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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 04/18/17 through 04/19/17. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 136 certified bed facility was 130 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents # 1 through 21) and 3 closed record reviews (Residents # 22 through 24).	F 000		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-	F 278	The admission MDS assessment for Resident #18 has been modified to reflect an assessed pressure ulcer. The Director of Nursing/Designee will audit all admission MDS assessments for current residents for accuracy in reflecting assessed pressure ulcers. Any admission MDS assessments that do not accurately reflect an assessed pressure ulcer will be modified. The MDS Coordinator will receive in-service education on accuracy of the admission MDS assessment with respect to coding of any pressure ulcers. The Director of Nursing/Designee will randomly audit admission MDS assessments for residents admitted with pressure ulcers to ensure accuracy monthly x 3 months, and as needed thereafter. Results of the audits will be submitted to the Performance Improvement/Risk Management Committee.	5/19/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 4-27-17

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

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

(2) Clinical disagreement does not constitute a material and false statement.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure an accurate minimum data set (MDS) for one of 24 residents in the survey sample. Resident #18's admission MDS failed to reflect an assessed pressure ulcer.

The findings include:

Resident #18 was admitted to the facility on 2/25/17 with diagnoses that included dementia with behaviors, pneumonia and anxiety. The MDS dated 3/2/17 assessed Resident #18 with severely impaired cognitive skills.

Resident #18's clinical record documented the resident was admitted to the facility on 2/25/17 with dark red/purple discoloration on her right heel. A nursing note dated 3/5/17 documented, "...dressing to Rt [right] heel wound (noted upon admission) dry and intact..." A skin assessment form dated 3/7/17 documented the resident's right heel was an unstageable pressure ulcer covered with dark eschar measuring 2.0 x 3.0 x 0 (length by width by depth in centimeters). This skin

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assessment listed the pressure ulcer was present on admission to the facility on 2/25/17.

Resident #18's admission MDS with a reference date of 3/2/17 did not reflect the resident's unstageable right heel pressure ulcer. Section M0210 of this MDS indicated the resident had no unhealed pressure ulcers. Section M0300 documented the resident had no unstageable and/or deep tissue wounds.

On 4/18/17 at 4:00 p.m. the registered nurse (RN #1) MDS coordinator was interviewed about Resident #18's admission MDS indicating no pressure ulcers or deep tissue injury. After reviewing the MDS dated 3/2/17, RN #1 stated she did not see the unstageable ulcer indicated on the assessment. RN #1 stated the MDS should have been marked to indicate an unstageable pressure ulcer present on admission.

Pages M-4 and M-5 of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual states concerning coding instructions for pressure ulcers,"...Identify any known or likely unstageable pressure ulcers...Code based on the presence of any pressure ulcer (regardless of stage) in the past 7 days...Code 0, no: if the resident did not have a pressure ulcer in the 7-day look-back period...Code 1, yes: if the resident had any pressure ulcer (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. Proceed to Current Number of Unhealed Pressure Ulcers at Each Stage item (M0300)..." Page M-17 states concerning unstageable pressure ulcers, Enter the number of pressure ulcers that are unstageable related to slough and/or

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F 278	Continued From page 3 eschar...Enter the number of these unstageable pressure ulcers related to slough and/or eschar that were first noted at the time of admission/entry..." (1) These findings were reviewed with the administrator and director of nursing during a meeting on 4/18/17 at 4:15 p.m. (1) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.14, Centers for Medicare & Medicaid Services, Revised October 2016.	F 278		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 279	The comprehensive care plan for Resident #1 has been updated to include a catheter. The Director of Nursing/Designee will audit all current residents with catheters to ensure the comprehensive care plan includes a catheter. Nurse #1 and Licensed nurses will receive in-service education on the expectations to develop a care plan that addresses the problem, goals, and interventions for a resident with a catheter. The Director of Nursing/Designee will randomly audit residents with catheters to ensure the comprehensive care plan includes a catheter monthly x 3 months, and as needed thereafter. Results of the audits will be submitted to the Performance Improvement/Risk Management Committee.	5/19/17

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

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

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

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

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

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on, staff interview and clinical record review, the facility staff failed to develop a

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comprehensive care plan for one of 24 residents, Resident #1.

Resident #1 did not have a comprehensive care plan to include a catheter.

Findings include:

Resident #1 was admitted to the facility on 2/08/05 with a readmission on 10/3/16 with diagnoses including neuromuscular bladder with catheter placement.

The most recent MDS (minimum data set) was a 60 day assessment with an ARD (assessment reference date) of 3/11/17. Resident #1 was assessed as being cognitively intact.

Resident #1's electronic record was reviewed on 4/18/17 and evidenced, via comprehensive MDS dated 1/19/17, section "V" (Care Area Assessment) that Resident #1 had triggered for a care plan for incontinence and indwelling catheter. Section "H" (Bladder and Bowel) of the MDS also evidenced use of an "indwelling catheter."

Review of Resident #1's care plan did not evidence a care plan to include problems, goals, or interventions for Resident #1's catheter.

On 4/18/17 at 2:30 p.m. the MDS coordinator (identified as registered nurse, RN #1) was interviewed. RN #1 verbalized that it was the responsibility of the nursing staff to develop care plans for anything that has triggered on the MDS.

On 4/18/17 at 4:20 p.m. the unit manager (RN #2) were Resident #1 resided was interviewed

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F 279	Continued From page 6 concerning the above finding. RN #2 reviewed Resident #1's care plan and verbalized that he could not find a care plan for the indwelling catheter. On 4/18/17 at 4:45 p.m. the above finding was brought to the attention of the director of nursing and administrator and assistant director of nursing (ADON). This surveyor asked how long had Resident #1 had a catheter. The ADON verbalized that Resident #1 has had the catheter since admission. No further information was presented prior to exit conference on 4/19/17.	F 279		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure medication was available for administration for one of 24 residents in the survey sample. Resident #2 missed two consecutive doses of the medication Razadyne because the medication	F 425	The supply of medications for Resident #2 was reviewed to ensure all medications are available to administer per physicians orders. The supply of medications for current residents will be reviewed to ensure all medications are available to administer per physician orders. LPN #1 received and in-service on the procedure to follow if a medication is not available. Licensed nurses will receive in-service education on the procedure to follow if a medication is not available to administer per physician orders. The Director of Nursing/Designee will randomly audit the supply of medications to ensure all medications are available to administer per physician orders monthly x 3 months, and as needed thereafter. Results of the audits will be submitted to the Performance Improvement/Risk Management Committee.	5/19/17

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was not available.

The findings include:

Resident #2 was admitted to the facility on 8/27/15 with a re-admission on 3/22/17. Diagnoses for Resident #2 included paraplegia, dementia, atrial fibrillation, pneumonia and glaucoma. The minimum data set (MDS) dated 3/29/17 assessed Resident #2 as cognitively intact.

Resident #2's clinical record documented a physician's order dated 3/22/17 for Razadyne (galantamine hydrobromide) 4 mg (milligrams) to be administered every 12 hours for treatment of dementia. Resident #2's medication administration record (MAR) documented the Razadyne was not administered on the evening of 4/8/17 and on the morning of 4/9/17. A note on the back of the MAR dated 4/8/17 stated, "Galantamine N/A [not available] pharmacy to refill..." A MAR note dated 4/9/17 stated, "Razadyne N/A [not available] Pharmacy will send tonight."

On 4/18/17 at 1:30 p.m. the licensed practical nurse (LPN #1) caring for Resident #2 was interviewed about the missed doses of Razadyne. LPN #1 stated the Razadyne was not delivered timely from the pharmacy resulting in the missed doses on 4/8/17 and 4/9/17. LPN #1 stated the pharmacy delayed refilling the medication as their records indicated there should have been an adequate supply available in the facility. LPN #1 stated, "They [pharmacy] said enough supply had already been sent but we were out."

The Nursing 2017 Drug Handbook on page 686

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describes Razadyne (galantamine hydrobromide) as an anti-Alzheimer drug used for the treatment of mild to moderate dementia. (1)

These findings were reviewed with the administrator and director of nursing during a meeting on 4/18/17 at 4:15 p.m.

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