| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 495240 | A. BUILDING ______ B. WING ______ | C 11/02/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| FREDERICKSBURG HEALTH AND REHAB | 3900 PLANK ROAD FREDERICKSBURG, VA 22407 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 10/31/17 through 11/2/17. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.<br><br>The census in this 177 certified bed facility was 104 at the time of the survey. The survey sample consisted of 23 current resident reviews (Residents #1 through #18, and Residents #22 through #26) and three closed record reviews (Residents #19 through #21). | F 000 | | |
| F 157 SS=D | 483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br><br>(g)(14) Notification of Changes.<br><br>(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-<br><br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br><br>(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);<br><br>(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 | 1. Facility notified Resident #7 physician on 9/25/17 and orders were received for Percocet. Pharmacy delivered Percocet and medications were administered per order for Resident #7 on 9/27/17.<br>2. Residents who reside in this facility are at risk for same deficient practice.<br><br>RECEIVED<br>DEC 12 2017<br>VDH/OLC | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 12/11/17

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

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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 and clinical record review, it was determined, the facility staff failed to notify the physician of a change in resident condition for one of 26 residents in the survey sample, Resident #7.

The facility staff failed to notify the physician when a prescription was needed to refill Resident #7's Percocet [1].

The findings include:

F 157 Continued from page 1

3. Any changes with residents will be noted on the 24 hour report and reviewed daily in the morning meeting and also the stand down meeting in the afternoon. In addition, a 24 hour chart check will be completed by the 11-7 shift and any changes needed will be verified at that time. The Director of Nursing (DON) or designee will re-educate nursing staff on physician notification by 11/24/17. An audit will be completed 2 X Week on 10 resident records for 4 weeks to monitor for physician notification.
4. Results from audits will be reviewed in the monthly Quality Assurance Performance Improvement (QAPI) meeting. Any trends or issues will be addressed and re-education to take place as needed.

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Resident #7 was admitted to the facility on 8/29/17 with diagnoses that included but were not limited to: peripheral vascular disease with vascular ulcers to bilateral legs, cellulitis to bilateral legs, COPD (chronic obstructive pulmonary disease), chronic back pain, and Non-Alzheimer's dementia. Resident #7's most recent MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 8/29/17. Resident #7 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 #7 was coded as requiring extensive assistance of one staff member with transfers, dressing, hygiene and bathing; and supervision only with meals. Section J "Pain" of the MDS assessment coded Resident #7 as having a pain of 10 out of 10 (10 being the worst possible pain, on a scale from 0-10).

Review of Resident #7's most recent physician order sheet revealed the following order: "Percocet Tablet 5-325 MG (milligrams) (Oxycodone-Acetaminophen) Give 2 tablet by mouth every 6 hours related to chronic pain." This order was initiated on 8/24/17.

Review of Resident 7's September 2017 MAR (Medication Administration Record) revealed that he did not receive his Percocet on the following dates and times: 9/24/17 6:00 a.m., 9/24/17 at 6:00 p.m., 9/25/17 at 12:00 a.m., and 9/25/17 at 06:00 a.m. A "7" (seven) was coded for each administration of Percocet indicating that a nurses' note was written.

Review of the nursing notes revealed the

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following:
- "9/24/17 06:48 a.m.: Percocet Tablet 5-325 mg Give 2 tablet by mouth every 6 hours related to OTHER CHRONIC PAIN. Medication not available. Pharmacy awaiting RX (prescription).

- 9/24/17 18:38 (6:38 p.m.): Percocet Tablet 5-325 mg Give 2 tablet by mouth every 6 hours related to OTHER CHRONIC PAIN. Medication not available. Pharmacy awaiting RX (prescription).

- 9/25/17 12:18 a.m.: Percocet Tablet 5-325 mg Give 2 tablet by mouth every 6 hours related to OTHER CHRONIC PAIN. Med (medication) not available per pharmacy prescription needed.

- 9/25/17 12:20 a.m.: All medications and treatments completed at scheduled time 09/24/17 0700-1500 (7 a.m. to 3 p.m.) ...unable to chart at time of administrations due to Point Click Care help desk ticket pending. Percocet continues to be unavailable from pharmacy. Night shift staff notified.

- 9/25/17 06:24 a.m.: "Percocet Tablet 5-325 mg Give 2 tablet by mouth every 6 hours related to OTHER CHRONIC PAIN. no (sic) available."

Review of the "On-Site Formula Alixa RX" (The facility's STAT [immediate] BOX) revealed that Percocet 5-325 mg was in the STAT BOX.

There was no evidence that the physician was made aware that Resident #7 needed a prescription for his Percocet. There was no evidence that the physician was made aware that Resident #7 missed four doses of his Percocet. There was no evidence that nursing staff

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attempted to obtain Percocet from the facility STAT medication supply.

On 11/1/17 at 6:13 p.m., an interview was conducted with RN (registered nurse) #1, the 11-7 shift nurse who was working on 9/24/17 and 9/25/17 with Resident #7. When asked about the process staff follows when a narcotic is not available on the medication cart for administration, RN #1 stated she would go into Alixa (STAT box) and see if the medication was available in Alixa. RN #1 stated in order to obtain medication from Alixa, she would have to call the pharmacy to receive a code to open the box. RN #1 stated if the narcotic needed a script (prescription), she would contact the physician to get a script. When asked if she could recall Resident #7 running out of his Percocet on 9/24/17 and 9/25/17; RN #1 stated that Resident #7's Percocet needed a script from the physician. RN #1 stated she had attempted to contact the on-call physician and NP (nurse practitioner) to receive a script. RN #1 stated she did not receive a call back. RN #1 stated she had passed this information to the 7-3 shift nurse on 9/24/17, but then when she arrived to work on 9/25/17, the medication was still not re-filled. RN #1 stated she could not get in touch with a physician on 9/25/17. RN #1 could not determine if she had documented the physician and NP were notified. RN #1 stated Resident #7 was not in any pain or distress during these two days. RN #1 stated Resident #7 also had a fentanyl patch [2] that was helping with his pain.

On 11/2/17 at 8:45 a.m., an interview was conducted with ASM (administrative staff member) #3, the nurse practitioner. She could not recall being notified about Resident #7's

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Percocet on 9/24/17 and 9/25/17. ASM #3 stated all of the nurses had her number and she has called scripts into the pharmacy during the 11-7 shift many times. ASM #3 stated if she was called for a script, she would ensure the medication was re-filled. ASM #3 stated she was not aware that Resident #7 did not receive his Percocet on 9/24/17 and 9/25/17.

On 11/2/17 at approximately 10:00 a.m., ASM #1, the interim administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

A facility policy could not be provided regarding the above concern.

[1] Percocet (oxycodone hydrochloride and acetaminophen tablet)- opioid analgesic used to treat moderate to severe pain. This information was obtained from The National Institutes of Health.
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3af57f54-117e-43fc-b0ae-21ef772d854e
.

[2] Fentanyl patch-skin patch used to treat severe pain. This information was obtained from The National Institutes of Health.
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010281/?report=details.

F 252 483.10(e)(2)(i)(1)(i)(ii)
SS=D SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT

(e)(2) The right to retain and use personal possessions, including furnishings, and clothing,

F 252

1. Facility replaced the privacy curtain for resident #11 on 11/3/17. The shower room on West 2 Unit was cleaned, including the toilet seat and bathtub on 11/2/17 by the housekeeping supervisor.

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as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

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

(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.

(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.

(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview and clinical record review, it was determined, the facility staff failed to maintain a clean, comfortable and homelike environment for one of 26 residents in the survey sample, Resident #11; and one of four shower rooms, the West 2 shower room.

1. The facility staff failed to ensure Resident #11's privacy curtain was free from dirt and stains.

2. The facility staff failed to ensure the West 2 shower room was free from feces in the bathtub and toilet seat.

F 252

2. An environmental audit was completed by the Administrator and Housekeeping Supervisor on 11/20/17.
3. Environmental issues will be audited 5 x week by department managers during carekeeper rounds to identify environmental issues in resident rooms and care areas. Administrator re-educated department managers on 11/17/17 on completing rounds to identify and report environmental issues to housekeeping or maintenance as appropriate.
Rounds will be discussed during morning meeting and addressed by housekeeping or maintenance as appropriate.
Staff will be re-educated on communication process of notifying housekeeping or maintenance of issues.

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The findings include:

1. Resident #11 was admitted to the facility on 12/20/2012 with diagnoses that included but were not limited to: Non-Alzheimer's Dementia, major depressive disorder, chronic kidney disease, high blood pressure, and unspecified psychosis. Resident #11's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 8/29/17. Resident #11 was coded as being cognitively intact in the ability to make daily decisions scoring 14 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #11 was coded as requiring limited assistance from one staff member with transfers and dressing; extensive assistance from one staff member with toileting, personal hygiene; and independent with meals.

On 10/31/17 at 11:18 a.m., and 2:35 p.m.; and 11/1/17 at 7:50 a.m., and 11:00 a.m., observations were made of Resident #11's room. His privacy curtain was observed to have black debris all over it, that appeared to be from dirt and dust. Many stains were also observed throughout the curtain that appeared to be orange in color.

On 10/31/17 at 11:19 a.m., an interview was conducted with Resident #11. Resident #11 stated that it bothered him "a little bit" that his privacy curtain was dirty. Resident #11 stated that he did not know how long his curtain had been dirty.

On 11/1/17 at 12:25 p.m., an interview was conducted with OSM (other staff member) #5, a housekeeper. When asked who was responsible for ensuring privacy curtains were clean, OSM #5

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4. Results of audits will be reviewed in the monthly QAPI meeting. Any trends or issues will be addressed and re-education to take place as needed. 11/30/17

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stated housekeeping checks privacy curtains at least once a week. OSM #5 stated if a curtain is dirty, she will alert the director of housekeeping to take the curtain down and send it to laundry. OSM #5 stated there was not a particular day that housekeeping checked the curtains. OSM #5 stated she had been assigned to Resident #11's room every day except Monday. When asked if she had already been in Resident #11's room that shift, OSM #5 stated she had. When asked if she had noticed anything in Resident #11's room, OSM #5 stated she did not. OSM #5 then followed this writer to Resident #11's room. When asked what she noticed about Resident #11's curtain, OSM #5 stated, "It appears to be dirty and needs to be changed." OSM #5 stated she would alert her manager to take it down.

On 11/2/17 at approximately 10:00 a.m., ASM (administrative staff member) #1, the interim administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

Facility policy titled, "Complete Room Cleaning" did not address privacy curtains.

No further information was presented prior to exit.

2. The facility staff failed to ensure the West 2 shower room was free from feces in the bathtub and on the toilet seat.

On 11/2/17 at 7:19 a.m., observation of the West 2 shower room was conducted. A basin used underneath a commode to collect urine and feces was observed in the bathtub with a brown liquid substance inside the basin. A brown smudge



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was also observed on the rim of the toilet seat in the shower room.

On 11/2/17 at 7:21 a.m., an interview was conducted with CNA (certified nursing assistant) #1. When asked who was responsible for cleaning the shower rooms, CNA #1 stated that the nursing aides were responsible for cleaning the shower rooms after each resident shower. CNA #1 stated that housekeeping will also clean the shower rooms once a day. When asked who used the shower room last, CNA #1 stated the 7 a.m. to 3 p.m. shift CNAs did not start giving their showers yet and that showers are not offered on 11 p.m. to 7 a.m. shift. CNA #1 stated the last shift to use the shower rooms would have been the 3 p.m. to 11 p.m. shift. CNA #1 followed this writer into the West 2 shower room. When asked what CNA #1 observed in the basin that was inside the bathtub, CNA #1 stated, "I see poop." When asked what CNA #1 observed on the rim of the toilet seat, CNA #1 stated, "That is poop." CNA #1 stated she would clean up the shower room. CNA #1 stated the housekeepers had not yet been in the shower rooms that morning.

On 11/2/17 at approximately 10:00 a.m., ASM (administrative staff member) #1, the interim administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

A policy could not be provided regarding the above concern.

No further information was presented prior to exit.

F 279 SS=D 483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS — F 279

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483.20
(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.

483.21
(b) Comprehensive Care Plans

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse 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

1. Care plan was updated for Resident # 1 to address mood state as triggered by the Care Area Assessment (CAA) on 11/20/17.
2. Residents admitted to facility are at risk for same deficient practice.
3. The MDS coordinator will re-educate the interdisciplinary team on care development, review, and revision to plan of care on 11/21/17. Education will include Care Area Assessments. An audit will be completed 3 x week x 4 weeks observing residents' plan of care to ensure it is being followed.
4. Results of audit will be discussed in the monthly QAPI meeting. Any noted trends will be addressed immediately and re-education provided as needed.

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findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv)In consultation with the resident and the resident's representative (s)-

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, it was determined, the facility staff failed to develop a comprehensive care plan for one of 26 residents in the survey sample, Resident #1.

The facility staff failed to develop a comprehensive care plan for Resident #1 to address the CAA (care area assessment) triggered care area of mood state on Resident #1's significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 9/15/17.

The findings include:

Resident #1 was admitted to the facility on 5/31/17. Resident #1's diagnoses included but

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were not limited to: heart failure, diabetes and major depressive disorder. Resident #1's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 9/15/17, coded the resident as cognitively intact. Section V documented an "X" beside the care area of mood state and documented the area would be care planned. Resident #1's comprehensive care plan initiated on 6/1/17 failed to document information regarding mood state.

On 11/1/17 at 1:30 p.m. an interview was conducted with LPN (licensed practical nurse) #5 (an MDS coordinator). LPN #5 was asked what should be done if a particular care area triggered in Section V and the MDS assessment documented the care area would be care planned. LPN #5 stated, "You go and you care plan. My motto is whatever is in the CAA should go on the care plan." LPN #5 confirmed she did not see mood state documented on Resident #1's care plan. When asked what documents she references when developing the care plan based on the care area assessments, LPN #5 stated she references the RAI (resident assessment instrument manual).

On 11/1/17 at 6:30 p.m. ASM (administrative staff member) #1 (the interim administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

The CMS (Centers for Medicare and Medicaid Services) RAI manual documented the following:
"Coding Instructions for V0200A, CAAs
·Facility staff are to use the RAI triggering mechanism to determine which care areas require review and additional assessment. The

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| F 279 | Continued From page 13<br>triggered care areas are checked in Column A "Care Area Triggered" in the CAAs section. For each triggered care area, use the CAA process and current standard of practice, evidence-based or expert-endorsed clinical guidelines and resources to conduct further assessment of the care area. Document relevant assessment information regarding the resident's status. Chapter 4 of this manual provides detailed instructions on the CAA process, care planning, and documentation.<br>·For each triggered care area, Column B "Care Planning Decision" is checked to indicate that a new care plan, care plan revision, or continuation of the current care plan is necessary to address the issue(s) identified in the assessment of that care area. The "Care Planning Decision" column must be completed within 7 days of completing the RAI, as indicated by the date in V0200C2, which is the date that the care planning decision(s) were completed and that the resident's care plan was completed."<br><br>No further information was presented prior to exit. | F 279 | | |
| F 280 SS=D | 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>483.10<br>(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:<br><br>(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. | F 280 | 1. Care plan was revised for Resident #9 on 11/20/17 to include Hospice Care.<br>2. Residents residing in facility are at risk for same deficient practice. | |

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F 280 Continued From page 14

(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 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--

F 280

3. An audit of residents on Hospice Services will be completed to ensure care plans reflect Hospice Care. The MDS Coordinator will re-educate the interdisciplinary team on care plan development, review, and revisions to plan of care on 11/21/17. Education will include Hospice Care. Licensed nursing staff will be re-educated on care plan process by 11/24/17 by the DON/designee. During morning meeting the care plans will be updated during the review of the 24 hour report to ensure current changes are reflected in resident care plans. An audit of 5 resident care plans will be completed weekly to ensure care plans are updated as indicated.
4. Results of audit will be discussed in the monthly QAPI meeting. Any noted trends will be addressed and re-education provided as needed.

11/30/17



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(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 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, the facility staff failed to review and revise the care plan for one of 26 residents in the survey sample, Resident #9.

The facility staff failed to review and revise the care plan when Resident #9 was readmitted to Hospice Care.

The findings include:

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Resident #9 was admitted to the facility on 5/8/17 with diagnoses that included senile degeneration of the brain (age related degeneration of the brain (1)), high blood pressure, chronic obstructive pulmonary disease (general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (2)), dementia, dyspnea (shortness of breath (3)), and insomnia.

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 10/13/17, coded Resident #9 as being severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance to being totally dependent upon one or more staff members for all of his activities of daily living. The resident was coded in Section O - Special Treatments, Procedures and Programs as receiving oxygen therapy and hospice care.

Review of the comprehensive care plan did not reveal any evidence of a hospice care plan. A printed copy of the care plan was requested. The printed copy of the care plan, documented, "RESOLVED: Patient is on Hospice care related to end of life care." The date the care plan was initiated was documented as 5/16/17. The resolved date was documented as 7/17/17.

The physician orders dated 9/16/17, documented in part, "Admit to Hospice on 9/16/17."

An interview was conducted on 11/1/17 at 2:30 p.m. with LPN (licensed practical nurse) #4. When asked who is responsible for updating the care plan, LPN #4 stated, "At first we were doing



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it in the computer and then we (the nurses) would do it on paper and the MDS nurse would then put it in the computer but now we are supposed to put it in the computer. Any nurse cam update a care plan."

An interview was conducted with LPN #14, the unit manager, on 11/1/17 at 3:12 p.m. LPN #14 verified Resident #9 was currently under hospice care. LPN #14 was asked to review the comprehensive care plan for Resident #9. When asked if she noted a care plan addressing hospice for Resident #9, LPN #14 verified the hospice care plan had been resolved and was not an active part of his care plan. When asked who can update the care plan, LPN #14 stated that she had just started and would get back with this surveyor with an answer. LPN #14 returned to this surveyor at 3:31 p.m. and stated anyone can update a care plan; nursing, social services, MDS or dietary.

A copy of the facility policy on reviewing and revising the care plans was requested on 11/2/17 at 6:30 p.m.

The facility presented a copy from Lippincott's Nursing Procedures, 6th edition, page 128, "If you must revise your plan as the patient's condition changes, fill out a new care plan and add it to the medical record. Sign and date the care plan whenever you make new entries to keep the plan current and to maintain accountability for planning the patient's care. Customize a standard care plan to avoid "standardizing the patient's care and to allow you to address the patient's individual concerns."

According to Fundamentals of Nursing Lippincott

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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..."

The interim administrator, ASM [administrative staff member] #1 and director of nursing, ASM #2 were made aware of the above findings on 11/1/17 at 6:30 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/medgen/509626.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 124.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 178.

F 281 SS=D — 483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS — F 281

(b)(3) Comprehensive Care Plans

The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-

Provider's plan of correction:

1. Care plan for resident #2 was updated to include oxygen use on 11/2/17. Resident #10 no longer resides at facility.

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(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for two of 26 residents in the survey sample; Resident #2 and Resident #10.

1. the facility staff failed to develop an interim care plan for Resident #2's use of oxygen.

2. The facility staff failed to clarify Resident #10's orders for as-needed pain medication. Resident #10 had orders for two different as needed pain medications, with no clarification as to when to give either medication.

The findings include:

1. Resident #2 was admitted to the facility on 10/25/17 with the diagnoses of but not limited to chronic obstructive pulmonary disease, shortness of breath, high blood pressure, aortic abdominal aneurysm, diabetes and dementia. The admission nursing assessment dated 10/25/17 documented the resident as having memory problems, being incontinent of bowel and as having a catheter for bladder; and requiring assistance with activities of daily living.

Observations made of Resident #2 on 10/31/17 at approximately 11:05 a.m., 10/31/17 at 2:15 p.m., 11/1/17 at 8:10 a.m., and 11/1/17 at 2:35 p.m. During each observation Resident #2 was observed on oxygen, with the oxygen flow rate set at 2.5 liters as evidenced of the flow meter

F 281

2. Residents receiving oxygen therapy were reviewed to ensure their care plans reflect oxygen use. Residents receiving pain medication were reviewed to ensure indication for use is indicated as appropriate.
3. The DON/designee will re-educate nursing staff on development and revision of care plans and physician orders to ensure medications have indications for use 11/24/17. DON/designee will review new admissions and residents with new orders daily in the morning meeting and also the stand down meeting in the afternoon. In addition, a 24 hour chart check will be completed by 11-7 shift and any changes needed will be verified at that time. An audit will be 2 x week on 10 resident records x 4 weeks to ensure care plans are in place and physician orders have indications for use.
4. Results of audits will be discussed in the monthly QAPI meeting. Any noted trends will be addressed immediately and re-educations provided as needed. 11/30/17

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ball being positioned between the 2 and 3 liter marks. On 11/2/17 at 8:21 a.m., revealed the resident to be on oxygen with the rate set at 2 liters as evidence of the ball on the flow meter being positioned on the 2-liter mark.

The admission Physician Order Sheet (POS) documented an order dated 10/25/17 for oxygen at 3 liters via nasal cannula, continuously. This order was discontinued and rewritten for the same rate on 10/31/17.

A review of the MAR (Medication Administration Record) for October 2017 and November 2017 revealed Resident #2 was receiving oxygen continuously at 3 liters as ordered, as evidenced by the nurse's initials each shift.

A review of the care plan failed to reveal any evidence Resident #2 was on oxygen.

On 11/2/17 at 8:21 a.m., in an interview with LPN #2 (Licensed Practical Nurse) when asked if the use of oxygen should be care planned, she stated to check with the unit manager.

On 11/2/17 at 8:32 a.m., in an interview with RN #4 (Registered Nurse) the unit manager, when asked about the development of an interim care plan, she stated that the "important" items of falls, pain, and skin are care planned at admission. When asked if oxygen should be care planned, RN #4 stated, "we tell the nurses to focus on the main areas - falls, skin, and pain." When asked if she follows up with the admission chart to ensure everything is care planned, RN #4 stated she does a chart audit to see that the required areas are care planned. When asked if oxygen therapy was not a required area to care plan, RN #4



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stated, "I'm not going to say that it is not required, but it has not been our focus."

A review of the facility policy, "Care Plan Preparation" documented, "A care plan directs the patient's nursing care from admission to discharge. This written action plan is based on nursing diagnoses that have been formulated after reviewing assessment findings, and it embodies the components of the nursing process.... A nursing care plan should be written for each patient, preferably within 24 hours of admission.... Document all pertinent nursing diagnoses, expected outcomes, nursing interventions, and evaluations of expected outcomes...."

On 11/2/17 at 8:57 a.m., ASM #1 (Administrative Staff Member - the Interim Administrator) and ASM #2 (the director of nursing - DON) were made aware of the findings. No further information was provided by the end of the survey.

According to "Fundamentals of Nursing Made Incredibly Easy" Lippincott Williams and Wilkins, Philadelphia PA page 56: "The first step in the nursing process--assessment--begins when you first see the patient. According to the American Nurses Association guidelines, data should accurately reflect the patient's life experiences, and his patterns of living...during the assessment you collect relevant information from various sources and analyze it to form a complete picture of your patient...it guides you through the rest of the nursing process, helping you formulate nursing diagnoses, expected outcomes, and nursing interventions. It serves as a vital communication tool for other team members- as

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a baseline for evaluating a patient's progress and for use as legal documentation...the initial assessment helps you determine what care the patient needs and sets the stage for further assessments...the history of the patient as well as medical problems are of great importance..." and on page 65, "A written care plan serves as a communication tool among health care team members that helps ensure the continuity of care...the care plan is developed on admission and includes the most significant problems and is reviewed and revised as necessary..."

2. The facility staff failed to clarify Resident #10's orders for as-needed pain medication. Resident #10 had orders for two different as needed pain medications, with no clarification as to when to give either medication.

Resident #10 was admitted to the facility on 10/24/17 with diagnoses that included, but were not limited to: high blood pressure, congestive heart failure (abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys, it is usually caused by heart disorder and most often develops chronically with shortness of breath due to fluid accumulation in the lungs, and edema of the extremities (1)), shortness of breath, heart disease and chronic obstructive pulmonary disease - COPD (general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (2)).

A MDS (minimum data set) assessment had not yet been completed at the time of survey.

The "Admission Data Collection Form" dated, 10/24/17, documented Resident #10 was alert

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and oriented. The resident was coded as having no memory difficulties and could understand others and could make herself understood.

The physician orders dated 10/24/17, documented, "Acetaminophen (Tylenol - used to treat minor pain and fever (3)) 500 MG (milligrams); give 1 tablet by mouth every 4 hours as needed for mild pain." The second physician order dated 10/24/17, documented, "Oxycodone - Acetaminophen Tablet (used to treat moderate to moderately severe pain (4)) 5 - 325 MG; give 1 tablet by mouth every 4 hours as needed for pain."

Resident #10's October 2017 MAR (medication administration record) documented, "Acetaminophen 500 MG; give 1 tablet by mouth every 4 hours as needed for mild pain." The Tylenol was administered once on 10/30/17 at 4:45 a.m. The MAR also documented, "Oxycodone - Acetaminophen Tablet 5 - 325 MG; give 1 tablet by mouth every 4 hours as needed for pain." The MAR documented the Oxycodone -Acetaminophen was administered six times on the following dates and times: 10/24/17 at 8:00 p.m., 10/25/17 at 9:33 p.m., 10/26/17 at 9:00 p.m., 10/27/17 at 9:25 p.m., 10/30/17 at 9:16 p.m. and 10/31/17 at 7:00 p.m.

On 11/1/17 at 2:58 p.m., an interview was conducted with LPN (licensed practical nurse) #13, the nurse who administered all of the above doses of medication. When asked how staff know which medication to give when a resident has two medications prescribed for pain, LPN #13 stated, "Each medication should have a scale so you can gauge which one to give." Resident #10's orders for the above medications were reviewed with

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LPN #13. When asked if the orders included a scale as she just had explained, LPN #13 stated, "No."

An interview was conducted with LPN #14, the unit manager, on 11/1/17 at 3:05 p.m. When asked how is the staff know which medication to give, when a resident has two pain medications prescribed for pain, LPN #14 stated, "It should be given according to the type of pain and the level of pain. The orders should have a definition of when to give; such as mild, moderate or extreme pain or using the pain scale." Resident #10's physician orders were reviewed with LPN #14. LPN #14 stated the orders require clarification.

The interim administrator, ASM (administrative staff member) #1 and director of nursing, ASM #2, were made aware of the above findings on 11/1/17 at 6:30 p.m.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 138.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 124.
(3) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=59282
(4) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=17971

F 282 SS=D 483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN F 282

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(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.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow the written plan of care for two of 26 residents in the survey sample, Residents #3 and #9.

1. The facility staff failed to utilize non-skid strips to Resident #3's bedside per the resident's care plan.

2. The facility staff failed to follow the comprehensive plan of care for Resident #9 for the administration of oxygen.

The findings include:

1. The facility staff failed to utilize non-skid strips to Resident #3's bedside per the resident's care plan.

Resident #3 was admitted to the facility on 10/5/16. Resident #3's diagnoses included but were not limited to: chronic kidney disease, urinary tract infection and dementia. Resident #3's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 9/26/17, coded the resident as cognitively intact. Section

F 282

1. Resident #3 care plan was reviewed and revised to ensure fall interventions are in place per the plan of care. Resident # 9 is currently receiving oxygen therapy per physician order.
2. An audit was completed for residents on oxygen therapy on 11/3/17 to ensure settings matched current orders. An audit was completed on residents at risk for falls to ensure fall interventions were in place.
3. The DON/designee will re-educate nursing staff to ensure following resident's plan of care. DON/designee will re-educate nursing staff regarding respiratory services, oxygen orders, and administration. Education will be completed by 11/24/17. Department managers will audit oxygen settings are per physician order and plan of care during carekeeper rounds 5 days a week.

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G documented Resident #3 required limited assistance of one staff with bed mobility and transfers. Section J coded the resident as not having a fall since the prior assessment.

Resident #3's comprehensive care plan initiated on 10/6/16 documented, "At risk for falls related to: Dizziness, syncope (fainting), History of falls, daily use of antidepressants and antianxiety medications, dx (diagnosis) of Parkinson's disease...Interventions: Non-skid strips to bedside. 11/23..." Resident #3's MDS kardex report (utilized by certified nursing assistants to care for residents) failed to document information regarding non-skid strips.

Resident #3's room was observed on 11/1/17 at 7:36 a.m. and 9:15 a.m. Non-skid strips were not observed at the bedside or anywhere on Resident #3's side of the room.

On 11/1/17 at 2:05 p.m. an interview was conducted with LPN (licensed practical nurse) #4 regarding the purpose of residents' care plans. LPN #4 stated the care plan helps staff provide better care for residents. LPN #4 was asked how staff ensures care plans are followed. LPN #4 stated the nurse aides follow the kardex and nurses can check the care plans. At this time, Resident #3's care plan was reviewed with LPN #4 and Resident #3's bedside was observed with LPN #4. LPN #4 confirmed there were no non-skid strips at Resident #3's bedside. LPN #4 stated according to the care plan Resident #3 should have the non-skid strips and the strips should be discontinued from the care plan if staff thinks the resident doesn't need them.

On 11/1/17 at 6:30 p.m. ASM (administrative staff

F 282

Department managers will audit to ensure fall interventions are in place during carekeeper rounds 5 days a week. Discrepancies will be immediately corrected.

4. Results of the audits will be reviewed in the monthly QAPI meeting. Any noted trends will be addressed immediately and re-education provided as needed.

11/30/17

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member) #1 (the interim administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

The facility document titled "CARE PLAN PREPARATION" (an excerpt taken from Lippincott's Nursing Procedures 6th edition; Lippincott, Williams &Wilkins) documented, "A care plan directs the patient's nursing care from admission to discharge. This written action plan is based on nursing diagnoses that have been formulated after reviewing assessment findings, and it embodies the components of the nursing process: assessment, diagnosis, planning, implementation, and evaluation..."

No further information was presented prior to exit.

2. The facility staff failed to follow Resident #9's written plan of care for the administration of oxygen.

Resident #9 was admitted to the facility on 5/8/17 with diagnoses that included senile degeneration of the brain (age related degeneration of the brain (1)), high blood pressure, chronic obstructive pulmonary disease - COPD (general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (2)), dementia, dyspnea (shortness of breath (3)), and insomnia.

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 10/13/17,



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coded Resident #9 as being severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance to being totally dependent upon one or more staff members for all of his activities of daily living. The resident was coded in Section O - Special Treatments, Procedures and Programs as receiving oxygen therapy and hospice care.

Resident #9 was observed on 10/31/17 at 10:47 a.m. in his bed. He had a nasal cannula on connecter to an oxygen concentrator that was administering oxygen. The oxygen flow meter on the oxygen concentrator was set with the top of the ball sitting at the level of 3 liters per minute (LPM) and the bottom of the ball sitting at the level of 2.5 LPM. The ball was set between the lines. Resident #9 was observed on 10/31/17 at 2:10 p.m., 11/.1/17 at 8:10 a.m., and 11/1/17 at 11:50 a.m. with the oxygen concentrator flow meter set with the top of the ball sitting at the level of 3 LPM and the bottom of the ball sitting at the level of 2.5 LPM. The ball was set between the lines.

The physician order dated, 10/31/17, documented, "O2 (oxygen) at 3 liters/min (per minute) via nasal cannula as needed every shift for SOB (shortness of breath)."

The comprehensive care plan dated, 10/17/17, documented in part, "Focus: Alteration in Respiratory Status D/T (due to) COPD is at risk for shortness of breath." The "Interventions" documented in part, "Administer oxygen as needed per physician order."

On 11/1/17 at 12:58 p.m. The oxygen flow meter was observed with LPN (licensed practical nurse)

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#12. When asked how to read the flow meter, LPN #12 stated the ball should be centered with the prescribed rate through the center of the ball. When asked if Resident #9's flow rate was correct, LPN #12 stated, "No, I need to turn it up some."

On 11/1/17 at 2:05 p.m. an interview was conducted with LPN (licensed practical nurse) #4 regarding the purpose of residents' care plans. LPN #4 stated the care plan helps staff provide better care for residents. LPN #4 was asked how staff ensures care plans are followed. LPN #4 stated the nurse aides follow the kardex and nurses can check the care plans.

The interim administrator and the director of nursing were made aware of the above findings on 11/1/17 at 6:30 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/medgen/509626.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 124.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 178.

F 309 SS=D 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING F 309

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

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facility must provide the necessary care and services to attain or maintain the highes1 practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

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

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

(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined, the facility staff failed to provide the necessary treatment and care to maintain the highest level of well-being for two of 26 residents in the survey sample, Residents #6, and Resident #7.

F 309

1. Care plan for Resident # 6 was reviewed and revised for weight monitoring on 11/5/17. Facility notified physician of Resident #7 on 9/25/17 and orders were received for Percocet. Pharmacy delivered the Percocet and medication was administered to Resident #7 as ordered on 9/25/17. Resident #7 care is provided with correct infection control practices.
2. Residents residing in the facility are at risk for same deficient practices.
3. DON/designee will re-educate nursing staff on providing care to maintain highest level of well-being by 11/24/17. Education will include following plan of care; including monitoring weights per order and/or documenting refusals, physician notification, medication availability, reordering process, and infection control practices.

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1. The facility staff failed to obtain Resident #6's physician ordered weekly weights from July 2017 to October 2017.

2a. The facility staff failed to ensure Resident #7 received his scheduled Percocet on 9/24/17 and 9/25/17; resulting in him missing a total of 4 doses.

2b. The facility staff failed to provide necessary treatment and services to promote healing and prevent infection to Resident #7's bilateral venous and arterial leg ulcers.

The findings include:

1. The facility staff failed to obtain Resident #6's physician ordered weekly weights from July 2017 to October 2017.

Resident #6 was admitted to the facility on 5/19/17. Resident #6's diagnoses included but were not limited to: heart disease, difficulty swallowing and anxiety. Resident #6's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/10/17, coded the resident as cognitively intact. Section K coded Resident #6's height as 60 inches, weight as 66 pounds and coded the resident as not having a weight loss of five percent or more in the last month or ten percent or more in the last six months.

Physician's orders dated 5/19/17 documented orders for monthly weights and weekly weights.

Resident #6's comprehensive care plan initiated

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DON/designee will review 24 hour report daily in morning meeting and also the stand down meeting in the afternoon. In addition, a 24 hour chart check will be completed by 11-7 shift and any changes needed will be verified at that time. DON/designee will audit residents on weekly and monthly weights to ensure care plan reflects current physician order. Audits will include verifying weights are documented and/or documentation to support why weights were not obtained. Audits will be completed during weekly weight meetings.

A random audit of residents' medications will be completed 3 x week x 4 weeks by DON/designee to ensure medications are available. An audit will be completed 3 x week x 4 weeks to observe patient (wound) care to ensure infection control practices are being followed.

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on 5/22/17 documented, "Underweight/inadequate food and beverage intake...Interventions: Monthly weights..." The care plan failed to document information regarding weekly weights.

A nutrition data assessment dated 5/31/17 documented, "(Name of Resident #6) had been admitted to the facility, presents underweight, has poor appetite & intake. Resident is receiving small portion diet, with snacks TID (three times a day). Per documentation, resident has fair intake of small portion meals. Resident has dx (diagnosis) dysphagia (difficulty swallowing), receiving regular diet, working with SLP (speech language pathologist) ...Will continue to monitor & f/u (follow up) per protocol."

A dietary aide note dated 6/20/17 documented, "(Name of Resident #6) has experienced 8# (pound) or 11% wt (weight) loss since admission 5/19...Resident maintains poor intake of meals, supplements & snacks. Refused weekly weighing..."

Review of Resident #6's weight summary revealed the following weights:

6/22/17- 65.2 lbs. (pounds)
6/28/17- 67 lbs.
7/3/17- 64.8 lbs.
7/18/17- 66.4 lbs.
7/26/17- 66.4 lbs.
8/4/17- 66.2 lbs.
9/5/17- 69 lbs.
10/12/17- 65.8 lbs.

Further review of Resident #6's clinical record (including the weight summary, dietary notes and

4. Results of audits will be reviewed in the monthly QAPI meeting. Any trends or issues will be discussed and addressed immediately. — 11/30/17



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nurses' notes) failed to reveal Resident #6's weekly weight was obtained from 7/3/17 through 7/18/17 (15 days), from 8/4/17 through 9/5/17 (32 days), and from 9/5/17 through 10/12/17 (37 days). The clinical record failed to reveal documentation that Resident #6 refused to be weighed during these periods of time.

On 11/1/17 at 2:05 p.m. an interview was conducted with LPN (licensed practical nurse) #4 regarding the facility process to ensure weekly weights are obtained per physician's order. LPN #4 stated the order should be put in the computer and the need for the weight usually pops up in the computer when the weight needs to be done. LPN #4 stated the assistant director of nursing also prints a report and has a list.

On 11/1/17 at 2:35 p.m. an interview was conducted with ASM (administrative staff member) #3 (the nurse practitioner). ASM #3 confirmed Resident #6 was supposed to have weekly weights.

On 11/1/17 at 6:30 p.m. ASM #1 (the interim administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

On 11/2/17 at 8:20 a.m. ASM #2 confirmed residents can have a monthly weight order and a weekly weight order, and when a resident does have both orders, staff should obtain weekly weights.

The facility policy titled, "Weighing the Resident" documented, "At a minimum, all residents of the facility shall be weighed upon admission and monthly unless ordered otherwise by the physician as directed by the weight committee..."

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No further information was presented prior to exit.
2 a. The facility staff failed to ensure Resident #7 received his scheduled Percocet on 9/24/17 and 9/25/17; resulting in him missing a total of 4 doses.

Resident #7 was admitted to the facility on 8/29/17 with diagnoses that included but were not limited to Peripheral vascular disease with vascular and arterial ulcers to bilateral legs, cellulitis to bilateral legs, COPD (chronic obstructive pulmonary disease), chronic back pain, and Non-Alzheimer's dementia. Resident #7's most recent MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 8/29/17. Resident #7 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 #7 was coded as requiring extensive assistance with one staff member with transfers, dressing, hygiene and bathing; and supervision only with meals. Section J "Pain" of the MDS coded Resident #7 as having a pain of 10 out of 10 (10 being the worst possible pain on a scale from 0-10).

Review of Resident #7's most recent physician order sheet revealed the following order: "Percocet Tablet 5-325 MG (milligrams) (Oxycodone-Acetaminophen) Give 2 tablet by mouth every 6 hours related to chronic pain." This order was initiated on 8/24/17.

Review of Resident 7's September 2017 MAR (Medication Administration Record) revealed that he did not receive his Percocet on the following dates and times: 9/24/17 6:00 a.m., 9/24/17 at

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6:00 p.m., 9/25/17 at 12:00 a.m., and 9/25/17 at 06:00 a.m. A "7" (seven) was coded for each administration of Percocet indicating that a nurses' note was written.

Review of the nursing notes revealed the following:
- "9/24/17 06:48 a.m.: Percocet Tablet 5-325 mg Give 2 tablet by mouth every 6 hours related to OTHER CHRONIC PAIN. Medication not available. Pharmacy awaiting RX (prescription).

- 9/24/17 18:38 (6:38 p.m.): Percocet Tablet 5-325 mg Give 2 tablet by mouth every 6 hours related to OTHER CHRONIC PAIN. Medication not available. Pharmacy awaiting RX (prescription).

- 9/25/17 12:18 a.m.: Percocet Tablet 5-325 mg Give 2 tablet by mouth every 6 hours related to OTHER CHRONIC PAIN. Med (medication) not available per pharmacy prescription needed.

- 9/25/17 12:20 a.m.: All medications and treatments completed at scheduled time 09/24/17 0700-1500 (7 a.m. to 3 p.m.) ...unable to chart at time of administrations due to Point Click Care help desk ticket pending. Percocet continues to be unavailable from pharmacy. Night shift staff notified.

- 9/25/17 06:24 a.m.: "Percocet Tablet 5-325 mg Give 2 tablet by mouth every 6 hours related to OTHER CHRONIC PAIN. no (sic) available."

Review of the "On-Site Formula Alixa RX" (The facility's STAT [immediate] BOX) revealed that Percocet 5-325 mg was in the STAT BOX.

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On 11/1/17 at 6:13 p.m., an interview was conducted with RN (registered nurse) #1, the 11-7 shift nurse who was working on 9/24/17 and 9/25/17 with Resident #7. When asked about the process staff follows when a narcotic is not available on the medication cart for administration, RN #1 stated she would go into Alixa (STAT box) and see if the medication was available in Alixa. RN #1 stated in order to obtain medication from Alixa, she would have to call the pharmacy to receive a code to open the box. RN #1 stated if the narcotic needed a script (prescription), she would contact the physician to get a script. When asked if she could recall Resident #7 running out of his Percocet on 9/24/17 and 9/25/17; RN #1 stated that Resident #7's Percocet needed a script from the physician. RN #1 stated she had attempted to contact the on-call physician and NP (nurse practitioner) to receive a script. RN #1 stated she did not receive a call back. RN #1 stated she had passed this information to the 7-3 shift nurse on 9/24/17, but then when she arrived to work on 9/25/17, the medication was still not re-filled. RN #1 stated she could not get in touch with a physician on 9/25/17. RN #1 could not determine if she had documented the physician and NP were notified. RN #1 stated Resident #7 was not in any pain or distress during these two days. RN #1 stated Resident #7 also had a fentanyl patch [2] that was helping with his pain. When asked when nursing should be re-ordering medications or obtaining prescriptions to ensure a resident does not run out of medications, RN #1 stated the computer system will not alert the nurses that a script (prescription) needs to be re-filled. RN #1 stated they find out this information when they re-order the medication from pharmacy and then the medication does not arrive to the facility. RN #1

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stated when the medication does not arrive to the facility, they call the pharmacy and then find out that it needs a script.

On 11/2/17 at 8:45 a.m., an interview was conducted with ASM (administrative staff member) #3, the nurse practitioner. She could not recall being notified about Resident #7's Percocet on 9/24/17 and 9/25/17. ASM #3 stated that all of the nurses had her number and that she has called scripts into the pharmacy during the 11-7 shift many times. ASM #3 stated that if she was called for a script, she would ensure that the medication was re-filled.

On 11/2/17 at approximately 10:00 a.m., ASM #1, the interim administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

The facility policy titled, "Medication Ordering and Receiving from Pharmacy," documents in part, the following: "reorder medication three to seven days in advance of need, as directed by the pharmacy order and delivery schedule, to assure an adequate supply is on hand."

A policy could not be provided regarding ordering and receiving controlled medications from the pharmacy.

[1] Percocet (oxycodone hydrochloride and acetaminophen tablet)- opioid analgesic used to treat moderate to severe pain. This information was obtained from The National Institutes of Health.
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3af57f54-117e-43fc-b0ae-21ef772d854e
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[2] Fentanyl patch-skin patch used to treat severe pain. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010281/?report=details.

2 b. The facility staff failed to provide necessary treatment and services to promote healing and prevent infection to Resident #7's bilateral venous and arterial leg ulcers.

On 10/31/17 at 11:10 a.m., an interview was conducted with Resident #7. Resident #7 expressed concerns regarding his dressing changes.

Review of Resident #7's wound physician notes dated 10/18/17, revealed the following treatment orders for his bilateral leg ulcers: "Venous wound of the right lateral ankle, Dry protective dressing-once daily, Silver Hydrogel [2]; Wound of the Right Shin, Dry protective dressing-once daily, Silver Hydrogel; Arterial Wound of the right, Dorsal Foot, Foam-once daily Silver Alginate [3]; Venous Wound of the right calf, Foam-Once daily, adaptic [4]; Venous Wound of the left, medial ankle, Dry protective dressing, Silver Hydrogel."

On 10/31/17 at 12:15 p.m., an observation of wound care was conducted with RN (registered nurse) #3, the wound care nurse. RN #3 first collected her supplies. RN #3 grabbed gauze pads off the treatment cart with her bare hands and carried them to Resident #7's room. The gauze pads were not in individual packages. RN #3 was not observed washing or sanitizing her

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hands prior to this. RN #3 then placed the gauze pads and other supplies on a clean field on Resident #7's bed side table. RN #3 was then observed putting on her gloves. After her gloves were in place, RN #3 was then observed pulling out scissors from her scrub pocket. RN #3 then proceeded to cut the old dressing off Resident #7's right leg. The scissors were not sanitized prior to removing the old dressing. RN #3 then placed the scissors on the clean field. RN #3, using the same gloves, put normal saline on a gauze pad and cleaned Resident #7's right shin. She proceeded to put normal saline on a new gauze pad and cleaned Resident #7's right dorsal foot. RN #3 was then observed putting normal saline on another gauze pad and cleaning Resident #7's right calf and right medial ankle. RN #3 then took her gloves off, threw the old gloves away and put on new gloves. She did not sanitize or wash her hands prior to donning new gloves. RN #3 was then observed using the dirty scissors to cut the silver alginate (Maxasorb (Brand Name). She then placed the silver alginate into the wound bed of Resident #7's right dorsal foot. The scissors were then placed on the resident's bed. After all wounds to his right leg were dressed, RN #3 placed her scissors back into her scrub pocket. Resident #3 then changed her gloves and proceeded to remove the dressing to his left ankle. No further issues were noted when changing Resident #3's dressing to his left leg. At this time another nurse, RN #5, entered the Resident's room and cued RN #3 when to wash her hands. All gauze pads that were taken off the treatment cart and carried with RN #3's bare hands were used during the dressing changes.

On 11/2/17 at 8:05 a.m., an interview was



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conducted with RN #3. When asked about the process staff follows to maintain infection control during wound care, RN #3 stated that she would wash hands prior to starting wound care and she would wash or sanitize her hands in between each dressing change. RN #3 stated that anytime she removes her gloves, she should also sanitize or wash her hands. When RN #3 was informed of the above observations of her not washing or sanitizing her hands before wound care and after each glove change, RN #3 stated she had forgotten to bring the hand sanitizer into the room. RN #3 agreed she did not wash or sanitize her hands. When asked how to maintain infection control of equipment such as scissors, RN #3 stated she would clean the scissors after the scissors came into contact with the soiled dressing. When RN #3 was informed about the above observations of the scissors and the gauze pads, she had picked up with her bare hands, RN #3 did not have a response. RN #3 stated she had worked at the facility for 2 weeks as the wound care nurse.

On 11/2/17 at approximately 10:00 a.m., ASM (administrative staff member) #1, the interim administrator and ASM #2, the DON (Director or Nursing) were made aware of the above concerns.

The facility's "Wound Prevention Program" did not address the above concerns.

No further information was presented prior to exit.

[1] Peripheral vascular disease-"is a disease in which plaque builds up in the arteries that carry blood to your head, organs, and limbs. Plaque is made up of fat, cholesterol, calcium, fibrous

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tissue, and other substances in the blood." This information was obtained from The National Institutes of Health.
https://www.nhlbi.nih.gov/health/health-topics/topics/pad/.

[2] Silver hydrogel- "Hydrogel Dressing is intended for the management of wounds and to provide an antimicrobial barrier. This information was obtained from The National Institutes of Health."
https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=91244d66-ed63-4a70-a1ce-e2b77a6b09e1.

[3] Silver alginate-"Alginate wound dressings have been found to be effective primary dressings and appropriate for use in the management of exudating wounds and are associated with positive clinical outcomes. Antimicrobials, in silver, are incorporated into wound dressings, including alginates, for use in the treatment of "at risk" or infected chronic wounds." This information was obtained from The National Institutes of Health.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4486446/.

[4] Adaptic dressing- "is designed to help protect the wound while preventing the dressing from adhering to the wound and to minimize pain and trauma upon removal." This information was obtained from
https://www.vitalitymedical.com/adaptic-non-adhering-dressing.html.

F 328 SS=D — 483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS — F 328

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(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:

(i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and

(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments

(f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.

(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.

(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.

(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure

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1. Resident #10 no longer resides at facility. Resident #9 and Resident #2 are currently receiving oxygen therapy per physician order.
2. Residents on oxygen therapy were reviewed to ensure orders were provided as ordered and matched their current settings on 11/2/17. Residents receiving oxygen and nebulizer treatments were audited to ensure supplies were stored in a sanitary manner.
3. DON/designee will re-educate nursing staff on respiratory services, oxygen orders and administration by 11/24/17. Education will include ensuring oxygen supplies is stored in a sanitary manner. Department managers will audit oxygen settings and ensure supplies are stored in a sanitary manager during carekeeper rounds 5 days a week. Discrepancies identified will be corrected immediately.

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that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.

(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide respiratory care and services for three of 26 residents in the survey sample, Residents #10, #9, and #2.

1.a. The facility staff failed to obtain a physician order to administer oxygen to Resident #10.

b. The facility staff failed to store a nebulizer mask in a sanitary manner for Resident #10. The resident's nebulizer mask was observed sitting on top of a plastic bag on the resident's dresser.

2. The facility staff failed to administer oxygen at the physician prescribed rate for Resident #9.

3. The facility staff failed to administer oxygen to Resident #2 at the physician ordered rate.

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4. Results of audits will be reviewed during the monthly QAPI meeting. Any trends or discrepancies will be discussed and corrected immediately. 11/30/17



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The findings include:

1.a. The facility staff failed to obtain a physician order to administer oxygen to Resident #10.

Resident #10 was admitted to the facility on 10/24/17 with diagnoses that included, but were not limited to: high blood pressure, congestive heart failure (abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys, it is usually caused by heart disorder and most often develops chronically with shortness of breath due to fluid accumulation in the lungs, and edema of the extremities (1)), shortness of breath, heart disease and chronic obstructive pulmonary disease - COPD (general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (2)).

A MDS (minimum data set) assessment had not yet been completed at the time of survey.

The "Admission Data Collection Form" dated, 10/24/17, documented Resident #10 was alert and oriented. The resident was coded as having no memory difficulties and could understand others and could make herself understood.

Observation was made of Resident #10 on 10/31/17 at 2:26 p.m. She was sitting in her room with her oxygen on via a nasal cannula (a tube that has two prongs that are inserted in the nose), the oxygen concentrator was set with the ball resting on the 1.5-liter mark and the top of the ball on the 2.0-liter mark. The resident was observed on 11/1/17 at 8:23 a.m. Resident #10 was in her bed with her oxygen on via the nasal cannula. The oxygen concentrator was set with the ball

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between the 2.5-liter mark and the 3.0-liter mark. Resident #10 was again observed on 11/1/17 at 12:08 p.m. up in the wheelchair at the nurse's station. Resident #10 had oxygen on via a nasal cannula but was hooked up to an oxygen tank on the back of her wheelchair. The rate was set at 2 liters per minute. This rate was verified by OSM (other staff member) #7, a physical therapy assistant.

A review of the clinical record failed to evidence any documented physician orders for Resident #10 to receive oxygen.

The nurse's notes on the following dates documented Resident #10 was receiving oxygen via a nasal cannula at 2 liters or no liter rate was documented, or just documented oxygen was in use: 10/24/17 at 6:28 p.m., 10/25/17 at 3:53 p.m., 10/25/17 at 10:56 p.m., 10/26/17 at 7:06 a.m., 10/26/17 at 4:03 p.m., 10/26/17 at 11:55 p.m., 10/27/17 at 4:23 p.m., 10/28/17 at 12:32 a.m., 10/28/17 at 11:03 p.m., 10/29/17 at 6:18 a.m., 10/29/17 at 4:15 p.m., 10/30/17 at 11:55 p.m., and 11/1/17 at 6:40 a.m.

Resident #10's October/November 2017 MAR (medication administration record) and TAR (treatment administration record) did not evidence any documentation of oxygen administration.

Resident #10's comprehensive care plan dated, 10/24/17, documented in part, "Focus: Alteration in Respiratory status due to asthma, due to chronic obstructive pulmonary disease, due to congestive heart failure." The "Interventions" documented in part, "Administer oxygen as needed per physician's order."

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An interview was conducted with LPN (licensed practical nurse) #12 on 11/1/17 at 1:00 p.m. LPN #12 was asked to verify the oxygen rate on the oxygen tank, supplying oxygen to Resident #10, LPN #12 stated the oxygen flow rate was set at 2 liters. When asked if a physician order was needed to administer oxygen, LPN #12 stated, "Yes." LPN #12 was asked to review Resident #10's physician orders. LPN #12 reviewed the orders and stated she did not see any order for oxygen.

An interview was conducted with LPN #14 on 11/1/17 at 1:05 p.m. When asked if oxygen requires a physician order, LPN #14 stated, "Yes, Ma'am." When asked if there was any risk for a patient with the diagnosis of COPD and the administration of oxygen, LPN #14 stated, "Yes, you have to be careful with oxygen because of the buildup of carbon dioxide so they can't be given too much oxygen." LPN #14 was asked, if a resident with COPD, who is receiving oxygen should have the oxygen flow rate prescribed by a physician. LPN #14 stated, "Yes."

A request was made for the facility policy on oxygen administration. The facility presented a copy of pages from Lippincott's Nursing Procedures, 6th edition; Lippincott, Williams and Wilkins, pages 537 - 540. This documented, "Verify the doctor's order for oxygen therapy."

"Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is



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receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration." Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122,

The interim administrator, ASM [administrative staff member) #1 and director of nursing, ASM #2, were made aware of the above concern on 11/1/17 at 6:30 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 138.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 124.

b. The facility staff failed to store a nebulizer mask in a sanitary manner for Resident #10. Resident #10's nebulizer mask was observed sitting on top of a plastic bag on the resident's dresser.

Observation was made on 10/31/17 at approximately 10:48 a.m. of Resident #10's room. A nebulizer machine and mask were located on top of the dresser next to the bed. The mask was not in a plastic bag; it was sitting on top of the bag. A second observation was made on 10/31/17 at 2:26 p.m. The nebulizer mask was still sitting on top of the plastic bag on the resident's dresser.

An interview was conducted with LPN #14 on 11/1/17 at 1:05 p.m. When asked how nebulizer

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masks should be stored when not in use, LPN #14 stated that they are stored in a plastic bag.

An interview was conducted with LPN #12 on 11/1/17 at 2:37 p.m. When asked how nebulizer masks should be stored when not in use, LPN #12 stated, "We store them in the plastic bag."

The interim administrator, ASM #1 and director of nursing, ASM #2, were made aware of the above concern on 11/1/17 at 6:30 p.m.

On 11/2/17 at approximately 8:00 a.m., a policy on the storage of nebulizer masks was requested. No information was provided prior to exit.

2. The facility staff failed to administer oxygen at the physician prescribed rate for Resident #9.

Resident #9 was admitted to the facility on 5/8/17 with diagnoses that included senile degeneration of the brain (age related degeneration of the brain (1)), high blood pressure, chronic obstructive pulmonary disease - COPD (general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (2)), dementia, dyspnea (shortness of breath (3)), and insomnia.

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 10/13/17, coded Resident #9 as being severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance to being totally dependent upon one or more staff

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members for all of his activities of daily living. The resident was coded in Section O - Special Treatments, Procedures and Programs as receiving oxygen therapy and hospice care.

Resident #9 was observed on 10/31/17 at 10:47 a.m. in his bed. He had a nasal cannula on connecter to an oxygen concentrator that was administering oxygen. The oxygen flow meter on the oxygen concentrator was set with the top of the ball sitting at the level of 3 liters per minute (LPM) and the bottom of the ball sitting at the level of 2.5 LPM. The ball was set between the lines. Resident #9 was observed on 10/31/17 at 2:10 p.m., 11/.1/17 at 8:10 a.m., and 11/1/17 at 11:50 a.m. with the oxygen concentrator flow meter set with the top of the ball sitting at the level of 3 LPM and the bottom of the ball sitting at the level of 2.5 LPM. The ball was set between the lines.

The physician order dated, 10/31/17, documented, "O2 (oxygen) at 3 liters/min (per minute) via nasal cannula as needed every shift for SOB (shortness of breath)."

The comprehensive care plan dated, 10/17/17, documented in part, "Focus: Alteration in Respiratory Status D/T (due to) COPD is at risk for shortness of breath." The "Interventions" documented in part, "Administer oxygen as needed per physician order."

On 11/1/17 at 12:58 p.m. The oxygen flow meter was observed with LPN (licensed practical nurse) #12. When asked how to read the flow meter, LPN #12 stated the ball should be centered with the prescribed rate through the center of the ball. When asked if Resident #9's flow rate was

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correct, LPN #12 stated, "No, I need to turn it up some."

An interview was conducted with LPN #14 on 11/1/17 at 1:05 p.m. When asked how to read an oxygen concentrator to be at the correct rate, LPN #14 stated, "You have to center the ball on the line of the prescribed rate."

The manufacturer's instruction manual for the oxygen concentrator documented, "To properly read the flowmeter, locate the prescribed flowrate line. Next, turn the flow knob to until the ball rises to the line. Now, center the ball on the L/Min (liters per minute) line prescribed."

The interim administrator, ASM #1 and director of nursing, ASM #2 were made aware of the above findings on 11/1/17 at 6:30 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/medgen/509626.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 124.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 178.

3. The facility staff failed to administer oxygen to Resident #2 at the physician ordered rate.

Resident #2 was admitted to the facility on 10/25/17 with the diagnoses of but not limited to chronic obstructive pulmonary disease, shortness

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of breath, high blood pressure, aortic abdominal aneurysm, diabetes and dementia. The admission nursing assessment dated 10/25/17 documented the resident as having memory problems, being incontinent of bowel and having a catheter for bladder; and requiring assistance with activities of daily living.

Observations made of Resident #2 on 10/31/17 at approximately 11:05 a.m., 10/31/17 at 2:15 p.m., 11/1/17 at 8:10 a.m., and 11/1/17 at 2:35 p.m. During each observation Resident #2 was observed on oxygen, with the oxygen flow rate set at 2.5 liters as evidenced of the flow meter ball being positioned between the 2 and 3 liter marks. On 11/2/17 at 8:21 a.m., revealed the resident to be on oxygen with the rate set at 2 liters as evidence of the ball on the flow meter being positioned on the 2-liter mark.

The admission Physician Order Sheet (POS) documented an order dated 10/25/17 for oxygen at 3 liters via nasal cannula, continuously. This order was discontinued and rewritten for the same rate on 10/31/17.

A review of the MAR (Medication Administration Record) for October 2017 and November 2017 revealed, Resident #2 was receiving oxygen continuously at 3 liters as ordered, as evidenced by the nurse's initials each shift.

On 11/1/17 at 2:35 p.m., in an interview with RN #2 (Registered Nurse), she observed the oxygen concentrator and verified the level was set at 2.5 liters. She stated it should be at 3 liters, and that "They (nurses) don't get down to eye level to check it."

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On 11/2/17 at 8:21 a.m., in an interview with LPN #2 (Licensed Practical Nurse) when asked about the rate that Resident #2's oxygen should be set at, LPN #2 stated 3 liters. When asked to verify what the rate was currently set at, she stated it was at 2 liters and she adjusted it to 3 liters.

On 11/2/17 at 8:32 a.m., in an interview with RN #4 (Registered Nurse) the unit manager, when asked about the oxygen rate for Resident #2, she stated, "I checked it all day yesterday (11/1/17) and at 7:00 a.m., this morning at it was at the right rate every time."

On 11/2/17 at 8:57 a.m., ASM #1 (Administrative Staff Member - the Interim Administrator) and ASM #2 (the director of nursing - DON) were made aware of the findings. No further information was provided by the end of the survey.

F 328

F 329 SS=D 483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

483.45(d) Unnecessary Drugs-General.
Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--

(1) In excessive dose (including duplicate drug therapy); or

(2) For excessive duration; or

(3) Without adequate monitoring; or

(4) Without adequate indications for its use; or

(5) In the presence of adverse consequences

F 329

1. Resident #6 medication was reviewed for use of PRN Antianxiety medications and care plan updated to include non-pharmalogical interventions.
2. An audit will be completed by clinical staff and pharmacy to review medication regimens on current residents and update care plan with non-pharmalogical interventions.



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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;

(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 resident interview, staff interview, facility document review and clinical record review, it was determined, the facility staff failed to ensure one of 26 residents in the survey sample, Resident #6, was free from unnecessary medication.

The facility staff failed to attempt non-pharmacological interventions prior to the administration of as needed Ativan (1) to Resident #6 on multiple occasions during October 2017.

The findings include:

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3. Licensed nursing staff will be re-educated by pharmacist/designee on unnecessary medication usage and non-pharmalogical interventions. An audit of 3 charts will be completed 2 x week x 4 weeks to review for unnecessary medication usage and ensure non-pharmalogical interventions are being offered.
4. Results of the audit will be reviewed in the monthly QAPI meetings and any identified issues and trends will be discussed with physician and pharmacist.

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Resident #6 was admitted to the facility on 5/19/17. Resident #6's diagnoses included but were not limited to: heart disease, difficulty swallowing and anxiety. Resident #6's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/10/17, coded the resident as cognitively intact. Section N documented Resident #6 received antianxiety medication four out of the last seven days.

Review of Resident #6's clinical record revealed a physician's order dated 5/19/17 for Ativan 0.5 mg (milligrams)- one tablet by mouth every six hours as needed for anxiety.

Resident #6's comprehensive care plan initiated on 5/24/17 documented, "Potential for drug related complications associated with use of psychotropic medications related to: Anti-Anxiety medication and Antidepressant medication...Interventions: Provide non-pharmaceutical interventions prior to administration of PRN (as needed) Antianxiety medications i.e. Offer food and or beverages Dim Lights, provide quiet setting, Play soothing music Offer relaxing massage..."

Review of Resident #6's October 2017 MAR (medication administration record) revealed the resident was administered PRN Ativan 17 out of 31 days in October 2017. Further review of Resident #6's clinical record (including the MAR and October 2017 nurses' notes) failed to reveal documentation that non-pharmacological interventions were attempted prior to administering PRN Ativan to the resident 14 out of 17 days.

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On 11/1/17 at 7:40 a.m. an interview was conducted with Resident #6. Resident #6 was asked if staff does anything for her anxiety and nervousness before giving her a pill. Resident #6 stated the pill is the last thing she gets at night to help her relax before going to sleep. Resident #6 stated she has been taking the pill long before her admission to the facility. Resident #6 was asked if staff turns off her lights or talks to her to calm her before they give her the pill and stated she does "things" herself.

On 11/1/17 at 5:05 p.m. an interview was conducted with LPN (licensed practical nurse) #3, the nurse who administered PRN Ativan to Resident #6 on three separate days in October 2017. LPN #3 was asked what should be done prior to administering PRN antianxiety medication to a resident. LPN #3 stated she assesses the patient first then checks to make sure the PRN medication is on the MAR and if a resident is having anxiety then she will give lorazepam (Ativan) or whatever is ordered. When asked if she should do anything else, LPN #3 stated she takes the resident's vital signs and makes sure the resident's oxygen saturation level is not low. LPN #3 was asked if she attempts non-pharmacological interventions prior to the administration of as needed antianxiety medication. LPN #3 stated in her past experience she would sometimes talk to residents and rub their backs and legs but the current MARs/TARs (treatment administration records) at the facility do not instruct nurses to do so. LPN #3 stated she does spend time assessing Resident #6 and checking the resident's vital signs and oxygen saturation level but she was told by another nurse to give Resident #6 her Ativan if the resident asks for it.

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An interview conducted on 11/1/17 at 6:06 p.m. with LPN (licensed practical nurse) #1, the nurse who administered PRN Ativan to Resident #6 on two separate days in October 2017, revealed the nurse attempted non-pharmacological interventions but failed to document them.

On 11/1/17 at 6:30 p.m. ASM (administrative staff member) #1 (the interim administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

The facility policy titled, "Chemical Restraint" documented, "7. Interventions to be used to avoid using psycho-pharmacologic drugs may include:

Exercise, all departments may be involved.
Verbal instructions, speak clearly.
Diversional Activities such as:
TV/Videos
Music therapy
Bingo
Picture books, etc.
Frequent visits
Massage/Therapeutic touch/warm baths
Pillows and other positioning aides
Food/warm beverages
Toileting..."

No further information was presented prior to exit.

(1) Ativan is used to treat anxiety. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682053.html

F 332 SS=D 483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE F 332

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(f) Medication Errors. The facility must ensure that its-

(1) Medication error rates are not 5 percent or greater;
This REQUIREMENT is not met as evidenced by:
Based on medication administration observation, staff interview, facility document review and clinical record review, the facility staff failed to ensure the facility was free of a less than 5% (five percent) medication error rate. Of 29 opportunities for error, three medication errors were observed involving two of six residents in the medication administration observation, Resident #5 and Resident #22.

1.a. The nurse, RN (registered nurse) #2 administered Omeprazole to Resident #22 while the resident was being fed by her husband.

b. The nurse RN #2 administered Lantus insulin to Resident #22 from a vial that had been opened on 9/30/17, (32 days after being opened).

2. The nurse, LPN (licensed practical nurse) #11 administered one Fish Oil capsule to Resident #5, when the physician order was for two capsules.

The findings include:

1.a. Resident #22 was admitted to the facility 11/2/13 with a recent readmission on 9/7/17 with diagnoses that included, but were not limited to: dementia, diabetes, GERD - gastroesophageal reflux disease - backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the

F 332

1. Resident #5 Fish Oil medication was clarified on 11/1/07. Resident #22 Lantus was replaced with a new insulin vial on 11/1/2017. Resident #22 order for Omeprazole was clarified to be given before meals. Physician was notified at the time the expired medication was administered.
2. Residents receiving medications are at risk for this deficient practice.
3. Licensed nursing staff will be re-educated by the pharmacist/designee on the 8-Rights of medication administration and the monitoring of expired medications by 11/24/2017. A random audit of medication observation will be completed 3 x week x 4 weeks to ensure correct medication administration process is followed.
4. Results of the audits will be reviewed in the monthly QAPI meeting. Any issues identified will be corrected immediately and re-education will be given as identified.

11/30/17

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two organs (1)), and high blood pressure.

The most recent MDS (minimum data set) assessment, a Medicare 30-day assessment, with an assessment reference date of 10/5/17, coded the resident as scoring a "2" on the BIMS (brief interview for mental status) score, indicating that she was severely impaired to make cognitive daily decisions. The resident was coded as requiring extensive assistance to being totally dependent upon one or more staff members for all of her activities of daily living.

Observation was made on 11/1/17 at 8:12 a.m. of RN (registered nurse) #2 preparing and administering medications to Resident #22. The nurse prepared Omeprazole (used to treat heartburn, stomach ulcers and GERD (2)) 20 MG (milligrams) one tablet. The nurse proceeded to enter the resident's room where the husband was feeding the resident. She interrupted the meal and gave Resident #22 the Omeprazole. Resident #22 then went back to eating her breakfast.

The physician order dated, 8/24/17, documented, "Omeprazole capsule delayed release 20 mg; give 1 capsule by mouth one time a day related to gastroesophageal reflux disease."

The November 2017 MAR (medication administration record) documented, "Omeprazole capsule delayed release 20 mg; give 1 capsule by mouth one time a day related to gastroesophageal reflux disease." The scheduled time was 9:00 a.m.

The comprehensive care plan dated, 6/22/17, documented in part, "Gastrointestinal distress



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due to constipation. Due to irritable bowel syndrome, occasional vomiting." The "Interventions" documented in part, "Administer medications as ordered."

An interview was conducted with RN #2 on 11/1/17 at 1:20 p.m. When asked what Omeprazole is given for, RN #2 stated, "For GERD and acid reflux." When asked if it should be given in the middle of a meal, RN #2 stated, "No." When asked if Resident #22's order for Omeprazole should have been clarified with the physician or the administration time changed, RN #2 stated, "Yes, it should have been."

An interview was conducted with administrative staff member (ASM) #3, the nurse practitioner, on 11/1/17 at 3:30 p.m. When asked what Omeprazole is given for, ASM #3 stated, "For GERD." When asked when should it be given, ASM #3 stated, "One hour before breakfast."

The facility policy provided titled, "Oral Drug Administration" documented in part, "Verify that the medication is being administered at the proper time, in the prescribed dose and by the correct route to reduce the risk of medication errors."

The "How to Use" instructions for Omeprazole documented, "Take one hour before the meal." (2)

The interim administrator, ASM #1 and the director of nursing, ASM #2 were made aware of the above findings on 11/1/17 at 6:30 p.m.

No further information was provided prior to exit.

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(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition; Rothenberg and Chapman, page 243.

(2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011495/?report=details.

b. The nurse, RN #2 administered Lantus insulin to Resident #22 from a vial that had been opened on 9/30/17, 32 days after opening.

Observation was made on 11/1/17 at 8:12 a.m. of RN (registered nurse) #2 preparing and administering medications to Resident #22. She drew up 15 units of Lantus Insulin (a long acting human insulin used to treat diabetes (1)). The vial had a sticker documenting that it was opened on 9/30/17. The vial itself documented, "discard after 28 days once opened." RN #2 administered the medication to Resident #22.

The physician order documented, "Lantus Solution 100 units/ml (milliliters) inject 15 units subcutaneously two times a day related to Type 2 diabetes mellitus."

The MAR (medication administration record) for November 2017 documented, "Lantus Solution 100 units/ml inject 15 units subcutaneously two times a day related to Type 2 diabetes mellitus." The scheduled time was at 9:00 a.m. and 5:00 p.m.

The comprehensive care plan dated 5/9/16 and revised on 1/4/17, documented in part, "Focus: Potential for alteration in Blood Glucose due to DX (diagnosis) of Diabetes Mellitus." The

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"Interventions" documented in part, "Administer medications as ordered."

An interview was conducted with RN #2 on 11/1/17 at 1:20 p.m. RN #2 was asked how many days a bottle of Lantus is good for once it has been opened. RN #2 stated, "30 days." RN #2 had changed units so she opened a medication cart on the unit she was currently working on. A bottle of Lantus Insulin was reviewed. RN #2 read the bottle and stated, "I guess I shouldn't have given that (Lantus Insulin to Resident #22). I will call down to the nurse on that unit to discard the insulin."

A copy of the facility instructions for Lantus storage was requested. A copy of "Lantus Storage instructions from the facility pharmacy documented, "Vials must be discarded 28 days after being opened."

The interim administrator, ASM (administrative staff member) #1 and the director of nursing, ASM #2 were made aware of the above findings on 11/1/17 at 6:30 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=B861FDD9-E134-436E-8C0C-A60DD0006DD3

2. The nurse, RN #2 administered one Fish Oil capsule to Resident #5, when the physician order was for two capsules.

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Resident #5 was admitted to the facility on 1/15/10 with a recent readmission 9/13/17 with diagnoses that included, but were not limited to: pressure ulcers, GERD, diabetes, and high blood pressure.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date (ARD) of 10/9/17 coded Resident #5 as scoring a "12" on the BIMS (brief interview for mental status) score indicating the resident was moderately impaired to make daily cognitive decisions. Resident #5 was coded as requiring extensive assistance of one or more staff members for most of his activities of daily living.

Observation was made on 11/1/17 at 8:26 a.m. of LPN (licensed practical nurse) #11 administering medications to Resident #5. The nurse prepared the following medications:
Vitamin C 500 mg (milligrams) 1 tablet (a water soluble vitamin (1))
Loratadine 10 mg 1 tablet (used to treat allergies (2))
Coenzyme Q 10 100mg 2 tablets (an antioxidant that is necessary for cells to function properly (3))
Fluoxetine 20 mg 1 tablet (used to treat depression and anxiety disorders (4))
Gabapentin 300 mg 1 capsule (used to treat seizures and neuralgia (5))
Hiprex 1 GM (gram) 1 tablet (used to treat and prevent infections (6))
Fish Oil 1000 mg 1 capsule (a fatty acid used in the management of cardiovascular disease (7))
Multi Vitamin 1 tablet (used as a supplement (8))
Cholestyramine 1 packet mixed in water (used to lower cholesterol levels (9)).

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The physician order dated, 9/13/17, documented, "Omega 3 (fish oil) capsule 1000 mg; give 2 capsules by mouth two times a day for heart health."

Resident #5's MAR (medication administration record) documented, "Omega 3 capsule 1000 mg; give 2 capsules by mouth two times a day for heart health."

The comprehensive care plan dated, 9/12/16 and revised on 7/29/17 documented in part, "Focus: Impaired Cardiovascular status related to hypertension (high blood pressure), Peripheral Vascular disease (any abnormal condition, including atherosclerosis, affection blood vessels outside the heart. (10)) " The "Interventions" documented in part, 'Medications as ordered by physician and observe use and effectiveness."

An interview was conducted with LPN #11 on 11/1/17 at 1:30 p.m. When asked how many fish oil capsules she gave Resident #5 this morning, LPN #11 stated, "One." Resident #5's physician order was reviewed with LPN #11. LPN #11 stated, "I didn't give him two. That seems like a high dose to me. I will clarify the order with (name of nurse practitioner). But I didn't give him two, that I know."

The interim administrator, ASM #1 and the director of nursing, ASM #2 were made aware of the above findings on 11/1/17 at 6:30 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the

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following website:
https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=vitamin+c&commit=Search.
(2) This information was obtained from the following website:
https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=679164cc-7505-7ed4-13fe-87f06cb777d8
(3) This information was obtained from the following website:
https://nccih.nih.gov/health/supplements/coq10#hed2
(4) This information was obtained from the following website:
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010346/?report=details
(5) This information was obtained from the following website:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=1a619a14-0b63-4cba-80e7-474c9a1c90b9.
(6) This information was obtained from the following website:
https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=6213
(7) This information was obtained from the following website:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3217043/
(8) This information was obtained from the following website:
https://ods.od.nih.gov/factsheets/MVMS-HealthProfessional/
(9) This information was obtained from the following website:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=9269d9ba-d791-4865-8a39-abd1733d79bd

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(10) Barron's Dictionary of Medical Terms for the Non=-Medical Reader 5th edition; Rothenberg and Chapman; page 447.

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

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

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

(1) Provides consultation on all aspects of the provision of pharmacy services in the facility;
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, and facility document review, it was determined, the facility staff failed to ensure medications were available for one of 26 residents in the survey sample, Resident #7.

The facility staff failed to ensure Resident #7's Nicotine patches [1] were available to be administered on several occasions in October of 2017.

The findings include:

Resident #7 was admitted to the facility on 8/29/17 with diagnoses that included but were not limited to: peripheral vascular disease with vascular and arterial ulcers to bilateral legs, cellulitis to bilateral legs, COPD (chronic

**Plan of Correction (F 425):**

1. Resident # 7 Nicotine patches were provided on 11/2/17 at 10:30 a.m.
2. Residents residing at facility are at risk for this deficient practice.
3. An audit was completed on 11/21/17 to match orders to medication carts to ensure that ordered medications were readily available for residents. A random audit of residents' medications will be completed 3 x week x 4 weeks to ensure medications are available. Staff will be re-educated by DON/designee on medication process when medications are not available and reordering process.
4. Results of audits will be discussed in the monthly QAPI meeting. Any noted trends will be addressed and re-education provided as needed.

Completion date: 11/30/17

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obstructive pulmonary disease), chronic back pain, and Non-Alzheimer's dementia. Resident #7's most recent MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 8/29/17. Resident #7 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 #7 was coded as requiring extensive assistance with one staff member with transfers, dressing, hygiene and bathing; and supervision only with meals.

Review of Resident #7's October physician orders, documented the following order: "Nicotine Patch 24 Hour 21 MG (milligrams)/24 HR (hour). Apply one patch transdermally (on the skin) one time a day related to Nicotine Dependence Unspecified, with withdrawal and remove per schedule."

Review of Resident #7's October 2017 TAR (treatment administration record) documented the following order: "Nicotine Patch 24 Hour 21 MG/24 HR. Apply one patch transdermally one time a day related to Nicotine Dependence Unspecified, with withdrawal and remove per schedule."

Further Review of the October 2017 TARS revealed that Resident #7 did not receive his nicotine patch on the following dates: 10/14/17, 10/15/17, and 10/16/17 (3 consecutive days), 10/24/17, 10/25/17, and 10/26/17 10/27/17, 10/28/17, 10/29/17, and 10/30/17 (7 consecutive days).

A "7" (seven) was coded for each administration of the Nicotine patch, indicating nursing notes



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were written for the above dates.

The October 2017 nursing notes revealed the following notes:

- "10/24/17 at 2:53 p.m., Did not receive patch at this time. NP (Nurse Practitioner) and RP (responsible party) made aware.

- 10/25/17 at 08:34 a.m., Nicotine Patch 24 Hour 21 MG/24HR Apply 1 patch transdermally one time a day related to Nicotine dependence unspecified, with withdrawal and remove per schedule, will apply when available.

- 10/26/17 at 08:03 a.m., Nicotine Patch 24 Hour 21 MG/24 HR Apply 1 patch transdermally one time a day related to Nicotine dependence unspecified, with withdrawal and remove per schedule, will give when available.

- 10/27/17 at 11:09 a.m., Nicotine Patch 24 Hour 21 MG/24 HR Apply 1 patch transdermally one time a day related to Nicotine dependence unspecified, with withdrawal and remove per schedule, Will (sic.) apply when available.

- 10/28/17 at 08:21 a.m., Nicotine Patch 24 Hour 21 MG/24 HR Apply 1 patch transdermally one time a day related to Nicotine dependence unspecified, with withdrawal and remove per schedule, will give when available.

- 10/29/17 at 08:28 a.m., Nicotine Patch 24 Hour 21 MG/24 HR Apply 1 patch transdermally one time a day related to Nicotine dependence unspecified, with withdrawal and remove per schedule, will apply when available.

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- 10/30/17 at 08:15 a.m., Nicotine Patch 24 Hour 21 MG/24 HR Apply 1 patch transdermally one time a day related to Nicotine dependence unspecified, with withdrawal and remove per schedule, will give when available."

On 11/2/17 at 8:00 a.m., an interview was conducted with LPN (licensed practical nurse) #6, Resident #7's nurse. When asked about the process staff follows if medication is not available for administration, LPN #6 stated if the medication was over the counter, she would check the house stock in the medication room. LPN #6 stated if the medication was not in the medication room, she would ask a nurse to borrow the medication from their cart. LPN #6 stated that the pharmacy does not send the facility medications that are over the counter. LPN #6 stated the facility receives over the counter medication from central supply. LPN #6 stated if the medication was not over the counter, she would check Alixa (stat [immediate] box) for the medication. When asked about the process staff follows if a resident ran out of Nicotine patches, LPN #6 stated that Nicotine patches have to be approved by corporate before they can be ordered. LPN #6 stated each time the Resident #7 runs out of nicotine patches, she has to get a physician's order from the physician or NP (nurse practitioner) and that order has to be given to central supply so they can send the order to corporate. LPN #6 stated there are always issues with ordering Resident #7's Nicotine patches. LPN #6 stated staff cannot get the patches from pharmacy because it is over the counter. When asked why a physician order has to be written each time Resident #7 runs out of his patches when there is a clear order in place for the patches, LPN #6 stated she was not sure if it was

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an order or a note. LPN #6 was not sure why Resident #7 went several days without his Nicotine patch. LPN #6 stated she has made the nurse practitioner aware in the past about the resident not receiving his patches.

On 11/2/17 at 8:30 a.m., an interview was conducted with OSM (other staff member) #2, medical supply. When asked the process for ordering Nicotine patches, OSM #2 stated the pharmacy doesn't usually send them, that a physician's order is needed to send to corporate for the patches. Once the physician's order is faxed to corporate, corporate will send the patches. When asked if a physician's order or note is needed every time the resident runs out of his patches, OSM #2 stated, "No. Not every time." When asked why Resident #7 had several days without his patches, OSM #2 stated, "We should have had them. I am not sure." When asked if there was any other way nursing could get Resident #7's patches while they were waiting for corporate to send patches, OSM #2 stated pharmacy could send the patches with approval from the DON (Director of Nursing) or administrator.

On 11/2/17 at 8:45 a.m., an interview was conducted with ASM (administrative staff member) #3, the nurse practitioner. ASM #3 stated that she has been made aware on occasion of Resident #7's patches not being available. ASM #3 stated she had just suspended the order that morning and will have staff re-start the order when the patches come in. ASM #3 stated she was not sure about the process followed for ordering Nicotine patches. ASM #3 stated she was not sure if she had to write an order or note for the patches every time

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Resident #7 ran out.

On 11/2/17 at 9:00 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (director of nursing). ASM #2 was asked about the process staff follows if a resident runs out of Nicotine patches and the facility was awaiting new patches from corporate. ASM #2 stated she could call corporate to get approval for the patches. ASM #2 stated that once she had approval, she could walk to the drug store and pick up the patches. ASM #2 stated she would expect her nurses to contact her in this situation. ASM #2 stated she was not aware of Resident #7 being out of his patches. ASM #2 stated she and the facility staff were still trying to wrap their heads around the new process of ordering Nicotine patches from corporate.

On 11/2/17 at approximately 10:00 a.m., ASM #1, the interim administrator and ASM #2, the DON were made aware of the above concerns.

The facility policy titled, "Unavailable Medications" documents in part, the following: "...B. Nursing staff shall: 1) Notify the attending physician of the situation and explain the circumstances, expected availability and optional therapies that are available. a. If the facility nurse is unable to obtain a response from the attending physician, the nurse should notify the nursing supervisor and contact the Facility Medical Director for orders and/or direction. 2) Obtain a new order and cancel/discontinue the order for the non-available medication. 3) Notify the pharmacy of the replacement order."

No further information was presented prior to exit.

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| F 425 | Continued From page 71<br><br>[1] Nicotine Patches- "Reduces withdrawal symptoms, including nicotine craving, associated with quitting smoking." This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=6b4a98b1-60ee-4a13-8362-acdb2eab4e3b. | F 425 | | |
| F 431 SS=D | 483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--<br><br>(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>(g) Labeling of Drugs and Biologicals. | F 431 | 1. Med room on East 2 Hall was cleaned and expired medication removed and disposed of on 11/2/17. Medications without 'date opened' as required were discarded.<br>2. Medication rooms in facility were audited for expired medications on 11/2/17. Medication carts were audited to ensure medications were labeled appropriately.<br>3. Licensed nursing staff will be re-educated regarding medication rooms and monitoring for expired medications by 11/24/17. In-service education included proper labeling of medication, such as 'date opened.' An audit of medication rooms and carts will be completed 5 x per week by DON/designee to ensure expired medications are not available and medications are properly labeled. | |

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Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to ensure medications available for use were not expired for one of four medication rooms, East 2.

1. A vial of Tuberculin, PPD (purified Protein Derivative) was not dated when opened and was observed available for resident use in the East 2 medication room.

2. There were two expired bags of normal saline with a mediation, Meropenim attached, were observed in the East 2 medication room.

F 431 (Continued from page 72)

3. Licensed nursing staff will be re-educated regarding medication rooms and monitoring for expired medications by 11/24/17. In-service education included proper labeling of medication, such as 'date opened.' An audit of medication rooms and carts will be completed 5 x per week by DON/designee to ensure expired medications are not available and medications are properly labeled.
4. Results of audits will be discussed and reviewed in the monthly QAPI meeting. Any trends or issues identified will be addressed and re-education as needed. 11/30/17

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The findings include:

1. Observation was made of the East 2 medication room on 11/1/17 at 6:10 p.m. A Tuberculin, PPD vial in the refrigerator was observed. There was no date on the vial or box indicating when it was opened. The box documented, "Once entered, vial should be discarded after 30 days." The package insert documented, "Vial in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency."

An interview was conducted with RN (registered nurse) #4 on 11/1/17 at 6:23 p.m. When asked if a vial of PPD is to be dated when it's opened, RN #4 stated, "All multi-dose vials are to be dated when opened. It's supposed to have an open date on it."

2.. Observation was made of the East 2 medication room on 11/1/17 at 6:10 p.m. Two 100 ml (milliliters) bags of 0.9 % NaCl (sodium chloride) solution with a bottle of Meropenem (used to treat infections (1)) was attached to the bag of solution. The two bags of NaCl solution had an expiration date of 8/17. The Meropenem was not expired.

During an interview with RN #4 on 11/1/17 at 6:23 p.m. RN #4 was asked if these solutions were available for use, RN #4 stated, "Yes, but that resident is no longer here." When asked if these solutions should be removed from the medication storage room, RN #4 stated, "They should have been sent back to the pharmacy."

The interim administrator and director of nursing



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were made aware of the above findings on 11/2/17 at 10:10 a.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011103/?report=details.

F 441 SS=D 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS F 441

(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

Provider's plan of correction:

1. Resident #7 care is provided with correct infection control practices. Shower room, including the bathtub and toilet seat on West 2 unit was cleaned on 11/2/17 during survey.
2. Shower rooms in facility were audited on 11/2/17 to ensure they were clean. Residents in facility are at risk for deficient practice.

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communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

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

(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, resident interview, staff

F 441

3. DON/designee will re-educate staff on infection control practices to include shower room use and cleaning, and patient care practices. RN # was re-educated on infection control practices regarding wound care and a return demonstration competency completed on 11/21/17. Shower rooms will be audited during carekeeper rounds by department managers' 5 x week to ensure infection control practices are being followed. An audit will be completed 3 x week x 4 weeks to observe patient (wound) care to ensure infection control practice is adhered to.
4. Results of audits will be reviewed in the monthly QAPI meeting. Any trending or non-compliance will be addressed immediately and re-education as needed.

11/30/17

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interview and clinical record review, it was determined that facility staff failed to maintain infection control practices for one of 26 residents in the survey sample, Resident #7; and for one of four shower rooms, the shower room on the West 2 nursing unit.

1. The facility staff failed to maintain infection control practices during Resident #7's dressing changes to his bilateral leg ulcers.

2. The facility staff failed to maintain the shower room on the West 2 nursing unit in a sanitary manner. The West 2 shower room was free from feces in the bathtub and toilet seat.

The findings include:

1. The facility staff failed to maintain infection control practices during Resident #7's dressing changes to his bilateral leg ulcers.

Resident #7 was admitted to the facility on 8/29/17 with diagnoses that included but were not limited to peripheral vascular disease [1] with arterial and venous ulcers to bilateral legs, cellulitis (infection) to bilateral legs, COPD (chronic obstructive pulmonary disease), chronic back pain, and Non-Alzheimer's dementia. Resident #7's most recent MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 8/29/17. Resident #7 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 #7 was coded as requiring extensive assistance with one staff member with transfers, dressing, hygiene and bathing; and supervision only with meals.

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On 10/31/17 at 11:10 a.m., an interview was conducted with Resident #7. Resident #7 expressed concerns regarding his dressing changes.

Review of Resident #7's wound physician notes dated 10/18/17, revealed the following treatment orders for his bilateral leg ulcers: "Venous wound of the right lateral ankle, Dry protective dressing-once daily, Silver Hydrogel [2]; Wound of the Right Shin, Dry protective dressing-once daily, Silver Hydrogel; Arterial Wound of the right, Dorsal Foot, Foam-once daily Silver Alginate [3]; Venous Wound of the right calf, Foam-Once daily, adaptic [4]; Venous Wound of the left, medial ankle, Dry protective dressing, Silver Hydrogel."

On 10/31/17 at 12:15 p.m., an observation of wound care was conducted with RN (registered nurse) #3, the wound care nurse. RN #3 first collected her supplies. RN #3 grabbed gauze pads off the treatment cart with her bare hands and carried them to Resident #7's room. The gauze pads were not in individual packages. RN #3 was not observed washing or sanitizing her hands prior to this. RN #3 then placed the gauze pads and other supplies on a clean field on Resident #7's bed side table. RN #3 was then observed putting on her gloves. After her gloves were in place, RN #3 was then observed pulling out scissors from her scrub pocket. RN #3 then proceeded to cut the old dressing off Resident #7's right leg. The scissors were not sanitized prior to removing the old dressing. RN #3 then placed the scissors on the clean field. RN #3, using the same gloves, put normal saline on a gauze pad and cleaned Resident #7's right shin.

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She proceeded to put normal saline on a new gauze pad and cleaned Resident #7's right dorsal foot. RN #3 was then observed putting normal saline on another gauze pad and cleaning Resident #7's right calf and right medial ankle. RN #3 then took her gloves off, threw the old gloves away and put on new gloves. She did not sanitize or wash her hands prior to donning new gloves. RN #3 was then observed using the dirty scissors to cut the silver alginate (Maxasorb (Brand Name). She then placed the silver alginate into the wound bed of Resident #7's right dorsal foot. The scissors were then placed on the resident's bed. After all wounds to his right leg were dressed, RN #3 placed her scissors back into her scrub pocket. Resident #3 then changed her gloves and proceeded to remove the dressing to his left ankle. No further issues were noted when changing Resident #3's dressing to his left leg. At this time another nurse, RN #5, entered the Resident's room and cued RN #3 when to wash her hands. All gauze pads that were taken off the treatment cart and carried with RN #3's bare hands were used during the dressing changes.

On 11/2/17 at 8:05 a.m., an interview was conducted with RN #3. When asked about the process staff follows to maintain infection control during wound care, RN #3 stated that she would wash hands prior to starting wound care and she would wash or sanitize her hands in between each dressing change. RN #3 stated that anytime she removes her gloves, she should also sanitize or wash her hands. When RN #3 was informed of the above observations of her not washing or sanitizing her hands before wound care and after each glove change, RN #3 stated she had forgotten to bring the hand sanitizer into

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the room. RN #3 agreed she did not wash or sanitize her hands. When asked how to maintain infection control of equipment such as scissors, RN #3 stated she would clean the scissors after the scissors came into contact with the soiled dressing. When RN #3 was informed about the above observations of the scissors and the gauze pads, she had picked up with her bare hands, RN #3 did not have a response. RN #3 stated she had worked at the facility for 2 weeks as the wound care nurse.

On 11/2/17 at approximately 10:00 a.m., ASM (administrative staff member) #1, the interim administrator and ASM #2, the DON (Director or Nursing) were made aware of the above concerns.

The facility's "Wound Prevention Program" did not address the above concerns.

The facility's "Wound Prevention Program" did not address maintaining infection control during wound care.

No further information was presented prior to exit.

[1] Peripheral vascular disease-"is a disease in which plaque builds up in the arteries that carry blood to your head, organs, and limbs. Plaque is made up of fat, cholesterol, calcium, fibrous tissue, and other substances in the blood." This information was obtained from The National Institutes of Health. https://www.nhlbi.nih.gov/health/health-topics/topics/pad/.

[2] Silver hydrogel- "Hydrogel Dressing is intended for the management of wounds and to



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provide an antimicrobial barrier. This information was obtained from The National Institutes of Health."
https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=91244d66-ed63-4a70-a1ce-e2b77a6b09e1.

[3] Silver alginate-"Alginate wound dressings have been found to be effective primary dressings and appropriate for use in the management of exudating wounds and are associated with positive clinical outcomes. Antimicrobials, in silver, are incorporated into wound dressings, including alginates, for use in the treatment of "at risk" or infected chronic wounds." This information was obtained from The National Institutes of Health.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4486446/.

[4] Adaptic dressing- "is designed to help protect the wound while preventing the dressing from adhering to the wound and to minimize pain and trauma upon removal." This information was obtained from
https://www.vitalitymedical.com/adaptic-non-adhering-dressing.html.

2. The facility staff failed to maintain the shower room on the West 2 nursing unit in a sanitary manner.

On 11/2/17 at 7:19 a.m., observation of the West 2 shower room was conducted. A basin used underneath a commode to collect urine and feces was observed in the bathtub with a brown liquid substance inside the basin. A brown smudge

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was also observed on the rim of the toilet seat in the shower room.

On 11/2/17 at 7:21 a.m., an interview was conducted with CNA (certified nursing assistant) #1. When asked who was responsible for cleaning the shower rooms, CNA #1 stated that the nursing aides were responsible for cleaning the shower rooms after each resident shower. CNA #1 stated that housekeeping will also clean the shower rooms once a day. When asked who used the shower room last, CNA #1 stated the 7 a.m. to 3 p.m. shift CNAs did not start giving their showers yet and that showers are not offered on 11 p.m. to 7 a.m. shift. CNA #1 stated the last shift to use the shower rooms would have been the 3 p.m. to 11 p.m. shift. CNA #1 followed this writer into the West 2 shower room. When asked what CNA #1 observed in the basin that was inside the bathtub, CNA #1 stated, "I see poop." When asked what CNA #1 observed on the rim of the toilet seat, CNA #1 stated, "That is poop." CNA #1 stated she would clean up the shower room. CNA #1 stated the housekeepers had not yet been in the shower rooms that morning.

On 11/2/17 at approximately 10:00 a.m., ASM (administrative staff member) #1, the interim administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

A policy could not be provided regarding the above concern.

No further information was presented prior to exit.

F 500 SS=E 483.70(g)(1)(2)(i)(ii) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT F 500

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(g) Use of outside resources.

(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section.

(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for-

(i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and

(ii) The timeliness of the services.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, it was determined, the facility staff failed to have a written agreement or contract, with four dialysis centers providing contractual services for five residents in the survey sample, Residents #14, #23, #24, #25, and #26.

The findings include:

1. Resident #14 was admitted to the facility on 2/5/15 with a recent readmission on 2/21/17 with diagnoses that included but were not limited to: end stage renal disease requiring hemodialysis (a

**Provider's Plan of Correction:**

1. Dialysis contracts were obtained for dialysis centers by the Administrator.
2. Residents receiving dialysis services are at risk for this deficient practice.
3. An audit of dialysis centers that are utilized was completed on 11/20/17. DON and Administrator were re-educated on contracted services requirements and process by the Chief Clinical Officer on 11/21/17. An audit will be completed monthly x 3 months by the Chief Clinical Officer to ensure outside services provided have contractual agreements.
4. Results of the audit will be reviewed in the monthly QAPI meeting. Any discrepancies will be corrected immediately.

Completion date: 11/30/17

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procedure used in toxic condition and renal [kidney] failure in which wastes and impurities are removed from the blood by a special machine (1)), high blood pressure, dementia and depression.

The most recent MDS (minimum data set) assessment an annual assessment with an assessment reference date (ARD) 10/3/17, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. In Section O - Special Treatments, Procedures and Programs, Resident #14 was coded as receiving dialysis.

A physician order dated 10/27/17, documented, "Dialysis on Tuesday, Thursday and Saturday at 6:00 a.m. Pick up time 5:20 a.m. (Name of dialysis Center [#1], address and phone number)."

2. Resident #23 was admitted to the facility on 1/2/17 with diagnoses that included but were not limited to: end stage renal disease requiring hemodialysis, diabetes, dementia, depression and stroke.

The most recent MDS assessment, a quarterly assessment, with an assessment reference date (ARD) of 9/19/17, coded Resident #23 as scoring a 14 on the BIMS score, indicating he was capable of making daily cognitive decisions. In Section O - Special Treatments, Procedures and Programs, the resident was coded as receiving dialysis.

The physician order dated, 4/10/17 documented, "Dialysis every Monday, Wednesday, and Friday

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at (Name of dialysis center [#2], address and phone number)."

3. Resident #24 was admitted to the facility on 10/25/17 with diagnoses that included but were not limited to acute kidney failure, dependent on dialysis and high blood pressure.

There was no MDS assessment completed as resident was a new admission.

The physician order dated 10/27/17 documented, "Dialysis Tuesday, Thursday and Saturday at (Name of dialysis center [#1], address and phone number."

4. Resident #25 was admitted to the facility on 10/19/17 with diagnoses that included, but were not limited to: end stage renal disease requiring hemodialysis, pain, and altered mental status.

The most recent MDS assessment, an admission assessment with an assessment reference date of 10/26/17, coded Resident #25 as scoring a 14 on the BIMS indicating she was capable of making daily cognitive decisions. In Section O - Special Treatments, Procedures and Programs, the resident was coded as receiving dialysis.

The physician order dated, 10/19/17, documented "Dialysis @ (at) (Name of dialysis center [#3]) on Mondays, Wednesday and Fridays. Chair time at 11:45 a.m. - 4:00 p.m."

5. Resident #26 was admitted to the facility on 10/10/17 with a readmission on 10/20/17 with diagnoses that included, but were not limited to: end stage renal disease, pneumonia, diabetes and high blood pressure.

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The most recent MDS assessment, a Medicare 5-day assessment, with an assessment reference date of 10/16/17, coded Resident #26 as being capable of making himself understood and usually understanding others. In Section O - Special Treatments, Procedures and Programs, the resident was coded as receiving dialysis.

The physician order dated, 10/24/17, documented, "Dialysis Tuesday, Thursday, and Saturday - chair time 11:00 a.m. one time a day Tue (Tuesday), Thurs. (Thursday) and Sat (Saturday). Needs to be at dialysis by 11:00 a.m." No name of dialysis center in order but resident goes to dialysis center #4.

During the entrance conference on 10/31/17 at approximately 10:45 a.m. the team leader requested the names of the residents receiving dialysis and the copy of the dialysis contracts.

On 11/1/17 at 4:37 p.m. administrative staff member (ASM) #2, the director of nursing, stated, "We don't have a contract. Each resident who goes out to dialysis is set up, before the resident gets here. We set up transportation. We do not have a contract for dialysis."

On 11/2/17 at 10:10 a.m. an interview was conducted with ASM #1, the interim administrator. When asked if they require a contract for contractual services, ASM #1 stated, "We do not have a contract with the dialysis centers." A copy of the facility policy on contractual services was requested.

On 11/2/17 at 11:35 a.m. ASM #2, the director of nursing, informed the survey team that the facility

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| F 500 | Continued From page 86<br>did not have a policy on contract services.<br><br>No further information was provided prior to exit.<br><br>(1) Barron's Dictionary for the Non=Medical Reader, 5th edition; Rothenberg and Chapman, page 266. | F 500 | | |
| F 503 SS=D | 483.50(a)(i)-(iv) LAB SVCS - FAC PROVIDED, REFERRED, AGREEMENT<br><br>(a) Laboratory Services<br><br>(i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.<br><br>(ii) If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in part 493 of this chapter.<br><br>(iii) If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter.<br><br>(iv) If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility staff failed to ensure laboratory supplies, | F 503 | 1. Medication room on East Hall 2 was cleaned and expired supplies removed and disposed of on 11/2/17.<br>2. Medication rooms in facility were audited for expired supplies on 11/2/17.<br>3. Licensed nursing staff will be re-educated regarding medication rooms and monitoring for expired supplies by DON/Designee by 11/24/17. An audit of medication rooms will be completed 5 x week during rounds by the DON/designee to ensure expired supplies are not available.<br>4. Results of audits will be discussed and reviewed in the monthly QAPI meeting. Any trends or issues identified will be addressed and re-education as needed. | 11/30/17 |

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available for use, were not expired in one of four medication rooms, East 2.

The facility staff failed to ensure three types of laboratory test tubes, available for use, were not expired in the East 2 medication room.

The findings include:

Observation was made of the East 2 medication room on 11/1/17 at 6:10 p.m. A EZ draw blood culture bottle was observed on the counter. The label documented it expired on 2017 - 08 (August 2017).

Located in a plastic drawer bin were laboratory test drawing supplies; needles, tubes, tourniquets and needle holders. There were seven 4 ml (milliliter) lavender topped test tubes that documented an expiration date of 2017 - 01 (January 2017). There were seven 9 ml red top serum separator tubes that documented an expiration date of 2016 - 12 (December 2016). There were nine 6 ml dry red top tubes that documented an expiration date of 2016 - 12 (December 2016). There were 13 3.5 ml blue top tubes that documented an expiration date of 2016 - 06 (June 2016).

An interview was conducted with RN (registered nurse) #5 on 11/1/17 at 6:10 p.m. When asked if the staff draw blood at the facility, RN #5 stated, "Yes, we draw stat (immediate) labs (laboratory tests) and the nurse can draw labs from PICC* (Peripherally inserted central catheter is a long-line catheter made of soft silicone or Silastic material that is placed peripherally but delivers medications and solutions centrally lines (1)).

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An interview was conducted with RN #4, on 11/1/17 at 6:23 p.m. When asked if expired test tubes would be a concern, RN #4 stated, "You don't want to use an expired tube." When asked why, RN #4 stated, "They could change the results of the tests."

The interim administrator, ASM 9administrative staff member) #1 and director of nursing, ASM #2, were made aware of the above findings on 11/2/17 at 10:10 a.m.

According to applicable requirements for laboratories specified in Part 493 of this chapter: § 493.1252 Standard: Test systems, equipment, instruments, reagents, materials, and supplies.
(4)
(d) Reagents, solutions, culture media, control materials, calibration materials, and other supplies must not be used when they have exceeded their expiration date, have deteriorated, or are of substandard quality.

No further information was provided prior to exit.

(1) Lippincott, Williams & Wilkins, Fundamental of Nursing, 5th edition, 2007, page 1423.

F 514 SS=E 483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

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

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1. Resident #6, Resident #8, and Resident #12 care plans were reviewed and revised to reflect non-pharmalogical interventions are in place. Resident #10 and Resident #13 no longer reside at facility.



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(i) Complete;

(ii) Accurately documented;

(iii) Readily accessible; and

(iv) Systematically organized

(5) The medical record must contain-

(i) Sufficient information to identify the resident;

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

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

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

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

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for five of 26 residents in the survey sample, Residents #6, #12, #13, #10 and #8.

1. The facility staff failed to document non-pharmacological interventions that were attempted prior to the administration of as needed Ativan to Resident #6 on 10/9/17 and

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2. Residents residing in facility are at risk for same deficient practice.
3. An audit will be completed by DON/designee to ensure residents receiving PRN pain management or antianxiety medications have non-pharmalogical interventions in place. DON/designee will re-educate nursing staff on non-pharmalogical interventions per plan of care by 11/24/17. Education will include documenting effectiveness of interventions. An audit of medical records of residents receiving PRN pain/antianxiety medications will reviewed of 3 residents' records 2 x week x 4 weeks to ensure documentation is present for non-pharmalogical interventions.
4. Results of audits will be reviewed in the monthly QAPI meeting. Trends and issues will be identified and addressed as needed.

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10/24/17.

2. The staff failed to document that non-pharmacological interventions were attempted or offered to Resident #12 prior to the administration of prn (as needed) anti-anxiety medication.

3. The facility staff failed to document non-pharmacological interventions for Resident #13's pain management.

4. a. The facility staff failed to document non-pharmacological interventions attempted prior to the administration of pain medication for Resident # 10.

4.b. The facility staff failed to document non-pharmacological interventions attempted prior to the administration of sleeping medication for Resident #10.

4.c. The facility staff failed to document non-pharmacological interventions attempted prior to the administration of anti-anxiety medication for Resident #10.

5. The facility staff failed to document non-pharmacological interventions attempted prior to the administration of pain medication for Resident #8.

The findings include:

1. The facility staff failed to document non-pharmacological interventions that were attempted prior to the administration of as needed Ativan (1) to Resident #6 on 10/9/17 and 10/24/17.

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Resident #6 was admitted to the facility on 5/19/17. Resident #6's diagnoses included but were not limited to: heart disease, difficulty swallowing and anxiety. Resident #6's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/10/17, coded the resident as cognitively intact. Section N documented Resident #6 received antianxiety medication four out of the last seven days.

Review of Resident #6's clinical record revealed a physician's order dated 5/19/17 for Ativan 0.5 mg (milligrams)- one tablet by mouth every six hours as needed for anxiety.

Resident #6's comprehensive care plan initiated on 5/24/17 documented, "Potential for drug related complications associated with use of psychotropic medications related to: Anti-Anxiety medication and Antidepressant medication...Interventions: Provide non-pharmaceutical interventions prior to administration of PRN (as needed) Antianxiety medications i.e. Offer food and or beverages Dim Lights, provide quiet setting, Play soothing music Offer relaxing massage..." The care plan failed to document information regarding the documentation of non-pharmacological interventions.

Review of Resident #6's October 2017 MAR (medication administration record) revealed the resident was administered PRN Ativan 17 out of 31 days in October 2017. Further review of Resident #6's clinical record (including the MAR and October 2017 nurses' notes) failed to reveal documentation that non-pharmacological



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interventions were attempted prior to administering PRN Ativan to the resident 14 out of 17 days.

An interview conducted on 11/1/17 at 6:06 p.m. with LPN (licensed practical nurse) #1, the nurse who administered PRN Ativan to Resident #6 on 10/9/17 and 10/24/17. LPN #1 was asked what should be done prior to administering PRN antianxiety medication to a resident. LPN #1 stated "non-medicative" interventions such as re-directing, talking, heat/cold therapy and activities should be attempted. LPN #1 was asked where these interventions should be documented and stated, "I know we have a book we document interventions attempted in the narc book (controlled substance utilization record)." LPN #1 was asked if she attempts non-pharmacological interventions prior to administering PRN Ativan to Resident #6. LPN #1 stated, "Absolutely." LPN #1 stated she attempts therapeutic one on one conversation with Resident #6 but the resident specifically asks for Ativan. LPN #1 stated her documentation of attempted non-pharmacological interventions should be documented in the "intervention book" (the book referenced earlier in the interview).

On 11/1/17 at 6:30 p.m. ASM (administrative staff member) #1 (the interim administrator) and ASM #2 (the director of nursing) were made aware of the above findings. The "intervention book" for Resident #6 was requested.

On 11/2/17 at 10:21 a.m. ASM #2 stated the facility had specific intervention documentation sheets for pain medication but not antianxiety medication. ASM #2 was asked where nurses should document attempted non-pharmacological

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interventions for residents receiving PRN antianxiety medication. ASM #2 stated the nurses should be prompted by the computer system to document when they give the medication and this should be seen in the progress notes.

The facility policy titled, "Chemical Restraint" documented, "7. Interventions to be used to avoid using psycho-pharmacologic drugs may include:
Exercise, all departments may be involved.
Verbal instructions, speak clearly.
Diversional Activities such as:
TV/Videos
Music therapy
Bingo
Picture books, etc.
Frequent visits
Massage/Therapeutic touch/warm baths
Pillows and other positioning aides
Food/warm beverages
Toileting..."

The policy failed to document information regarding documentation of non-pharmacological interventions.

No further information was presented prior to exit.

(1) Ativan is used to treat anxiety. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682053.html
2. The staff failed to document that non-pharmacological interventions were attempted or offered to Resident #12 prior to the administration of prn (as needed) anti-anxiety medication.

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Resident #12 was admitted to the facility on 10/17/17 with diagnoses that included but were not limited to: cirrhosis (scarring) of the liver, fracture of the right femur from a fall at home, high blood pressure, and chronic pain. Resident #12's most recent MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 10/24/17. Resident #12 was coded as being cognitively intact in the ability to make daily decisions scoring 11 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #12 was coded as requiring extensive assistance with one staff member with transfers, ambulation, dressing, and personal hygiene; and supervision with meals.

Review of Resident #12's October 2017 POS (physician order sheet) documented the following order: "Xanax [1] Tablet 0.5 MG (milligrams) Give 1 tablet by mouth every 8 hours as needed for anxiety." This order was initiated on 10/17/17.

Resident #12's October 2017 MAR (medication administration record) documented the following order: "Xanax Tablet 0.5 MG (milligrams) Give 1 tablet by mouth every 8 hours as needed for anxiety."

Review of Resident #12's MAR revealed that Resident #12 received Xanax on the following dates and times:
"10/17/17 at 9:25 p.m., 10/18/17 at 11:45 a.m. and 9:33 p.m., 10/19/17 at 11:34 a.m. and 8:28 p.m., 10/20/17 at 8:11 a.m., 10/21/17 at 9:57 a.m. and 6:03 p.m., 10/22/17 at 8:45 a.m. and 8:10 p.m., 10/23/17 at 8:30 a.m. and 5:28 p.m., 10/24/17 at 8:00 a.m. and 4:00 p.m., 10/25/17 at 1:26 p.m. and 10:00 p.m., 10/26/17 1:56 p.m.,

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10/27/17 at 4:19 a.m. and 3:14 p.m., 10/28/17 at 8:05 a.m., 10/29/17 at 5:14 a.m., 10/30/17 at 8:30 a.m., and 4:54 p.m., and 10/31/17 at 2:34 p.m. and 11:50 p.m."

Further review of the October 2017 MAR and nursing notes revealed that non-pharmacological interventions were attempted or offered on: 10/20/17 8:11 a.m., 10/22/17 at 8:45 a.m., 10/24/17 at 8:00 a.m. and 4:00 p.m., 10/25/17 at 10:00 p.m., 10/28/17 at 8:05 a.m., and 10/30/17 at 8:30 a.m.

Evidence that non-pharmacological interventions were attempted or offered for all other dates the Xanax was administered could not be found in the clinical record.

On 11/1/17 at 5:00 p.m., an interview was conducted with Resident #12. When asked if facility staff offered alternatives other than medications to help relieve his anxiety, Resident #12 stated that sometimes staff will try to do other things but they don't help. Resident #12 stated that staff used to ask him all the time. Resident #12 stated, "If I want my pill, they know to give me my pill. I get very claustrophobic."

On 11/1/17 at 5:51 p.m., an interview was conducted with LPN (licensed practical nurse) #8, a nurse who administered prn Xanax on most of the above dates. When asked the process prior to administering a prn (as needed) anti-anxiety medication, LPN #8 stated that she would first assess the cause of anxiety and try to eliminate the cause such as re-directing thoughts, and turning the lights off. When asked if she would attempt or offer non-pharmacological interventions before every administration of prn

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anti-anxiety medications, LPN #8 stated, "If they ask for it, I will give it, but I still try to talk to them and try other things." When asked if LPN #8 documents that non-pharmacological interventions were attempted or offered, LPN #8 stated that sometimes she will try to document in a nurses' note. LPN #8 stated that she doesn't always document.

On 11/2/17 at approximately 10:00 a.m., ASM (administrative staff member) #1, the interim administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

The facility policy titled, "Chemical Restraint" does not address documenting non-pharmacological interventions prior to the administration of prn anti-anxiety medication in the clinical record.

No further information was presented prior to exit.

[1] Xanax- is used to relieve symptoms of anxiety and panic disorder. This information was obtained from The National Institutes of health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008896/?report=details.

3. The facility staff failed to document non-pharmacological interventions for Resident #13's pain management.

Resident #13 was admitted to the facility on 9/15/17 with the diagnoses of but not limited to pneumonia, atrial fibrillation, dysphagia, high blood pressure, congestive heart failure, chronic kidney disease, and a pacemaker. The most

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recent MDS (Minimum Data Set) was the admission assessment with an ARD (Assessment Reference Date) of 9/22/17. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident required total care for bathing; extensive assistance for transfers, hygiene, and dressing; supervision for eating; and was frequently incontinent of bowel and bladder.

A review of the clinical record revealed an order dated 9/15/17 for "Acetaminophen....650 mg (milligrams) by mouth every 4 hours as needed for pain...."

A review of the clinical record revealed the resident received this medication on 9/20/17, 9/23/17, 9/24/17, 9/28/17, 9/30/17, 10/2/17, 10/21/17, and 10/23/17 without any documented evidence of non-pharmacological interventions being attempted.

A care plan initiated 9/19/17 for "Needs Pain management and monitoring related to recent pacemaker placement, history of arthritis" included the interventions:
Administer Pain medication as ordered.
Dim lighting/quiet environment.
Evaluate and Establish level of pain on numeric scale/evaluation tool.
Evaluate characteristics and frequency/pattern of pain.
Evaluate what makes the patient's pain worse.
Implement preferred non-pharmacological pain relief strategies: i.e. Offer soothing massage, Dim lights, play soothing music, Offer comfort foods and or beverages, Check environmental factors before administering Prn pain medication.
Observe for potential medication side effects.

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Relaxation techniques.
Repositioning.
Rest.

On 11/1/17 at 2:36 p.m., in an interview with RN #2 (Registered Nurse) she stated that non-pharmacological interventions should be attempted and documented.

On 11/2/17 at 8:21 a.m., in an interview with LPN #2 (Licensed Practical Nurse) she stated that non-pharmacological interventions are attempted but that nurses probably forgot to document it.

On 11/2/17 at 8:32 a.m., in an interview with RN #4 she stated that non-pharmacological interventions should be attempted and documented.

On 11/2/17 at approximately 8:35 a.m., in an interview with LPN #6 she stated that non-pharmacological interventions are attempted but that they may not always be documented. She stated they should be documented.

On 11/2/17 at 8:57 a.m., ASM #1 (Administrative Staff Member - the Interim Administrator) and ASM #2 (the director of nursing - DON) were made aware of the findings. No further information was provided by the end of the survey.

4. a. The facility staff failed to document non-pharmacological interventions attempted prior to the administration of pain medication for Resident # 10.

Resident #10 was admitted to the facility on 10/24/17 with diagnoses that included, but were

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not limited to: high blood pressure, congestive heart failure (abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys, it is usually caused by heart disorder and most often develops chronically with shortness of breath due to fluid accumulation in the lungs, and edema of the extremities (1)), shortness of breath, heart disease and chronic obstructive pulmonary disease - COPD (general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (2)).

A MDS (minimum data set) assessment had not yet been completed at the time of survey.

The "Admission Data Collection Form" dated, 10/24/17, documented Resident #10 was alert and oriented. The resident was coded as having no memory difficulties and could understand others and could make herself understood.

The physician orders dated 10/24/17, documented, "Acetaminophen (Tylenol - used to treat minor pain and fever (3)) 500 MG (milligrams); give 1 tablet by mouth every 4 hours as needed for mild pain." The second physician order dated 10/24/17, documented, "Oxycodone - Acetaminophen Tablet (used to treat moderate to moderately severe pain (4)) 5 - 325 MG; give 1 tablet by mouth every 4 hours as needed for pain."

Resident #10's October 2017 MAR (medication administration record) documented, "Acetaminophen 500 MG; give 1 tablet by mouth every 4 hours as needed for mild pain." The Tylenol was administered once on 10/30/17 at 4:45 a.m. The MAR also documented,



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"Oxycodone - Acetaminophen Tablet 5 - 325 MG; give 1 tablet by mouth every 4 hours as needed for pain." The MAR documented the Oxycodone 0 Acetaminophen was administered six times; 10/24/17 at 8:00 p.m., 10/25/17 at 9:33 p.m., 10/26/17 at 9:00 p.m., 10/27/17 at 9:25 p.m., 10/30/17 at 9:16 p.m. and 10/31/17 at 7:00 p.m.

Review of the nurse's notes for October 2017 failed to evidence any documentation related to non-pharmacological interventions attempted prior to the administration of the Tylenol or the Oxycodone to Resident #10 on the above dates and times.

The comprehensive care plan dated, 10/24/17 documented in part, "Focus: Needs: Pain management and monitoring." The "Interventions" documented, "Administer pain medication as ordered. Repositioning."

An interview was conducted with LPN (licensed practical nurse) #13, a nurse who cares for Resident #10, on 11/1/17 at 2:41 p.m., regarding pain management for residents'. LPN #13 stated, "First you asses where the pain is. Have them rate the pain; with most people you try other things, diversions, repositioning, or massage. If the diversional things attempted are not effective, try a pain medication and then reassess." When asked where she documents the things attempted prior to the medication, LPN #13 stated, "In the eMAR note there is a place to document it." When shown her initials on Resident #10's MAR evidencing the administration of Oxycodone-Acetaminophen, with no documentation of the non-pharmacological interventions, LPN #13 stated, "I know it's (documentation) not

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happening and I own it."

An interview was conducted with LPN #14, the unit manager, on 11/1/17 at 3:05 p.m., regarding pain management for residents'. LPN #14 stated, "First you assess the location, cause of pain and level of pain. If they are unable to give me a verbal level of pain, I look for other indicators of pain; elevated blood pressure or grimacing. Then I would administer medication accordingly. Oh, I would try to reposition or something to relieve the pain before administering medications."

The interim administrator and the director of nursing were made aware of the above findings on 11/1/17 at 6:30 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 138.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 124.
(3) This information was obtained from the following website:
https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=59282
(4) This information was obtained from the following website:
https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=17971

4. b. The facility staff failed to document non-pharmacological interventions attempted prior to the administration of sleeping medication for Resident #10.

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The physician order dated, 10/24/17, documented, "Zolpidem Tartrate (used to treat insomnia, difficulty sleeping (1)) tablet 5 MG; Give 1 tablet by mouth every 24 hours as needed for sleep aide."

The October 2017 MAR documented, Zolpidem Tartrate tablet 5 MG; Give 1 tablet by mouth every 24 hours as needed for sleep aide." The Zolpidem was documented as administered seven times; every day between 10/24/17 and 10/31/17 except 10/28/17.

Review of the nurse's note for the above dates did not evidence any documentation regarding non-pharmacological interventions attempted prior to the administration of the sleep medication.

The care plan dated 10/24/17, did not address insomnia for Resident #10.

On 11/1/17 at 2:41 p.m., an interview was conducted with LPN #13, Resident #10's nurse on six evenings. When asked what she does for a resident that complains they can't sleep, LPN #13 stated, "You try to be supportive. Offer a snack." When asked where this is information is documented, LPN #13 stated, "It should be on the MAR where you document the medication. There is no documentation but I can guarantee you I do them."

An interview was conducted with LPN #14, the unit manager, on 11/1/17 at 3:05 p.m. When asked what she does for a resident that complains they can't sleep, LPN #14 stated, "You try some non-pharmacological interventions; take

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them for a walk, get them in the wheelchair, fresh air, warm milk, talk to them, reposition them. If those things fail, you document them in the MAR and then administer the sleeping pill as ordered."

The interim administrator and the director of nursing were made aware of the above findings on 11/1/17 at 6:30 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012721/?report=details

4.c. The facility staff failed to document non-pharmacological interventions attempted prior to the administration of anti-anxiety medication for Resident #10.

The physician order dated 10/24/17, documented, "Ativan Tablet (used to treat anxiety (1)) 0.5 MG; give 1 tablet by mouth every 24 hours as needed for anxiety may give every 24 hours at HS (hours of sleep)."

The October 2017 MAR documented, Ativan Tablet 0.5 MG; give 1 tablet by mouth every 24 hours as needed for anxiety may give every 24 hours at HS (at bedtime)." The Ativan was documented as being administered on 10/24/17.

Review of the nurse's notes did not evidence any documentation of any non-pharmacological interventions provided prior to the administration of medication.

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The care plan dated 10/24/17 did not document anything related to anxiety.

An interview was conducted with LPN #13 on 11/1/17 at 2:41 p.m. regarding what she does for residents' with complaints of anxiety, LPN #13 stated, "I try to see what is going on; are they in pain. I try to offer other things and if they are not effective, I give them the medication." When asked if she documents all the things she tried before giving the medication, LPN #13 stated, "I know it's (documentation) not happening and I own it."

An interview was conducted with LPN #14 on 11/1/17 at 3:05 p.m. regarding what she does for residents with complaints of anxiety, LPN #14 stated, "First you try some non-pharmacological interventions, like talking to them, find out why they are anxious, listen to them." When asked where this is documented these things attempted prior to the administration of medication, LPN #14 stated, "In the MAR or nurses' notes."

The interim administrator and the director of nursing were made aware of the above findings on 11/1/17 at 6:30 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010988/?report=details

5. The facility staff failed to document non-pharmacological interventions attempted

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prior to the administration of pain medication for Resident #8.

Resident #8 was admitted to the facility on 8/15/17 with diagnoses that included, but were not limited to: displaced fracture of the right femur, Parkinson's disease (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling and muscle weakness (1)), deep vein thrombosis, dysphagia, dementia, and pain.

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 10/17/17, coded Resident #8 as scoring a "13" on the BIMS (brief interview for mental status) score, indicating he was cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance for most of his activities of daily living.

The physician order dated, 8/15/17, documented, "Oxycodone HCL (hydrochloride) (used to treat moderate to severe pain (2)) tablet 5 MG (milligrams); give 1 tablet by mouth every 4 hours as needed for pain."

Resident #8's August 2017 MAR (medication administration record) documented, "Oxycodone HCL tablet 5 MG; give 1 tablet by mouth every 4 hours as needed for pain." The Oxycodone was documented as having been given eight times on the following dates and times: 8/17/17 at 5:30 p.m., 8/18/17 at 6:19 a.m. and 9:00 p.m., 8/19/17 at 1:33 a.m., 8/20/17 at 8:46 p.m., 8/21/17 at 5:35 p.m., 8/22/17 at 9:15 p.m. and 8/28/17 at 7:30 p.m.

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The nurse's notes were reviewed for the above dates and times. There was no documentation of non-pharmacological interventions offered prior to the administration of the pain medication on all but three dates. On 8/19/17 and 8/28/17, the nurses documented non-pharmacological interventions attempted.

Resident #8's September 2017 MAR documented, "Oxycodone HCL tablet 5 MG; give 1 tablet by mouth every 4 hours as needed for pain." The Oxycodone was documented as having been given 11 times on: 9/1/17 at 6:37 a.m. and 6:50 p.m., 9/3/17 at 8:38 a.m., 9/5/17 at 12:32 a.m. And 11:54 p.m., 9/9/17 at 12:11 a.m., 9/10/17 at 12:15 a.m., 9/21/17 at 2:40 p.m., 9/22/17 at 1:18 p.m., 9/28/17 at 5:31 a.m., and 9/30/17 at 4:08 a.m.

The nurse's notes were reviewed for the above dates and times. There was no documentation of non-pharmacological interventions offered prior to the administration of the pain medication on all but four dates. On 9/3/17, 9/9/17, 9/10/17 and 9/30/17, there was documentation of non-pharmacological interventions attempted prior to the administration of the pain medication.

Resident #8's October 2017 MAR documented, "Oxycodone HCL tablet 5 MG; give 1 tablet by mouth every 4 hours as needed for pain." The Oxycodone was documented as having been given five times on: 10/1/17 at 2:08 p.m., 10/15/17 at 10:25 a.m., 4:14 p.m. and 9:21 p.m., and 10/20/17 at 12:00 p.m.

The nurse's notes were reviewed for the above dates and times. There was no documentation of non-pharmacological interventions offered prior to

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495240 | A. BUILDING ______ B. WING ______ | C 11/02/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FREDERICKSBURG HEALTH AND REHAB | 3900 PLANK ROAD FREDERICKSBURG, VA 22407 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

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the administration of the pain medication on all but two times. On 9/15/17 at 4:14 p.m. and 9:21 p.m. there was documentation that non-pharmacological interventions were attempted.

The comprehensive care plan was reviewed. The care plan addressed pain but did not address non-pharmacological interventions to be offered.

An interview was conducted with LPN (licensed practical nurse) #13, a nurse who cares for Resident #8, on 11/1/17 at 2:41 p.m., regarding pain management for residents'. LPN #13 stated, "First you asses where the pain is. Have them rate the pain, with most people you try other things, diversions, repositioning, or massage, if the diversional things attempted are not effective, try a pain medication and reassess." When asked where she documents the things attempted prior to the medication, LPN #13 stated, "In the eMAR note there is a place to document it." When shown her initials on the MAR for the administration of Oxycodone with no documentation of non-pharmacological interventions, LPN #13 stated, "I know it's (documentation) not happening and I own it."

An interview was conducted with LPN #2, a nurse that cares for Resident #8, on 11/2/17 at 8:05 a.m. When asked what she does when Resident #8 complains of pain, LPN #2 stated, "With (Resident #8) he doesn't complaint too often of pain. He will request it before therapy or being repositioned. You can tell he's in pain because he grimaces and winces. We try to reposition him, offer snacks or transfer him back to bed." When asked where the things that they attempt prior to the administration of medication is

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|---|---|---|---|---|
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documented, LPN #2 stated, "We are supposed to write it in the eMAR. I promise you, I do them, but I forget to document it. I even give him his Bible to read and that works to help relieve pain and anxiety for him."

The interim administrator and the director of nursing were made aware of the above findings on 11/2/17 at 10:10 a.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 437.
(2) This information was obtained from the following website:
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011537/



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