAAs is her responsibility. She stated she usually prints off the CAA worksheets to see why a particular area triggers, and develops the care plan from there. When asked about the care plan for the CAA triggered area of psychoactive medications for Resident #4, RN #2 stated she would look at the MDS and the care plan, and would get back to the surveyor. At 8:05 a.m., RN #2 returned to the surveyor and stated: "You are right. There is not a care plan. I can see it should have been done."

No further information was provided prior to exit.

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3. The facility staff failed to develop a comprehensive care plan for the triggered care areas of cognitive loss, communication, pressure ulcer, and psychotropic drug use in Section V - Care Area Assessment (CAA), on Resident #6's admission comprehensive MDS (minimum data set) assessment with an ARD (assessment reference date) of 5/19/17.

Resident #6 was admitted to the facility on 4/27/17, readmitted on 5/12/17 and readmitted on 6/21/17 with diagnoses that included, but were not limited to: stroke, sepsis (a blood stream infection), high blood pressure, abrasion of the penis, diabetes, urinary retention, chronic kidney disease, BPH (benign prostatic hyperplasia - an enlarged prostate gland), and difficulty swallowing.

Resident #6's most recent comprehensive MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 5/19/17. Resident #6 was coded as scoring a two out of a possible 15 on the BIMS (brief interview for mental status) in Section C, Cognitive Patterns, indicating that Resident #6 was severely cognitively impaired in daily decision making.

Further review of Resident #6's comprehensive MDS with an ARD of 5/19/17 revealed in Section V - Care Area Assessment (CAA), that the following care areas were checked under the heading "B. Care Planning Decision":

- "02. Cognitive Loss"
- "04. Communication"
- "16. Pressure Ulcer"

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F 279	Continued From page 42 - "17. Psychotropic Drug" The instruction provided in Section V states, "2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. Check column B if the triggered care area is addressed in the care plan." Section V, Column B for Resident #6's MDS was checked for cognitive loss/dementia, communication, pressure ulcer and psychotropic drug. A review of Resident #6's comprehensive care plan dated 6/21/17 did not reveal a care plan to address cognitive loss, communication, pressure ulcer and psychotropic drugs. On 6/28/17 at 2:40 p.m. an interview was conducted with RN (registered nurse) #8, a unit manager. RN #8 was asked who was responsible for developing a care plan from the CAA triggered areas. RN #8 stated that the unit managers developed the care plans. RN #8 further stated, "The care plans are not as developed as they should be, I have been asking for help to get through the care plans, they are so overwhelming but I haven't received any." On 6/29/17 at approximately 9:00 a.m. an interview was conducted with RN #1, an MDS coordinator and RN #6, an MDS coordinator. RN #1 and RN #6 were both asked who was responsible for developing a care plan from the CAAs. RN #6 stated, "The CAA worksheets are done by the MDS coordinators and then the unit managers develop the care plans from the CAA worksheets.	F 279		

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On 6/29/17 at 10:12 a.m. RN #6 reviewed Resident #6's comprehensive care plan to determine if the areas of concern had been care planned. RN #6 confirmed that cognitive loss, communication, pressure ulcer and psychotropic drugs were not care planned. When asked if these areas should have been care planned, RN #6 stated, "yes".

On 6/29/17 at approximately 2:00 p.m. a meeting was conducted with ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above concerns. No further information was provided prior to the end of the survey process.

4. The facility staff failed to develop a comprehensive care plan for the triggered care areas of cognitive loss, communication, urinary incontinence, nutritional status, pressure ulcer, and psychotropic drug use in Section V - Care Area Assessment (CAA), on Resident #11's admission comprehensive MDS with an ARD of 11/16/16.

Resident #11 was admitted to the facility on 6/5/13 with a readmission on 11/9/16 with diagnoses that included, but were not limited to: high blood pressure, high lipid level in the blood, depression, anxiety, atrial fibrillation (an irregular heart beat), stroke and macular degeneration (a condition of the eye that causes blindness).

Resident #11's most recent comprehensive MDS (minimum data set) is an admission assessment with an ARD (assessment reference date of 11/16/16. Resident #11 is coded as scoring a five

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out of a possible 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired of cognition.

Further review of Resident #11's comprehensive MDS with an ARD of 11/16/16 revealed in Section V - Care Area Assessment (CAA), that the following care areas were checked under the heading "B. Care Planning Decision":

- "02. Cognitive Loss"
- "04. Communication"
- "06. Urinary Incontinence"
- "12. Nutritional Status"
- "16. Pressure Ulcer"
- "17. Psychotropic Drugs"

The instruction provided in Section V states, "2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. Check column B if the triggered care area is addressed in the care plan." Section V, Column B for Resident #11's MDS was checked for cognitive loss/dementia, communication, urinary incontinence, nutritional status, pressure ulcer and psychotropic drug.

A review of Resident #11's comprehensive care plan dated 11/9/16 did not reveal a care plan to address cognitive loss, communication, urinary incontinence, nutritional status, pressure ulcer and psychotropic drugs.

On 6/28/17 at 2:40 p.m. an interview was conducted with RN (registered nurse) #8, a unit manager. RN #8 was asked who was responsible for developing a care plan from the

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CAA triggered areas. RN #8 stated that the unit managers developed the care plans. RN #8 further stated, "The care plans are not as developed as they should be, I have been asking for help to get through the care plans, they are so overwhelming but I haven't received any."

On 6/29/17 at approximately 9:00 a.m. an interview was conducted with RN #1, an MDS coordinator and RN #6, an MDS coordinator. RN #1 and RN #6 were both asked who was responsible for developing a care plan from the CAAs. RN #6 stated, "The CAA worksheets are done by the MDS coordinators and then the unit managers develop the care plans from the CAA worksheets.

On 6/29/17 at 10:12 a.m. RN #6 reviewed Resident #11's comprehensive care plan to determine if the areas of concern had been care planned. RN #6 confirmed that cognitive loss, communication, urinary incontinence, nutritional status, pressure ulcer and psychotropic drugs were not care planned. When asked if these areas should have been care planned, RN #6 stated "yes".

On 6/29/17 at approximately 2:00 p.m. a meeting was conducted with ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above concerns. No further information was provided prior to the end of the survey process.

5. The facility staff failed to develop a comprehensive care plan for Resident #5 for the triggered areas in section V on the CAA summary

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of the 6/2/17 Admission/5-day MDS assessment.

Resident #5 was admitted to the facility on 5/21/17 and readmitted on 5/26/17 with the diagnoses of but not limited to gastrostomy tube, stroke, dysphagia, atrial fibrillation, dementia, heart failure, high blood pressure and a pacemaker.

The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 6/2/17. The resident was coded as moderately impaired in ability to make daily life decisions, scoring a 9 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #5 was coded as requiring extensive to total assistance for transfers; total assistance for eating and bathing; extensive assistance for dressing and hygiene; and as incontinent of bowel and with a urinary catheter for bladder.

A review of the above MDS revealed the resident was triggered on Section V "Care Area Assessment (CAA) Summary" in Column A "Care Area Triggered" for "02. Cognitive Loss/Dementia, 04. Communication, 06. Urinary Incontinence and Indwelling Catheter, 11. Falls, 13. Feeding Tube, 14. Dehydration/Fluid Maintenance, 15. Dental Care, 16. Pressure Ulcer, 17. Psychotropic Drug Use, 19. Pain."

Column B of this assessment, titled "Care Planning Decision" had each of the above identified areas marked as to be care planned.

Observations of Resident #5 on 6/27/17 at 4:30 p.m., 6/28/17 at 8:00 a.m., and on 6/28/17 at approximately 11:00 a.m., revealed the resident

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had an indwelling catheter and the resident was noted to be wearing dentures. A tube feeding pump was at the bedside but was not running. Thickened water was noted at the bedside.

A review of the care plan revealed that "06. Urinary Incontinence and Indwelling Catheter, 14. Dehydration/Fluid Maintenance, 15. Dental Care" were not care planned.

On 6/29/17 at 10:26 a.m., RN #2 (Registered Nurse), the Care Manager, reviewed the care plan and did not see the above identified areas on it. She stated that triggered areas should be care planned.

On 6/29/17 at 4:50 p.m., the Administrator (ASM #1 - Administrative Staff Member) and the DON (Director of Nursing, ASM #2) were made aware of the findings. No further information was provided by the end of the survey.

6. The facility staff failed to develop a comprehensive care plan for Resident #17 for the triggered areas in section V on the CAA summary of the 6/6/17 significant change MDS assessment.

Resident #17 was admitted to the facility on 9/21/16 with the diagnoses of but not limited to atrial fibrillation, high blood pressure, left arm fracture, hypothyroidism, dementia, adult failure to thrive, and ulcerative pancolitis.

The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 6/6/17. The

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resident was coded as being severely cognitively impaired in ability to make daily life decisions. Resident #17 was coded as requiring total care for bathing; extensive care for hygiene; limited assistance for dressing; supervision for transfers and ambulation; as independent for eating; and as incontinent of bowel and bladder.

A review of the above MDS revealed the resident was triggered on Section V "Care Area Assessment (CAA) Summary" in Column A "Care Area Triggered" for "02. Cognitive Loss/Dementia, 05. ADL Functional/Rehabilitation Potential, 06. Urinary Incontinence and Indwelling Catheter, 11. Falls, 12. Nutritional Status, 16. Pressure Ulcer, 19. Pain."

Column B of this assessment, titled "Care Planning Decision" had each of the above identified areas marked as to be care planned.

A review of the care plan revealed that "02. Cognitive Loss/Dementia, and 06. Urinary Incontinence and Indwelling Catheter" were not care planned.

On 6/29/17 at 10:26 a.m., RN #2 (Registered Nurse), the Care Manager, reviewed the care plan and did not see the above identified areas on it. She stated that triggered areas should be care planned.

A review of the facility policy, "Assessment and Care of Patient/Resident Through Care Plan" documented, "A comprehensive care plan is developed for each resident that includes measurable objectives and time tables to meet a resident's medical, nursing, and mental and psychological needs that are identified in the

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F 279	Continued From page 49 comprehensive assessment....The comprehensive care plan is completed upon the completion of a comprehensive MDS." On 6/29/17 at 4:50 p.m., the Administrator (ASM #1 - Administrative Staff Member) and the DON (Director of Nursing, ASM #2) were made aware of the findings. No further information was provided by the end of the survey.	F 279		
F 280 SS=E	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the	F 280		8/13/17

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right to participate in his or her treatment and shall support the resident in this right. The planning process must--

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

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

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

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

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

(ii) Prepared by an interdisciplinary team, that includes but is not limited to--

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of 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

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F 280	Continued From page 51 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, facility document review and clinical record review it was determined that the facility staff failed to review and revise the comprehensive care plan for four of 29 residents in the survey sample, Residents # 1, # 12, # 5, and #11. 1. The facility staff failed to revise Resident # 1's comprehensive care plan following a fall on 6/25/17. 2. The facility staff failed to review and revise the comprehensive care plan after Resident #12 for five falls on: 12/25/16, 5/4/17, 5/18/17, 6/8/17 and 6/18/17. The staff also failed to review and revise the comprehensive care plan after Resident #12's last fall on 6/18/17 resulted in rib fractures and an increase in pain. 3. The facility staff failed to review and revise the comprehensive care plan after a physician's order dated 6/23/17 documented that Resident #5 must have dentures on for ground food. 4. The facility staff failed to review and revise	F 280	1. Care plans for Residents #1, #12, #5, and #11 will be reviewed and revised, to include fall interventions, mobility and transfer status, pain, and ADL support or assistance by correction date. 2. All residents will be reviewed to ensure each resident has an interim and/or comprehensive care plan that reflects their medical, nursing, mental, and psychosocial needs. 3. Care Managers, MDS RNs, and the clinical team will be re-educated on the development and completion of care plans, including interim, comprehensive, and significant changes in resident's condition. The DON or designee will review new admissions and residents identified with changes in condition to ensure care plan are in place, reviewed, and revised as needed. MDS RNs or designee will review residents requiring comprehensive care plans, as triggered by the CAAs.	

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F 280	Continued From page 52 Resident #11's comprehensive care plan after she had fallen on 1/9/17, 2/15/17, 3/24/17 and 3/26/17. The findings include: 1. The facility staff failed to revise Resident # 1's comprehensive care plan following a fall on 6/25/17. Resident # 1 was admitted to the facility on 12/2/14 and most recently readmitted on 4/7/15 with diagnoses that included but were not limited to: anemia, osteoporosis (1), hypertension (2), diabetes, and stroke (3). Resident # 1's most recent MDS (minimum data set) an annual assessment with an ARD (assessment reference date) of 6/12/17 coded the resident as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, indicating that Resident # 1 was cognitively intact. Resident # 1 was coded as requiring extensive assistance of two+ staff with transfers on/off the toilet. Review of Resident # 1's clinical record revealed a note documented on 6/25/17 at 12:30 p.m.: the type of note was an "Incident Note" "Type: While trying to put on toilet, resident shifted weight away from toilet and slid on floor." "Location: Residents (sic) bathroom." "Person Discovering Incident: [name of CNA (certified nurse's assistant) # 8..." signed by [name of LPN (licensed practical nurse) # 9]. Review of the compressive care plan with a "Focus - Name of Resident # 1 sustained an	F 280	4. DON or designee will audit 10% of care plans weekly for 30 days, then monthly for 60 days to ensure care plans are implemented, reviewed, and revised. Issues identified will be corrected, including staff re-education or counseling as needed. Results of audits will be reviewed by the QAPI committee for guidance and further instruction.	

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actual fall 8/14/15 with No Injury, related to Unsteady gait, Poor Balance, Poor communication/comprehension." Resident # 1's falls were listed in the "Focus" section of the care plan with the exception for the most recent fall that occurred on 6/25/17. The care plan documented a revision date of 5/24/17.

During an interview on 6/29/17 at 10:53 a.m. with RN (registered nurse) # 2, a care manager, Resident # 1's care plan was reviewed. RN # 2 could find no documentation or interventions for Resident # 1's fall on 6/25/17. RN # 2 stated, "The care plan should be updated within 24 hours of the incident and I see that the fall (6/25/17) and any new interventions are not on the care plan."

During an interview on 6/29/17 at approximately 3:00 p.m. with ASM (Administrative staff member) # 1, the administrator, this concern was shared and a copy of the facility policy on falls and care planning was requested.

Review of the Facility policy: "Fall Resident Assessment and Investigation, 6110-1701" documented the following: under "Purpose: To provide a comprehensive, consistent approach to assess residents at risk for falls and to implement interventions to reduce risks for recurrence and injury." Under "Policy ...3. Residents will be re-elevated, no less than quarterly, by interdisciplinary care plan team. The care plan is to contain evidence of review and revision related to the causative factors and preventative measures...6. A fall investigation will be completed with each incident. The charge nurse to complete incident documentation promptly after fall has occurred. Input from involved parties, including but not limited to: resident,

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family, physician, nursing staff, rehab therapist, activity staff, and social worker. 7. The fall investigation form will be utilized in reviewing and revising the resident's care plan to minimize the recurrence of falls or injury."

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..."

Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care."

References:

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(1) Osteoporosis -- Makes your bones weak and more likely to break. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/osteoporosis.html.

(2) Hypertension: A condition present when blood flows through the blood vessels with a force greater than normal. Also called high blood pressure, hypertension can strain the heart, damage blood vessels, and increase the risk of heart attack, stroke, kidney problems, and death. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0024199/

(3) A stroke occurs when blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm.

2. The facility staff failed to review and revise the comprehensive care plan after Resident #12 for five falls on: 12/25/16, 5/4/17, 5/18/17, 6/8/17 and 6/18/17. The staff also failed to review and revise the comprehensive care plan after Resident #12's last fall on 6/18/17 resulted in rib fractures and an increase in pain.

Resident #12 was admitted to the facility on 5/4/16 and readmitted on 6/19/17, (after an overnight only stay in the hospital emergency room for evaluation), with diagnoses that included

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but were not limited to: dementia, high blood pressure, anxiety, insomnia, depression, abnormal weight loss and protein calorie malnutrition.

The most recent MDS (minimum data set), an annual assessment, with an assessment reference date of 5/18/17, coded the resident as being severely impaired to make daily cognitive decisions. Resident #12 was coded as requiring limited assistance of one staff member for moving in the bed and dressing, extensive assistance of one staff member for transfers and toileting, and as independent after set up assistance was provided for eating. Resident #12 was not coded for any impairment in her range of motion. In Section J - Health Conditions, the resident was coded as having had two falls without injuries.

The "Fall Risk Assessment" dated, 10/9/16, documented the following:
Reason for Assessment - recent fall
Date of admission - less than 90 days
History of Falls within Last 3 months - #2. 1-2 times
Medication Use - antiseizure, antihypertensive, NSAID (non -steroidal anti-inflammatory drug) narcotics, psychotropic, anti-Parkinson's
Medication Usage - takes 3 or more of these medications currently or within last 7 days.
Systolic Blood Pressure - no drop between lying & standing
Memory/Recall - disoriented x (times) 1
Vision - adequate with or without glasses
Continence - Continent complete control in past 7 days.
Behavior in last 7 days - no behavior exhibited in

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last 7 days
Confined to Chair - not
Gait Analysis - unable to independently come to a standing position
Predisposing Conditions - Parkinson's disease
Response based on number of predisposing condition - 1-2 present.
There was no risk score or documentation of the resident's fall risk.

The nurse's note dated, 12/25/16 at 8:13 p.m. documented, "Pt (patient) wheeled self into bathroom unassisted and attempted to put self onto toilet unassisted. pt (sic) sitting on buttocks on floor, sitting upright holding onto grab rail with both hands. pt (sic) stated 'I couldn't hold on too long', 'I fell on my butt.' Pt assessed and toileted with staff assist, pt reeducated to get staff assistance with transfers, pt denies pain or discomfort, ROM (range of motion) W/N/L (within normal limits) without c/o (complaint of) pain or discomfort, no s/s (signs and symptoms) of distress, resp (respirations) even/non-labored, skin intact. will cont (continue) to monitor for changes."

The "Fall Incident Report" dated, 12/25/16 documented in part, "Immediate Action Taken - pt assessed and toileted with staff assist, pt reeducated to get staff assistance with transfers."
The review by the director of nursing (DON) on 12/26/16 documented, "Resident is impulsive in her actions and has been observed frequently by this writer attempting to transfer herself from her wheelchair to the bed, bed to wheelchair, and even wheelchair to bathroom without calling for staff assistance. Resident has unsteady gait/balance."

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The "Fall Risk Assessment" dated, 2/15/17, documented in part, "Score - 16. Category - High Risk (for falls)."

A nurse's note dated, 5/4/17 at 3:35 p.m. documented, "Found on floor in room. Assess for injury. Skin intact. No outward rotation of hips noted. Able to move all extremities well. Denies pain.

The "Fall Incident Report" dated, 5/4/17 documented in part, "Found resident lying on L (left) side on floor with head against visitor leg. Mobility alarm in place. Works intermitten (sic). New alarm applied. Assess for injuries. Able to move all extremities well. No outward rotation of hips. Skin intact. Denies pain. Resident did not have brakes on w/c (wheelchair). Resident Description - Stated wheelchair tip over....Other info (information) Gets up and down from w/c, was bending over and standing up, the w/c did not have brakes on and w/c moved backwards and resident went to sit down and missed w/c. Notes: Did not have brakes on w/c, and moved backwards while bend over and fell to floor. Mobility alarm changed due to alarm only working internitten (sic)."

The "Fall Risk Assessment" dated, 5/18/17, documented in part, "Score - 22. Category - High Risk."

A nurse's note dated, 5/18/17 at 6:05 p.m. documented, "Resident observed leaning forward in wheelchair rearranging items in bottom dresser drawer, this writer began to ask resident to sit back, resident continued to lean forward when wheelchair slid from under resident. Educated to not lean forward, use call light for any

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assistance."

The "Fall Incident Report" dated, 5/18/17 documented in part, "Resident observed in wheelchair leaning forward rearranging items in bottom dresser drawer, this writer began to ask resident to sit back when resident continued to lean forward and wheelchair slid from under resident....Other info - Resident often displays impulsive behaviors and suffered from parkinsonian dystonia/tremors. Resident was attempting to arrange items in her bottom dresser drawer when she slid out of her wheelchair. Resident has poor balance and is unable to judge her movements."

The "Fall Incident Report" dated, 6/8/17 documented in part, "Housekeeping stated that she was walking by pt's room and pt was lying on the floor. Pt found lying on her left side, head against the wall. Pt states, "I tapped my head on the wall, I was trying to pick this thing from the floor...Other info - Impulsive/determines (sic) behavior, did not call for assistance, unsteady balance."

A nurse's note dated, 6/18/17 at 9:12 p.m. documented, "Pt fell onto floor witnessed by roommate; roommate stated that pt was 'looking at papers and some dropped and she went to pick them off the floor and fell out of her wheelchair on to the floor.' Pt stated, 'I fell, I was picking up my papers.' Pt laying on right side on floor, wheelchair next to pt, papers on floor. pt c/o (complained of) right hip, back and coccyx pain, immobilized pt, MD (medical doctor) notified, new order to send pt to er (emergency room) for eval (evaluation), called 911, pt sent out

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to er via 911, rp (responsible party) notified, er notified.."

The "Fall Incident Report" dated, 6/18/17, documented in part, "Pt fell onto floor witnessed by roommate; roommate stated that pt was 'looking at papers and some dropped and she went to pick them off the floor and fell out of her wheelchair onto the floor. Resident description - I fell, I was picking up my papers." Immediate action taken - pt laying on right side on floor, wheelchair next to pt papers on floor...Notes - x-ray revealed broken 7th and 8th right lateral rib fractures.

The x-ray results dated, 6/20/17, documented in part, "There is a fracture of the ninth and 10th lateral fibs, with slight displacement, possibly involving the eighth lateral rib as well. Impression: Right-sided lateral rib fractures as mentions."

The physician orders dated, 6/20/17 documented the order for the rib x-rays and Tramadol (non-narcotic used to treat moderate to severe pain (1)) 50 mg (milligrams); give 1 tablet by mouth every 6 hours as needed for pain."

The June 2017 MAR (medication administration record) documented Resident #12 received Tramadol three times on 6/20/17 for a pain score of 10 (scale of one to ten, ten being the worse pain ever in). Resident #12 was documented as receiving the Tramadol on 6/21/17 once for a pain level of seven. The resident was documented as receiving the Tramadol on 6/22/17 for a pain level of five and one of eight.

The comprehensive care plan dated 5/5/16 and

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revised on 6/28/17, documented in part, "Focus: (Resident #12) is at risk for injury r/t (related to) falls characterized by multiple risk factors related to: unstable health condition, non-compliance with mobility aide use, visual deficit, new surroundings and psychotropic medication. (Resident #12) had an actual fall on 8/14/16. (Resident #12) had a fall on 9/14/16. (Resident #12) sustained a fall on 10/1/16, resulting in a skin tear to left elbow." The following were added to the care plan after this surveyor asked for information on the falls. "(Resident #12) had an actual fall on 5/18/17. (Resident #12) had an actual fall on 6/8/17. (Resident #12) had an actual fall on 6/18/17."

The "Interventions" documented in part, "5/5/16 - Encourage resident to ask for assistance when walking with walker and not to walk independently. 10/2/16 - Ensure that nursing staff continues to monitor and remind (Resident #12) to ask for assistance when wishing to transfer. 5/5/16 - Maintain locked brakes on wheelchair when resident is sitting in it. 7/12/16 - Place objects that resident frequently uses within resident's reach. 5/5/16 - Reinforce need to call for assistance. 8/22/16 - Staff to continuously remind (Resident #12) not to lean over in her chair r/t poor safety awareness." The last update to her care plan was dated, 10/2/16. There were no updates after Resident #12's falls on 12/25/16, 5/4/17, 5/18/17, 6/8/17 and 6/18/17.

The comprehensive care plan dated, 7/14/16, documented in part, "Focus: (Resident #12) is at risk for Alteration in comfort r/t pain from osteoporosis and generalized pain." The care plan goal was last updated 5/12/17. The "Interventions" were all dated 7/14/16. Further

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review of the care plan did not reveal any evidence of the rib fractures and the resident's pain management for them.

On 6/29/17 at 9:16 a.m. an interview was conducted with RN (registered nurse) #3. When asked who is responsible for updating the care plans, RN #3 stated, "The unit managers."

An interview was conducted with RN #1, the MDS coordinator, on 6/29/17 at 10:10 a.m. When asked who is responsible for updating the care plan with new interventions after a resident has a fall, RN #1 stated, "The clinical coordinator (unit manager) updates the care plan with the fall and new interventions." RN #1 was asked to review Resident #12's fall care plan. When asked if she saw any documentation regarding Resident #12's falls on 12/25/16, 5/4/17, 5/18/17, 6/8/17 and 6/18/17, RN #1 stated she did not see those falls on the care plan.

An interview was conducted with LPN (licensed practical nurse) #2 on 6/29/17 at 10:50 a.m. When asked how the staff identify a resident who is at risk for falls, LPN #2 stated, "They have a yellow band on and there is a list in the computer of what they need." When asked how the CNA's know what devices a resident needs, LPN #2 stated, "There is a falling leaf outside the door." LPN #2 and this surveyor identified the leaf at the doorway to Resident #12's room. LPN #2 was asked to look at the care card in Resident #12's closet. LPN #2 stated, "Well that needs to be filled in." An orange dot with "M/M" was noted next to Resident #12's name outside her door. When asked what that indicated, LPN #2 stated, "I don't know but I will find out."

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A second interview was conducted with LPN #2 who cared for Resident #12 for one of her falls, on 6/29/17 at 11:09 a.m. When asked what happened on 5/4/17, LPN #2 stated, "She gets up and down in her chair. She fidgets. She takes off her alarms and plays with them. "LPN #2 stated, "I found out what the M/M on the orange dot was, it's her mobility monitor she has." LPN #2 was asked if she put any new interventions in place at the time of the 5/4/17, fall to prevent further falls. LPN #2 stated no, she hadn't.

An interview was conducted with RN #4, the care manager for Resident #12, on 6/29/17 at 11:55 a.m. When asked who updates the care plans, RN #4 stated, "I'm supposed to do that. It's been a struggle to do so." The care plan for Resident #12 was reviewed with RN #4. RN #4 was asked if Resident #12's care plan had been updated with new interventions to prevent further falls after each fall on 12/25/16, 5/4/17, 5/18/17, 6/8/17 and 6/18/17. RN #4 stated, "No, I don't see it there." When asked if the care plan should have been updated, RN #4 stated, "Yes, Ma'am." When asked should interventions be put in place to prevent further falls, RN #4 stated, "Yes, it should be updated. She is my special person. She has a mobility alarm. I go in to her room a lot and she's very busy. Her business increases with her roommate but her family doesn't want her moved." RN #4 was informed Resident #12 has had five falls in six months with the last fall resulting in a fracture and increased pain, and was asked if something should have been put in place to prevent further falls. RN #4 stated, "Yes, we should have done something." When asked if the resident's care plan should have been updated for the increase in pain she was experiencing from the fractured ribs, RN #4

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stated, "Yes, Ma'am."

The facility policy, "Assessment and Care of Patient/Resident Through Care Plan" documented in part, "7. The care plan includes treatment objectives that have measurable outcomes with time tables and specific approaches to me the defined needs. 8. The care plan is evaluated and changed in reference to the resident's response to treatment and whenever there is a change in the resident. All disciplines participate in maintaining the care plan so that it reflects the current status of the resident. A kardex is utilized by the CNA and other caregivers for basic caregiving needs. 9. The care plan is reviewed and revised no less than with the completion of each quarterly MDS assessment. The kardex will be updated at this time as well.

An interview was conducted with the director of nursing (DON) on 6/29/17 at 1:15 p.m. When asked if a care plan should be updated for pain related to recent diagnosis of rib fractures, the DON stated, "Yes, it should reflect that."

The Administrator and DON were made aware of the above concern on 6/29/17 at 1:15 p.m.

(1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012486/?report=details

3. The facility staff failed to review and revise the comprehensive care plan after a physician's order dated 6/23/17 documented that Resident #5 must have dentures on for ground food.

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Resident #5 was admitted to the facility on 5/21/17 and readmitted on 5/26/17 with the diagnoses of but not limited to gastrostomy tube, stroke, dysphagia, atrial fibrillation, dementia, heart failure, high blood pressure and a pacemaker.

The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 6/2/17. The resident was coded as moderately impaired in ability to make daily life decisions, scoring a 9 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #5 was coded as requiring extensive to total assistance for transfers; total assistance for eating and bathing; extensive assistance for dressing and hygiene; as incontinent of bowel and as having a urinary catheter for bladder.

A physician's order dated 6/23/17 documented the resident must have dentures on for ground food.

A review of the care plan failed to reveal that this order was included as a care need for Resident #5.

On 6/29/17 at 10:26 a.m., RN #2 (Registered Nurse), the Care Manager, reviewed the care plan and did not see the above identified area included in the care plan. She stated that any ordered care needs should be care planned.

A review of the facility policy, "Assessment and Care of Patient/Resident Through Care Plan" documented, "8. The care plan is evaluated and changed in reference to the resident's response to treatment and whenever there is a change in

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the resident. All disciplines participate in maintaining the care plan so that it reflects the current status of the resident....11. The night licensed nursing staff or designee will review new orders daily to ensure appropriate care plan revisions."

On 6/29/17 at 4:50 p.m., the Administrator (ASM #1 - Administrative Staff Member) and the DON (Director of Nursing, ASM #2) were made aware of the findings. No further information was provided by the end of the survey.

4. The facility staff failed to review and revise Resident #11's comprehensive care plan after she had fallen on 1/9/17, 2/15/17, 3/24/17 and on 3/26/17 resulting in a rib fracture.

Resident #11 was admitted to the facility on 6/5/13 with a readmission on 11/9/16 with diagnoses that included, but were not limited to; high blood pressure, high lipid level in the blood, depression, anxiety, atrial fibrillation (an irregular heart beat), stroke and macular degeneration (a condition of the eye that causes blindness).

Resident #11's most recent comprehensive MDS (minimum data set) is an admission assessment with an ARD (assessment reference) date of 11/16/16. Resident #11 was coded as scoring a five out of a possible 15 on the BIMS (brief interview for mental status) in Section C, Cognitive Patterns, indicating that Resident #11 was severely cognitively impaired in daily decision making.

A review of Resident #11's clinical record revealed that she had four falls dated 1/9/17,

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2/15/17, 3/24/17 and 3/26/17.

The review of Resident #11's clinical record revealed, in part, the following incident report:

- "3/26/2017 08:30 (8:30 a.m.) Incident Description: Nursing Description: pt (patient) was attempting to reposition self on side of bed to put on shoe on (sic) and slid onto floor on buttocks with bed items (mattress topper and blankets) pt sitting upright on buttocks on top of mattress topper and blankets. "I was trying to put on my shoe." Immediate Action Taken: Description: assessment done and range of motion, pt reeducated to ask staff for assistance for transfers and adl's (activities of daily living), rp (responsible party) and md (medical doctor) notified, (name of doctor) in building and notified. (Name of doctor) preformed (sic) physician exam on pt. Injuries Report Post Incident: No injuries Observed Post Incident. Notes: new order for left rib x-ray."

A review of Resident #11's clinical record revealed the following X-Ray report: "Date 3/27/17. Examination: XR (X-Ray) Ribs 2V (views) LT (left). Indication: Pain. Impression: There is a minimally displaced fracture of the anterior (front) aspect of the left 10th rib."

Review of the incident reports for each fall documented above did not provide any evidence that new interventions were initiated following each fall to prevent Resident #11 from sustaining further falls.

A review of Resident #11's comprehensive care plan dated 11/9/16 revealed, in part, the following documentation; "Focus: (Name of Resident) is

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high risk for falls r/t (related to) weakness, vision problems, hx (history) of falls with injury. 5/24/17 Family identified risk of mattress topper slipping off bed if both mattresses are not covered with the bottom fitted sheet. Date initiated: 11/22/2016. Revision on 5/24/2017. Interventions/ Tasks: Anticipate and meet (name of Resident #11's) needs. Date Initiated: 11/22/2016. Educate (name of Resident #11)/family/caregivers about safety reminders and what to do if a fall occurs. Date Initiated: 11/22/2016. Revision on: 11/22/2016. Encourage (name of Resident #11) to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Date Initiated: 11/22/2016. Revision: 11/22/2016. Ensure that (name of Resident #11) is wearing appropriate footwear when ambulating or mobilizing in w/c (wheelchair). Date Initiated: 11/22/2016. Revision on: 11/22/2016. Follow facility fall protocol. Date Initiated: 11/22/2016. Revision: 11/22/2016. (Name of Resident #11's) call light is within reach when in room and encourage her to use it for assistance as needed. Date Initiated: 11/22/2016. Revision on: 11/22/2016. Pt (physical therapy) evaluate and treat as ordered or PRN (as needed). Date Initiated: 11/22/2016."

There was no evidence or documentation that the comprehensive care plan was reviewed / revised or that interventions were initiated following each of the falls.

On 6/29/17 at approximately 9:00 a.m. an interview was conducted with RN (registered nurse) #1, an MDS coordinator, and RN #6, an MDS coordinator. RN #1 and RN #6 were asked who was responsible for the review and revision

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of comprehensive care plans following a fall. RN #1 stated that the process is to put in a new intervention for every fall that occurs, and that the care plan would be revised accordingly. RN #1 was asked when the staff knew which care plans needed to be reviewed and/ or revised. RN #1 stated that every morning during stand up meetings falls were discussed and the administrator would ask if the care plan had been updated, the unit manager would be responsible for the updates. RN #1 was asked if there was a process in place to ensure that care plans were being updated. RN #1 stated, "It is the expectation that it is done."

On 6/29/17 at 10:12 a.m. an interview was conducted with RN #6, an MDS coordinator. RN #6 reviewed the care plan with this surveyor to determine if each fall had been reviewed and whether the care plan had been updated accordingly. RN #6 reviewed the care plan and looked for references to the falls that occurred on 1/9/17, 2/15/17, 3/24/17 and 3/26/17. RN #6 stated, "There is nothing there." When asked if the care plan should have been reviewed following each fall, RN #6 stated that it should have been done.

On 6/29/17 at 10:30 a.m. an interview was conducted with LPN #2, a floor nurse working with Resident #11. LPN #2 was asked what was put into place following each fall that Resident #11 had. LPN #2 stated, "I don't know what they (the unit manager) considered, I don't do anything about it. If there are no alarms, we would put an alarm on." LPN #2 was asked if that was done for Resident #11, LPN #2 stated, "No I don't think so. I have not been made aware of any interventions that may have been put into place."

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F 280	Continued From page 70 On 6/29/17 at approximately 2:00 p.m. a meeting was conducted with ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above concerns. A policy on care plan review and revision was requested. A facility policy titled "Assessment and Care of Patient/Resident Through Care Plan" revealed, in part, the following documentation; "Purpose: All patients/resident (sic) hereafter referred to as resident admitted to (name of facility) are required to have an assessment of care needs made by each discipline. The goal of the assessment of residents function is to determine what kind of care is required to meet a patient/resident's initial needs, as well as the needs as they change in response to care. Procedure: 8. The care plan is evaluated and changed in reference to the resident's response to treatment and whenever there is a change in the resident. 9. The care plan is reviewed and revised no less than with the completion of each quarterly MDS assessment. 11. The night licensed nursing staff or designee will review new orders daily to ensure appropriate care plan revisions. No further information was provided prior to the end of the survey process.	F 280		
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 281		8/13/17

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F 281	Continued From page 71 must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility failed to follow professional standards of practice for three of 29 residents in the survey sample, Residents #19, #3 and #2. 1. The facility staff failed to clarify an order for Valium (1) and failed to follow the Rights of Medication Administration for Resident #19. 2. Resident #3's physician ordered medications to be administered prior to dialysis on Tuesday, Thursday, and Saturday. The facility staff failed to clarify the physicians order when the Resident #3's dialysis days were changed to Monday/Wednesday/Friday. 3. For Resident #2, facility staff failed to transcribe a physician's order to increase the frequency of a blood pressure medication onto the physician order sheet on 5/15/17. The findings include: 1. The facility staff failed to clarify an order for Valium (medication used to relieve anxiety, muscle spasms, and seizures and to control agitation caused by alcohol withdrawal (1)) and failed to follow the Rights of Medication Administration for Resident #19. Resident #19 was admitted to the facility on 12/23/16 with diagnoses including pneumonia,	F 281	1. Resident #19 has been discharged from the facility. RN #10 is no longer employed at facility. Physician was notified of Resident #3 medication order for Seroquel for clarification and use on 6/29/17 by RN#2. Resident #2 medication order for Coreg was discontinued during her hospital stay on 5/23/2017. 2. All residents have the potential to be affected by this deficient practice. 3. All licensed nurses and care managers will be re-educated on professional standards of practice, including transcribing and clarifying physician orders and pharmacy recommendations. Care managers or designee will review pharmacy recommendations for necessary follow up to implement new orders by MD. Night shift nurses will complete a 24 hour chart check to ensure new orders are verified and entered into the medical record as ordered. Issues identified will be immediately corrected. Pharmacy consultant will provide the DON, attending physician, and Medical Director pharmacy recommendations at least monthly. 4. Care manager or designee will audit 10% of new orders weekly for 30 days to ensure orders have transcribed, input into the Electronic Medical Record (EMR) and	

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F 281	Continued From page 72 congestive heart failure, dementia and depression. On the most recent MDS (minimum data set), a 30-day Medicare assessment with an ARD (assessment reference date) of 1/20/17, Resident #19 was coded as being moderately cognitively impaired for making daily decisions, scoring eight out of 15 on the BIMS (brief interview for mental status). She was coded as not having received medications for anxiety during the look back period. Resident #19 was discharged from the facility on 1/27/17. A review of the final FRI (facility reported incident) submitted to the state agency on 12/30/16 revealed, in part, the following: "This letter is provided as written follow up to the investigation of an unusual occurrence, medication error. On 12/26/16, facility reported a medication error involving resident [name of Resident #19]. [Resident #19] was noted with increased drowsiness by nursing supervisor during rounds on 12/25/16. Upon resident assessment, family interview, and clinical record review, supervisor noted resident received Valium 8 mg (milligrams) by [RN (registered nurse) #10. Physician ordered Valium 1 mg po (by mouth) for anxiety/agitation. An investigation was conducted regarding the medication error. [RN #10] was placed on suspension, pending investigation on 12/26/16. Physician and RP (responsible party) were notified of medication error on 12/25/16. New orders received and updated plan of care, including psych (psychology) consult for agitation and behaviors. Resident's drowsiness subsided within 24 hours. Lab (laboratory) results revealed no adverse reaction, no other changes in condition noted to resident. Upon personnel file review, counseling, and interview with [RN #10] facility met with RN on 12/29/2016 to discuss final	F 281	implemented correctly, then monthly for 60 days. DON will audit 100% of pharmacy recommendations monthly. Discrepancies noted will result in MD/RP notification if indicated, staff re-education and/or counseling as necessary. The results of audits will be presented to the QAPI committee for guidance and further instruction.	

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investigation. [RN #10] resigned from her position."

A review of the physician's orders for Resident #19 revealed, in part the following: "Valium Tablet 2 mg Give 1 mg by mouth as needed for 1 mg po qhs (every evening) prn (as needed) for anxiety/agitation." This order was written and signed by the physician on 12/23/16.

A review of the MAR (medication administration record) for December 2016 revealed RN #10's initials in two boxes for the Valium order stated above. One box contained the following information: [RN #10's initials], 1800 (6:00 p.m.) E (effective)." The other box contained the following information: [RN #10's initials], 2003 (8:03 p.m.) E (effective)."

A review of the nurses' notes for Resident #19 revealed the following:

- 12/24/16 at 8:39 p.m.: "Pt (patient) list of medications taken at home shows that pt take 100 mg of diazepam (Valium) every evening prior to bed. Coming from hospital, Pt was given half a 2 mg tablet which is 1% of her previous strength. Pt showed hostility to family by trying to hit them, throwing water at them and swearing at them when they came close. Family said they had mentioned discrepancy to Nurse upon admissions but stated they were told they would need a psychiatric consultation to get anything changed. Since the orders were as needed pt was given 8 addition (sic) mg of diazepam and after half an hour calmed down and talked normally with her daughter who is a nurse. Family will ask for psychiatric meeting and will contact Dr. (doctor) for further assistance on

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dosage. Family reported that Pt had been taking 100 mg of diazepam prior to bed for the last 8 years prior to her recent hospitalization." This note was signed by RN #10.

- 12/25/16 at 4:26 p.m.: "Home medication list and current medication list reviewed by this nurse with the patient and daughter, [name of daughter], at bedside. N.O. (new order) to discontinue Valium and to monitor patient for behaviors. New order received for psych (psychiatric) consult. Daughter, [name of daughter], is requesting to be notified the day of the psych consult so that she can come hear what the psychiatrist has to say. Patient is currently restringing (sic) in bed; noted to be drowsy but in pleasant mood. Denied headache at this time, denied SOB (shortness of breath). Primary nurse notified of new orders." This note was signed by RN #8, a care manager.

- 12/25/16 at 7:12 p.m.: "Pt [patient] is alert and oriented but lethargic at time (sic) and able to arouse for conversation when you get her up. Pt receiving skilled care r/t [related to] PNA [pneumonia]. Pt is able to verbalize needs know (sic) to staff. Pt continue (sic) to be monitored for increase (sic) lethargy and depression. Pt's husband and family have been here and kept her comfortable." This note was signed by LPN (licensed practical nurse) #11.

- 12/25/16 10:27 p.m.: "Pt has been stable, no adverse reactions noted." This note was signed by LPN (licensed practical nurse) #11.

- 12/26/16 at 11:28 a.m.: "Late Entry Note: Writer is clarifying an entry made on December 24, 2016 at 2039 (8:39 p.m.). Writer stated that

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pt takes 100 mg of diazepam every evening at home but upon reviewing the home medication reconciliation record, writer noted the pt takes 100 mg of trazadone (sic) (2) at home." This note was written by RN #8.

A review of Resident #19's comprehensive care plan dated 12/25/16 revealed, in part, the following: "[Resident #19] uses psychotropic medications r/t Behavior management, disease process, anxiety, major depression disorder...Administer medications as ordered. Monitor/document for side effects and effectiveness."

A review of the facility document "Controlled Medication Utilization Record" revealed, in part, the following: "Diazepam 2 mg Tablet 0.5 tab (tablet) (1 mg) by mouth daily at bedtime as needed for anxiety or agitation...12/24, 2100 (9:00 p.m.), Dose given - 8." This line of the document contained the initials of RN #10.

A review of laboratory test results for Resident #19 dated 12/27/16 revealed no evidence that any of the resident's results were critically high or low, as compared to the normal range.

A review of the facility's investigative file regarding this incident revealed a statement signed by RN #10 dated 12/25/16. Review of this statement revealed, in part, the following: "On December 24 I had rooms [number of rooms] on [name of unit]. At about 1700 (5:00 p.m.), I gave [Resident #19] who had been admitted the previous evening in [room number] 1 mg tablet of Diazepam. It was half of a 2 mg pill. The instructions were to give 1 mg at bedtime as needed for anxiety. Later that evening I was approached by a family group

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consisting of one of her daughters, a son-in-law, a grandson, her husband another male family member. They stated the pt had tried to hit them, swore at them, and threw cups of water at them. They said that she must be under medicated and that she had never acted like that at home. I told them I had given her 1 mg of Diazepam earlier and they stated she took larger doses of the medication at home. I asked them if that was the medication and they said yes. I asked if they had a list of medications they had given the hospital. No one had that so the one daughter began to call 2 other daughters who were nurses and ask them about the medication and the dosages. One did not answer the phone and the other did not have precise information. I volunteered that the doctor was being cautious. I also knew [name of another resident] had a prn for 5 mg of Diazepam every 8 hours for anxiety. The daughter here asked if the hospital had send (sic) over a list of medications she was taking when she entered the hospital. I said I would look in the [room number] folder. Looking through I saw the list of Home Medications. At the bottom of the page I saw Trazadone (sic) 100 mg tablet was on the list. The daughter was looking at the list too. Somehow in my mind I was thinking Diazepam. I asked how much the mother weighed. They said 180 lbs (pounds). Thinking that she had taken 100 mg Diazepam at bedtime in the past, I gave 8 additional mg and documented it in the Health Notes. I read the directions about giving one tablet at bedtime as needed but also interpreted as needed to mean more could be given if the 1 mg was not sufficient. Later another daughter (one of the nurses) arrived and said the mom seemed calm and did not need any more medication and that her mother was speaking normally. Later when I

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gave the 2100 (9:00 p.m.) medications the mother was pleasant and asked about separating the pills and applesauce when she received her morning meds. I said I would put a note on the med (medication) cart. Today when I came to work I talked to [name of RN #8] about getting an air mattress to help [name of another resident]'s pressure sore and also mentioned giving the 8 extra Diazepam to [Resident #19]. Now of course I understand the mistakes I made about interpreting the medication administration directions and that I also transposed the two different medications. I will double check the directions when I administer narcotics in the future follow them (sic). If I am not clear I will ask another experienced nurse. Also I think I have learned a lesson about believing everything a family member says about a situation without verifying it with the physician."

Further review of the investigative file revealed the document "Just Culture Investigation Documentation Form." The form was dated 12/29/16, and stated, in part: "[RN #10] administered an incorrect dose of Diazepam without a provider order to a patient, which resulted in a major medication error. The patient experienced a change in mental status and the dose of the Diazepam (8 mg) and the justification for administration is considered a chemical restraint to the patient. Nursing staff must follow provider orders and only administer medications for which they have an order for and within safe administration guidelines. [RN#10] should have clarified the order with the patient's attending provider before administering the dose of the medication. [RN #10] explained that she confused the dose of Diazepam with the patient's reported home dose of Trazadone (sic) and

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administered the medication based upon her own nursing judgment/interpretation of the written order. The patient's family and attending MD were notified. Patient was monitored for changes in health condition and lab (laboratory) work was obtained. Medication order was discontinued and changed to a safe dose range for the patient. [RN #10] was placed on administrative leave pending investigation."

On 6/28/17 at 11:30 a.m., RN #3 was interviewed. She worked in Resident #19's vicinity during 12/24/16 through 12/26/16. She stated she remembered Resident #19, but was never assigned to care for her, and did not remember any specifics about Resident #19.

On 6/28/17 at 11:32 a.m., CNA (certified nursing assistant) #3 was interviewed. She stated Resident #19 was "not with it." She stated she would lash out, especially with her family. She stated the resident's family "would come in and aggravate her." She stated she did not remember specifically anything about Resident #19 from 12/24/16 through 12/25/16.

Attempts to interview LPN #11 during the survey were unsuccessful.

On 6/28/17 at 11:40 a.m., RN #8 was interviewed. She stated: "[Resident #19] was a new admit. Her family was pushy and invasive." She stated she was not present in the building when RN #10 gave the incorrect dose of Valium to Resident #19. She stated RN #10 identified the medication error inadvertently during a conversation. RN #8 stated: "It happened on Saturday evening, and we identified it on Sunday. The nurse came and told me she'd had trouble on 12/24/16. She told

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me how she'd handled it. It was clear she had no idea what she had done." When asked about Resident #19's behaviors, RN #8 stated the resident experienced anxiety, frequent crying, and depression. She needed something prn, and the Valium was appropriately prescribed. This was a new nurse (referring to RN #10). She had struggled during orientation." She stated RN #10 thought the terms 'at hs (bedtime)' and 'as needed' were two separate instructions, and that she could give both. She stated: "[RN #10] also confused the Diazepam and the Trazodone. She did not call anyone for clarification." RN #8 stated when she began to understand what had happened, she looked at the resident's MAR, the narcotic count sheet, and the resident's supply of Valium in the medication card. RN #8 stated: "I verified what she had done, and I went to assess the resident." She stated Resident #19 was drowsy, but arousable and alert when awakened. She stated she called the physician, who told her to continue to monitor the resident closely for the next 12 hours or so. RN #8 stated: "Valium has a relatively short half-life, and we were on the end of that time frame." She stated the facility also arranged for a psychology consult for Resident #19 "very quickly."

On 6/28/17 at 1:15 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated that RN #10 had required an extended orientation, but she felt RN #10 was ready to work the floor. She stated that as soon as the facility staff became aware of the medication error, RN #10 was suspended. Ultimately, RN #10 was called back to the facility to meet with her (ASM #2) and representatives from human resources. She stated during this meeting, RN #10 resigned. At this time, ASM #2

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informed the surveyor that the facility had put an action plan in place to correct this deficiency. The surveyor requested a copy of the action plan, and of credible evidence that the facility had completed all points of the plan.

On 12/28/17 at 5:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, RN #2, a care manager, and RN #8 were informed of these concerns.

A review of the facility professional standard printout "Safe medication administration practices, long-term care" revealed, in part the following: To promote a culture of safety and prevent medication errors, nurses must adhere to the 'rights of medication administration:' identify the right resident...select the right medication, give the right dose, give the medication at the right time, give the medication by the right route, and provide the right documentation."
This information was printed from the website http://procedures.lww.com/lnp/view.do?pId=1970995&hits (a Lippincott website).

A review of the facility policy "Medication Procedure" revealed, in part, the following: "Medications will be given according to doctor's prescribed time and dosage...Medication dosage - check MAR for dosage, correct time and amount to be administered. Check dosage with medication dispensed by pharmacy for accuracy."

On 12/28/17 at 3:30 p.m., ASM #2 presented the surveyor with the document "QA (quality assurance) Action Plan." This document stated, in part, the following: "Medication error - psych med for resident w/ (with) behaviors. Corrective Action: 1. MD/RP notification for resident

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identified. New drugs received. Care plan updated. 2. Responsible nurse was educated and counseled. How other residents at risk for related non-compliance will be identified and what corrective actions will be taken: Review all residents receiving psych meds for change in condition, behaviors...Follow up as indicated. System Changes to maintain compliance: 1. Licensed nurses will be educated on medication administrations - avoiding errors. 2. Care manager or designee will review all residents with new psych meds [medications] and/or residents with behaviors assess and intervene as indicated. Monitoring for effectiveness of New Systems and Compliance: DON (director of nursing) or designee will audit 10% of residents receiving psych meds and conduct QA audit regarding medication admin (administration), physician order and clinical record. Review monthly X 3 months (for 3 months). Findings will be reported to QAPI (quality assurance performance improvement) committee monthly for review and adjust plan accordingly." At this time, ASM #2 also provided the surveyor with a file folder, which she stated contained the credible evidence that this plan had been implemented. A review of the credible evidence by the surveyor failed to reveal evidence of a complete audit by the facility staff of all residents receiving psychoactive medications at the time of the medication error. It also failed to reveal evidence of the monthly audits outlined in the plan. It also failed to reveal evidence that all licensed nurses had been educated regarding medication administration and order clarification as outlined in the plan. When asked about this, ASM #2 stated: "You are right. I cannot provide that evidence."

No further information was provided prior to exit.

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(1) "Diazepam (generic for Valium) is used to relieve anxiety, muscle spasms, and seizures and to control agitation caused by alcohol withdrawal." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682047.html.

(2) "Trazodone is used to treat depression. Trazodone is in a class of medications called serotonin modulators. It works by increasing the amount of serotonin, a natural substance in the brain that helps maintain mental balance." This information is taken from the website https://medlineplus.gov/druginfo/meds/a681038.html.

2. Resident #3's physician ordered medications to be administered prior to dialysis on Tuesday, Thursday, and Saturday. The facility staff failed to clarify the physicians order when the Resident #3's dialysis days were changed to Monday/Wednesday/Friday.

Resident #3 was admitted to the facility on 6/22/09 with a recent readmission on 12/20/16, with diagnoses that included but were not limited to: end stage renal disease requiring hemodialysis (a procedure used in toxic conditions and renal failure, in which wastes and impurities are removed from the blood by a special machine (1)), high blood pressure, dementia, stroke, depression, anxiety, and diabetes.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 6/4/17,

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coded the resident as having both short and long term memory difficulties and as being moderately impaired to make daily cognitive decisions. Resident #3 was coded as requiring extensive assistance of one or more staff members for dressing; as dependent of one or more staff members for transfers, moving in the bed, moving on the unit, toileting needs and bathing. The resident was coded as being independent in eating after set up assistance was provided.

The physician order dated, 3/10/17, documented, "Seroquel (an antipsychotic medication used to treat schizophrenia and bipolar disorder (2)) 25 MG (milligrams); Give 12.5 mg by mouth one time a day every Tue (Tuesday), Thu (Thursday), Sat (Saturday) for anxiety, administer prior to dialysis on Tuesday, Thursday, and Saturday."

A physician order dated, 6/9/17, documented, "Dialysis M/W/F (Monday/Wednesday/Friday) pick up via (name of transport company) at 0645 (6:45 a.m.); one time every Mon, Wed, Fri related to End Stage Renal Disease."

The June 2017 MAR (medication administration record) documented, Seroquel 25 MG; Give 12.5 mg by mouth one time a day every Tue, Thu, Sat for anxiety, administer prior to dialysis on Tuesday, Thursday, and Saturday." The MAR documented that the resident received the medication on the following days when she did not go to dialysis:
6/10/17 - Saturday
6/13/17 - Tuesday
6/15/17 - Thursday
6/17/17 - Saturday
6/20/17 - Tuesday
6/22/17 - Thursday

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F 281	Continued From page 84 6/24/17 - Saturday 6/27/17 - Tuesday Review of the clinical record documented the resident went to dialysis on 6/12/17, 6/14/17, 6/16/17, 6/19/17, 6/21/17, 6/23/17, 6/26/17 and 6/28/17. The comprehensive care plan dated, 1/24/14 and revised on 6/28/17, documented in part, "Focus: (Resident #3) receives antipsychotic medications for treatment of bipolar depression and antianxiety medication for management /treatment of anxiety." The "Interventions" documented in part, "Administer antidepressant and bipolar medications per MD order or new order see MARs, monitor for effectiveness as well as for side effects." The Psychiatry Nurse Practitioner Note dated, 6/29/17 documented in part, "Diagnosis: Vascular dementia with behavioral disturbance, anxiety disorder secondary to medical condition, and major depression, mild without psychotic features....last visit pt (patient) Seroquel increased due to continued bhvl (behavioral) issues, pt has improved for symptoms however staff reports lethargy on the off days of HD (hemodialysis)." An interview was conducted with LPN (licensed practical nurse) #1, a nurse that works with Resident #3 frequently, on 6/29/17 at 7:15 a.m. When asked what Seroquel is used for, LPN #1 stated, "It's for agitation and mood disorder changes." When asked what day Resident #3 goes to dialysis, LPN #1 stated, "Monday, Wednesday, and Friday. She used to be Tuesday, Thursday and Saturday." When asked	F 281		

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what medications Resident #3 was to receive prior to dialysis, LPN #1 stated, "The night shift gives her Ativan before she gets picked up." When asked if dialysis reported any concerns recently with her behavior on dialysis days, LPN #1 stated, "Most of the time the Ativan works." When asked what class of medication Seroquel is, LPN #1 stated, "I can't tell you, I'd have to look it up." The above physician order for Seroquel was reviewed with LPN #1. LPN #1 stated, "That needs to be changed." When informed that she had given the medication on her non-dialysis days, LPN #1 stated, "I didn't follow the five rights of medication administration."

On 6/29/17 at 7:18 a.m., an interview was conducted with RN (registered nurse) #2, the care manager for the unit Resident #3 resides on. When asked what days Resident #3 goes to dialysis, RN #2 stated, "Monday, Wednesday and Fridays." When asked what class of drug is Seroquel was, RN #2 stated, "It's an antipsychotic, for her it's given for her dementia symptoms." When asked why Resident #3 was receiving Seroquel prior to dialysis, RN #2 stated, "The Ativan (an anti-anxiety medication (3)) wasn't helping. (Name of physician) decided to add the Seroquel to the mix." When asked if Resident #3 was followed by psychiatry, RN #2 stated, "Yes." The physician orders documented above for the Seroquel were reviewed with RN #2. RN #2 stated, "When her dialysis days were changed, the Seroquel order wasn't changed." When asked if that order should have been clarified, RN #2 stated, "Yes, 100%." When asked if she understood why this surveyor was questioning this order, RN #2 stated, "She's getting an unnecessary medication, it's not being given when it was ordered."

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RN #2 returned to this surveyor on 6/29/17 and stated, "The Seroquel was ordered by the dialysis doctor. I called the dialysis center and they have not had any concerns for her behavior since changing to Monday, Wednesday and Friday and she's not been getting the Seroquel before then. I called (name of physician) and he discontinued the Seroquel."

The policy "Psychoactive Medication Management and Behavior Monitoring" did not address the above issue.

In Fundamental of Nursing, 5th edition, Lippincott, Williams and Wilkens, page 564 documented, "Five Rights of Medication Administration: Right client, right medication, right dose, right time and right route."

At the end of the day meeting on 6/28/17 at 5:50 p.m. the director of nursing, ASM (administrative staff member) #1, was asked which standard of practice they used at the facility, ASM #1, the director of nursing stated they used Fundamentals of Nursing by Lippincott. She was asked to provide a copy of their standard for clarifying physician orders.

The administrator and director of nursing were made aware of the above concern on 6/29/17 at 1:15 p.m.

The document provided by the director of nursing on 6/29/17 at approximately 10:10 a.m. did not address clarifying a physician order. Though it did document, "Safe medication administration practices include: following the 'rights' of medication administration (right patient, drug,

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route, time, dose documentation, action, form and response (4))."

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 266.
(2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011909/?report=details
(3) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010988/?report=details.
(4) This information was obtained from the following website: http://procedures, lww.com/lnp/viw.do?pId+3480317 &hits=ordering, medication, order.

3. For Resident #2, facility staff failed to transcribe a physician's order to increase the frequency of a blood pressure medication onto the physician order sheet on 5/15/17.

Resident #2 was admitted to the facility on 9/25/2015 with diagnoses that included but were not limited to: syncope/collapse, high blood pressure, failure to thrive, heart failure, peripheral vascular disease, and dementia without behavioral disturbance. Resident #2's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/4/17. Resident #2 was coded as being moderately cognitively impaired in the ability to make daily decisions scoring 11 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #2 was coded

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as requiring supervision only with transfers, ambulation, personal hygiene, and locomotion; and independent with meals.

Review of Resident #2's clinical record revealed a Pharmacy Consultation Report dated 4/13/17 that documented the following: "(Name of Resident #2) has been receiving Coreg (Carvedilol [1]) 6.26 mg (milligrams) daily. This medication is usually given twice a day. Blood pressures have been between 189/67 to 120/72 for January through today.

Recommendation: Please re-evaluate and if this medication is to continue daily document that the benefit is greater than the risk for this resident. "

A check mark was placed next to the following option by the physician: "I have re-evaluated this therapy and wish to implement the following changes: Increase Coreg to BID (two times a day)." The recommendation was signed by the physician on 5/15/17.

Review of the physician telephone orders for May 2017 revealed that this order was never implemented.

Review of Resident #2's May 2017 MAR (Medication Administration Record) revealed that Resident #2 continued to receive Coreg 6.25 mg daily until 5/23/17 when Resident #2 was sent to the hospital for a UTI (Urinary Tract Infection).

Review of Resident #2's blood pressures under the vital sign tab of the POC documented one blood pressure reading between 5/15/17 and 5/23/17. The following blood pressure was documented on 5/16/17: 142/84.

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F 281	Continued From page 89 On 6/29/17 at 7:52 a.m., an interview was conducted with LPN (licensed practical nurse) #1, the nurse who works with Resident #2. When asked about the process staff follows when pharmacy makes a medication recommendation, LPN #1 stated that nursing will get the fax from pharmacy and then nursing will fax the recommendation to the physician. Once the physician signs the recommendation, he/she will fax the signed recommendation over to the facility with any new orders written on the sheet. The nurse on the floor, who receives the fax, will then enter any new orders into the computer system. LPN #1 stated that she had never seen the above pharmacy recommendation. LPN #1 stated that the order was never implemented. LPN #1 stated that Resident #2 went out to the hospital on the 23rd of May but the order should have been implemented before that. LPN #1 stated that the hospital had discontinued her Coreg. On 6/29/17 at 3:13 p.m., an interview was conducted with LPN #8. When asked about the process staff follows when the pharmacy makes a medication recommendation, LPN #8 stated that when nursing receives a fax from pharmacy with the recommendation, nursing will send the recommendation to the physician where he or she will deny or accept the recommendation. If the physician writes a new order on the recommendation, nursing is responsible for transcribing the order into the computer system. LPN #8 stated that she would have clarified the order for Coreg because a dose was not documented on the physician's order. LPN #8 stated that the order was never implemented. LPN #8 did not recall ever seeing the above pharmacy recommendation.	F 281		

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F 281	Continued From page 90 On 6/29/17 at 4:50 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. ASM #2 stated that the facility uses Lippincott as a professional standard of practice. The facility policy titled, "Telephone Orders," documents in part the following: "It is the policy of this facility to accept verbal, telephone and fax orders from attending physician and other physicians who are credentialed and privileged for clinical privileges. Procedure: ...Order communicated by fax may be utilized as the telephone order and scanned into the EMR (electronic medication record), after the order is entered in the EMR and "Physician Pharmacy Order" form is printed and faxed to pharmacy." [1] Coreg is used to alone or in combination with other medications to treat high blood pressure. This information was obtained from The National Institutes of Health. http://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009479/?report=details.	F 281		
F 282 SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care.	F 282		8/13/17

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F 282	Continued From page 91 This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and facility document review and clinical record review, it was determined that facility staff failed to follow the written plan of care for two of 29 residents in the survey sample, Resident #8 and #25. 1. The facility staff failed to follow Resident #8's comprehensive plan of care and ensure he was receiving showers three times per week. 2. The facility staff failed to follow Resident #25's comprehensive plan of care and transfer the resident into her wheelchair by 11:00 a.m. and back into bed at 4:00 p.m. The findings include: 1. The facility staff failed to follow Resident #8's comprehensive plan of care and ensure he was receiving showers three times per week. Resident #8 was admitted to the facility on 6/2/17 with diagnoses that included but were not limited to non-infective gastroenteritis, colitis, cerebral palsy, high blood pressure, constipation, and chronic lower back pain. Resident #8's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 6/7/17. Resident #8 was coded as being severely cognitively impaired in the ability to make daily decisions scoring 00 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #8 was coded as requiring total dependence on staff with two plus persons with transfers; extensive assistance from two plus	F 282	1. Resident #8 received a shower on 6/29/17. Care plan and kardex was updated to include showers 3 times weekly. Resident #25 was interviewed regarding preference of getting up on 7/20/17, care plan updated to reflect resident preference. 2. All residents will be reviewed to ensure each residents' care plan and kardex reflects assistance needed and preference for the ADL status, including showers and mobility status. 3. All nursing staff will be re-educated on providing ADL care per the care plan and kardex. Education will include documentation requirements for care provided and refusals. 4. Care manager or designee will audit ADL records to ensure ADL care provided is documented in the medical record. Care manager or designee will audit 10% of ADL records on a weekly basis for 30 days, then monthly for 60 days. Issues identified will be addressed, including revisions to the plan of care, staff re-education and/or counseling as necessary. Results of audits will be present to the QAPI committee for further guidance or instruction.	

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persons with bed mobility; extensive assistance with one person physical assist with dressing and personal hygiene, and total dependence on one person with toileting.

Review of Resident #8's current care plan revised 2/12/17, documented the following intervention under ADL (activities of daily living) care: "(Name of Resident #8) will be showered 3x (times) a week." This intervention was initiated on 12/08/2010.

Review of Resident #8's ADL record for June 2017 revealed that Resident #8 was showered or bathed on 6/16/17. "Not applicable" was documented on the ADL record for 6/4/17, 6/7/17, 6/14/17, 6/18/17, and 6/22/17 under the bathing section.

On 6/28/17 at 4:24 p.m., an interview was conducted with CNA (certified nursing assistant) #11, a CNA who works with Resident #8. When asked how often a resident should be showered, CNA #11 stated, "Two times per week." When asked what "N/A's" meant on the ADL sheet for bathing, CNA #11 stated that it probably meant that the resident was not supposed to receive a shower that day. When asked how to determine whether the resident received a bed bath or shower under the bathing section, CNA #11 stated, "It doesn't differentiate that." When asked when Resident #8 was supposed to receive showers, CNA #11 stated that the POC (point click care) task manager should specify shower days. This writer followed CNA #11 to the nursing station to find out Resident #8's shower days. RN #1, the MDS coordinator, assisted CNA #11 with that information. RN #1 stated, "It doesn't say. It is not in the POC how many times he is supposed

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to get a shower."

On 6/28/17 at 4:34 p.m., RN (registered nurse) #2, the care manager started to search for Resident #8's shower days. RN #2 looked at the POC and stated, "It is Wednesday/Saturdays night shift." When asked if she could look at Resident #8's care plan under the ADL section, RN #2 looked at the care plan and stated, "Yup. He is supposed to get showers three days a week according to the care plan." When asked who was responsible for updating the care plan and POC task manager, RN #2 stated that she was responsible. When asked how many times Resident #8 was showered in the past month (June 2017), RN #2 stated, "It looks like he has gotten one shower in the past month."

The facility policy titled, "Assessment and Care of Patient/Resident Through the Plan of Care," documents in part, the following: "All patients/residents hereafter referred to as resident admitted to (Name of Facility) are required to have an assessment of care needs made by each discipline. The goal of the assessment of residents function is to determine what kind of care is required to meet a patient/resident's initial needs, as well as the needs as they change in response to care..."

2. The facility staff failed to follow Resident #25's comprehensive plan of care and transfer the resident into her wheelchair by 11:00 a.m. and back into bed at 4:00 p.m.

Resident #25 was admitted to the facility on 10/27/16 with diagnoses that included but were not limited to rheumatoid arthritis, osteomyelitis,

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right ankle and foot PVD (peripheral vascular disease), and anxiety disorder. Resident #25's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 5/6/17. Resident #25 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #25 was coded as requiring total dependence on two or more staff with transfers, dressing, locomotion on and off the unit, and toileting. Resident #25 was coded as requiring extensive assistance from staff with bed mobility.

On 6/27/17 at 3:00 p.m., an observation was made of Resident #25. She was groomed and dressed and lying in bed.

On 6/28/17 at 9:11 a.m., an observation was made of Resident #25. She was lying in bed. She was not yet groomed or dressed for the day.

On 6/28/17 at 1 p.m., an observation was made of Resident #25. She was lying in bed groomed and dressed.

On 6/28/17 at 4 p.m., an observation was made of Resident #25. She was lying in bed in bed groomed and dressed.

On 6/29/17 at 9:34 a.m., an observation was made of Resident #25. She was not in her room.

Review of Resident #25's ADL care plan dated 11/4/16 and revised 4/21/17 documented the following: "(Name of Resident #25) has an ADL self-care performance deficit r/t (related to) Osteomyelitis, Rheumatoid arthritis and Pain... (Name of Resident #25) has impaired trunk

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strength as well as endurance r/t (related to) to immobility and pain....Goal: (Name of Resident #25) will improve current level of function in Bed mobility, transfers, dressing, toilet use, and personal hygiene through next review date. Date initiated: 11/04/16. Revision on: 04/27/17 Target date: 07/26/17...(Name of Resident #25) will be out of bed daily for significant amount of time (goal of 5 hours/day) to improve her trunk strength and her endurance. Date initiated: 04/21/17. Revision on: 4/27/17. Target Date: 07/26/17...Interventions: "(Name of resident #25) to be up in chair beginning at 10:00 AM, in her chair by 11: 00 AM; return to bed at 4:00 PM. Date initiated 4/21/17."

Further review of the care plan dated 11/4/16 and revised 4/21/17, did not document that Resident #25 was non-compliant with getting out of bed.

Review of the June 2017 nursing notes did not reveal that the Resident #25 had refused to get out of bed on 6/29/17.

Review of the June 2017 ADL tracker for 6/29/17 failed to show any documentation of Resident #25's transfer status out of bed.

On 6/28/17 at 9:11 a.m., an interview was conducted with Resident #25. When asked if she likes to get out of bed, Resident #25 stated that she is never offered to get of out the bed. Resident #25 stated that she used to do physical therapy but is now lying in bed filling up "empty space." Resident #25 stated that she does not ask to get out of bed. Resident #25 stated that she thought she was supposed to get up for a few hours a day but she never gets up. When asked if she ever refuses to get out of bed, Resident

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#25 stated that staff never asks for her to refuse.

On 6/28/17 at 4 p.m., further interview was conducted with Resident #25. Resident #25 stated that no one had offered her to get out of bed that day. Resident #25 stated that she would have liked to get out of bed. When asked if she had asked to get out of bed, Resident #25 stated, "No."

On 6/29/17 at 11:01 a.m., an interview was conducted with NA (nursing assistant) #10, Resident #25's NA on 6/28/17. When asked if Resident #25 is supposed to get out of bed, NA #10 stated, "In her care plan she is supposed to get out of bed before 11:00 (AM) and until about 4 or 5 (PM). I offer her every morning and sometimes she will say ok but sometimes she will tell me no." When asked if this refusal is documented anywhere, NA #10 stated, "I let the nurse know. Maybe they write it in their notes. She started refusing me yesterday morning for her care so I am not sure if the other CNA offered to get her out of bed."

On 6/29/17 at 11:10 a.m., an interview was conducted with LPN (licensed practical nurse) #9, Resident #25's nurse on 6/28/17. When asked if Resident #25 ever gets out of bed, LPN #9 stated, "Yes. She will get out of bed. She refuses a lot or makes an excuse sometimes. When asked if her refusals should be documented in the clinical record, LPN #9 stated that refusals should be documented if the nursing aides tell the nurses. When asked if Resident #25 was in a restorative nursing program, LPN #9 stated, "I don't think so." LPN #9 stated that she thought Resident #25 was supposed to be out of her bed by 11:00 a.m., but she didn't know. LPN #9

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stated that the resident will say that she wants to get out of bed and then she will change her mind. LPN #9 could not recall if she was made aware of Resident #25 refusing to get out of bed on 6/28/17.

On 6/29/17 at 12:14 p.m., an interview was conducted with RN (registered nurse) #4, the case manager. When asked if Resident #25 had special instructions to get out of bed, RN #4 stated that Resident #25 was supposed to be out of bed every day at 11:00 a.m. until about 4 p.m. When asked if Resident #25 gets out of bed, RN #4 stated, "Most of the time she does unless she refuses." When asked if refusals are documented, RN #4 stated, "I try to document if I know about it. Most days she is up."

On 6/29/17 at 12:30 p.m., an interview was conducted with CNA (certified nursing assistant) #15, the CNA who took over care on 6/28/17. When asked if she had offered Resident #25 to get out of bed on 6/28/17, CNA #15 stated, "Before I could ask her to get out of bed, she said she didn't want to." When asked if she had notified the nurse that the resident did not want to get out of bed, CNA #15 stated that she didn't think so. CNA #15 stated that she didn't know the resident had to be out of bed because she did not work with the resident every day. When asked where CNAs can find out information on a resident's needs, CNA #15 stated that they look at the Kardex that is located in the closet door for each resident. A copy of the Kardex was requested.

Review of Resident #25's current Kardex failed to reveal directions for Resident #25 to get out of bed at 11:00 a.m. and to be put back into bed at 4

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F 282	Continued From page 98 p.m. On 6/29/17 at 4:50 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit.	F 282		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 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,	F 309		8/13/17

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F 309	Continued From page 99 and the residents' goals and preferences. (I) 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 clinical record review, staff interview, family interview, and facility document review, it was determined that the facility staff failed to follow physician's orders for one of 29 residents in the survey sample; Residents #6. The facility staff failed to obtain a urology consult for Resident #6 as ordered by the physician at the time of admission on 5/12/17. The findings include: Resident #6 was admitted to the facility on 4/27/17, readmitted on 5/12/17 and readmitted on 6/21/17 with diagnoses that included, but were not limited to, stroke, sepsis (a blood stream infection), high blood pressure, abrasion of the penis, diabetes, urinary retention, chronic kidney disease, BPH (benign prostatic hyperplasia - an enlarged prostate gland), and difficulty swallowing. Resident #6's most recent comprehensive MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 5/19/17. Resident #6 was coded as scoring a two out of a possible 15 on the BIMS (brief interview for mental status) in Section C, Cognitive Patterns, indicating that Resident #6	F 309	1. Resident #6 was scheduled a urology appointment on 7/7/2017. RP of notified of appointment on 7/7/17. 2. All residents have the potential to be affected by this deficient practice. 3. Nursing staff and social services will be re-educated on following physician orders, including notification of social services or administration of services needed, such as appointments or consults, to maintain their highest well-being. Social services will assist with coordination of care to ensure medically related services are provided for each resident. Care manager or designee will review new admission orders and 24 hour report M-F in clinical stand up meeting for physician orders and follow up appointments are scheduled as ordered. Issues identified will be corrected immediately. 4. 24 hour report and new admission orders will be reviewed M-F by the clinical team to address changes in resident condition and physician orders. DON or designee will audit 25% of 24 hour reports and new	

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F 309	Continued From page 100 was severely cognitively impaired in daily decision making. In Section G, Functional Status, Resident #6 was coded as being totally dependent of two people for bed mobility and transfers. Resident #6 was coded as being totally dependent of one person for toilet use. A review of Resident #6's discharge summary from the hospital dated 5/12/17 documented the following; "Urinary retention. Likely due to BPH. Appreciate urology input, (name of urologist). Recommendations to get post voiding residual. Patient is off Foley catheter for now 48 hours. Intermittently continues to retain urine on bladder scan. We'll try to avoid reinsertion of Foley catheter unless absolutely indicated." No further instructions were provided in regards to a Foley catheter at discharge. A review of Resident #6's "Order Summary Report" revealed, in part, the following order dated 5/12/17 on admission to the facility, signed and dated by the physician on 5/15/17; - "f/u (follow up) Urology every day shift for urinary retention and Foley catheter. Please put appointment date/time/transportation information in new order and d/c (discontinue) this order once complete. Communication Method: Phone. Order Status: Active. Order Date: 5/12/17. Start Date: 5/13/17." Review of the clinical record failed to reveal any evidence that the facility attempted to obtain a urology appointment between the date of admission on 5/12/17 and the date of discharge on 5/29/17. A review of Resident #6's physician progress	F 309	admission orders weekly for 30 days, then 10% monthly for 60 days to ensure follow up appointments and other issues are addressed. Results of audits will be reviewed by the QAPI committee for further guidance or instruction.	

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notes did not reveal any further documentation regarding a urology consult to be done.

A review of Resident #6's nurse practitioner notes revealed, in part, the following documentation; "5/23/17 + Foley catheter. F/U (follow up) with urology (name of urologist) as able to."

A review of Resident #6's TAR (treatment assessment record) revealed, in part, the following orders;
- "16 French Foley placed 5/12/17 change q (every) 30 days every evening shift every 30 days. Start Date 5/13/2017 D/C date 6/21/2017." Under the column for 5/13/17 there was a check mark and nurse's initials, indicating that this order was completed.

- "f/u Urology every day shift for urinary retention and Foley catheter. Please put appointment date/time/transportation information in new order and d/c (discontinue) this order once complete. Start date: 5/13/2017 D/C date 6/21/2017." Under the columns for 5/13/17 through 5/31/17 there were check marks for each date along with nursing initials for all dates except for 5/20/17, 5/23/17, 5/30/17 and 5/31/17.

A review of Resident #6's comprehensive care plan dated 5/13/17 revealed, in part, the following documentation; "Focus: (Name of Resident #6) has alteration in self-care related to CVA (cerebral vascular accident - stroke) with left side hemiplegia (paralysis), weakness, abnormality of gait and mobility. Date Initiated: 5/13/2017. Revision on: 5/13/2017. Interventions/Tasks: Toileting: Patient has Foley catheter and requires Foley care q shift. Date Initiated: 5/13/17." There was no further documentation in the care plan

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F 309	Continued From page 102 referring to an order for a urology consult. On 6/29/17 at approximately 10:00 a.m. a meeting was conducted with ASM (administrative staff member) # 1, the administrator and ASM #2 the director of nursing. ASM #1 and ASM #2 were made aware of the concern at this time that Resident #6 had not been provided a urology consult as ordered by the physician. ASM #1 and ASM #2 were asked if they were aware that Resident #6 was ordered to have a follow up appointment with an urologist. ASM #1 and ASM #2 stated that they were aware but because they were unable to reach the RP (responsible party) the follow up did not occur. A policy was requested at this time that referenced obtaining consults and following the physician orders. No further information was provided prior to the end of the survey process.	F 309		
F 311 SS=D	TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS CFR(s): 483.24(a)(1) (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide a restorative nursing program for one of 29 residents in the survey sample, Resident #25.	F 311	1. Resident #25 will be evaluated for a restorative nursing program with care plan updated as indicated. 2. All residents not receiving therapy services will be evaluated for restorative	8/13/17

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F 311	Continued From page 103 The facility staff failed to provide a restorative nursing program to Resident #25 when she was discontinued from physical therapy on 1/30/17. The findings include: Resident #25 was admitted to the facility on 10/27/16 with diagnoses that included but were not limited to: rheumatoid arthritis, osteomyelitis, right ankle and foot PVD (peripheral vascular disease), and anxiety disorder. Resident #25's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 5/6/17. Resident #25 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #25 was coded as requiring total dependence on two or more staff with transfers, dressing, locomotion on and off the unit, and toileting. Resident #25 was coded as requiring extensive assistance from staff with bed mobility. Section O (Special Treatments, Procedures, and Programs) of Resident #25's quarterly MDS dated 5/6/17 documented all "0" zeros under section "O0500. Restorative Nursing Program" indicating restorative nursing was not performed during the look back period. Review of Resident #25's physical therapy discharge summary dated 1/30/17 documented in part, the following information: "Discharge Recommendations: We are recommending the following: 1. 24/7 care 2. restorative (sic) nursing program (RNP) while pt (patient) is here at (Name of facility); 3. home-health (sic) PT	F 311	nursing with care plan updated as indicated. 3. Nursing staff, including the clinical team, will be re-educated on RNP to ensure resident's maintain or improve ADL functional abilities. Restorative nursing provided or refusals will be documented in the clinical record. MDS coordinator or designee will oversee the Restorative Nursing Program. 4. DON or designee will audit residents on a RNP to ensure care is provided and documented. DON or designee will audit 25% of residents on a RNP weekly for 30 days, then audit 10% of residents on a RNP monthly for 60 days. Issues identified will be addressed, including care plan revision, staff re-education, or counseling as needed. Results of audits will be reviewed by the QAPI committee for further instruction.	

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(physical therapy), OT (occupational therapy) and nursing (if/when pt (patient) returns home).
RNP/FMP (Restorative Nursing Program/Functional Maintenance Program): For her last week of physical therapy, for nursing/CNA (certified nursing assistant)/caregiver training, placed emphasis on Hoyer [1] lift for transfers and emphasis on RNP for the following: 1. bed (sic) mobility and 2. transfers (sic) with hoyer lift. I have instructed nursing/CNAs not to attempt sliding board and/or stand-pivot transfers."

Review of Resident #25's Rehabilitation/Restorative Care Recommendation sheet dated 1/25/17, documented in part, the following: "Rehabilitative or restorative care refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimum physical, mental, and psychosocial functioning. Restorative nursing does not require a physician's order. The restorative activity must occur for a minimum of fifteen minutes within a 24 hr (hour) period for six days of the seven. The restorative program must be written by a licensed health professional and have daily documentation with monthly evaluations on the Nursing Monthly Summary Sheet. The program also must be documented in the care plan. Restorative programs are documented in the care tracker. Please check the type of program..."
A check mark was placed next to option: "Transfer (Hoyer Lift) and "Bed mobility."

Further review of Resident #25's Rehabilitation/Restorative Care recommendation sheet documented the following information:

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"Program 1...Goal: allow pt (patient) to participate in bed mobility and ADLS (activities of daily living) (bathing, dressing) in bed. MAX (assist) + (plus) 1-2 (persons)...Program 2: Problem: Pt is total assist for transfer for wheelchair to bed. Goal: Maintain pt's tolerance sitting in wheelchair, out of bed. Intervention: Prefers transfer with Hoyer lift."

Review of Resident #25's current POS (physician order sheet) dated 5/31/17 documented the following order: "Discharge patient from Physical Therapy service with RNP (fro (sic) bed mobility and Hoyer lift transfers) to follow." This order was initiated on 1/31/17.

Review of Resident #25's ADL (Activities of Daily Living) care plan dated 11/4/16 and revised 4/21/17 documented the following: "(Name of Resident #25) has an ADL self care performance deficit r/t (related to) Osteomyelitis, Rheumatoid arthritis and Pain...(Name of Resident #25) has impaired trunk strength as well as endurance r/t to immobility and pain....Goal: (Name of Resident #25) will improve current level of function in Bed mobility, transfers, dressing, toilet use, and personal hygiene through next review date. Date initiated: 11/04/16. Revision on: 04/27/17 Target date: 07/26/17...(Name of Resident #25) will be out of bed daily for significant amount of time (goal of 5 hours/day) to improve her trunk strength and her endurance. Date initiated: 04/21/17. Revision on: 4/27/17. Target Date: 07/26/17...Interventions: "(Name of resident #25) to be up in chair beginning at 10:00 AM, in her chair by 11: 00 AM; return to bed at 4:00 PM. Date initiated 4/21/17.

Further review of Resident #25's care plan failed to reveal a care plan that addressed restorative

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nursing.

Review of Resident #25's clinical record failed to reveal daily and quarterly restorative nursing notes. There was no evidence in the clinical record of a restorative nursing program for Resident #25.

Review of Resident #25's June 2017 ADL tracker revealed that Resident #25 was being transferred out of the bed 3-4 times per week (7 days) with extensive assistance of two or more staff members. There were several times on the ADL tracker that Bed mobility was not documented.

On 6/28/17 at 9:11 a.m., an interview was conducted with Resident #25. When asked if she likes to get out of bed, Resident #25 stated that she is never offered to get of out the bed. Resident #25 stated that she used to do physical therapy but is now "lying in bed filling up empty space." Resident #25 stated that she does not ask to get out of bed. Resident #25 stated that she thought she was supposed to get up for a few hours a day but she never gets up.

On 6/29/17 at 10:12 a.m., an interview was conducted with OSM (other staff member) #3, the therapy director. When asked the about the process followed when a resident is discharged from physical therapy and restorative nursing therapy is recommended, OSM #3 stated that restorative therapy is recommended for residents to maintain their current level of function. OSM #3 stated that therapy will make the recommendation for restorative nursing and then nursing will take it from there. OSM #3 stated that restorative nursing notes should be documented in the clinical record.

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On 6/29/17 at 11:01 a.m., an interview was conducted with NA (nursing assistant) #10, Resident #25's NA on 6/28/17. When asked if Resident #25 is supposed to get out of bed, NA #10 stated, "In her care plan she is supposed to get out of bed before 11:00 (AM) and until about 4 or 5 (PM). I offer her every morning and sometimes she will say ok but sometimes she will tell me no." When asked if this refusal is documented anywhere, NA #10 stated, "I let the nurse know. Maybe they write it in their notes. She started refusing me yesterday morning for her care so I am not sure if the other CNA offered her to get out of bed." When asked if Resident #25 was on a restorative nursing program, NA #10 stated, "I believe so, I am not sure. I can ask."

On 6/29/17 at 11:10 a.m., an interview was conducted with LPN (licensed practical nurse) #9, Resident #25's nurse. When asked if Resident #25 ever gets out of bed, LPN #9 stated, "Yes. She will get out of bed. She refuses a lot or makes an excuse. When asked if her refusals should be documented in the clinical record, LPN #9 stated that refusals should be documented if the nursing aides tell the nurses. When asked if Resident #25 was in a restorative nursing program, LPN #9 stated, "I don't think so." LPN #9 stated that she thought Resident #25 was supposed to be out of her bed by 11:00 a.m., but she didn't know. When asked who the restorative aides were, LPN #9 stated that right now they didn't have one and that the bedside aide was supposed to be providing restorative nursing care. LPN #9 stated, "They have a lot of their plate right now." LPN #9 stated that restorative nursing should be documented under

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the ADL section of the care tracker.

On 6/29/17 at 12:14 p.m., an interview was conducted with RN (registered nurse) #4, the care manager. When asked who the current restorative aides were, RN #4 stated that she was aware of two CNAs who act as the restorative aides when they are not assigned to their own set of residents. RN #4 stated that the CNAs assigned to the residents perform restorative nursing care when the restorative aides were on the floor. When asked where restorative nursing is documented, RN #4 stated that restorative nursing is documented when the CNAs provide ADL care. ADL care is then documented in the ADL tracker.

On 6/29/17 at 2:20 p.m., an interview was conducted with RN (registered nurse) #1, the MDS coordinator, ASM (administrative staff member) #1, the administrator, and ASM #2, the Director of Nursing. When asked who was responsible for supervising the restorative nursing program, ASM #1 stated that there was an MDS coordinator that was supervising the restorative nursing program. ASM #1 stated that therapy initiates the restorative nursing program and the MDS coordinator oversees the program. RN #1, the MDS coordinator was asked if she is overseeing the restorative nursing program. RN #1 stated, "At this point I haven't been." RN #1 stated the charge nurse should be checking the restorative nursing program. When asked about the process followed by staff if a resident is placed on restorative nursing, ASM #2 stated the order is put into the system along with the restorative recommendation form. ASM #2 stated that restorative nursing is documented under the "task" section in POC (point click care) so the

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CNAs know that the resident is on a restorative nursing program. ASM #2 stated that the CNAs are then given restorative nursing training and they sign off that they understand the training. When asked who the restorative CNAs were at this time, ASM #2 stated that the restorative CNAs are usually pulled to the floor and they currently do not have one. ASM #2 stated that the CNA assigned to the resident at that time was responsible for restorative nursing care. When asked where restorative nursing was documented, ASM #1, ASM #2 and RN #1 stated that there was not a special section for restorative nursing on the care tracker, but it was to be included in the daily ADL report. When asked why a resident would be put on a restorative nursing program for transferring with a hoyer lift, ASM #2 stated, "They probably shouldn't be." Evidence that all CNAs were educated on restorative nursing was requested.

On 6/29/17 at 2:20 p.m., ASM #1, the administrator and ASM #2, the Director of Nursing were made aware of the above concerns. Evidence could not be provided that all CNAs were trained on the Restorative Nursing Program.

The facility policy titled, "Restorative Nursing," documents in part the following: "Purpose: Restorative nursing care refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently as safely as possible. This concept focuses on achieving and maintaining optimum physical, mental and psychosocial functioning. Restorative interventions include repetition, physical, or verbal cueing, and task segmentation provided by a trained staff member or volunteer under the

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supervision of a licensed nurse. These interventions center on bed mobility, transfer walking, dressing, grooming, eating or swallowing, amputation, or prosthesis cared, splint or brace assistance application of continuous passive motion (CPM), communication, active and passive range of motion, any scheduled toileting program and bladder retraining program. Procedure:

1. A licensed nurse, rehabilitation therapist, and/or physician evaluate the resident for the benefit of participating in a restorative program. Potential need for restorative programs may also be identified through analysis of the MDS triggers, quality indicators, from a facility focused committee such as falls, weight, or risk committee, and from the interdisciplinary care plan team.

2. The restorative program is written with measurable objectives and interventions. The program is identified in the resident's care plan with tasks assigned in POC (point click care) for CNAs to carry out.

3. The program is provided by a trained Certified Nursing Assistant, volunteer or other staff member who has received training in the specifics of the restorative program.

4. The program is supervised by the Director of Nursing or designated licensed nurse.

5. The program is given for fifteen minutes a day and can be given in segments, such as five minutes for three times in a twenty four hour period. It must be given for at least six days out of the seven days. The provider of the program

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F 311	Continued From page 111 must document the program on a daily basis for the amount of time given. 6. Evaluation of the program must be done on a periodic basis by a licensed nurse who evaluates the resident's response to the program. This is part of the medical record. 7. The care plan team can also reassess the restorative program as part of the care plan review. 8. The restorative program can be provided to a group of four or less per supervised caregiver or CNA. " No further information was presented prior to exit. [1]Maxi Move (Trademark) Hoyer lift- According to the manufacturer's instructions the Maxi Move hoyer lift is a mobile patient lifter and is used for transferring patients from bed or chair to the toilet or bath.	F 311		
F 312 SS=D	ADL CARE PROVIDED FOR DEPENDENT RESIDENTS CFR(s): 483.24(a)(2) (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide assistance with ADLS (activities of daily living) for	F 312	1. Resident #8 received nail care on 6/29/17. 2. All residents will be reviewed to ensure	8/13/17

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F 312	Continued From page 112 one of 29 residents in the survey sample, (Resident #8) who was coded as totally dependent on staff for personal hygiene. The facility staff failed to ensure Resident #8's fingernails nails were trimmed and free from black debris or dirt. Observations of Resident #8 during the survey revealed Resident #8's nails on both hands were long and his pointer, middle and index finger on both hands appeared to have black dirt or debris underneath the distal edge of the nail plate [1]. The findings include: The facility staff failed to ensure Resident #8's fingernails nails were trimmed and free from black debris or dirt. Observations of Resident #8 during the survey revealed Resident #8's nails on both hands were long with black dirt or debris underneath the distal edge of the nail plate. Resident #8 was admitted to the facility on 6/2/17 with diagnoses that included but were not limited to: non-infective gastroenteritis, colitis, cerebral palsy, high blood pressure, constipation, and chronic lower back pain. Resident #8's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 6/7/17. Resident #8 was coded as being severely cognitively impaired in the ability to make daily decisions scoring 00 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #8 was coded as requiring total dependence on staff with two plus persons with transfers; extensive assistance from two plus persons with bed mobility; extensive assistance with one person physical assist with dressing and personal hygiene, and total dependence on one	F 312	nail care and ADL care is provided per plan of care. 3. Nursing staff will be re-educated on providing ADL care, including nail care and documentation requirements. Care provided or refusals will be documented on the ADL record. Residents will be encouraged to participate and efforts made by nursing staff for refusals will be documented in the clinical record. 4. Care manager or designee will complete rounds M-F to ensure residents' nails are trimmed and clean. Issues identified will corrected immediately. Care manager or designee will audit 10% of ADL records weekly for 30 days, then monthly for 60 days. Results of rounds and audits will be reviewed by the QAPI committee for further guidance and instruction.	

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person with toileting.

On 6/27/17 at 4:50 p.m., an observation was made of Resident #8. His nails on both hands were long. His pointer, middle and index finger on both hands appeared to have black dirt or debris underneath the distal edge of the nail plate.

On 6/28/17 at 7:10 a.m., an observation was made of Resident #8. His pointer, middle and index finger on both hands appeared to have black dirt or debris underneath the distal edge of the nail plate.

On 6/28/17 at 12:15 p.m., an observation was made of Resident #8. His nails on both hands were long. His pointer, middle and index finger on both hands appeared to have black dirt or debris underneath the distal edge of the nail plate.

On 6/28/17 at 2:35 p.m., an interview was conducted with LPN (licensed practical nurse) #10. When asked who was responsible for ensuring resident's nails are cleaned, LPN #10 stated the CNA's (certified nursing assistant) or the nurses are responsible for checking the nails for cleanliness. LPN #10 stated, "Whoever sees it should clean the nails if they are dirty." LPN #10 stated the nurse is responsible for cutting the resident's finger nails on shower days during the weekly skin assessment. LPN #10 stated that staff do not usually document when a resident's nails have been trimmed.

On 6/28/17 at 2:56 p.m., an interview was conducted with CNA #1, the CNA who was assigned to Resident #8. When asked who was responsible for ensuring fingernails were clean and trimmed, CNA #1 stated that nurses and the

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nursing aides were all responsible for ensuring nails were clean. CNA #1 stated she will have residents who are independent wash their hands every morning as part of their bed bath or she will assist those residents who cannot wash their own hands. When asked if she washed Resident #8's hands that morning, CNA #1 stated that she was not his CNA that morning and that CNA #6 was Resident #8's CNA up until 2 p.m. CNA #1 was asked what Resident #8's nails looked like at that moment. CNA #6 looked at Resident #8's nails and stated, "They definitely need trimming and underneath his nails needs to be cleaned." CNA #1 stated that nurses trimmed the resident's nails.

On 6/28/17 at 4:50 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

The facility policy titled," Care of Nails" documents in part, the following: Objective: 1. To provide cleanliness. 2. To prevent infection...Procedure: 1. Explain the procedure to the resident and bring equipment to bedside. 2. Wash hands before and after procedure. 3. Place protective covering with towel beneath the area to be treated. 4. Soak hands before and after the procedure. 5. Remove from basin and place on towel. 6. Cleanse nails and under nails using orange sticks if needed. File and/or trim if needed. 6. CNAs do not trim nails of diabetic Residents or residents with peripheral blood vessel disease. 7. Apply lotion to hands. 8. Cleanse and return equipment to designate area. 8. Cleanse clippers with alcohol or other sanitizing wipes. 9. Discard disposable equipment. 10. Chart pertinent observations on Nurses' notes. NOTE: Nail care can be done in

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F 312	Continued From page 115 the shower or tub bath, or directly after. The nails will be soft and easy to trim." [1] Nail plate- the transparent covering of the nail that covers the white half-moon lunula and distal nail bed. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/books/NBK211/.	F 312		
F 323 SS=G	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced	F 323		8/13/17

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F 323	Continued From page 116 by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide adequate supervision and assistive devices to prevent accidents for five of 29 residents in the survey sample, Resident # 11, #12, #8, #1 and #10. 1. Resident #11 had four falls in three months on: 1/9/17, 2/15/17, 3/24/17 and 3/26/17. The facility staff failed to evaluate the effectiveness of interventions in place after each fall and failed to implement new interventions to prevent further falls. On 3/26/17, Resident #11's last fall, the resident sustained a displaced fracture of the left 10th rib, resulting in harm. 2. Resident #12 had five falls in six months on: 12/25/16, 5/4/17, 5/18/17, 6/8/17 and 6/18/17. The facility staff failed to evaluate the effectiveness of the interventions in place after each fall and failed to implement new interventions to prevent further falls. On 6/18/17, Resident #12's last fall, the resident sustained fractured ribs, resulting in harm. 3 The facility staff failed to ensure a safe transferr for Resident #8. On 2/12/17 Resident #8 had a fall and was assessed as requiring a Hoyer lift for transferss. On 6/28/17 during an observation the facility staff transferred Resident #8 using the wrong mechanical lift. 4. Resident # 1 sustained a fall during a transfer on 6/25/17. The facility failed to evaluate the effectiveness of the interventions in place after Resident #1's fall on 6/25/17 and failed to implement new interventions to prevent further	F 323	1. Resident #11, #12, #1, and #8 care plans were reviewed and revised to reflect fall interventions, pain management measures, and transfer status. CNA #1 was re-educate on resident #8 transfer status. Lancets were removed from Resident #10 room and stored in the locked medication cart. 2. All residents at risk for falls will be reviewed to ensure fall interventions, pain management, transfer status and other measures and reflected on their plan of care and nursing Kardex. Medical supplies, such as needles and lancets will be stored in the medication room or locked in medication carts for all residents. 3. All staff will be educated on fall prevention program. Nursing staff will be educated on fall prevention, including post fall measures, transfer techniques and use of transfer equipment with return demonstration competency, and updating the care plan to prevent further falls. All staff will be educated on preventing hazards to ensure sharps and other medical supplies are stored in locked areas. Care manager or designee will re re-educated on the revision of care plans to ensure interventions are in place to prevent further incidents. Changes to the care plan will be communicated to direct care staff for implementation. 4. DON or designee will review 24 hour report M-F for residents who have	

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F 323	Continued From page 117 falls. 5. The facility staff failed to ensure safe storage of Resident #10's lancets (a short pointed blade used to obtain a drop of blood (1)). Resident #10's lancets were observed stored at the bedside with the residents diabetic supplies and were not secured in a locked cabinet or medication cart. The findings include; 1. Resident #11 had four falls in three months on: 1/9/17, 2/15/17, 3/24/17 and 3/26/17. The facility staff failed to evaluate the effectiveness of interventions in place after each fall and failed to implement new interventions to prevent further falls. On 3/26/17, Resident #11's last fall, the resident sustained a displaced fracture of the left 10th rib, resulting in harm. Resident #11 was admitted to the facility on 6/5/13 with a readmission on 11/9/16 with diagnoses that included, but were not limited to; high blood pressure, high lipid level in the blood, depression, anxiety, atrial fibrillation (an irregular heart beat), stroke and macular degeneration (a condition of the eye that causes blindness). Resident #11's most recent comprehensive MDS (minimum data set) was an admission assessment with an ARD (assessment reference) date of 11/16/16. Resident #11 was coded as scoring a five out of a possible 15 on the BIMS (brief interview for mental status) in Section C, Cognitive Patterns, indicating that Resident #11 was severely cognitively impaired in daily decision	F 323	experienced a fall or who have had a change in pain to ensure plan of care is review and revised, including fall interventions and pain measures. DON or designee will audit 25% of 24 hour reports weekly for 30 days, then monthly for 60 days to ensure care plans are reviewed and revised. Care manager or designee will complete rounds M-F to observe for proper storage of supplies. The rounds will be analyzed by the DON or designee for trends and need for further action and/or education. Care manager or designee will observe at least 3 transfers weekly for 30 days, then 1 transfer a week for 60 days to ensure that proper technique and/or equipment is being used based upon the resident's plan of care and that appropriate procedures were taken by staff for resident safety. A copy of these observations will be given to the DON and/or designee to monitor and track for additional action and/or education. Results of rounds and audits will be reviewed by the QAPI committee for further guidance or instruction.	

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making. Section G, Functional Status, coded Resident #11 as requiring extensive assistance of one to two people for transfers, walking, toileting, personal hygiene as well as having impairment to her upper extremities. Resident #11 was further coded in Section J, Health Conditions, as having a fall with a fracture prior to entry into the facility.

Resident #11 was observed on the following occasions:
- 6/27/17 at 11:00 a.m., during the initial facility tour, Resident #11 was sitting in a chair at the foot of her bed, a bedside table and the call bell were within reach. Resident #11 stated she "gets tired" sitting in the chair all day. No motion monitors/alarms were observed in the bed or on the resident's chair.

- 6/28/17 at 7:30 a.m. Resident #11 was sitting in a chair at the foot of her bed. The call bell within reach. Resident #11 stated she had just received her shower and was waiting on breakfast. No motion monitors/alarms were observed in the bed or on the resident's chair.

- 6/29/17 at 7:00 a.m. Resident #11 was lying in her bed and was observed attempting to get herself out of bed. The bed was in a standard position. Resident #11 stated her back was in pain from "lying in bed too long." Resident #11 was observed attempting to swing her legs out of the bed to get up. The call bell light outside the room was engaged; several aides passed by the doorway and did not stop to respond to the light. This surveyor walked to the end of the hallway, and within five minutes the call light was turned off. At 7:30 a.m., this surveyor returned to Resident #11's room with RN (registered nurse) #1, an MDS coordinator. Resident #11 was still

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lying in her bed, in the same position. When asked if someone had helped her, Resident #11 stated someone came into the room and asked her if she needed the bathroom, then left without taking her to the bathroom. At this time, RN #1 offered to take Resident #11 to the bathroom. There were no motion monitors/alarms observed in the bed or on the resident's chair.

A review of Resident #11's clinical record revealed, in part, the following incident reports:

- "1/9/17 Incident Description: Nursing Description: Found resident sitting on floor in room @0800 (8:00 a.m.). Fecal matter noted on floor. Resident Description: Resident stated had to go to the bathroom and got up in a hurry and slid on floor. Did not hit head. Immediate Action Taken: Description: Assessed for injuries. Assisted resident to bathroom. Crackles noted in L (left) lower lobe. Resident stated of (sic) pain on 1 (one) side of back (name of doctor) notified. Resident Taken to Hospital: N (no). Other Info: Incontinent of stool while attempting to go to bathroom. Notes: 1/9/2017 Mobility monitor (a motion alarm used on a bed or chair to alert staff when a resident attempts to get up without assistance) on and functioning." A corresponding progress note, completed and electronically signed by LPN (licensed practical nurse) #2 on 1/9/2017, documented the following; "Assessed for injury. Assisted to bathroom with help of 2 (two). Stated of (sic) L (left) mid back pain. (Name of doctor) notified and new order for Stat (immediate) CXR (chest x-ray)." There was no further mention of mobility monitors in place. This documentation was also documented in a nursing progress note.

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- "2/15/17 1:17 (1:17 a.m.) Incident Description: Nursing Description: This writer was notified by the CNA (certified nursing assistant) that the resident was on the floor. Upon entering the room. The resident was sitting on her bottom, with her feet out in front of her, in between her wheelchair and her bed. No visible injuries. Resident Description: When asked, the resident stated she was trying to go to the restroom. Resident also stated she bumped her head on her wheelchair, but denies any pain. Immediate Action Taken: Description: This writer assessed resident for injuries. No injuries noted. ROM (range of motion) performed and ROM WNL (within normal limits). Assisted resident back into bed. Resident Taken to Hospital? N (no)." This documentation was also documented in a nursing progress note.

- "3/24/17 15:45 (3:45 p.m.). Incident Description: Nursing Description: resident finished toileting, stood to pull pants up and became unsteady, fell to floor and landed on buttocks, this writer present at time with head turned to speak to CNA about residents (sic) mattress sliding out lost balance (sic). Immediate Action Taken: Description: assisted up and assessed." This documentation was also documented in a nursing progress note.

- "3/26/2017 08:30 (8:30 a.m.) Incident Description: Nursing Description: pt (patient) was attempting to reposition self on side of bed to put on shoe on (sic) and slid onto floor on buttocks with bed items (mattress topper and blankets) pt sitting upright on buttocks on top of mattress topper and blankets. "I was trying to put on my shoe." Immediate Action Taken: Description: assessment done and range of

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motion, pt reeducated to ask staff for assistance for transfers and adl's (activities of daily living), rp (responsible party) and md (medical doctor) notified, (name of doctor) in building and notified. (Name of doctor) preformed (sic) physician exam on pt. Injuries Report Post Incident: No injuries Observed Post Incident. Notes: new order for left rib x-ray." This documentation was also documented in a nursing progress note.

A review of Resident #11's clinical record revealed the following X-Ray report: "Date 3/27/17. Examination: XR (X-Ray) Ribs 2V (views) LT (left). Indication: Pain. Impression: There is a minimally displaced fracture of the anterior (front) aspect of the left 10th rib."

The incident reports did not provide any evidence that new interventions were initiated following each fall to prevent Resident #11 from sustaining further falls.

A review of Resident #11's physician progress notes revealed, in part, the following documentation: "3/26/17 P (plan): 3. Fall precautions. Tfr (transfer) only w (with)/ assist. Bed alarm and chair alarm on. 3/27/17 Assessment/Plan: 3. Assessment Frequent falls. 5/25/17 Assessment/plan: Frequent falls. due to her (Resident #11) deconditioned status and rapid shifts in position, we continue to encourage slow supported movement."

A review of Resident #11's physician order summaries dated November 30, 2016 and May 1, 2017 did not document any fall prevention orders. When asked for the physician order summaries for the months between November 2016 and May 2017 ASM (administrative staff member) #2, the

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director of nursing, stated that because Resident #11 was a long term care resident the physician reviewed the orders every 60 days. ASM #2 further stated that these were the only physician order summaries available.

Further review of Resident #11's physician orders did not reveal any orders for motion alarms to be used on the bed or chair.

A review of Resident #11's nursing progress notes did not provide documentation that any alarms were in place following the 1/9/17 incident.

A review of Resident #11's Kardex (an information system for CNAs) dated 11/9/16 (the date of admission) documented, in part, the following: "Resident Care: For her (Resident #11) comfort, ensure mobility pad (a bed alarm) is flat, w/o (without) bulky connections, folds etc. under (name of Resident #11) at bedtime."

A review of Resident #11's fall risk assessments revealed fall risk assessments were completed weekly from 11/10/16 through 1/17/17. The scores were not completed to indicate Resident #11's level of risk for falls.

Further review of Resident #11's fall risk assessments revealed that between 2/1/17 and 2/28/17 and between 2/28/17 and 5/16/17, Resident #11 was assessed as a high risk for falls.

A review of Resident #11's comprehensive care plan dated 11/9/16 revealed, in part, the following documentation; "Focus. (Name of Resident #11) has impaired visual function r/t (related to) Macular Degeneration, legally blind. Date

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Initiated: 11/22/2016. Revision on: 11/22/2016. Focus: (Name of Resident) is high risk for falls r/t (related to) weakness, vision problems, hx (history) of falls with injury. 5/24/17 Family identified risk of mattress topper slipping off bed if both mattresses are not covered with the bottom fitted sheet. Date initiated: 11/22/2016. Revision on 5/24/2017. Interventions/ Tasks: Anticipate and meet (name of Resident #11's) needs. Date Initiated: 11/22/2016. Educate (name of Resident #11)/family/caregivers about safety reminders and what to do if a fall occurs. Date Initiated: 11/22/2016. Revision on: 11/22/2016. Encourage (name of Resident #11) to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Date Initiated: 11/22/2016. Revision: 11/22/2016. Ensure that (name of Resident #11) is wearing appropriate footwear when ambulating or mobilizing in w/c (wheelchair). Date Initiated: 11/22/2016. Revision on: 11/22/2016. Follow facility fall protocol. Date Initiated: 11/22/2016. Revision: 11/22/2016. (Name of Resident #11's) call light is within reach when in room and encourage her to use it for assistance as needed. Date Initiated: 11/22/2016. Revision on: 11/22/2016. Pt (physical therapy) evaluate and treat as ordered or PRN (as needed). Date Initiated: 11/22/2016."

There was no evidence that Resident #11's comprehensive care plan was updated following her falls that occurred on 1/9/17, 2/15/17, 3/24/17 and 3/26/17.

On 6/9/17 at 9:00 a.m. an interview was conducted with RN (registered nurse) #1, an MDS coordinator. RN #1 was asked to describe the process followed when a resident falls, RN #1

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stated, "If a resident has a fall it is documented in the progress notes, a risk report is completed and the care plan is reviewed and revised to review the current interventions. We have to put in a new intervention for each fall. We discuss the falls in our stand up meetings and (name of administrator) always asks if the care plan has been updated. The expectation is that it (updated care plan) is being done." RN #1 was then asked specifically about Resident #11 and evidence was requested to show that Resident #11's care plan was updated with new interventions, following each fall, to prevent further falls.

On 6/29/17 at approximately 10:00 a.m. a meeting was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above concern for harm for Resident #11. ASM #1 and ASM #2 were asked if they were aware of any interventions that were put into place and implemented after each of Resident #11's falls to prevent further falls. ASM #1 and ASM #2 were unable to say what had been done. A policy was requested for fall prevention at this time. ASM #1 and ASM #2 were asked to provide any documentation that would evidence attempts by the facility after each fall to protect Resident #11 from further falls.

On 6/9/17 at 10:12 a.m. an interview was conducted with RN #6, an MDS coordinator. RN #6 reviewed Resident #11's care plan with this writer and stated that there were no revisions done following each of Resident #11's falls. When asked if it should have been done, RN #6 stated yes.

On 6/29/17 at 10:30 a.m. an interview was

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conducted with LPN (licensed practical nurse) #2, a floor nurse caring for Resident #11. LPN #2 was asked to describe the process followed by staff when a resident falls. LPN #2 stated, "I check the surroundings, check for injuries/ movement, check to see if they hit their head, and notify the RP (responsible part) and MD (medical doctor)." LPN #2 stated, "I would complete the risk management incident report, follow the questions." LPN #2 was asked if she would consider implementing any new interventions, LPN #2 stated, "I might consider interventions but I would ask the unit manager, they would have a better understanding. I might initiate alarms if the resident didn't have alarms and make sure the environment was safe." LPN #2 was asked if she would initiate a fall alarm if the resident was a fall risk. LPN #2 stated, "Not typically." LPN #2 was asked about Resident #11 and her falls and whether or not she was aware of any interventions put into place to reduce Resident #11's risk for falls. LPN #2 stated, "I have not been made aware of any." When asked if Resident #11 had any alarms in place, LPN #2 stated she didn't think so. LPN #2 was asked about the fall that occurred in January 2017 where she documented that an alarm was in place. LPN #2 stated she didn't remember, but if she wrote that there was an alarm it must have been in place. LPN #2 was asked if she was aware of Resident #11's risk for falls. LPN #2 stated that she had not been made aware of the risk or of any interventions. LPN #2 further stated, "This is not discussed as a team, so I don't know."

The unit manager on Resident #11's hall was not available for an interview on 6/29/17.

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On 6/29/17 at 1:15 p.m. a meeting was conducted with ASM #1, the administrator, ASM #2, the director of nursing. ASM #1 and ASM #2 stated that they did not have any further information regarding Resident #11's falls. The care plan had not been reviewed/revised and there were no interventions put into place following each fall.

A review of the facility document, "Fall Resident Assessment and Investigation" revealed, in part, the following documentation; "Purpose: To provide a comprehensive, consistent approach to assess residents at risk for falls and to implement interventions to reduce risks for recurrence and injury. Policy: 7. The fall investigation form will be utilized in reviewing and revising the residents care plan to minimize the recurrence of falls or injury. 8. The interdisciplinary team will review incident at the next clinical meeting for completeness of documentation and evaluated for trends. Residents that have recurrent falls (more than 2 falls per month or a fall with a significant injury - fracture ....) will be evaluated for other causative factors or treatment interventions."

No further information was provided prior to the end of the survey process.

2. Resident #12 had five falls in six months on: 12/25/16, 5/4/17, 5/18/17, 6/8/17 and 6/18/17. The facility staff failed to evaluate the effectiveness of the interventions in place after each fall and failed to implement new interventions to prevent further falls. On 6/18/17, Resident #12's last fall, the resident sustained fractures of the right ninth and 10th ribs, resulting in harm.

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Resident #12 was admitted to the facility on 5/4/16 and readmitted on 6/19/17, (after an overnight only stay in the hospital emergency room for evaluation), with diagnoses that included but were not limited to: dementia, high blood pressure, anxiety, insomnia, depression, abnormal weight loss and protein calorie malnutrition.

The most recent MDS (minimum data set), an annual assessment, with an assessment reference date of 5/18/17, coded the resident as being severely impaired to make daily cognitive decisions. Resident #12 was coded as requiring limited assistance of one staff member for moving in the bed and dressing, extensive assistance of one staff member for transfers and toileting, and as independent after set up assistance was provided for eating. Resident #12 was not coded for any impairment in her range of motion. In Section J - Health Conditions, the resident was coded as having had two falls without injuries.

The "Fall Risk Assessment" dated, 10/9/16, documented the following:
Reason for Assessment - recent fall
Date of admission - less than 90 days
History of Falls within Last 3 months - #2. 1-2 times
Medication Use - antiseizure, antihypertensive, NSAID (non -steroidal anti-inflammatory drug) narcotics, psychotropic, anti-Parkinson's
Medication Usage - takes 3 or more of these medications currently or within last 7 days.
Systolic Blood Pressure - no drop between lying & standing
Memory/Recall - disoriented x (times) 1

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Vision - adequate with or without glasses
Continence - Continent complete control in past 7 days.
Behavior in last 7 days - no behavior exhibited in last 7 days
Confined to Chair - not
Gait Analysis - unable to independently come to a standing position
Predisposing Conditions - Parkinson's disease
Response based on number of predisposing condition - 1-2 present.
There was no risk score or documentation of the resident's fall risk.

The nurse's note dated, 12/25/16 at 8:13 p.m. documented, "Pt (patient) wheeled self into bathroom unassisted and attempted to put self onto toilet unassisted. pt (sic) sitting on buttocks on floor, sitting upright holding onto grab rail with both hands. pt (sic) stated 'I couldn't hold on too long', 'I fell on my butt.' Pt assessed and toileted with staff assist, pt reeducated to get staff assistance with transfers, pt denies pain or discomfort, ROM (range of motion) W/N/L (within normal limits) without c/o (complaint of) pain or discomfort, no s/s (signs and symptoms) of distress, resp (respirations) even/non-labored, skin intact. will cont (continue) to monitor for changes."

The "Fall Incident Report" dated, 12/25/16 documented in part, "Immediate Action Taken - pt assessed and toileted with staff assist, pt reeducated to get staff assistance with transfers." The review by the director of nursing (DON) on 12/26/16 documented, "Resident is impulsive in her actions and has been observed frequently by this writer attempting to transfer herself from her wheelchair to the bed, bed to wheelchair, and

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even wheelchair to bathroom without calling for staff assistance. Resident has unsteady gait/balance."

The "Fall Risk Assessment" dated, 2/15/17, documented in part, "Score - 16. Category - High Risk (for falls)."

A nurse's note dated, 5/4/17 at 3:35 p.m. documented, "Found on floor in room. Assess for injury. Skin intact. No outward rotation of hips noted. Able to move all extremities well. Denies pain.

The "Fall Incident Report" dated, 5/4/17 documented in part, "Found resident lying on L (left) side on floor with head against visitor leg. Mobility alarm in place. Works intermitten (sic). New alarm applied. Assess for injuries. Able to move all extremities well. No outward rotation of hips. Skin intact. Denies pain. Resident did not have brakes on w/c (wheelchair). Resident Description - Stated wheelchair tip over....Other info (information) Gets up and down from w/c, was bending over and standing up, the w/c did not have brakes on and w/c moved backwards and resident went to sit down and missed w/c. Notes: Did not have brakes on w/c, and moved backwards while bend over and fell to floor. Mobility alarm changed due to alarm only working internitten (sic)."

The "Fall Risk Assessment" dated, 5/18/17, documented in part, "Score - 22. Category - High Risk."

A nurse's note dated, 5/18/17 at 6:05 p.m. documented, "Resident observed leaning forward in wheelchair rearranging items in bottom dresser

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drawer, this writer began to ask resident to sit back, resident continued to lean forward when wheelchair slid from under resident. Educated to not lean forward, use call light for any assistance."

The "Fall Incident Report" dated, 5/18/17 documented in part, "Resident observed in wheelchair leaning forward rearranging items in bottom dresser drawer, this writer began to ask resident to sit back when resident continued to lean forward and wheelchair slid from under resident....Other info - Resident often displays impulsive behaviors and suffered from parkinsonian dystonia/tremors. Resident was attempting to arrange items in her bottom dresser drawer when she slid out of her wheelchair. Resident has poor balance and is unable to judge her movements."

The "Fall Incident Report" dated, 6/8/17 documented in part, "Housekeeping stated that she was walking by pt's room and pt was lying on the floor. Pt found lying on her left side, head against the wall. Pt states, "I tapped my head on the wall, I was trying to pick this thing from the floor...Other info - Impulsive/determines (sic) behavior, did not call for assistance, unsteady balance."

A nurse's note dated, 6/18/17 at 9:12 p.m. documented, "Pt fell onto floor witnessed by roommate; roommate stated that pt was 'looking at papers and some dropped and she went to pick them off the floor and fell out of her wheelchair on to the floor.' Pt stated, 'I fell, I was picking up my papers.' Pt laying on right side on floor, wheelchair next to pt, papers on floor. pt

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c/o (complained of) right hip, back and coccyx pain, immobilized pt, MD (medical doctor) notified, new order to send pt to er (emergency room) for eval (evaluation), called 911, pt sent out to er via 911, rp (responsible party) notified, er notified.."

The "Fall Incident Report" dated, 6/18/17, documented in part, "Pt fell onto floor witnessed by roommate; roommate stated that pt was 'looking at papers and some dropped and she went to pick them off the floor and fell out of her wheelchair onto the floor. Resident description - I fell, I was picking up my papers." Immediate action taken - pt laying on right side on floor, wheelchair next to pt papers on floor...Notes - x-ray revealed broken 7th and 8th right lateral rib fractures.

The x-ray results dated, 6/20/17, documented in part, "There is a fracture of the ninth and 10th lateral fibs, with slight displacement, possibly involving the eighth lateral rib as well. Impression: Right-sided lateral rib fractures as mentions."

The comprehensive care plan dated,5/5/16 and revised on 6/28/17, documented in part, "Focus: (Resident #3) is at risk for injury r/t (related to) falls characterized by multiple risk factors related to: unstable health condition, non-compliance with mobility aide use, visual deficit, new surroundings and psychotropic medication. (Resident #12) had an actual fall on 8/14/16. (Resident #12) had a fall on 9/14/16. (Resident #12) sustained a fall on 10/1/16, resulting in a skin tear to left elbow." The following were added to the care plan after this surveyor asked for information on the falls. "(Resident #12) had

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an actual fall on 5/18/17. (Resident #12) had an actual fall on 6/18/17."

The "Interventions" documented in part, "5/5/16 -Apply bed and chair mobility monitors at all times to enhance safety. Encourage resident to ask for assistance when walking with walker and not to walk independently. 10/2/16 - Ensure that nursing staff continues to monitor and remind (Resident #12) to ask for assistance when wishing to transfer. 5/5/16 - Maintain locked brakes on wheelchair when resident is sitting in it. 7/12/16 - Place objects that resident frequently uses within resident's reach. 5/5/16 - Reinforce need to call for assistance. 8/22/16 - Staff to continuously remind (Resident #12) not to lean over in her chair r/t poor safety awareness." The last update to Resident #12's care plan was dated, 10/2/16. There were no updates after her falls on 12/25/16, 5/4/17, 5/18/17, 6/8/17 and 6/18/17.

The physician orders dated, 6/20/17 documented the order for the rib x-rays and Tramadol (non-narcotic used to treat moderate to severe pain (1)) 50 mg (milligrams); give 1 tablet by mouth every 6 hours as needed for pain."

The June 2017 MAR (medication administration record) documented Resident #12 received Tramadol three times on 6/20/17 for a pain score of 10 (scale of one to ten, ten being the worse pain ever in). Resident #12 was documented as receiving the Tramadol on 6/21/17 once for a pain level of seven. The resident was documented as receiving the Tramadol on 6/22/17 for a pain level of five and one of eight.

On 6/29/17 at 9:16 a.m. an interview was

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conducted with RN (registered nurse) #3. When asked who is responsible for updating the care plans, RN #3 stated, "The unit managers."

An interview was conducted with RN #1, the MDS coordinator, on 6/29/17 at 10:10 a.m. When asked who is responsible for updating the care plan with new interventions after a resident has a fall, RN #1 stated, "The clinical coordinator (unit manager) updates the care plan with the fall and new interventions." RN #1 was asked to review Resident #12's fall care plan. When asked if she saw any documentation regarding Resident #12's falls on 12/25/16, 5/4/17, 5/18/17, 6/8/17 and 6/18/17, RN #1 stated she did not see those falls on the care plan.

An interview was conducted with CNA (certified nursing assistant) #4 on 6/29/17 at 9:25 a.m. CNA #4 was asked how she knows what a resident's transfer status is and what safety devices a resident requires. CNA #4 stated, "There is a sheet in the resident's closet that tells us their mobility status. Sometimes they list the safety devices, it sometimes depends what the therapist has written on it." When asked about residents not on therapy caseload, CNA #4 stated, "I guess the nurse writes on it." The closet for Resident #12 was viewed with CNA #4. The "Care Card" was blank. It didn't have the resident's name or anything documented on it. CNA #4 was asked how staff knows what to do for a resident, if there is no information on the Care Card, CNA #4 stated, "I would ask another CNA who is familiar with the resident."

An interview was conducted with CNA (certified nursing assistant) #3 on 6/29/17 at 10:40 a.m. When asked how she knows what safety devices

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a resident requires, CNA #3 stated, "It's in the Kardex in (name of computer program)."

The "Bedside Kardex Report" for Resident #12 with an admission date of 6/19/17 and a print date of 6/29/17, documented, "Dressing - (Resident #12) is to wear hose daily. Transferring - Use lifting device, draw sheet etc. to reduce friction. Resident Care - Heel lift boots bilaterally when in bed. May need to face (Resident #12) or decrease ambient noise if she is having difficulty hearing or understanding. Staff to continuously remind (Resident #12) not to lean over in her chair r/t her poor safety awareness. Eating - (Resident #12) is to have her lower partial dentures put in every am and out every pm. Monitor - Vitals All (BP (blood pressure) P (Pulse) R (respirations) T (temperature)." There was no documentation for a mobility alarm.

An interview was conducted with LPN (licensed practical nurse) #2 on 6/29/17 at 10:50 a.m. When asked how the staff identify a resident who is at risk for falls, LPN #2 stated, "They have a yellow band on and there is a list in the computer of what they need." When asked how the CNA's know what devices a resident needs, LPN #2 stated, "There is a falling leaf outside the door." LPN #2 and this surveyor identified the leaf at the doorway to Resident #12's room. LPN #2 was asked to look at the care card in Resident #12's closet. LPN #2 stated, "Well that needs to be filled in." An orange dot with "M/M" was noted next to Resident #12's name outside her door. When asked what that indicated, LPN #2 stated, "I don't know but I will find out."

A second interview was conducted with LPN #2 who cared for Resident #12 for one of her falls,

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on 6/29/17 at 11:09 a.m. When asked what happened on 5/4/17, LPN #2 stated, "She gets up and down in her chair. She fidgets. She takes off her alarms and plays with them. "LPN #2 stated, "I found out what the M/M on the orange dot was, it's her mobility monitor she has." LPN #2 was asked if she put any new interventions in place at the time of the 5/4/17, fall to prevent further falls. LPN #2 stated no, she hadn't.

An interview was conducted with RN #4, the care manager for Resident #12, on 6/29/17 at 11:55 a.m. When asked who updates the care plans, RN #4 stated, "I'm supposed to do that. It's been a struggle to do so." The care plan for Resident #12 was reviewed with RN #4. RN #4 was asked if Resident #12's care plan had been updated with new interventions to prevent further falls after each fall on 12/25/16, 5/4/17, 5/18/17, 6/8/17 and 6/18/17. RN #4 stated, "No, I don't see it there." When asked if the care plan should have been updated, RN #4 stated, "Yes, Ma'am." When asked should interventions be put in place to prevent further falls, RN #4 stated, "Yes, it should be updated. She is my special person. She has a mobility alarm. I go in to her room a lot and she's very busy. Her business increases with her roommate but her family doesn't want her moved." RN #4 was informed Resident #12 has had five falls in six months with the last fall resulting in a fracture and increased pain, and was asked if something should have been put in place to prevent further falls. RN #4 stated, "Yes, we should have done something."

The facility policy, "Fall Resident Assessment and Investigation" documented in part, "7. The fall investigation will be utilized in reviewing and revising the residents care plan to minimize the

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recurrence of falls or injury. 8. The interdisciplinary team will review incident at the next clinical meeting for completeness of documentation and evaluated for trends. Residents that have recurrent falls (more than 2 falls per month or a fall with a significant injury - fracture, ER eval, diagnostic test), will be evaluated for other causative factors or treatment interventions. A falling leaf will be placed outside resident/patient room to alert staff of high risk for falls. The leaf will be removed if no recurrent falls in 90 days."

Fundamentals of Nursing, 5thedition, Lippincott, Williams and Wilkins, page 679 - 686; "Falls are common inside and outside the healthcare environment, especially among older adults and ill or disoriented people. Falls can cause, pain, permanent disability and even death. Sometimes falls in odder adults result in hip fractures.....Variables that increase a client's risk for fall include gait and balance disorders, weakness, dizziness, environmental hazards, decreased mobility of the lower extremities, sleeplessness, incontinence, confusion, visual impairment, sedating medications depression and substance abuse...After the nursing diagnosis and related factors have been formulated, client goals and nursing interventions are identified. These goals must be individualized to reflect the unique needs of the person at risk. Once they are individualized, specific nursing interventions suppose the goals."

On 6/29/17, ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing were made aware of the concern regarding Resident #12's five falls in six months with no new interventions being implemented to

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prevent further falls and the concern regarding Resident #12's fall with rib fractures on 6/18/17, resulting in harm.

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012486/?report=details

3. The facility staff failed to ensure a safe transferr for Resident #8. On 2/12/17 Resident #8 had a fall and was assessed as requiring a Hoyer lift for transferss. On 6/28/17 during an observation the facility staff transferred Resident #8 using the wrong mechanical lift.

Resident #8 was admitted to the facility on 6/2/17 with diagnoses that included but were not limited to non-infective gastroenteritis, colitis, cerebral palsy, high blood pressure, constipation, and chronic lower back pain. Resident #8's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 6/7/17. Resident #8 was coded as being severely cognitively impaired in the ability to make daily decisions scoring 00 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #8 was coded as requiring total dependence on staff with two plus persons with transfers; extensive assistance from two plus persons with bed mobility; extensive assistance with one person physical assist with dressing and personal hygiene, and total dependence on one person with toileting.

On 6/28/17 at 1:50 p.m., an observation was

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conducted of CNA (certified nursing assistant) #1, the CNA working with Resident #8 and another CNA assisting Resident #8 into bed. The two CNAs were observed transferring Resident #8 into bed using the sit to stand lift.

Review of Resident #8's fall report dated 2/12/17 documented the following: "Incident Location: Resident's Room. Incident Description: Fall-CNA (certified nursing assistant) called writer into resident room for assistance, resident noted to be on the floor leaning against the bed. According to CNA, she was using the stand-up lift to transfer resident when he began to slip out of the harness. CNA guide resident to the floor, no injury had occurred. four (sic) staff members assisted resident back to the bed. Resident stated, "I just slipped, my shoes don't fit right...Notes: Pt (Patient) eval'd (evaluated) by therapy for appropriate transfer method. Staff educated on transfer technique and plan of care."

Review of a post fall therapy screen dated 2/14/17 documented the following: "Comments: I recommend nursing use hoyer lift from now on. No PT (physical therapy) services recommended at this time."

Review of Resident #8's fall care plan revised 2/12/17, documented the following intervention: "CNA educated on having 2 staff members in room during transfers. Now deemed to be a hoyer lift."

On 6/28/17 at 1:52 p.m., an interview was conducted with CNA #1. When asked what type of lift Resident #8 should be using for transfers, CNA #1 stated that she usually uses to sit to stand lift with two nursing aides. When asked

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what CNA's use a as reference to determine a Resident's needs, CNA #1 stated that each resident had a kardex inside of their closet that documents the resident's needs. This writer followed CNA #1 into Resident #8's room. When CNA #1 was asked to read Resident #8's kardex, CNA #1 stated, "It does say hoyer lift only. That is my mistake." CNA #1 stated that she rarely checks the kardex because she works with the same residents on a daily basis. CNA #1 stated, "Someone must have updated it." When asked if she knew why the resident was now to be using a hoyer lift rather than the sit to stand lift, CNA #1 stated that it may of had to do with his fall a few months ago.

On 6/28/17 at approximately 6 p.m. during the end of day meeting, ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and RN (registered nurse) #2, the care manager were made aware of the above concerns.

On 6/29/17 at approximately 12:00 p.m., education provided to the CNAs after Resident #8's 2/12/17 fall was requested from ASM #1, the administrator. This education could not be provided.

The facility policy titled, "Mechanical Lifts" documents in part, the following: "It is the policy of the facility to ensure that all residents are cared for in a manner that is safe for both the resident and the employee. All direct care staff must assess resident handling tasks in advance to determine the safest way to accomplish them. Mechanical lifts are used for the transfer of residents to and from bed, chair, bedside commode, floor and stretcher. Procedure: The

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Mechanical Lifts are devices utilized in assisting residents and patients in transfer who require more than maximum assist of two for a safe transfer or whose medical status necessitates its use; i.e., blood pressure concerns, excessive resident's weight, non-weight bearing status and/or resident's mental status. These devices require two persons for transfer to maintain safety, one to operate the controls, and one to assist with controlling the resident's legs."

No further information was presented prior to exit.

4. Resident # 1 sustained a fall during a transfer on 6/25/17. The facility failed to evaluate the effectiveness of the interventions in place after Resident #1's fall on 6/25/17 and failed to implement new interventions to prevent further falls.

Resident # 1 was admitted to the facility on 12/2/14 and most recently readmitted on 4/7/15 with diagnoses that included but were not limited to: anemia, osteoporosis (1), hypertension (2), diabetes, and stroke (3).

Resident # 1's most recent MDS (minimum data set) an annual assessment with an ARD (assessment reference date) of 6/12/17 coded the resident as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, indicating that Resident # 1 was cognitively intact. Resident # 1 was coded as requiring extensive assistance of two+ staff with transfers on/off the toilet.

Review of the clinical record revealed a note documented on 6/25/17 at 12:30 p.m.: the type of note was an "Incident Note" "Type: While trying

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to put on toilet, resident shifted weight away from toilet and slid on floor." "Location: Residents (sic) bathroom." "Person Discovering Incident: [name of CNA (certified nurse's assistant) # 8 ..." signed by [name of LPN (licensed practical nurse) # 9].

Review of the compressive care plan with an initiation date of 9/14/15 and revision date of 5/24/17, documented, "Focus - Name of Resident # 1 sustained an actual fall 8/14/15 with No Injury, related to Unsteady gait, Poor Balance, Poor communication/comprehension." Resident # 1's falls were listed in the "Focus" section of the care plan with the exception of the most recent fall that occurred on 6/25/17. The care plan documented a revision date of 5/24/17, indicating Resident # 1's care plan was not reviewed or updated after his most recent fall on 6/25/17 with interventions to prevent further falls.

During an interview on 6/29/17 at 8:40 a.m. with Resident # 1 concerning his fall, Resident # 1 stated that only one CNA went into the bathroom with him when he fell. "I was not hurt. After I fell two came in to get me up."
During an interview on 6/29/17 at 10:00 a.m. with CNA # 8 (the CNA that transferred Resident # 1 during the incident on 6/25/17), CNA # 8 stated, "I prefer to have two persons when transferring (name of Resident # 1) because at times it (transfers with Resident # 1) have not gone smoothly. If I could have found another staff member I would have. We (Resident # 1 and I) went from bed to wheelchair and that transfer went smoothly. In the bathroom (name of Resident # 1) held himself up with the grab bar with his right hand while I pulled his brief down. He (Resident # 1) turned and on the way to sitting and his weight shifted and he swung around from

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sitting on the toilet to facing the toilet. I grabbed him and was not able to turn him so I sat him on the floor. I called out to (name of LPN [licensed practical nurse] # 2 on the hall)."

During an interview on 6/29/17 at 10:40 a.m. with LPN # 2, LPN # 2 stated she wrote the note concerning Resident # 1's fall on 6/25/17. LPN # 2 stated that she was called to the Resident's room by (name of CNA # 8) and assessed the resident and then assisted the CNA in getting the resident up and onto the toilet. LPN # 2 stated, "I only have the resident (Resident #1) every other weekend and am not that familiar with him."

During an interview on 6/29/17 at 10:53 a.m. with RN (registered nurse) # 2, a care manager, Resident # 1's care plan was reviewed. RN # 2 could find no documentation or interventions for Resident # 1's fall on 6/25/17. RN # 2 stated, "The care plan should be updated within 24 hours of the incident and I see that the fall (on 6/25/17) and any new interventions are not on the care plan."

During an interview on 6/29/17 at approximately 3:00 p.m. with ASM (Administrative staff member) # 1, the administrator, this concern was shared and a copy of the facility policy on falls was requested.

During an interview on 6/29/17 at 3:10 p.m. with RN (registered nurse) # 2, the care manager, an updated care plan for Resident #1 with a revision dated of 6/29/17 was presented and reviewed. The following was documented under "Interventions/Tasks" ...*S/p (status post) fall 6/25/17 ...CNA staff verbally educated that resident is to be assist x2 for all transfers ..."

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No further information was provided prior to exit.

References:

(1) Osteoporosis -- Makes your bones weak and more likely to break. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/osteoporosis.html.

(2) Hypertension: A condition present when blood flows through the blood vessels with a force greater than normal. Also called high blood pressure, hypertension can strain the heart, damage blood vessels, and increase the risk of heart attack, stroke, kidney problems, and death. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0024199/

(3) A stroke occurs when blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm.

5. The facility staff failed to ensure safe storage of Resident #10's lancets (a short pointed blade used to obtain a drop of blood (1)). Resident #10's lancets were observed stored at the bedside with the residents diabetic supplies and were not secured in a locked cabinet or medication cart.

Resident #10 was admitted to the facility on

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2/29/08 and most recently readmitted on 3/13/17 with the diagnoses of but not limited to altered mental status, diabetes, bipolar, chronic kidney disease, human immunodeficiency virus, acidosis, chronic pain syndrome, delusional disorder, adrenal gland disorder, glaucoma, stage 4 breast cancer with metastasis, deafness, and blindness.

The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/28/17. The resident was coded as being cognitively intact, scoring a 15 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident required limited to extensive assistance for transfers; supervision to limited assistance for ambulation; supervision for hygiene; limited assistance for bathing; independent for eating; and was generally continent of bowel and bladder, with incontinence at times.

On 6/27/17 at 4:35 p.m., an observation was made of Resident #10's room. On the bedside table was noted to be a hospital wash basin, containing the resident's diabetic monitoring and care supplies. This included a box of single-use lancets used to prick the resident's finger for blood glucose testing.

On 6/28/17 at 8:00 a.m., the same basin of supplies, and lancets were noted to still be on the bedside table.

On 6/28/17 at 1:52 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #10 who was the nurse for Resident #10. LPN #10 stated Resident #10's diabetic supplies, including the single-use lancets, were stored at

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the resident's bedside, separated from the diabetic supplies of other residents in the secured medication cart, because of this resident's diagnosis of HIV. When asked, how storing single-use lancets in the medication cart, and then taking only one or two to the resident's bedside for use, would contaminate other residents' diabetic monitoring supplies? LPN #10 stated he did not know. He stated that Resident #10's lancets have been kept at the bedside for "several months." LPN #10 stated "they" decided this was the way to do it. He could not identify who "they" was.

On 6/28/17 at 1:54 p.m., in an interview with the DON (Director of Nursing, Administrative Staff Member (ASM) #2), ASM #2 stated that she was not aware the lancets were being stored at the bedside. ASM #2 stated that they (single use lancets) are considered a "sharp" and should be stored securely in the medication cart, the same as syringes. ASM #2 stated that she did not know why the nursing staff decided that this was best practice, but that it was not facility policy to have lancets kept at the bedside.

A review of the facility policy, "Storage and Expiration of Medications, Biologicals, Syringes and Needles" documented, "3.3 Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors."

No further information was provided by the end of the survey.

(1) This information was obtained from the

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F 323	Continued From page 146 website:http://medical-dictionary.thefreedictionary.com/lancet	F 323		
F 329 SS=D	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 329		8/13/17

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F 329	Continued From page 147 (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure that one of 29 residents in the survey sample was free from unnecessary medications; Resident #3. The facility staff administered Seroquel on the resident's non-dialysis days when the physician order was for the medication to be administered on dialysis days only. The findings include: Resident #3 was admitted to the facility on 6/22/09 with a recent readmission on 12/20/16, with diagnoses that included but were not limited to: end stage renal disease requiring hemodialysis (a procedure used in toxic conditions and renal failure, in which wastes and impurities are removed from the blood by a special machine (1)), high blood pressure, dementia, stroke, depression, anxiety, and diabetes. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD of 6/4/17, coded the resident as having both short and long term memory difficulties and as being moderately impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for dressing, as dependent of one	F 329	1. Resident #3 Seroquel medication was discontinued on 6/29/17. 2. All residents have the potential to be affected by this deficient practice. 3. Clinical staff will be re-educated on following physician orders. Night shift nurses will complete 24 hour chart check to ensure physician orders are followed. 4. Care manager or designee will audit medication administration records (MARs) to ensure medications are administered according to physician orders. Issues identified will be investigated and immediately addressed. Staff will be re-educated and/or counseled as necessary. Audits will be completed on 10% of MARs on a weekly basis for 30 days, then monthly for 60 days. Audits will be reviewed by the QAPI committee for guidance or further instruction.	

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or more staff members for transfers, moving in the bed, moving on the unit, toileting needs and bathing. The resident was coded as being independent in eating after set up assistance was provided.

The physician order dated, 3/10/17, documented, "Seroquel (an antipsychotic medication used to treat schizophrenia and bipolar disorder (2)) 25 MG (milligrams); Give 12.5 mg by mouth one time a day every Tue (Tuesday), Thu (Thursday), Sat (Saturday) for anxiety, administer prior to dialysis on Tuesday, Thursday, and Saturday."

A physician order dated, 6/9/17, documented, "Dialysis M/W/F (Monday/Wednesday/Friday) pick up via (name of transport company) at 0645 (6:45 a.m.); one time every Mon, Wed, Fri related to End Stage Renal Disease."

The June 2017 MAR (medication administration record) documented, Seroquel 25 MG; Give 12.5 mg by mouth one time a day every Tue, Thu, Sat for anxiety, administer prior to dialysis on Tuesday, Thursday, and Saturday." The MAR documented that the resident received the medication on the following days, when she did not go to dialysis:
6/10/17 - Saturday
6/13/17 - Tuesday
6/15/17 - Thursday
6/17/17 - Saturday
6/20/17 - Tuesday
6/22/17 - Thursday
6/24/17 - Saturday
6/27/17 - Tuesday

Review of the clinical record documented the resident went to dialysis on 6/12/17, 6/14/17,

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6/16/17, 6/19/17, 6/21/17, 6/23/17, 6/26/17 and 6/28/17.

The comprehensive care plan dated, 1/24/14 and revised on 6/28/17, documented in part, "Focus: (Resident #3) receives antipsychotic medications for treatment of bipolar depression and antianxiety medication for management /treatment of anxiety." The "Interventions" documented in part, "Administer antidepressant and bipolar medications per MD order or new order see MARs, monitor for effectiveness as well as for side effects."

The Psychiatry Nurse Practitioner Note dated, 6/29/17 documented in part, "Diagnosis: Vascular dementia with behavioral disturbance, anxiety disorder secondary to medical condition, and major depression, mild without psychotic features....last visit pt (patient) Seroquel increased due to continued bhvl (behavioral) issues, pt has improved for symptoms however staff reports lethargy on the off days of HD (hemodialysis)."

An interview was conducted with LPN (licensed practical nurse) #1, a nurse that works with Resident #3 frequently, on 6/29/17 at 7:15 a.m. When asked what Seroquel is used for, LPN #1 stated, "It's for agitation and mood disorder changes." When asked what day Resident #3 goes to dialysis, LPN #1 stated, "Monday, Wednesday, and Friday. She used to be Tuesday, Thursday and Saturday." When asked what medications Resident #3 was to receive prior to dialysis, LPN #1 stated, "The night shift gives her Ativan before she gets picked up." When asked if dialysis reported any concerns recently with her behavior on dialysis days, LPN

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#1 stated, "Most of the time the Ativan works." When asked what class of medication Seroquel is, LPN #1 stated, "I can't tell you, I'd have to look it up." The above physician order for Seroquel was reviewed with LPN #1. LPN #1 stated, "That needs to be changed." When informed that she had given the medication on her non-dialysis days, LPN #1 stated, "I didn't follow the five rights of medication administration."

On 6/29/17 at 7:18 a.m., an interview was conducted with RN (registered nurse) #2, the care manager for the unit Resident #3 resides on. When asked what days Resident #3 goes to dialysis, RN #2 stated, "Monday, Wednesday and Fridays." When asked what class of drug is Seroquel was, RN #2 stated, "It's an antipsychotic, for her it's given for her dementia symptoms." When asked why Resident #3 was receiving Seroquel prior to dialysis, RN #2 stated, "The Ativan (an anti-anxiety medication (3)) wasn't helping. (Name of physician) decided to add the Seroquel to the mix." When asked if Resident #3 was followed by psychiatry, RN #2 stated, "Yes." The physician orders documented above for the Seroquel were reviewed with RN #2. RN #2 stated, "When her dialysis days were changed, the Seroquel order wasn't changed." When asked if that order should have been clarified, RN #2 stated, "Yes, 100%." When asked if she understood why this surveyor was questioning this order, RN #2 stated, "She's getting an unnecessary medication, it's not being given when it was ordered."

RN #2 returned to this surveyor on 6/29/17 and stated, "The Seroquel was ordered by the dialysis doctor. I called the dialysis center and they have not had any concerns for her behavior since

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changing to Monday, Wednesday and Friday and she's not been getting the Seroquel before then. I called (name of physician) and he discontinued the Seroquel."

The policy "Psychoactive Medication Management and Behavior Monitoring" did not address the above issue.

At the end of the day meeting on 6/28/17 at 5:50 p.m. the director of nursing, ASM (administrative staff member) #1, was asked which standard of practice they used at the facility, ASM #1, the director of nursing stated they used Fundamentals of Nursing by Lippincott.

In Fundamental of Nursing, 5th edition, Lippincott, Williams and Wilkens, page 564 documented, "Five Rights of Medication Administration: Right client, right medication, right dose, right time and right route."

The administrator and director of nursing were made aware of the above concern on 6/29/17 at 1:15 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 266.
(2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011909/?report=details
(3) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010988/?report=details.

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F 333 SS=D	RESIDENTS FREE OF SIGNIFICANT MED ERRORS CFR(s): 483.45(f)(2) 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to administer medications in a manner to prevent a significant medication error to one of 29 residents in the survey sample, Resident #19. The facility staff administered eight milligrams of Valium (used to relieve anxiety (1)) to Resident #19 on 12/24/16, exceeding the dosage ordered by the physician. The findings include: Resident #19 was admitted to the facility on 12/23/16 with diagnoses including pneumonia, congestive heart failure, dementia and depression. On the most recent MDS (minimum data set), a 30-day Medicare assessment with an ARD (assessment reference date) of 1/20/17, Resident #19 was coded as being moderately cognitively impaired for making daily decisions, scoring eight out of 15 on the BIMS (brief interview for mental status). She was coded as not having received medications for anxiety during the look back period. Resident #19 was discharged from the facility on 1/27/17.	F 333	1. Resident #19 has been discharged from the facility. RN #10 is no longer employed at facility. 2. Other residents had the potential to be affected. 3. On 12/28/17, an audit of all residents who received psychotropic medications was completed as a part of facility quality assurance plan. No residents were identified with adverse reactions or harm. Resident clinical records were reviewed, including physician orders and narcotic records. Medications given reflected physician orders for all records reviewed. 4. Care manager or designee will audit MARs to ensure medications are administered according to physician orders. Issues identified will be investigated and addressed, including staff re-education or counseling as indicated. Audits will be completed on 10% of MARs weekly for 30 days, then monthly for 60 days. Audits will be reviewed by the QAPI committee to determine the need of continued	8/13/17

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F 333	Continued From page 153 A review of the final FRI (facility reported incident) submitted to the state agency on 12/30/16 revealed, in part, the following: "This letter is provided as written follow up to the investigation of an unusual occurrence, medication error. On 12/26/16, facility reported a medication error involving resident [name of Resident #19]. [Resident #19] was noted with increased drowsiness by nursing supervisor during rounds on 12/25/16. Upon resident assessment, family interview, and clinical record review, supervisor noted resident received Valium 8 mg (milligrams) by [RN (registered nurse) #10. Physician ordered Valium 1 mg po (by mouth) for anxiety/agitation. An investigation was conducted regarding the medication error. [RN #10] was placed on suspension, pending investigation on 12/26/16. Physician and RP (responsible party) were notified of medication error on 12/25/16. New orders received and updated plan of care, including psych (psychology) consult for agitation and behaviors. Resident's drowsiness subsided within 24 hours. Lab (laboratory) results revealed no adverse reaction, no other changes in condition noted to resident. Upon personnel file review, counseling, and interview with [RN #10] facility met with RN on 12/29/2016 to discuss final investigation. [RN #10] resigned from her position." A review of the physician's orders for Resident #19 revealed, in part the following: "Valium Tablet 2 mg Give 1 mg by mouth as needed for 1 mg po qhs (every evening) prn (as needed) for anxiety/agitation." This order was written and signed by the physician on 12/23/16. A review of the MAR (medication administration record) for December 2016 revealed RN #10's	F 333	monitoring, re-education, and/or corrective action.	

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initials in two boxes for the Valium order stated above. One box contained the following information: [RN #10's initials], 1800 (6:00 p.m.) E (effective)." The other box contained the following information: [RN #10's initials], 2003 (8:03 p.m.) E (effective)."

A review of the nurses' notes for Resident #19 revealed the following:

- 12/24/16 at 8:39 p.m.: "Pt (patient) list of medications taken at home shows that pt take 100 mg of diazepam (Valium) every evening prior to bed. Coming from hospital, Pt was given half a 2 mg tablet which is 1% of her previous strength. Pt showed hostility to family by trying to hit them, throwing water at them and swearing at them when they came close. Family said they had mentioned discrepancy to Nurse upon admissions but stated they were told they would need a psychiatric consultation to get anything changed. Since the orders were as needed pt was given 8 addition (sic) mg of diazepam and after half an hour calmed down and talked normally with her daughter who is a nurse. Family will ask for psychiatric meeting and will contact Dr. (doctor) for further assistance on dosage. Family reported that Pt had been taking 100 mg of diazepam prior to bed for the last 8 years prior to her recent hospitalization." This note was signed by RN #10.

- 12/25/16 at 4:26 p.m.: "Home medication list and current medication list reviewed by this nurse with the patient and daughter, [name of daughter], at bedside. N.O. (new order) to discontinue Valium and to monitor patient for behaviors. New order received for psych (psychiatric) consult. Daughter, [name of

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daughter], is requesting to be notified the day of the psych consult so that she can come hear what the psychiatrist has to say. Patient is currently restringing (sic) in bed; noted to be drowsy but in pleasant mood. Denied headache at this time, denied SOB (shortness of breath). Primary nurse notified of new orders." This note was signed by RN #8, a care manager.

- 12/25/16 at 7:12 p.m.: "Pt [patient] is alert and oriented but lethargic at time (sic) and able to arouse for conversation when you get her up. Pt receiving skilled care r/t [related to] PNA [pneumonia]. Pt is able to verbalize needs know (sic) to staff. Pt continue (sic) to be monitored for increase (sic) lethargy and depression. Pt's husband and family have been here and kept her comfortable." This note was signed by LPN (licensed practical nurse) #11.

- 12/25/16 10:27 p.m.: "Pt has been stable, no adverse reactions noted." This note was signed by LPN (licensed practical nurse) #11.

- 12/26/16 at 11:28 a.m.: "Late Entry Note: Writer is clarifying an entry made on December 24, 2016 at 2039 (8:39 p.m.). Writer stated that pt takes 100 mg of diazepam every evening at home but upon reviewing the home medication reconciliation record, writer noted the pt takes 100 mg of trazadone (sic) (2) at home." This note was written by RN #8.

A review of Resident #19's comprehensive care plan dated 12/25/16 revealed, in part, the following: "[Resident #19] uses psychotropic medications r/t Behavior management, disease process, anxiety, major depression disorder...Administer medications as ordered.

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Monitor/document for side effects and effectiveness."

A review of the facility document "Controlled Medication Utilization Record" revealed, in part, the following: "Diazepam 2 mg Tablet 0.5 tab (tablet) (1 mg) by mouth daily at bedtime as needed for anxiety or agitation...12/24, 2100 (9:00 p.m.), Dose given - 8." This line of the document contained the initials of RN #10.

A review of laboratory test results for Resident #19 dated 12/27/16 revealed no evidence that any of the resident's results were critically high or low, as compared to the normal range.

A review of the facility's investigative file regarding this incident revealed a statement signed by RN #10 dated 12/25/16. Review of this statement revealed, in part, the following: "On December 24 I had rooms [number of rooms] on [name of unit]. At about 1700 (5:00 p.m.), I gave [Resident #19] who had been admitted the previous evening in [room number] 1 mg tablet of Diazepam. It was half of a 2 mg pill. The instructions were to give 1 mg at bedtime as needed for anxiety. Later that evening I was approached by a family group consisting of one of her daughters, a son-in-law, a grandson, her husband another male family member. They stated the pt had tried to hit them, swore at them, and threw cups of water at them. They said that she must be under medicated and that she had never acted like that at home. I told them I had given her 1 mg of Diazepam earlier and they stated she took larger doses of the medication at home. I asked them if that was the medication and they said yes. I asked if they had a list of medications they had given the hospital. No one had that so the one daughter began to

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call 2 other daughters who were nurses and ask them about the medication and the dosages. One did not answer the phone and the other did not have precise information. I volunteered that the doctor was being cautious. I also knew [name of another resident] had a prn for 5 mg of Diazepam every 8 hours for anxiety. The daughter here asked if the hospital had send (sic) over a list of medications she was taking when she entered the hospital. I said I would look in the [room number] folder. Looking through I saw the list of Home Medications. At the bottom of the page I saw Trazadone (sic) 100 mg tablet was on the list. The daughter was looking at the list too. Somehow in my mind I was thinking Diazepam. I asked how much the mother weighed. They said 180 lbs (pounds). Thinking that she had taken 100 mg Diazepam at bedtime in the past, I gave 8 additional mg and documented it in the Health Notes. I read the directions about giving one tablet at bedtime as needed but also interpreted as needed to mean more could be given if the 1 mg was not sufficient. Later another daughter (one of the nurses) arrived and said the mom seemed calm and did not need any more medication and that her mother was speaking normally. Later when I gave the 2100 (9:00 p.m.) medications the mother was pleasant and asked about separating the pills and applesauce when she received her morning meds. I said I would put a note on the med (medication) cart. Today when I came to work I talked to [name of RN #8] about getting an air mattress to help [name of another resident]'s pressure sore and also mentioned giving the 8 extra Diazepam to [Resident #19]. Now of course I understand the mistakes I made about interpreting the medication administration directions and that I also transposed the two

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different medications. I will double check the directions when I administer narcotics in the future follow them (sic). If I am not clear I will ask another experienced nurse. Also I think I have learned a lesson about believing everything a family member says about a situation without verifying it with the physician."

Further review of the investigative file revealed the document "Just Culture Investigation Documentation Form." The form was dated 12/29/16, and stated, in part: "[RN #10] administered an incorrect dose of Diazepam without a provider order to a patient, which resulted in a major medication error. The patient experienced a change in mental status and the dose of the Diazepam (8 mg) and the justification for administration is considered a chemical restraint to the patient. Nursing staff must follow provider orders and only administer medications for which they have an order for and within safe administration guidelines. [RN#10] should have clarified the order with the patient's attending provider before administering the dose of the medication. [RN #10] explained that she confused the dose of Diazepam with the patient's reported home dose of Trazadone (sic) and administered the medication based upon her own nursing judgment/interpretation of the written order. The patient's family and attending MD were notified. Patient was monitored for changes in health condition and lab (laboratory) work was obtained. Medication order was discontinued and changed to a safe dose range for the patient. [RN #10] was placed on administrative leave pending investigation."

On 6/28/17 at 11:30 a.m., RN #3 was interviewed. She worked in Resident #19's vicinity during

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12/24/16 through 12/26/16. She stated she remembered Resident #19, but was never assigned to care for her, and did not remember any specifics about Resident #19.

On 6/28/17 at 11:32 a.m., CNA (certified nursing assistant) #3 was interviewed. She stated Resident #19 was "not with it." She stated she would lash out, especially with her family. She stated the resident's family "would come in and aggravate her." She stated she did not remember specifically anything about Resident #19 from 12/24/16 through 12/25/16.

Attempts to interview LPN #11 during the survey were unsuccessful.

On 6/28/17 at 11:40 a.m., RN #8 was interviewed. She stated: "[Resident #19] was a new admit. Her family was pushy and invasive." She stated she was not present in the building when RN #10 gave the incorrect dose of Valium to Resident #19. She stated RN #10 identified the medication error inadvertently during a conversation. RN #8 stated: "It happened on Saturday evening, and we identified it on Sunday. The nurse came and told me she'd had trouble on 12/24/16. She told me how she'd handled it. It was clear she had no idea what she had done." When asked about Resident #19's behaviors, RN #8 stated the resident experienced anxiety, frequent crying, and depression. She needed something prn, and the Valium was appropriately prescribed. This was a new nurse (referring to RN #10). She had struggled during orientation." She stated RN #10 thought the terms 'at hs (bedtime)' and 'as needed' were two separate instructions, and that she could give both. She stated: "[RN #10] also confused the Diazepam and the Trazodone. She

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did not call anyone for clarification." RN #8 stated when she began to understand what had happened, she looked at the resident's MAR, the narcotic count sheet, and the resident's supply of Valium in the medication card. RN #8 stated: "I verified what she had done, and I went to assess the resident." She stated Resident #19 was drowsy, but arousable and alert when awakened. She stated she called the physician, who told her to continue to monitor the resident closely for the next 12 hours or so. RN #8 stated: "Valium has a relatively short half-life, and we were on the end of that time frame." She stated the facility also arranged for a psychology consult for Resident #19 "very quickly."

On 6/28/17 at 1:15 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated that RN #10 had required an extended orientation, but she felt RN #10 was ready to work the floor. She stated that as soon as the facility staff became aware of the medication error, RN #10 was suspended. Ultimately, RN #10 was called back to the facility to meet with her (ASM #2) and representatives from human resources. She stated during this meeting, RN #10 resigned. At this time, ASM #2 informed the surveyor that the facility had put an action plan in place to correct this deficiency. The surveyor requested a copy of the action plan, and of credible evidence that the facility had completed all points of the plan.

On 12/28/17 at 5:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, RN #2, a care manager, and RN #8 were informed of these concerns.

A review of the facility professional standard

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printout "Safe medication administration practices, long-term care" revealed, in part the following: To promote a culture of safety and prevent medication errors, nurses must adhere to the 'rights of medication administration:' identify the right resident...select the right medication, give the right dose, give the medication at the right time, give the medication by the right route, and provide the right documentation."
This information was printed from the website http://procedures.lww.com/lnp/view.do?pId=1970995&hits (a Lippincott website).

A review of the facility policy "Medication Procedure" revealed, in part, the following: "Medications will be given according to doctor's prescribed time and dosage...Medication dosage - check MAR for dosage, correct time and amount to be administered. Check dosage with medication dispensed by pharmacy for accuracy."

On 12/28/17 at 3:30 p.m., ASM #2 presented the surveyor with the document "QA (quality assurance) Action Plan." This document stated, in part, the following: "Medication error - psych med for resident w/ (with) behaviors. Corrective Action: 1. MD/RP notification for resident identified. New drugs received. Care plan updated. 2. Responsible nurse was educated and counseled. How other residents at risk for related non-compliance will be identified and what corrective actions will be taken: Review all residents receiving psych meds for change in condition, behaviors...Follow up as indicated. System Changes to maintain compliance: 1. Licensed nurses will be educated on medication administrations - avoiding errors. 2. Care manager or designee will review all residents with new psych meds [medications] and/or residents

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with behaviors assess and intervene as indicated. Monitoring for effectiveness of New Systems and Compliance: DON (director of nursing) or designee will audit 10% of residents receiving psych meds and conduct QA audit regarding medication admin (administration), physician order and clinical record. Review monthly X 3 months (for 3 months). Findings will be reported to QAPI (quality assurance performance improvement) committee monthly for review and adjust plan accordingly." At this time, ASM #2 also provided the surveyor with a file folder, which she stated contained the credible evidence that this plan had been implemented. A review of the credible evidence by the surveyor failed to reveal evidence of a complete audit by the facility staff of all residents receiving psychoactive medications at the time of the medication error. It also failed to reveal evidence of the monthly audits outlined in the plan. It also failed to reveal evidence that all licensed nurses had been educated regarding medication administration and order clarification as outlined in the plan. When asked about this, ASM #2 stated: "You are right. I cannot provide that evidence."

No further information was provided prior to exit.

(1) "Diazepam (generic for Valium) is used to relieve anxiety, muscle spasms, and seizures and to control agitation caused by alcohol withdrawal." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682047.html.

(2) "Trazodone is used to treat depression. Trazodone is in a class of medications called serotonin modulators. It works by increasing the amount of serotonin, a natural substance in the

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F 333	Continued From page 163 brain that helps maintain mental balance." This information is taken from the website https://medlineplus.gov/druginfo/meds/a681038.html.	F 333		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (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); (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	F 441		8/13/17

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F 441	Continued From page 164 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. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview, and facility document review, it was determined that the facility staff failed to provide incontinent care in a manner to prevent the spread of infection for one of 29 residents in	F 441	1. CNA #6 was re-educated on Infection Control Procedures during incontinence care and Hand Hygiene standards. 2. All residents have the potential to be	

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F 441	Continued From page 165 the survey sample; Resident #10. The facility staff failed to change gloves when moving from a dirty to clean task during Resident #10's incontinent care. The facility staff also failed to wash or sanitize hands after incontinent care and before using sign language to communicate with Resident #10, a deaf and blind resident who touches the hands of care givers to receive the communication being signed. The findings include: Resident #10 was admitted to the facility on 2/29/08 and most recently readmitted on 3/13/17 with the diagnoses of but not limited to altered mental status, diabetes, bipolar, chronic kidney disease, human immunodeficiency virus, acidosis, chronic pain syndrome, delusional disorder, adrenal gland disorder, glaucoma, stage 4 breast cancer with metastasis, deafness, and blindness. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/28/17. Resident #10 was coded as being cognitively intact, scoring a 15 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring limited to extensive assistance for transfers; supervision to limited assistance for ambulation; supervision for hygiene; limited assistance for bathing; independent for eating; and as generally continent of bowel and bladder, with incontinence at times. On 6/28/17 at 7:50 a.m., incontinent care was observed on Resident #10 being performed by CNA #6 (Certified Nursing Assistant). The	F 441	affected by this deficient practice. 3. Nursing staff will be re-educated on Infection control procedures, incontinence care, and proper hand hygiene. 4. DON or designee will conduct rounds daily M-F for 4 weekly, then on a weekly basis for 60 days. DON or designee will conduct rounds to ensure staff is following hand hygiene and incontinence care correctly to prevent the spread of infection. Results of rounds will be presented to the QAPI committee for further guidance or instruction.	

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resident was noted to have voided and stooled in her brief. CNA #6 was observed to clean the resident of urine and feces and remove the soiled brief. CNA #6 then applied a clean brief to the resident without first changing her gloves and washing her hands, after cleaning the resident of stool. Once finished, CNA #6 then removed the contaminated glove from her right hand and signed with the resident. The staff communicates with the resident by sign language into the resident's hands wherein she can feel what is being signed. The CNA did not sanitize or wash her hands after removing the contaminated glove, before allowing the resident to touch her hands for signing.

On 6/28/17 at 1:41 p.m., in an interview with CNA #6, she stated that she did not know to change gloves from dirty task to clean task. CNA #6 stated she did not realize that signing with the resident before washing her hands was an infection control issue.

A review of the facility policy, "Routine Hand Hygiene" documented, "Routine hand hygiene will be performed:...3. Between tasks (related to patient care) as appropriate."

In addition, the facility provided the procedures used in the on-site CNA training program for incontinence care. This procedure, titled "Lippincott Procedures - Incontinence briefs and pad handling, long-term care" documented, "....If the briefs or pad is soiled, and the resident is lying in bed, remove the briefs or pad; roll the pad or briefs toward the inside soiled area during removal.....Immediately clean the resident's skin gently.....Remove and discard your gloves. Perform hand hygiene. Put on clean

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F 441	Continued From page 167 gloves.....Replace the soiled briefs or pad with a clean one...." On 6/28/17 at 6:00 p.m., the Administrator (ASM #1 - Administrative Staff Member), the DON (Director of Nursing - ASM #2) and the care manager, (RN - Registered Nurse #2) were made aware of the findings. No further information was provided by the end of the survey.	F 441		
F 513 SS=D	X-RAY/DIAGNOSTIC REPORT IN RECORD-SIGN/DATED CFR(s): 483.50(b)(2)(iv) (b) Radiology and other diagnostic services. (2) The facility must- (iv) File in the resident's clinical record signed and dated reports of radiologic and other diagnostic services. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to file an x-ray report in the electronic clinical record for one of 29 residents in the survey sample; Resident #12. An x-ray completed on 6/20/17 and acknowledged as read by the physician on 6/21/17, was not filed in the clinical record for Resident #12 when the record was reviewed on 6/28/17 and 6/29/17. The findings include: Resident #12 was admitted to the facility on 5/4/16 and readmitted on 6/19/17, (after an	F 513	1. The X-ray report dated 6/20/17 was filed in Resident #12 EMR on 6/29/17. Documentation of physician acknowledgement of the x-ray report was documented in the EMR. The physician evaluated Resident #23 on 6/21/17. 2. All residents have the potential be affected by this deficient practice. 3. Nursing staff and the Medical Records employee will be re-educated on filing of documents in the EMR. X-ray/diagnostic reports will be scanned into the EMR by the Medical records employee or Care manager once acknowledged by the	8/13/17

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F 513	Continued From page 168 overnight only stay in the hospital emergency room for evaluation), with diagnoses that included but were not limited to: dementia, high blood pressure, anxiety, insomnia, depression, abnormal weight loss and protein calorie malnutrition. The most recent MDS (minimum data set), an annual assessment, with an assessment reference date of 5/18/17, coded the resident as being severely impaired to make daily cognitive decisions. Resident #12 was coded as requiring limited assistance of one staff member for moving in the bed and dressing, extensive assistance of one staff member for transfers and toileting, and as independent after set up assistance was provided for eating. Resident #12 was not coded for any impairment in her range of motion. In Section J - Health Conditions, the resident was coded as having had two falls without injuries. On 6/19/17, the physician order documented, "Right rib x-ray one time only for pain, fall for 2 days." The review of the electronic medical record did not evidence the results of the x-ray. The "Fall Investigation" dated, 6/18/17, documented in part, "Mental Status: X-ray revealed broken 7th and 8th right lateral rib fractures." The "Department of Radiology" report dated, 6/20/17, documented in part, "There is a fracture of the ninth and 10th lateral ribs, with slight displacement, possible involving the eighth lateral rib as well. These are probably acute or recent.	F 513	physician. 4. Administrator or designee will audit x-ray/diagnostic reports to ensure they are scanned into the EMR. Administrator or designee will audit will audit 10% of x-ray/diagnostic reports for 30 days, then monthly for 60 days. Discrepancies noted will be corrected with staff re-education as necessary. Results of audits will be reviewed by QAPI committee for further guidance or instruction.	

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Impression: Right sided lateral rib fractures as mentioned." The attending physician documented his review of the report on 6/21/17.

An interview was conducted with LPN (licensed practical nurse) on 6/29/17 at 11:40 a.m. When asked who is responsible for filing the x-ray results in the clinical record, LPN #1 stated, "The nurses get the results. We call or send them to the doctor and after we receive it back from the doctor it goes in a folder for medical records to scan it into the medical record."

An interview was conducted with other staff member (OSM) #1, the medical records staff member on 6/29/17 at 11:41 a.m. When asked about the process followed for filing x-ray results into the clinical record, OSM #1 stated, "Once they are signed by the doctor, there is a folder on each station with things that need to be scanned in the computer. I check the folders daily." When asked why the x-ray report dated 6/20/17, signed by the doctor on 6/21/17 was not in Resident #12's clinical record, OSM #1 stated, "Lately, I'm behind. It was in the building. I guess the care coordinator had it in her scan book. They review it and then put it in my folder. I didn't have it." OSM #1 was asked for a policy on the filing of x-ray reports in the clinical record.

On 6/29/17 at 12:10 p.m., OSM #1 provided a copy of a facility policy, "Medical Record" that documented in part: "All medical/clinical information, including MDS and Care plans will be documented in electronic medical record, with exception that documents completed outside of community will be scanned into electronic medication record."

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F 513	Continued From page 170 The administrator and director of nursing were made aware of the above concern on 6/29/17 at 1:15 p.m. No further information was provided prior to exit.	F 513		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (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	F 514		8/13/17

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F 514	Continued From page 171 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 resident interview, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to ensure a complete and accurate clinical record for three of 29 residents in the survey sample, Resident #2, #23 and #1. 1. The facility staff failed to provide documented evidence that Resident #2 was given a bath or shower for the month of April 2017. 2. The facility staff failed to document weekly wound measurements/assessments of Resident #23's stage two pressure ulcers [1] to the sacrum and the right buttock that the resident had upon admission to the facility on 2/22/17. 3. Resident #1's clinical record contained documents that belonged to another resident. The findings include: 1. The facility staff failed to provide documented evidence that Resident #2 was given a bath or shower for the month of April 2017. Resident #2 was admitted to the facility on 9/25/2015 with diagnoses that included but were not limited to syncope/collapse, high blood pressure, failure to thrive, heart failure, peripheral vascular disease, and dementia without behavioral disturbance. Resident #2's most	F 514	1. Documentation of showers given in April for Resident #2 cannot be entered into the EMR due to time lapse. No further documentation is available for resident #23 weekly wound measurements/skin assessment for stage two pressure ulcers to the sacrum and right buttock that were present upon admission on 2/22/17. Skin measurements/assessment for resident #23 will be completed weekly and assessments documented in the EMR. The misfiled document was removed from Resident #1 clinical record on 6/30/2017. 2. All residents have the potential to be affected by this deficient practice. 3. Nursing staff will be re-educated on documentation requirements, including baths and wound measurements, to ensure complete and accurate records. Nursing staff and Medical records will be re-educated to ensure accurate filing of documents in the correct residents EMR. 4. Care manager or designee will audit 10% of ADL records on a weekly basis for 30 days, then monthly for 60 days, to ensure documentation is completed by nursing staff. Care manager or designee will audit all new admissions and 10% of weekly skin assessments to ensure skin assessments are completed. Audits will	

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recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/4/17. Resident #2 was coded as being moderately cognitively impaired in the ability to make daily decisions scoring 11 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #2 was coded as requiring supervision only with transfers, ambulation, personal hygiene, and locomotion; and independent with meals.

Resident #2 was coded as an "8/8" for bathing in Section G "Functional Status," of the 4/4/17 MDS assessment indicating that this activity did not occur over the entire 7 day period.

On 6/28/17 at 1:50 p.m., an interview was conducted with Resident #2. When asked if she received her scheduled showers, Resident #2 stated, "I always get them." Resident #2 had no concerns regarding showers or bathing.

On 6/29/17 at 7:15 a.m., a copy of Resident #2's ADL (activities of daily living) tracker for bathing was requested from RN (registered nurse) #2, the care manager.

On 6/29/17 at 7:30 a.m., RN #2 stated, "There was no bathing documented for April. It looks like it wasn't done."

On 6/29/17 at 8:06 a.m., an interview was conducted with CNA (certified nursing assistant) #14, a CNA who regularly works with Resident #2. When asked about the process followed for documentation after she gives a resident a shower, CNA #14 stated that she will document on the ADL care tracker that a shower was completed. CNA #14 stated that it should also be

be completed weekly for 30 days, then monthly for 60 days. Administrator or designee will audit 10% of x-ray/diagnostic reports, consults, or other documents requiring filing in the medical record, to ensure they are filed in the correct EMR. Audits will be completed on 10% of records weekly for 30 days, then monthly for 60 days. Results of all audits will be presented to the QAPI for review and further instruction.

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documented if a resident did not receive a shower. When asked it was ever ok to not document whether a shower was completed or not, CNA #14 stated, "No. There's no excuse." CNA #14 stated that whenever she has Resident #2, she will give the resident a shower. CNA #14 stated, "She usually gets them on Thursday nights when I work." When asked if CNA #14 worked with Resident #2 back in April of 2017, CNA #14 stated that she was out most of April for surgery.

On 6/29/17 at 10:38 a.m., an interview was conducted with RN (registered nurse) #1, the MDS coordinator. When asked what 8/8 meant on the MDS for bathing, RN #1 stated that the activity did not occur or they could not find the documentation to support that bathing was completed.

On 6/29/17 at 4:50 p.m., ASM (administrative staff member) #1, the administrator and ASM 2, the DON (Director of Nursing) were made aware of the above concerns.

The facility policy titled, "Medical Record," documents in part, the following: "Clinical Records are maintained on each resident in accordance with federal and state regulations and within accepted professional standards and practices. The clinical record shall be accurate, complete, and present organized clinical information about each resident in a manner that is readily accessible for resident care."

No further information was presented prior to exit.

2. The facility staff failed to document weekly

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wound measurements/assessments of Resident #23's stage two pressure ulcers [1] to the sacrum and the right buttock that the resident had upon admission to the facility on 2/22/17.

Resident #23 was admitted to the facility on 2/21/17 with diagnoses that included but were not limited to: displaced intertrochanteric fracture of the left femur, high blood pressure, vascular dementia without behavioral disturbance, non-traumatic intracranial hemorrhage, anxiety disorder and major depressive disorder. Resident #23's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 5/15/17. Resident #23 was coded as severely cognitively impaired in the ability to make daily decisions scoring 99 out of 15 on the BIMS (Brief interview for Mental Status) exam. Resident #23 was coded as requiring extensive assistance from two plus persons with transfers; extensive assistance from one person with dressing, and personal hygiene; and total dependence on staff with bathing.

Review of Resident #23's nursing notes revealed the following admission note dated 2/22/17: "Patient receiving skilled care for L (left) hip fx (fracture). VS (Vital signs) stable A&O (alert and oriented) x1 (to self), remains incontinent of bowel and bladder. Incision to L lateral femur, L hip, sutures in place. no (sic) s/s (signs/symptoms) infection noted. no (sic) c/o (complaints) pain this shift. bed (sic) monitor in place for fall prevention. call (sic) bell in reach. working (sic) with therapy."

The next note dated 2/22/17 documented the following: "Stage 2 pressure to sacrum measuring

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3 cm (centimeters) x 2 cm (centimeters) x 0.1 cm. Wound bed pink, new treatment orders initiated. Intact blister to right buttock measuring 2 cm x 0.5 cm, new treatment orders initiated."

No other nursing notes were found in the clinical record regarding Resident #23's stage two pressure ulcers.

Review of Resident #23's weekly skin observation sheet dated 3/21/17, documented the following: "Site: Right buttock, Type: Pressure, Length: 0, Width: 0, Depth: 0. Site: Sacrum, Type: Pressure, Length: 0, Width: 0, Depth: 0...Comments: R (right) buttock PU (pressure ulcer) has resolved, scar remains Sacrum PU has resolved, scar remains."

Review of Resident #23's February and March 2017 TARs (Treatment administration record) revealed that weekly skin observation assessments were checked as being completed on the following dates:

2/27/17, 3/6/17, 3/13/17, and 3/20/17.

Weekly skin assessment sheets for the above dates did not address the stage two pressure ulcers to Resident #23's right hip and sacrum.

Further review of Resident #23's February and March 2017 TARS revealed that treatments were put into place and completed until both stage two pressures sores healed on 3/21/17.

Review of Resident #23's care plan dated 3/14/17, failed to document the stage two pressure ulcers to Resident #23's right buttock and sacrum.

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F 514	Continued From page 176 On 6/29/17 at 3:20 p.m., an interview was conducted with LPN (licensed practical nurse) # 2, the nurse who works with Resident #23. When asked how often wound assessments were conducted, LPN #2 stated that wound assessments were conducted weekly. When asked what type of things were assessed and documented on the weekly wound sheets, LPN #2 stated that the location, appearance, size and stages of the wound were documented on a weekly wound observation sheet. LPN #2 was asked if she could find weekly wound assessments for Resident's #23's stage two pressure sores to her sacrum and right buttock. LPN #2 looked through the weekly wound observation sheets and then stated that she could only find the admission note and the weekly skin observation sheet dated 3/21/17 when the pressure sores were documented as healed. LPN #2 stated that there should have been more documentation on the two stage two pressure ulcers. When asked if these pressure sores were healed, LPN #2 stated that Resident #23 did not have any pressure areas to her bottom. LPN #2 stated that the wound care nurse practitioner usually assesses wounds behind the nurses. Notes from the wound care nurse practitioner could not be found regarding Resident #23's stage two pressure ulcers. On 6/29/17 at 4:50 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director or Nursing) were made aware of the above concerns. The facility policy titled, "Skin and Wound Care" documents in part, the following:	F 514		

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"Documentation:..3. All pressure ulcers require weekly assessment and documentation includes (sic): stage, size, (measure head to toe and record greatest length X greatest width X greatest depth), and description of ulcer. 4. When there are several ulcers, each ulcer is assess (sic) individually."

No additional information was presented prior to exit.

[1] A pressure ulcer is an inflammation or sore on the skin over a bony prominence (e.g., shoulder blade, elbow, hip, buttocks, or heel), resulting from prolonged pressure on the area, usually from being confined to bed. Most frequently seen in elderly and immobilized persons, decubitus ulcers may be prevented by frequently change of position, early ambulation, cleanliness, and use of skin lubricants and a water or air mattress. Also called bedsores. Pressure sores. Barron's Dictionary of Medical Terms for the Non Medical Reader 2006; Mikel A. Rothenberg, M.D. and Charles F. Chapman. Page 155.

[2] Stage II pressure ulcer: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Further description: Presents as a shiny or dry shallow ulcer without slough or bruising. This information was obtained from the National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm.

3. Resident #1's clinical record contained documents that belonged to another resident.

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Resident # 1 was admitted to the facility on 12/2/14 and most recently readmitted on 4/7/15 with diagnoses that included but were not limited to: anemia, osteoporosis (1), hypertension (2), diabetes, and stroke (3). Resident # 1's most recent MDS (minimum data set) an annual assessment with an ARD (assessment reference date) of 6/12/17 coded the resident as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, indicating that Resident # 1 was cognitively intact. Resident # 1 was coded as requiring extensive assistance of two+ staff with transfers on/off the toilet.

During a review of Resident # 1's electronic clinical record a document belonging to another resident was noted to have been scanned into Resident # 1's record.

During an interview on 6/29/17 at 1:20 p.m. with OSM (other staff member) # 1, the medical records staff person, this was reviewed. OSM # 1 stated, "I do audit the records, I just missed it."

During an interview on 6/29/17 at approximately 3:00 p.m. with ASM (Administrative staff member) # 1, the administrator, this concern was shared and a request for the facility policy was requested.

Review of the facility policy "Medical Record, 778-001" documented the following under "Purpose: Clinical records are maintained on each resident in accordance with federal and state regulations and within accepted professional standards and practices. The clinical record shall be accurate, complete and present organized clinical information about each resident in a manner that is readily accessible for

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resident care. The facility will safeguard clinical record information to ensure confidentiality and to prevent loss, destruction, or unauthorized used. All information in medical records is confidential..."

According to "Fundamental Nursing Skills and Concepts": Eighth edition, Chapter 3, pg. 36 read: "Each healthcare setting requires accurate and complete documentation. The medical record is a legal document....Records must be timely, objective, accurate, complete and legible..."

No further information was provided prior to exit.

References:

(1) Osteoporosis -- Makes your bones weak and more likely to break. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/osteoporosis.html.

(2) Hypertension: A condition present when blood flows through the blood vessels with a force greater than normal. Also called high blood pressure, hypertension can strain the heart, damage blood vessels, and increase the risk of heart attack, stroke, kidney problems, and death. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0024199/

(3) A stroke occurs when blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing

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F 514	Continued From page 180 lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm.	F 514		