STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495301	A. BUILDING _____ B. WING _____	C 07/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 7/25/17 through 7/28/17. 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.

The census in this 60 certified bed facility was 58 at the time of the survey. The survey sample consisted of 15 current resident reviews (Residents #1 through #14 and Resident #21) and ten closed record reviews (Residents #15 through #20 and Residents #22 through #25).

F 157 SS=D 483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

(g)(14) Notification of Changes.

(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to

F 157

F-157

Corrective Action(s)

Resident #5's attending physician and responsible party have been notified that facility staff failed to notify the attending physician & RP that resident #5 refused her 6 AM dose of Ativan and Buspar 10 times in the month of July. A Facility Incident & Accident form has been completed for this incident.

Identification of Deficient Practices
& Corrective Action(s):

All residents may have potentially been affected. The DON and Unit

RECEIVED
AUG 21 2017
VDH/HOLC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 8-18-17

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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F 157	Continued From page 1 commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to notify the physician and RP (responsible party) of a change in condition for one of 25 residents in the survey sample, Resident #5. The facility staff failed to notify the physician and RP after Resident #5 refused her 6 AM doses of Ativan [1] and Buspar [2] 10 times during the month of July.	F 157	Manager's will conduct a 100% review of all clinical records for the last 30 days to identify residents who may have had changes in their medical treatment or condition that would have required physician and responsible party notification. An incident & accident form will be completed for all negative findings and will be corrected at time of discovery. **Systemic Change(s):** The facility policy and procedures have been reviewed and no changes are warranted at this time. The 24 Hour Report and documentation in the medical record will serve as the source document for communicating changes in resident condition/status, refusal of medical care and treatment and proper notification to responsible parties and physicians. Licensed staff will be inserviced by the DON and/or Regional nurse consultant on the Notification of Rights & Services and issued a copy of company policy and	

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F 157	Continued From page 2	F 157		

The findings include:

Resident #5 was admitted to the facility on 9/14/13 with diagnoses that included but were not limited to Alzheimer's disease, age-related osteoporosis, and dementia with behavioral disturbance. Resident #5's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 6/28/17. Resident #5 was coded as being severely cognitively impaired in the ability to make daily decisions scoring 00 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #5 was coded as requiring total dependence on two staff members with bed mobility, transfers, toileting, and personal hygiene; and total dependence on one staff member with dressing, and eating.

Review of Resident #5's July 2017 MAR (Medication Administration Record) revealed the following orders:
Lorazepam (Ativan) 1 MG (milligram) tablet. Take 1 mg PO (by mouth) TID (three times a day) at 0600 (6 a.m.) for Anxiety.
Buspirone (Buspar) 5 mg (milligram) tablet, Give 1 tab PO (by mouth) TID (three times a day), DX (diagnoses) Anxiety D/T (due to) Mood disorder.

Further review of the July 2017 MAR revealed that Resident #5 had refused her 6 AM doses of Ativan and Buspar on the following days: 7/12/17, 7/14/17, 7/15/17, 7/18/17, 7/19/17, 7/23/17, 7/24/17, 7/25/17, and 7/26/17.

Review of the July 2017 nursing notes failed to reveal any evidence that the physician or responsible party were made aware of Resident

procedure. The inservice will include staff education on the timeliness of notification to the attending physician and responsible party when changes in treatment or condition occur in order to prevent a delay of services while promoting continuity of care.

Monitoring:
The DON is responsible for maintaining compliance. The DON will complete weekly chart audits coinciding with the care plan calendar. Any/all negative findings will be corrected at time of discovery. Aggregate findings of these audits will be reported to the QA committee for review, analysis and recommendation for changes in facility policy, procedure and/or practice.

Completion Date: **9/11/17**

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#5's refusals.

On 7/28/17 at 9:23 a.m., an interview was conducted with LPN (licensed practical nurse) #8, the nurse who documented Resident #5 refused her Buspur and Ativan on all of the above dates. LPN #8 stated the doctor is usually made aware if a resident continuously refuses medications for three consecutive days in a row. When asked if the doctor was made aware that Resident #5 refused her Ativan and Buspar nine times in July, some days consecutively, LPN #8 stated that it wasn't that Resident #5 didn't want to take her medications, but rather she did not want them from him (LPN #8), because he was a man. LPN #8 stated he was the only nurse on the 11-7 shift. When asked what the facility was doing about Resident #5 not wanting her medications given from a male nurse, LPN #8 stated that he would pass onto the 7am-3pm shift that Resident #5 did not take her 6 a.m. medications and the 7-3 shift were going to try to reschedule her medications. When asked if this was done, LPN #8 stated that he was not sure. When asked if he had documented anywhere that the 7-3 shift was going to reschedule her medications, LPN #8 stated that he did not. When asked again if he had notified the MD (medical doctor) or RP (responsible party) that Resident #5 was refusing her 6 AM medications, LPN #8 stated he was not sure if 7-3 shift notified the MD and RP, but he personally did not. When asked the appropriate time frame to administer a medication, LPN #8 stated that nurses have an hour before the medication is due to an hour after the medication is due to administer the medication. When asked why the 7 a.m. shift did not administer the 6 a.m. dose of Atvian and Buspar, LPN #8 stated they may not have felt comfortable with administering

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the medication, especially with a narcotic. When asked why nursing staff would not feel comfortable, LPN #8 stated, "They may not know if I really administered the medication or not." When asked if he had a narcotic log for each medication given, LPN #8 stated, "Yes."

On 7/27/17 at 6:32 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the corporate nurse were made aware of the above concerns. No further information was presented prior to exit.

In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician notification. Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient.

[1] Ativan is used to treat anxiety disorders. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010988/?report=details.
[2] Buspar is used to treat certain anxiety disorders or to relieve symptoms of anxiety. This information was obtained from The National

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F t57	Continued From page 5 Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009364/?report=details.	F t57		
F t64 SS=D	483. t0(h)(t)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483. t0 (h)(I) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR t64.506;	F t64	**F164** **Corrective Action:** LPN #7 performing wound care on resident #4 has received a one-on-one inservice on the facility policy and procedure for providing privacy during personal care to include wound care. **Identification of Deficient Practice(s) & Corrective Action(s):** All residents receiving wound care may have been potentially affected. A 100% observation audit of all residents receiving wound care will be conducted to identify any residents at risk for the potential unnecessary exposure of their bodies during personal care and services. Any residents identified as being exposed during the audit will be corrected at time of discovery and staff involved will receive immediate inservice training and disciplinary action. An Incident & Accident Form will be completed for any/all incidents of exposure.	

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(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide full visual privacy during care for one of 25 residents in the survey sample, Resident #4.

The facility staff failed to provide full visual privacy while measuring Resident #4's wound. LPN (licensed practical nurse) #7 failed to shut the room door and failed to pull the privacy curtain around Resident #4's bed. Resident #4's roommate was in the room and in Resident #4's line of sight.

The findings include:

Resident #4 was admitted to the facility on 3/24/11. Resident #4's diagnoses included but were not limited to: dementia (1), high blood pressure and dysphagia (2). Resident #4's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 6/2/17, coded the resident's cognitive skills for daily decision making as severely impaired. Section M coded Resident #4 as not having a pressure injury (3).

Systemic Change(s):
The facility policy and procedure has been reviewed and no changes are warranted at this time. All staff will be inserviced by the DON on Resident Rights, Confidentiality and Personal Privacy to include unnecessary exposure during personal care and services.

Monitoring:
The DON is responsible for compliance. The DON, ADON and/or designee will perform two weekly wound care audits on each unit in order to maintain compliance. Any/all negative findings will be corrected immediately and disciplinary action will be taken as warranted. Aggregate findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice.

Completion Date: **9/11/17**

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A wound assessment report dated 7/27/17 documented Resident #4 developed a pressure injury on the right heel on 7/18/17 that was documented as unstageable due to suspected deep tissue injury (3).

On 7/27/17 at 10:20 a.m., LPN (licensed practical nurse) #7 was asked to measure Resident #4's wound. On 7/27/17 at 10:25 a.m. Resident #4 was lying in bed on the side of the room closest to the door. LPN #7 exposed and measured Resident #4's wound. During this process, LPN #7 failed to shut the room door and failed to pull the privacy curtain around Resident #4's bed. Resident #4's roommate was in the room and in Resident #4's line of sight.

On 7/27/17 at 3:05 p.m., an interview was conducted with LPN #5. LPN #5 was asked what should be done prior to exposing and measuring residents wound. LPN #5 stated nurses should let the resident know what they are going to do and pull both privacy curtains to meet and surround the resident to provide privacy.

On 7/27/17 at 5:40 p.m., an interview was conducted with LPN #7. LPN #7 was asked what should be done when providing treatment to a resident. LPN #7 stated during a normal treatment nurses should clean off the cart, let the resident know they are going to provide treatment, clean the bedside table, wash their hands, take clean supplies into the room, pull the privacy curtain, shut the door and provide privacy. When asked if privacy should have been provided when she exposed and measured Resident #4's wound, LPN #7 stated, "Yes."

On 7/27/17 at 6:32 p.m., ASM (administrative

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

The facility policy titled, "Quality of Life-Dignity/Privacy" documented, "10. Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures..."

No further information was presented prior to exit.

(1) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dementia&_ga=2.205672787.1977489418.1501503571-139120270.1477942321

(2) Dysphagia is difficulty swallowing. This information was obtained from the website: https://medlineplus.gov/swallowingdisorders.html

(3) A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition

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F 164	Continued From page 9 of the soft tissue... Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface..." This information was obtained from the website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/	F 164		
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual	F 167	**F167** **Corrective Action(s):** The facility has now posted notification of 3 years survey results and their location and the placement of the Survey Results has been modified to be accessible to all families, visitors and residents to include those in wheel chairs. **Identification of Deficient Practice(s) & Corrective Action(s):** All residents may have been affected. The Administrator has been inserviced regarding the regulation stating that a resident and	

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F 167	Continued From page 10 to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined that the facility staff failed to post a notice of the preceding three years of the survey results and failed to keep the survey results in an accessible location. A notice was not posted to the residents and responsible parties that the results of the previous three years of survey results, with the plan of corrections, were available for review. The survey book was also located on the receptionist desk that was a high desk where wheelchair bound residents would not have access. The findings include: On 7/25/17 at 12 p.m., the results of the surveys for the previous three years were observed in a binder on the receptionist desk in the front lobby. A sign that documented, "THE MOST RECENT SURVEY RESULTS" was observed hanging right above the survey binder. The sign failed to post notice that the survey results of the preceding three years were available. The receptionist desk was also a high desk not allowing easy access to the survey results for wheelchair bound residents. A tall stand up hand sanitizer machine was also located right in front of the receptionist desk blocking the view of the survey results binder.	F 167	visitors have the right to examine the results of the most recent 3 years of survey results for the facility conducted by Federal or State surveyors and that the facility must make the results available for examination in a place readily accessible to residents and visitors and must post a notice of their availability. The Administrator will meet with the resident council to remind residents that survey results are posted for their review. **Systemic Change(s):** The Facility's Policy and Procedure has been reviewed and no changes are warranted at this time. All staff will be inserviced on the policy for posting and the availability of the facilities survey result. **Monitoring:** The Administrator is responsible for compliance. The administrator will perform weekly audits to ensure that the notice of the survey results location and the current survey results are available for examination. Findings from these audits will be reported to the Quality Assurance	

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(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETION DATE
F 167	Continued From page 11 On 7/26/17 at 10:00 a.m., a group interview was conducted with five cognitively intact residents. All residents stated that they did not know where the survey results were located in the facility. On 7/26/17 at 3:00 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator. ASM #1 stated that he was responsible for ensuring that the survey book was in the front lobby and that it contained all three years of past survey results in the binder. When ASM #1 was informed of the above findings, ASM #1 did not have a response. ASM #1 was also made aware that the residents in group did not know where to find the survey results binder. No further information was presented prior to exit. On 7/27/17 at 9:39 a.m., ASM #3, the corporate nurse, stated that they did not have a policy on survey results.	F 167	Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 9/11/17**	
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or	F 225	**F-225** **Corrective Action(s)** A thorough investigation into the allegations of abuse involving resident #6 has been conducted and the outcome of the internal investigations have been reported to the appropriate State agencies. **Identification of Deficient Practices & Corrective Action(s):** All residents to include may have been potentially affected. A 100%	

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	495301	A. BUILDING _____ B. WING _____	C 07/28/2017

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(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the

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review of all Facility Incident & Accident Forms for the previous 60 days has been reviewed to identify residents at risk. Any/all negative findings of reportable occurrences identified will result in an internal investigation with appropriate notification of outcomes to the State agencies, attending physician and responsible parties.

Systemic Change(s):
Policy and Procedure for reporting resident abuse & neglect has been reviewed. No changes are required. All staff will be inserviced on the facility policy and procedures regarding reporting, investigation and proper notification to state agencies of allegations of verbal or physical abuse and injuries of unknown origin by the Administrator. A copy of the facility policy and procedure will distributed to each employee. The Administrator, DON and/or designee is responsible for completing internal investigations of neglect, abuse, and/or complaints. The Administrator will review all findings and verify that

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investigation is in progress.

(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to report an allegation of abuse for one of 25 residents in the survey sample, Resident #6.

The facility staff failed to report an allegation of abuse made by Resident #6 on 4/18/17 to the administrator of the facility and to other officials (including to the State Survey Agency) in accordance with State law through established procedures.

The findings include:

Resident #6 was admitted to the facility on 7/13/12 and readmitted on 12/17/15 with diagnoses that included but were not limited to post right mastectomy, major depressive disorder, polyarthritis, type two diabetes mellitus, and dementia without behavioral disturbance.
Resident #6's most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 7/7/17.
Resident #6 was coded as being moderately impaired of cognition, scoring 08 out of 15 on the BIMS (Brief Interview for Mental Status) exam.

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the appropriate notification to the RP, attending physician and State agencies was completed as indicated.

Monitoring:
The Administrator is responsible for maintaining compliance. Facility Incident & Accidents forms will be reviewed daily by the Administrator and initialed as reviewed. Confidential files of reported incidents and all follow-up documentation will be maintained in the Administrator's office. The Risk Management Committee will review I&A form to identify and/or correcting negative patterns weekly. All negative findings will be reported and investigated. Aggregate findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice.

Completion Date: **9/11/17**

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Resident #6 was coded as requiring total dependence on two staff members with transfers; and extensive assistance with two staff members with bed mobility, dressing, toileting, and personal hygiene.

Review of Resident #6's nursing notes revealed the following note dated 4/18/17 that documented the following: "@ (at) 0745 (7:45 a.m.) this morning resident made a report to CNA (certified nursing assistant). CNA requested presence of a nurse. This nurse entered room and resident stated 'that girl that got me up beat me to no end.' then asked resident where and resident stated 'she grabbed my arm when she was getting me up.' this nurse then reported to DON (Director of Nursing) who went with another nurse from night shift down resident's room to speak with her as well. Observed area of concern and there were no bruising this morning and still no bruising and redness at this time. After speaking with resident this nurse was outside of resident's room and resident continued to yell out. No words just sounds. Asked why resident was yelling. She then thought that this nurse asked 'why are you lying' so the word 'yelling' was written on paper for her to read and understand. Resident then stated she was having back pain. Asked resident why she was not using her call bell which was clasped to her blanket that was sitting on her lap. Administered morning medications at this time which included her scheduled pain pill and then staff assisted her back into her bed to rest..."

Review of the incident report dated 4/18/17 documented the following: "Description of event: Accused staff member of "beating me to no end this morning...No apparent injury."

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The following witness statement was documented from the nurse on duty that shift: "4/18/17 at 8:00 a.m., (Name of Resident #6) stated- she beat me- asked how- said she pulled on my arm, hurt my hip. She described a color girl with curly hair...I was in hallway doing meds [medications] when CNA getting resident OOB (out of bed) - heard no yelling. No one notified me that she had yelled out at all."

The following witness statement was documented from the CNA on shift during the incident: "On 4/18/17 on 11-7, I went into (room number of Resident #6) and I made rounds. It was 2:20 a.m.. I woke (Name of Resident #6) to change her and she asked me 'What are you doing.' I replied to her I was there to change her brief. I proceeded to uncover her and take off her brief when she started to yell 'what are you doing.' As I turned her and changed brief she yelled 'I'm going to kill that little girl' repeatedly. When I finished and covered her up again she was fine and went back to sleep. At 6 AM I again returned to (Resident #6's room) and proceeded to change and dress (Name of Resident #6). As I woke her to change her brief she (Resident #6) started yelling. Once I changed her brief I sat her up in bed to change the gown that she had on the night previous. I rolled her again to put the hoyer pad underneath of her and that's when she started yelling again. I got her in the hoyer and into her chair. When she was in her chair she stopped yelling and went back to sleep. I then brushed her hair, gave her a cover and gave her a call bell. When I made her bed I left."

A FRI (Facility Reported Incident) could not be found regarding this allegation of abuse.

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On 7/27/17 at 2:44 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator. ASM #1 stated that he was not made aware of this incident and he did not report this to the Office of Licensure and Certification. ASM #1 stated that corporate had advised him to send a FRI regarding the incident now. ASM #1 stated that he would create a FRI and send it to the office.

On 7/27/17 at 3:30 p.m., an interview was conducted with ASM #1, the administrator and ASM #2, the DON (Director of Nursing). ASM #2 was asked about the process followed if a resident reports an allegation of abuse. ASM #2 stated that the allegation is usually reported to her by her nurses. ASM #2 stated she will speak with the resident and get a statement, and also obtain statements from staff who worked on the shift of the reported abuse and the shift right before and after the reported abuse. ASM #2 stated she would report the allegation to the administrator who will then send a FRI to the Office of Licensure and Certification. ASM #1 stated, "I was not aware. Normally (Name of DON, ASM #2) tells me. Otherwise I would have done it." ASM #1 stated, "I review it, send to you (Office of Licensure and Certification), APS (adult protective services) and depending on the allegation sometimes the police is involved." When asked the timeframe of reporting an allegation of abuse, ASM #1 stated an allegation used to have to be reported within 24 hours and now it has to be within 2 hours. When asked when the follow-up should be provided to the state agency, ASM #1 stated, "Within 5 days." ASM #2 stated, "My past ADON (assistant director of nursing) and I did tell (Name of administrator, ASM #1). My night nurse reported

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it to me at 7:45 a.m."

On 7/27/17 at 3:30 p.m., ASM and ASM #2 were made aware of the above findings.

Review of the abuse policy documented the following: "Each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents must not be subject to abuse by anyone, including, but not limited to; facility staff, other residents, consultants, contractors, volunteers, or staff of other agencies serving the resident, family members, legal guardians, friends, or other individuals...9. Response and Reporting of Abuse, Neglect and exploitation-Anyone in the facility can report suspected abuse to the abuse agency hotline. When abuse, neglect, or exploitation is suspected, the Licensed Nurse should: a. Respond to the needs of the resident and protect them from further incident (document) b. Notify the Director of Nursing and Administrator (document) c. Initiate an investigation immediately. d. Notify the attending physician, resident's family/legal representative e. Obtain witness statements, following appropriate policies. Suspend the accused employee pending completion of the investigation. Remove the employee from resident care areas immediately. f. Contact the State Agency and local Ombudsman office to report the alleged abuse. g. If a crime or suspicion of a crime has occurred, notify the local law enforcement agency. h. Monitor and document the resident's condition, including the response to medical treatment or

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F 225	Continued From page 18 nursing interventions. i. Document actions taken in steps above in the medical record.	F 225	**F226** **Corrective Action(s):** A thorough investigation into the allegations of abuse involving resident #6 has been conducted and the outcome of the internal investigation has been reported to the appropriate State agencies.	
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced	F 226	**Identification of Deficient Practices and Corrective Action(s):** All other residents may have been potentially affected. A 100% review of all Facility Incident & Accident Forms for the previous 60 days has been reviewed to identify residents at risk. Any/all negative findings of reportable occurrences identified will result in an internal investigation with appropriate notification of outcomes to the State agencies, attending physician and responsible parties. **Systemic Change(s):** The Policy & Procedure for reporting and investigating abuse, neglect, misappropriation of resident property and injuries or	

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by:
Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to implement abuse policies for reporting an allegation of abuse to the appropriate state agencies for one of 25 residents in the survey sample, Resident #6.

The facility staff failed to implement abuse policies and report an allegation of abuse made by Resident #6 on 4/18/16, to the facility administrator and the appropriate agencies.

The findings include:

Resident #6 was admitted to the facility on 7/13/12 and readmitted on 12/17/15 with diagnoses that included but were not limited to post right mastectomy, major depressive disorder, polyarthritis, type two diabetes mellitus, and dementia without behavioral disturbance. Resident #6's most recent MDS (Minimum Data Set) was quarterly assessment with an ARD (Assessment Reference Date) of 7/7/17. Resident #6 was coded as being moderately impaired of cognition, scoring 08 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #6 was coded as requiring total dependence on two staff members with transfers; and extensive assistance with two staff members with bed mobility, dressing, toileting, and personal hygiene.

Review of Resident #6's nursing notes revealed the following note dated 4/18/17 that documented the following: "@ (at) 0745 (7:45 a.m.) this morning resident made a report to CNA (certified nursing assistant). CNA requested presence of a

unusual/unknown occurrences has been reviewed. No changes are warranted at this time. Staff will be inserviced and issued copies of the Abuse Investigation Policy. These educational inservices will focus on prevention, identifying, reporting, and investigating incidents of potential abuse that are reported. The Administrator and DON are responsible for completing internal investigations for all reported incidents of abuse, neglect, unusual occurrences and misappropriation of resident property. The Administrator will review all findings and verify that the appropriate notification to the RP, attending physician and State agencies was completed as indicated.

Monitoring:
The Administrator and DON are responsible for compliance. All resident to resident incidents, resident abuse and neglect allegations and unusual occurrences will be thoroughly investigated, reported to the RP, attending physicians and

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nurse. This nurse entered rDDm and resident stated 'that girl that got me up beat me to no end.' then asked resident where and resident stated 'she grabbed my arm when she was getting me up.' this nurse then reported to DON (Director of Nursing) who went with another nurse from night shift down resident's room to speak with her as well. Observed area of concern and there were no bruising this morning and still no bruising and redness at this time. After speaking with resident this nurse was outside of resident's room and resident continued to yell out. No words just sounds. Asked why resident was yelling. She then thought that this nurse asked 'why are you lying' so the word 'yelling' was written on paper for her to read and understand. Resident then stated she was having back pain. Asked resident why she was not using her call bell which was clasped to her blanket that was sitting on her lap. Administered morning medications at this time which included her scheduled pain pill and then staff assisted her back into her bed to rest..."

Review of the incident report dated 4/18/17 documented the following: "Description of event: Accused staff member of "beating me to no end this morning...No apparent injury."

The following witness statement was documented from the nurse on duty that shift: "4/18/17 at 8:00 a.m., (Name of Resident #6) stated- she beat me- asked how- said she pulled on my arm, hurt my hip/ She described a color girl with curly hair...I was in hallway doing meds when CNA getting resident OOB (out of bed) - heard no yelling. No one notified me that she had yelled out at all."

The following witness statement was documented

appropriate state agencies as needed. Confidential files of all reported incidents and all follow-up documentation will be maintained in the Administrator's office. All facility reported incidents will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice.

Completion Date: **9/11/17**

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from the CNA on shift during the incident: "On 4/18/17 on 11-7, I went into (room number of Resident #6) and I made rounds. It was 2:20 a.m.. I woke (Name of Resident #6) to change her and she asked me 'What are you doing.' I replied to her I was there to change her brief. I proceeded to uncover her and take off her brief when she started to yell 'what are you doing.' As I turned her and changed brief she yelled 'I'm going to kill that little girl' repeatedly. When I finished and covered her up again she was fine and went back to sleep. At 6 AM I again returned to (Resident #6's room) and proceeded to change and dress (Name of Resident #6). As I woke her to change her brief she (Resident #6) started yelling. Once I changed her brief I sat her up in bed to change the gown that she had on the night previous. I rolled her again to put the hoyer pad underneath of her and that's when she started yelling again. I got her in the hoyer and into her chair. When she was in her chair she stopped yelling and went back to sleep. I then brushed her hair, gave her a cover and gave her a call bell. When I made her bed I left."

A FRI (Facility Reported Incident) could not be found regarding this allegation of abuse.

On 7/27/17 at 2:44 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator. ASM #1 stated that he was not made aware of this incident and he did not report this to the Office of Licensure and Certification. ASM #1 stated that corporate had advised him to send a FRI regarding the incident now. ASM #1 stated that he would create a FRI and send it to the office.

On 7/27/17 at 3:30 p.m., an interview was

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conducted with ASM #1, the administrator and ASM #2, the DON (Director of Nursing). ASM #2 was asked about the process followed if a resident reports an allegation of abuse. ASM #2 stated that the allegation is usually reported to her by her nurses. ASM #2 stated she will speak with the resident and get a statement, and also obtain statements from staff who worked on the shift of the reported abuse and the shift right before and after the reported abuse. ASM #2 stated she would report the allegation to the administrator who will then send a FRI to the Office of Licensure and Certification. ASM #1 stated, "I was not aware. Normally (Name of DON, ASM #2) tells me. Otherwise I would have done it." ASM #1 stated, "I review it, send to you (Office of Licensure and Certification), APS (adult protective services) and depending on the allegation sometimes the police is involved." When asked the timeframe of reporting an allegation of abuse, ASM #1 stated an allegation used to have to be reported within 24 hours and now it has to be within 2 hours. When asked when the follow-up should be provided to the state agency, ASM #1 stated, "Within 5 days." ASM #2 stated, "My past ADON (assistant director of nursing) and I did tell (Name of administrator, ASM #1). My night nurse reported it to me at 7:45 a.m."

On 7/27/17 at 3:30 p.m., ASM and ASM #2 were made aware of the above findings.

Review of the abuse policy documented the following: "Each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment involuntary seclusion, and any physical or

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chemical restraint not required to treat the resident's medical symptoms. Residents must not be subject to abuse by anyone, including, but not limited to; facility staff, other residents, consultants, contractors, volunteers, or staff of other agencies serving the resident, family members, legal guardians, friends, or other individuals...9. Response and Reporting of Abuse, Neglect and exploitation-Anyone in the facility can report suspected abuse to the abuse agency hotline. When abuse, neglect, or exploitation is suspected, the Licensed Nurse should: a. Respond to the needs of the resident and protect them from further incident (document) b. Notify the Director of Nursing and Administrator (document) c. Initiate an investigation immediately. d. Notify the attending physician, resident's family/legal representative e. Obtain witness statements, following appropriate policies. Suspend the accused employee pending completion of the investigation. Remove the employee from resident care areas immediately. f. Contact the State Agency and local Ombudsman office to report the alleged abuse. g. If a crime or suspicion of a crime has occurred, notify the local law enforcement agency. h. Monitor and document the resident's condition, including the response to medical treatment or nursing interventions. i. Document actions taken in steps above in the medical record.

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

(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permils, unless to do so would infringe upon the rights or health and safety of other

F 252

F252
Corrective Action(s):
Resident #1 & #7 have had their wheelchair cushion and their arm rests replaced.

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F 252	Continued From page 24	F 252	Room 310 has been thoroughly deep cleaned to include the resident bathroom area. The entire room has been repainted.	

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 resident1o 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, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a clean, comfortable, homelike environment for four of 25 residents in the survey sample (Residents #1, #7, #3 and #5); for five of 31 resident rooms/bathrooms, (rooms 310 A, 309, 201, 208 and 304); on one of three unit halls (the 300 hall); and in one of two facility shower rooms (the shower room on the 100 hall).

1. The facility staff failed to maintain Resident #1's wheelchair cushion in good repair. Two corners of the cushion were torn and foam was exposed.

2. The facility staff failed to maintain Resident

Resident #3 has had their bed replaced and all side rails are in correct working order.

The air conditioning unit and the commode have been replaced in room 309

Room 201 has had all the wall repair completed and the entire room was repainted.

The commode in room 208 has been replaced and the entire room to include, the bathroom have been deep cleaned.

Room 304 has had all the wall repairs completed and the entire room has been repainted.

The stained ceiling tiles at the entrance of the 300 hall have been replaced.

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F 252	Continued From page 25 #7's wheelchair armrests in good repair. The armrests were torn and foam was exposed. 3. Multiple areas of scratched paint were observed on the walls in Room 310A. Also, a brown stain was observed in the bottom of the toilet and black/brown debris, were observed on the floor around the base of the toilet in the bathroom. 4. The facility staff failed to maintain Resident #3's bed rail in a home-like manner. The bed rail was held together by duct tape. 5. The air conditioning unit in room 309 was dented and marred on the outside, and dirty on the inside. The ceramic inside the toilet bowl was chipped away, leaving an appearance of being black. 6. In room 201, all four walls were covered with multiple patches of spackle. 7. In room 208, the ceramic inside the toilet bowl was chipped away, leaving an appearance of being black. Also, black/brown debris, were observed on the floor around the base of the toilet in the bathroom. 8. In room 304, two gouges were observed in the wall that measured approximately 5.5 inches. 9. Water stains were observed on the ceiling tiles in the entrance of the 300 hall. 10. The call bell in the 100 hall shower room was observed ripped out of the wall and dangling by exposed blue wires.	F 252	The call bell switch in the 100 hall shower room has been replaced and is in complete working order. Both resident shower rooms have been deep cleaned by the housekeeping department. **Identification of Deficient Practice(s) and Corrective Action(s):** All other resident rooms, equipment and common areas may have potentially been affected. A complete documented environmental walkthrough of the facility will be conducted by the administrator, maintenance director, and environmental services director to identify resident rooms, resident equipment and common areas at risk. All resident areas and common areas identified that require repair or replacement will be placed on a repair/replace schedule to establish priority of completion by the administrator and the housekeeping, and/or maintenance departments.	

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F 252	Continued From page 26 11. The facility staff gave Resident #5 a shower with feces on the bathroom floor from a previous resident. The findings include: 1. The facility staff failed to maintain Resident #1's wheelchair cushion in good repair. Two corners of the cushion were torn and foam was exposed. Resident #1 was admitted to the facility on 3/1/17. Resident #1's diagnoses included but were not limited to: diabetes, high blood pressure and anxiety disorder. Resident #1's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 5/2/17, coded the resident's cognition as severely impaired. On 7/26/17 at 5:15 p.m. Resident #1 was observed sitting in a wheelchair in the dining room. The front left corner of Resident #1's wheelchair cushion was torn approximately one and a half inches and foam was exposed. The other corners of the cushion were not observed. On 7/27/17 at 8:36 a.m. Resident #1 was in the bathroom and the wheelchair was observed outside of the bathroom door. The front left corner of Resident #1's wheelchair cushion was torn approximately one and a half inches and foam was exposed; the front right corner of the cushion was torn approximately one half inch and foam was exposed. On 7/27/17 at 8:39 a.m. an interview was conducted with CNA (certified nursing assistant) #5. When asked who was responsible for	F 252	**Systemic Change(s):** The facility's policy & procedure for providing a safe, sanitary, and comfortable environment has been reviewed. No changes are warranted at this time. The Maintenance Director and/or administrator will provide inservices to all staff on facility policy and procedure on the notification system to use when repairs are needed throughout the facility. The nursing staff and environmental staff will be inserviced on the process for cleaning and disinfection the shower rooms between resident showers. The maintenance request logs will be reviewed by the administrator weekly for completion of repairs. **Monitoring:** The Maintenance Director and administrator are responsible for maintaining compliance. The Maintenance Director and Environmental Services director will complete documented facility rounds weekly to monitor compliance. The administrator will	

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ensuring wheelchairs and cushions are in good repair, CNA #5 stated all staff is responsible but night shift usually notices any issues. CNA #5 stated if anything is wrong then staff has to fill out a slip and turn it into the maintenance department. CNA #5 was shown Resident #1's wheelchair cushion. When asked if the cushion should contain the torn areas, CNA #5 stated, "No." CNA #5 stated Resident #1 used to have a different cushion and she thought the rehab (rehabilitation) department gave her a new one.

On 7/27/17 at 3:05 p.m. an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated the night shift staff is responsible for cleaning wheelchairs and should let the day shift employees know when there is an issue so the day shift staff can talk to the therapy staff who can order new cushions.

Resident #1's comprehensive care plan initiated on 5/4/17 failed to document information regarding the resident's wheelchair cushion.

On 7/27/17 at 6:32 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

The facility policy titled, "Quality of Life- Homelike Environment" documented, "Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible..."

No further information was presented prior to exit.

2. The facility staff failed to maintain Resident

F 252 review weekly rounds to ensure negative findings are being corrected. Cumulative findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice

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#7's wheelchair armrests in good repair. The armrests were torn and foam was exposed.

Resident #7 was admitted to the facility on 7/17/17. Resident #7's diagnoses included but were not limited to: stroke, high cholesterol and dementia (1). Resident #7 did not have a completed MDS (minimum data set). On his admission nursing assessment dated 7/17/17, he was documented as being "alert" and "confused."

On 7/25/17 at 2:45 p.m., 7/26/17 at 3:21 p.m. and 7/27/17 at 8:49 a.m. Resident #7 was observed lying in bed. The following was observed on the resident's wheelchair during the above dates/times:
-One torn area (approximately 0.5 inch [length] by 0.5 inch [width]) on the left armrest with foam exposed.
-One torn area (approximately 0.75 inch [length] by 1.25 inch [width]) on the right armrest with foam exposed.
-Another torn area (approximately 0.5 inch [length] by 1 inch [width]) on the right armrest with foam exposed.

On 7/27/17 at 8:39 a.m. an interview was conducted with CNA (certified nursing assistant) #5. When asked who was responsible for ensuring wheelchairs and cushions are in good repair, CNA #5 stated all staff is responsible but night shift usually notices any issues. CNA #5 stated if anything is wrong then staff has to fill out a slip and turn it into the maintenance department.

On 7/27/17 at 3:05 p.m. an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated the night shift staff is responsible

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for cleaning wheelchairs and should let the day shift employees know when there is an issue so the day shift staff can talk to the therapy staff who can order new arm rests. At this time, LPN #5 was asked to observe Resident #7's wheelchair armrests. During this observation, the right armrest was replaced and did not contain any torn areas. LPN #5 was asked to observe the left armrest. LPN #5 confirmed the armrest should not have been torn and stated, "They should fix that."

Resident #7's comprehensive care plan was initiated on 7/18/17 but was not complete.

On 7/27/17 at 6:32 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

No further information was presented prior to exit.

(1) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dementia&_ga=2.205672787.1977489418.1501503571-139120270.1477942321

3. Multiple areas of scratched paint were observed on the walls in Room 310A. Also, a brown stain was observed in the bottom of the

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toilet and black/brown debris, were observed on the floor around the base of the toilet in the bathroom.

On 7/25/17 at approximately 12:15 p.m. and 7/27/17 at 8:35 a.m. the following was observed in room 310A:
- The back wall (painted a cocoa color) was observed with multiple white areas of scratched paint.
-The left wall (while facing the back wall) (painted a tan color) was observed with multiple white areas of scratched paint.
-A brown stain was observed in the bottom of the toilet in the bathroom.
-Black/brown debris, were observed on the floor around the base of the toilet in the bathroom.

The maintenance director was newly employed and ASM (administrative staff member) #1 (the administrator) requested all maintenance concerns be reported to him.

On 7/27/17 at 4:30 p.m. an interview was conducted with ASM #1. ASM #1 stated the former maintenance director left the facility in early May and the new maintenance director started 6/5/17. ASM #1 stated he covered the maintenance department during the time no maintenance director was employed. ASM #1 stated he completed multiple maintenance audits during this time period. ASM #1 stated the audits included checking toilets, sink faucets, beds for bumpers and walls. ASM #1 stated some issues were repaired but he was still working on some areas. In regards to the walls, ASM #1 stated he conducted an audit and the current maintenance director spackled multiple walls and was about to paint the walls. ASM #1 stated he and the

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maintenance director had now decided to spackle and paint one room at a time then move on to the next room because the time frame from when some walls were spackled then painted was too long. In regards to the toilets, ASM #1 stated toilets that were leaking were replaced with new rings to seal the leak. ASM #1 stated some toilets also needed to be replaced because the porcelain on the inside bottom of the toilet had come off, creating a brown stain. ASM #1 stated all resident bathroom toilets were 19 inches in height and those types of toilets were safer for residents but were not made any more so the toilets were going to have to be removed, repainted and put back in. ASM #1 stated this process had not yet been started. ASM #1 stated he wanted to ensure a homelike environment. ASM #1 stated he had been taking steps to do so but the facility environment was not where he wanted it to be although he was working on it. ASM #1 presented the environmental audits and stated the audits were completed during the second week of May 2017. The audits contained a column for closet trim, sink leaks, wall, screens and bed bumper. A check mark was documented in the "wall" column for room 310A.

On 7/27/17 at 5:10 p.m. room 310A and the bathroom were observed with ASM #1. In regards to the black/brown debris around the base of the toilet, ASM #1 stated the floor had previously been replaced as evidenced by the difference in the floor tile color. ASM #1 stated it appeared there had been another leak. In regards to the walls in the room, ASM #1 stated the scratches on the tan wall may have come from staff attaching and removing items from the wall. ASM #1 stated the scratches on the cocoa wall may have come from the metal on the back

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of the bed. ASM #t stated some beds had wheels on the back of the bed to protect the wall but some beds did not.

No further information was presented prior to exit.

4. The facility staff failed to maintain Resident #3's bed rail in a home-like manner. The bed rail was held together by duct tape.

Resident #3 was admitted to the facility on 6/23/t0 and most recently readmitted on tt/t2/t5 with diagnoses including, but not limited to: rhabdomyolysis (t), arthritis, diabetes and dementia. On the most recent MDS (minimum data set), an annual assessment with the assessment reference date of 7/t8/t7, Resident #3 was coded as being moderately impaired for making daily decisions. She was coded as requiring the extensive assistance of two staff members for bed mobility.

On the following dates and times during the survey, Resident #3 was observed lying in her bed: 7/25/t7 at 2:42 p.m. and 5:30 p.m.; 7/26/t7 at 2:30 p.m.; 7/27/t7 at 8:40 a.m. On each of these occasions, the resident's left bedrail was observed to be held together at the bottom portion by gray duct tape.

On 7/27/t7 at 2:20 p.m., CNA (certified nursing assistant) #3 accompanied the surveyor to Resident #3's bedside. When asked about the bed rail, CNA #3 stated: "It has been that way ever since I started working here." CNA #3 stated she had been employed at the facility for over a year. When asked if the duct tape on the bedrail provided a home-like environment for Resident

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#3, CNA #3 stated: "You are right. I would not have that in my house." When asked about the process for getting the bedrail fixed, CNA #3 stated: "We can put requests into the computer system. The maintenance guys come by and take care of things as they have time." When asked if she had ever put in a maintenance request for Resident #3's bed rail to be fixed, CNA #3 stated: "No ma'am."

On 7/27/17 at 4:25 p.m., ASM (administrative staff member) #1, the executive director, was interviewed. He stated the facility maintenance director had left in early May, and that the new director had started in early June. ASM #1 stated that he covered the maintenance tasks in the absence of a director. He stated he performed audits throughout the building of repairs that needed to be made. ASM #1 stated he performed audits on all toilets, faucets, and bed bumpers. He stated he did not put all the repair needs that were identified by the audits in the facility's computerized maintenance request system. ASM #1 described the facility's computerized maintenance request system, and stated: "It gives us things to work on daily, weekly, monthly, quarterly and yearly." ASM #1 agreed with the survey team that the duct tape on Resident #3's bedrail does not promote a clean, comfortable, home-like environment.

On 7/27/17 at 6:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate nurse, were informed of these concerns.

No further information was provided prior to exit.

(1) "Rhabdomyolysis is the breakdown of muscle

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tissue that leads to the release of muscle fiber contents into the blood. These substances are harmful to the kidney and often cause kidney damage." This information was taken from the website https://medlineplus.gov/ency/article/000473.htm.

5. The air conditioning unit in room 309 was dented and marred on the outside, and dirty on the inside. The ceramic inside the toilet bowl was chipped away, leaving an appearance of being black.

On 7/25/17 at 12:20 p.m. during the facility tour, Room #309 was observed. The air conditioner was dented in multiple places, and had large sections of paint chipped off. The area under the top screen of the air conditioner contained debris and black material. In the bathroom, the toilet bowl appeared to be black in places.

On 7/27/17 at 4:25 p.m., ASM (administrative staff member) #1, the executive director, was interviewed. He stated the facility maintenance director had left in early May, and that the new director had started in early June. ASM #1 stated that he covered the maintenance tasks in the absence of a director. He stated he performed audits throughout the building of repairs that needed to be made. ASM #1 stated he performed audits on all toilets, faucets, and bed bumpers. He stated he did not put all the repair needs that were identified by the audits in the facility's computerized maintenance request system. ASM #1 described the facility's computerized maintenance request system, and stated: "It gives us things to work on daily,

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weekly, monthly, quarterly and yearly." He stated he was aware that the air conditioning unit in Room 309 was old and needed to be replaced, and that this is on the list of things that still needs to be done. ASM #1 stated that some toilets need to be repaired on the inside because the ceramic has worn off, and gives a dark appearance. He stated the facility staff will be undertaking these toilet repairs.

A review of the facility audits provided by ASM #1 did not reveal information related to the toilet in Room #309.

On 7/27/17 at 6:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate nurse, were informed of these concerns.

No further information was provided prior to exit.
6. In room 201, all four walls were observed covered with multiple patches of spackle.

On 7/25/17 at 11:35 a.m., tour of the facility was conducted. At 11:36 a.m., Room 201 was observed to have multiple patches of spackle on all four walls of the room.

On 7/26/17 at 3:27 p.m., an interview was conducted with OSM (other staff member) #3, the maintenance director. OSM #3 stated that he had been going from room to room and spackling any areas that were damaged and then his next phase, was to paint over the spackle. OSM #3 stated that he has only been the maintenance director for two months and it was only him doing repairs. OSM #3 stated that he had spackled room 201 and was going to paint it next. OSM #3 stated that he had spackled room 201 the week

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prior.

On 7/27/17 at 4:27 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator. ASM #1 stated that he had been doing audits of all rooms to see what needed repair. ASM #1 stated that his main concerns were toilets that were leaking and that cosmetic things/issues were put on hold until the toilets were fixed. The audits for room 201 were requested. Review of the audits revealed that 201 needed repair on the sink for leaks, walls, and a bed bumper for the resident's bed. ASM #1 stated that he started his audits the second week of May.

On 7/27/17 at 6:32 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of nursing) and ASM #3, the corporate nurse were made aware of the above findings. No further information was presented prior to exit.

7. In room 208, the porcelain inside the toilet bowl was chipped away, leaving an appearance of being black. Also, black/brown debris, were observed on the floor around the base of the toilet in the bathroom.

On 7/25/17 at 11:35 a.m., tour of the facility was conducted. At 11:40 a.m., room 208's bathroom was observed. The porcelain inside the toilet bowl was chipped away, leaving the appearance of being black. There was also black/brown debris observed on the floor around the base of the toilet in the bathroom

On 7/26/17 at 3:30 p.m., an interview was

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conducted with OSM #3. OSM #3 stated that it appeared that the porcelain inside the toilet had come up from the toilet. When asked how often he inspected the toilets, OSM #3 stated that he looked at the toilets once in the past two months. OSM #3 stated he did not notice the porcelain coming up from the toilet in the bathroom of room 208. OSM #3 stated the black/brown debris around the toilet must have been from a previous leak. OSM #3 stated that the grout around the toilet needed to come up and be cleaned.

On 7/27/17 at 4:27 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator. ASM #1 stated he had been doing audits of all rooms to see what needed repair. ASM #1 stated that his main concerns were toilets that were leaking and that cosmetic things were put on hold until the toilets were fixed. ASM #1 stated he looked into new toilets; however newer toilets are shorter than the old standard for toilets. ASM #1 stated putting new toilets into place would make it harder for residents to use because they are 3 inches lower than the old toilets. ASM #1 stated his new plan was to remove all toilets that had porcelain missing, and replace the porcelain. ASM #1 stated that this would be a long process because they would have to give a resident a temporary toilet in the meantime. ASM #1 stated they do not have many temporary toilets and would have to do this process one resident at a time.

On 7/27/17 at 6:32 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3 the corporate nurse, were made aware of the above findings. No further information was presented prior to exit.

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8. In Room 304, two gouges were observed in the wall that measured approximately 5.5 inches.

On 7/25/17 at 11:35 a.m., tour of the facility was conducted. At 11:45 a.m., Room 304 room was observed to have two gouges in the wall measuring approximately 5.5 inches in length. The gouges were located at the bottom of the wall were a resident bed used to be on the side closest to the window.

On 7/26/17 at 3:27 p.m., an interview was conducted with OSM (other staff member) #3. OSM #3 stated he had been going from room to room and spackling any areas that were damaged and then his next phase, was to paint over the spackle. OSM #3 stated he was not aware of the gouges in room 304. OSM #3 stated he has only been the Maintenance director for two months and it was only him doing repairs.

On 7/27/17 at 4:27 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator. ASM #1 stated he had been doing audits of all rooms to see what needed repair. ASM #1 stated his main concerns were toilets that were leaking and that cosmetic things/issues were put on hold until the toilets were fixed. The audit for room 304 was requested. Review of the audit for room 304 room revealed that nothing was needed for the resident's walls. The following was documented as the only thing needed for room 304: "Needs plastic glove holder." ASM #1 stated he started doing audits the second week of May.

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On 7/27/17 at 6:32 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the corporate nurse, were made aware of the above findings. No further information was presented prior to exit.

9. Water stains were observed on the ceiling tiles in the entrance of the 300 hall.

On 7/25/17 at 11:35 a.m., tour of the facility was conducted. At 11:41 a.m., water stains were observed on the ceiling tiles in the entrance to the 300 hall.

On 7/26/17 at 3:25 p.m., an interview was conducted with OSM (other staff member) #3, the maintenance director. OSM #3 stated the facility has had multiple roof leaks and he has already replaced several ceiling tiles. OSM #3 stated that as soon as he replaces ceiling tiles, another leak occurs and stains them again. OSM #3 stated there was an issue with the roof that was currently being addressed by the administrator.

On 7/27/17 at approximately 4:27 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator. ASM #1 stated that seven years ago the roof was replaced. Three years ago the valves started leaking affecting the areas of the ceiling near the nursing station. ASM #1 stated the roof was never put on correctly when the facility was first built and that the roof had dry wall underneath, allowing water to drip into the ceiling. ASM # 1 stated that they had a roofing company come in to look at the roof that day (7/27/17) to possibly replace the roof. When asked if ASM #1 had

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evidence that the roofing company had come in and that the roof was in the process of repair, ASM #1 stated that he did not have that evidence.

On 7/27/17 at 6:32 p.m., ASM #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the corporate nurse were made aware of the above findings. No further information was presented prior to exit.

10. The call bell in the 100 hall shower room was observed ripped out of the wall and dangling by exposed blue wires.

On 7/26/17 at 3:00 p.m., an observation of the shower room located on the 100 hall was conducted with OSM (other staff member) #3, the maintenance director. The call bell was observed hanging out of the wall dangling by blue exposed wires.

On 7/26/17 at 3:05 p.m., OSM #3 stated the call bell looked broken. When asked how often he checks the shower rooms for maintenance, OSM #3 stated he checks the shower rooms monthly. OSM #3 stated, "I hardly come in here." When asked how he is made aware of anything that needs repair, OSM #3 stated any staff member can put a work order into the computer system. OSM #3 stated he will then get that work order and repair what needs to be fixed. OSM # 3 stated he was not aware of the call bell needing repair.

On 7/27/17 at 6:32 p.m. ASM #1, the administrator stated that he and OSM #3 tested the call bell (in the 100 hall shower room) as soon

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as this writer was finished with general observations. ASM #1 stated that the call bell was still functioning even though it was coming out of the wall.

On 7/28/17 at 7:48 a.m., further interview was conducted with OSM #3. When asked what he did to fix the call bell in the shower room, OSM #3 stated he re-secured the call bell to the wall with screws. OSM #3 stated the call bell looked broken, but he and the administrator had tested the call bell system on 7/26/17 and it was still functioning. When asked if the exposed wires were a safety risk for the residents, OSM #3 stated the wires had such a low voltage that the residents would not be shocked if they ever got a hold of the wires.

On 7/28/17 at approximately 12:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the corporate nurse were made aware of the above findings. No further information was presented prior to exit.

11. The facility staff gave Resident #5 a shower with feces on the bathroom floor from a previous resident.

Resident #5 was admitted to the facility on 9/14/13 with diagnoses that included but were not limited to Alzheimer's disease, age-related osteoporosis, and dementia with behavioral disturbance. Resident #5's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date of 6/28/17. Resident #5 was coded as being

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severely cognitively impaired in the ability to make daily decisions scoring 00 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #5 was coded as requiring total dependence on two staff members with bed mobility, transfers, toileting, and personal hygiene; and total dependence on one staff member with dressing, and eating.

On 7/26/17 at 3:00 p.m., an observation of the shower room located on the 100 hall was conducted with OSM (other staff member) #3, the maintenance director. Brown feces, was observed in the drain and on the floor of the shower room. An Allevyn [1] dressing was also observed in the drain of the shower room. The shower room floor appeared to be wet.

On 7/26/17 at 3:00 p.m., an interview was conducted with OSM #3. When asked how often the shower rooms were cleaned, OSM #3 stated he was not sure when the CNAs cleaned up the room. When asked what was in the drain, OSM #3 stated that it appeared to be feces in the drain. On 7/26/17 at approximately 3:03 p.m., CNA (certified nursing assistant) #10 walked into the shower room. When asked how often shower rooms were cleaned, CNA #10 stated that CNAs should be cleaning any mess after each resident uses the shower room. CNA #10 was asked when she had last showered a resident in the shower room. CNA #10 stated that her last shower given was at 10:25 that morning. CNA #10 stated that the dressing and feces were not in the drain at that time or the shower she had provided. CNA #10 stated she did not know who used the shower room last.

On 7/26/17 at 3:40 p.m., an interview was

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conducted with CNA #9, a 3-11 shift CNA. When asked who was responsible for cleaning the shower room, CNA #9 stated that CNAs are supposed to clean the shower room after each use. When asked if it was ever ok to leave feces and dressings in the shower drain, CNA #9 stated, "Absolutely not. No ma'am."

On 7/26/17 at approximately 4:00 p.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). ASM #2 stated, "I want to talk to you about the stuff that was left in the drain." ASM #2 stated the CNA who was assigned to Resident #5, was giving Resident #5 a shower when she became combative with the CNA. The CNA then decided to quickly get the resident back to her room safely before her behaviors escalated. ASM #2 stated that the CNA was on her way back to clean the bathroom when this writer had already observed the dressing and feces in the drain. When asked what time the CNA gave Resident #5 her shower, ASM #2 stated that she was not sure but Resident #5 was usually the last shower of the day shift.

On 7/26/17 at approximately 4:29 p.m., an interview was conducted with CNA #7, the CNA who gave Resident #5 her shower. When asked when she had given Resident #5 her shower, CNA #7 stated that she went into the shower room around 2:35 p.m. CNA #5 stated that she brought the resident back to her room around 2:50-2:55 p.m. because the resident was becoming restless. CNA #5 stated, "I was getting ready to go back to the shower room when you all discovered my mess."

On 7/28/17 at 8:30 a.m., an interview was

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conducted with LPN (Licensed practical nurse) #10. When asked about the process for showering a resident with a dressing in place, LPN #10 stated if dressings get wet, then the CNAs would alert the nurse, and the nurse would re-dress the affected area. LPN #10 stated that allevyn dressings were able to get wet. LPN #10 stated if an allevyn dressing were to come off during a shower, she would re-dress (reapply a dressing) after the shower.

On 7/28/17 at approximately 10:54 a.m., further interview was conducted with CNA #7. When asked about the process followed for showering a resident with a dressing such as allevyn, CNA #7 stated that allevyn dressings can get wet and she would notify the nurse if the dressing were to come off during the shower. When asked about the process followed for showering an incontinent resident, CNA #7 stated CNA's were supposed to put a bucket underneath the shower chair in case the resident has an incontinent episode in the shower room. When asked if Resident #5 was incontinent, CNA #7 stated that she was. When asked if she had used a bucket underneath Resident #5 while giving her a shower on 7/26/17, CNA #7 stated, "I didn't use a bucket that day but she (Resident #5) did not have an incontinent episode in the shower with me. She doesn't usually go to the bathroom during showers." CNA #7 was asked where the feces observed in the shower drain came from, if Resident #5 did not have an incontinence episode. CNA #7 stated the feces, was on the floor and in the drain prior to her giving Resident #5 a shower. CNA #7 stated the dressing in the drain was from her (Resident #5) but not the feces. When CNA #7 was asked if she brought Resident #5 into the shower room with feces on the floor, CNA #7

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F 252	Continued From page 45 confirmed the feces was on the floor when she brought Resident #5 into the shower room for her shower. CNA #7 could not recall who used the shower room prior to her. On 7/28/17 at approximately 12 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the corporate nurse were made aware of the above findings. [1] Allevyn dressing is waterproof and requires no secondary dressing, tape or bandages. It is able to conform to the most awkward body areas such as the sacrum, heels and elbows. It is suitable for use on a variety of exuding wounds and can be used in conjunction with a hydrogel for sloughy wounds. This information was obtained from the National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmed/8845677.	F 252		
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	F 279	**F 279** **Corrective Action(s):** Resident #4's comprehensive care plan has been reviewed and completely revised to reflect the appropriate goals, interventions and approaches to address the resident's specific medical and treatment needs as identified in section Vof the comprehensive MDS assessment. A Facility Incident & Accident Form was completed for this incident.	

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F 279	Continued From page 46	F 279	**Identification of Deficient Practices & Corrective Action(s):**	

set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

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

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

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

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

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

(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.

All residents may have potentially been affected. A 100% review of all comprehensive care plans will be conducted by the DON, RCC and/or designee to identify residents with inaccurate or incomplete care plans. Resident identified with inaccurate or incomplete care plans will have their care plan reviewed and updated to reflect their current interventions and appropriate approaches to address their medical and treatment needs. A Facility Incident & Accident Form will be completed for each incident identified.

Systemic Changes:
The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record and physician orders will be used to develop and revise comprehensive plans of care. The

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F 279	Continued From page 47 (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 that the facility staff failed to develop a comprehensive care plan from the CAA (care area assessment) section of the MDS (minimum data set) assessment for one of 25 residents in the survey sample, Resident #4. The facility staff failed to develop a care plan to address the CAA triggered area of psychosocial well-being on Resident #4's annual assessment with an ARD (assessment reference date) of 6/2/17. The findings include: Resident #4 was admitted to the facility on 3/24/11. Resident #4's diagnoses included but were not limited to: dementia (1), high blood pressure and dysphagia (2). Resident #4's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 6/2/17, coded the resident's cognitive skills for daily decision making as severely impaired. Section V of the above MDS assessment documented an "X" beside the care area of psychosocial well-being and documented the area would be care planned. Resident #4's comprehensive care plan initiated on 5/31/17 failed to document information regarding psychosocial well-being.	F 279	RCC, IDT and the DON will be inserviced by the regional nurse consultant on the development and implementation process of individualized care plans within 7 days of the completion of the comprehensive assessment and or quarterly assessment. **Monitoring:** The RCC and DON are responsible for maintaining compliance. The DON and/or RCC will perform care plan audits weekly coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be reported to the RCC for immediate correction. Detailed findings of the Care Plan audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** **9/11/17**	

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On 7/27/17 at 3:37 p.m. an interview was conducted with LPN (licensed practical nurse) #6 (the MDS coordinator). LPN #6 was asked what should be done if a care area is checked as being triggered on the MDS assessment and staff check they will care plan the triggered area. LPN #6 stated the area should be care planned. LPN #6 stated psychosocial well-being may be included in the cognition or activities portions of the care plan. LPN #6 was asked to review Resident #4's annual MDS assessment dated 6/2/17, and Resident #4's care plan, and to show this surveyor where psychosocial well-being was care planned. LPN #6 reviewed Resident #4's MDS assessment, care area documentation and care plan. LPN #6 stated the care area of psychosocial well-being triggered on the MDS assessment due to the activities interview portion of the MDS assessment. LPN #6 stated she guessed the activities director would have had to interview staff because Resident #4 doesn't respond and is unable to participate in the interview. When asked how psychosocial well-being was addressed on the care plan, LPN #6 stated the care plan really didn't address psychosocial well-being. LPN #6 stated when the staff assessment of daily and activity preferences was completed, the activities director checked "None of the above" (indicating the resident didn't prefer any of activity options listed on the assessment) and by checking "None of the above," psychosocial well-being triggered as a care area. LPN #6 was again asked how psychosocial well-being was addressed on Resident #4's care plan. LPN #6 stated, "He (the activities director) documented on the care plan staff must speak loudly and directly to communicate though she (Resident #4) rarely gestures a response." When asked if this

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addressed psychosocial well-being, LPN #6 stated, "He kind of did but kind of didn't." When asked what resource she references when developing care plans based on triggered care area assessments, LPN #6 stated she references the RAI (resident assessment instrument) manual.

The activities director was not available for interview.

On 7/27/17 at 6:32 p.m., ASM (administrative staff member) #1 (the 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 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.
·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

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F 279	Continued From page 50 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." No further information was presented prior to exit. (1) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dementia&_ga=2.205672787.1977489418.1501503571-139120270.1477942321 (2) Dysphagia is difficulty swallowing. This information was obtained from the website: https://medlineplus.gov/swallowingdisorders.html	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 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.	F 280	**F-280** **Corrective Action(s):** Resident #5's comprehensive care plan have been reviewed and revised to reflect a resident to resident altercation and interventions in place to prevent future occurrences, that a bruise was noted to the left eye and upper right chest and the new pressure area located on resident #5's	

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(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 coccyx area. A Facility Incident & Accident Form was completed for this incident.

Resident #8's comprehensive care plan have been reviewed and revised to reflect a resident to resident altercation and nursing interventions in place to prevent future occurrences. A Risk Management Incident & Accident Form was completed for this incident.

Identification of Deficient Practices
& Corrective Action(s):
All residents may have potentially been affected. A 100% review of all resident comprehensive care plans will be conducted by the RCC and/or designee to identify residents at risk. Residents identified at risk will have their comprehensive care plans corrected at time of discovery and a Risk Management Incident & Accident Form will be completed for each incident identified.

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F 280	Continued From page 52 (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 observation, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to review and revise the comprehensive care plan for two of 25 residents in the survey sample, Resident #5 and #8. 1. a. The facility staff failed to review and revise Resident #5's comprehensive care plan after an 8/11/16 resident-to-resident altercation.	F 280	**Systemic Changes:** The assessment process will continue to be utilized as the primary tool for developing comprehensive plans of care. The RCC is responsible for implementing the RAI Process. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record/physician orders will be used to develop and revise comprehensive plans of care. The Regional Nurse Consultant and/or RCC will provide in-service training to the interdisciplinary care plan team on the mandate to develop individualized care plans within 7 days of the completion of the comprehensive assessment and/or revisions to the comprehensive care plan as indicated with any changes in condition. **Monitoring:** The RCC and DON are responsible for maintaining compliance. The interdisciplinary team will audit all comprehensive care plans prior to finalization to monitor for	

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F 280	Continued From page 53 b. The facility staff failed to review or revise the comprehensive care plan after a bruise to Resident #5's left eye and upper right chest were found on 11/29/16 and 11/30/16. c. The facility staff failed to revise Resident #5's comprehensive care plan after a stage two pressure ulcer to her coccyx was resolved on 6/29/17. 2. The facility staff failed to update Resident #8's comprehensive care plan after an 8/11/16 resident-to-resident altercation. The findings include: 1. a. The facility staff failed to review and revise Resident #5's comprehensive care plan after an 8/11/16 resident-to-resident altercation. Resident #5 was admitted to the facility on 9/14/13 with diagnoses that included but were not limited to Alzheimer's disease, age-related osteoporosis, and dementia with behavioral disturbance. Resident #5's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 6/28/17. Resident #5 was coded as being severely cognitively impaired in the ability to make daily decisions scoring 00 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #5 was coded as requiring total dependence on two staff members with bed mobility, transfers, toileting, and personal hygiene; and total dependence on one staff member with dressing, and eating.	F 280	compliance. Any/all negative findings will be reported to the DON and RCC for immediate correction. Detailed findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** **9/11/17**	

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Review of Resident #5's nursing notes revealed the following note dated 8/11/16 at 1:38 a.m. that documented the following: "S/P (status post) recipient (sic) by another resident kicked in L (left shin), no unusual bruising noted, no s/s (signs/symptoms) pain or discomfort, Moved LLE (left lower extremity) without difficulty. Noted awake at times shaking grab bars, no s/s of distress/discomfort noted. VS (vital signs) -97.1 (temperature) -76 (pulse) - 20 (respirations) - 139/77 (blood pressure), SPO2 (oxygen saturation) 98 % RA (room air)." No additional nursing notes could be found regarding the incident.

Review of Resident #5's care plans dated 6/29/16 and 8/19/16 failed to reveal that the comprehensive care plan was reviewed or revised after this incident.

Review of Resident #5's incident report dated 8/11/16, did not evidence any long term interventions to keep the resident safe from the resident who kicked her.

On 7/26/17 at 9:30 a.m., an interview was conducted with LPN (licensed practical nurse) #6, the MDS coordinator. When asked the purpose of the comprehensive care plan, LPN #6 stated that the purpose of the care plan was to guide patient care, problems, and how to take care of problems. When asked who had access to the comprehensive care plan, LPN #6 stated nurses and nurse management had access to the care plan. When asked when the comprehensive care plan would be updated, LPN #6 stated that the care plan would be updated for things such as falls, acute illnesses, skin related issues such as bruises, pressure sores or skin tears, etc. When

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asked if the comprehensive care plan would be updated for a resident to resident altercation, LPN #6 stated that the social worker would make a behavior care plan for the aggressor, or they would update the care plan for the victim of the resident to resident altercation if there was an injury. When asked how nursing staff are keeping Resident #5 safe from the resident who kicked her on 8/11/16, LPN #6 stated, "Well we know (Name of aggressor) gets agitated very quickly. We would tell nursing staff verbally to keep them separated. We let the staff know so we can be prepared." When asked how a new nurse would know to keep the two residents separated if it is not documented on Resident #5's care plan, LPN #6 stated that she wasn't sure, that she would hope a nurse would inform this new nurse. LPN #6 stated the social worker was currently on vacation and could not be reached for an interview. LPN #6 confirmed that she could not find a care plan regarding the resident to resident altercation for Resident #5.

On 7/27/17 at 9:35 a.m., an interview was conducted with LPN #1, the QA (quality assurance) nurse. LPN #1 stated the care plans for both residents should be updated regarding the resident to resident altercation. LPN #1 stated the MDS nurse and/or social worker was responsible for updating the behavior care plans.

On 7/27/17 at 6:32 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing), and ASM #3, the corporate nurse were made aware of the above concerns.

The facility policy titled, Resident to Resident Altercations, documents in part, the following: "If

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two residents are involved in an altercation, staff will:...f. Make necessary changes in the care plan approaches to any or all of the involved individuals..."

No further information was presented prior to exit.

b. The facility staff failed to review or revise the comprehensive care plan after a bruise to Resident #5's left eye and upper right chest were found on 11/29/16 and 11/30/16.

Review of Resident #5's nursing notes revealed the following note dated 11/29/16: "No unusual behaviors noted for1his shift. Resident has a small bruise under left eye that was observed by staff rubbing eyes with hands. MD (medical doctor) and RP (responsible party) aware. Resident refused the bruise to be measured and VS (vital signs) to be taken..."

Further review of the nursing notes revealed the following note dated 11/30/16 at 3:35 p.m.: "Resident is alert and oriented to name with no s/sx (signs/symptoms) of abnormal behaviors noted. Continues with bruise to left eye with no change noted. Noted to have a bruise to her upper right breast the size of a penny appeared to be dark purple in color. Will make RP and NP (nurse practitioner) is aware. No orders given. Vitals as follows: 97.1 (temperature), 72 (pulse), 16 (respirations), 130/72 (blood pressure), 95 % (percent oxygen)...Addendum 11/30/16 at 7:12 PM: Resident has been observed by staff pinching self1o the hand and chest area."

Review of Resident #5's comprehensive care

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plan dated 8/19/16 failed to reveal that the care plan was updated for the bruise to her left eye and her right chest.

On 7/26/17 at 9:30 a.m., an interview was conducted with LPN (licensed practical nurse) #6, the MDS coordinator. When asked the purpose of the comprehensive care plan, LPN #6 stated that the purpose of the care plan was to guide patient care, problems, and how to take care of problems. When asked who had access to the comprehensive care plan, LPN #6 stated nurses and nurse management had access to the care plan. When asked when the comprehensive care plan would be updated, LPN #6 stated that the care plan would be updated for things such as falls, acute illnesses, skin related issues such as bruises, pressure sores or skin tears, etc. When asked who would be responsible for updating the care plan for bruises, LPN #6 stated she was responsible. When asked if Resident #5's comprehensive care plan was updated after her two bruises on 11/29/16 and 11/30/16, LPN #6 stated that she would have to check.

On 7/26/17 at 11:13 a.m., LPN #6 stated that she could not find where the care plan was updated.

On 7/27/17 at 6:32 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing), and ASM #3, the corporate nurse were made aware of the above concerns.

The facility policy titled, "Care Planning" documents in part, the following: "The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans:
a. When there has been a significant change in

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the resident's condition;
b. When the desired outcome is not met;
c. When the resident has been readmitted to the facility from a hospital stay; and
d. At least quarterly."

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

c. The facility staff failed to revise Resident #5's comprehensive care plan after a stage two pressure ulcer [1] to her coccyx was resolved on 6/29/17.

Review of Resident #5's clinical record revealed that she had developed a stage two pressure ulcer [2] to her coccyx on 5/9/17. The following was documented on the Wound Assessment Report: "Date of Assessment 5/9/17 ...Wound Type: Pressure ...Wound Location: Coccyx ...Stage: 2 ...Measurements: Length: 1.50 cm (centimeter) x 1.00 cm x 0.10 cm ...MD (medical

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doctor) made aware, tx (treatment) per ordered, RP (responsible party) aware."

Review of Resident #5's nursing notes revealed the following note dated 6/29/17: "Late entry from 6/26/17...She is alert and oriented x 1 (to self), 1-2 assist with ADL's (activities of daily living), incontinent of B/B (bowel/bladder). Stage 2 to coccyx has been resolved. T&P (turn and position) q (every) 2 hours as resident will allow..."

Review of Resident #5's comprehensive care plan dated 6/29/17 documented the following: "At risk for developing a pressure ulcer due to decreased mobility. 5/10/17 stage 2 to coccxy (sic)...skin will remain intact over next review...5/10/17 treatment per order d/c (discontinue) 7/27/17."

On 7/26/17 at 9:30 a.m., an interview was conducted with LPN (licensed practical nurse) #6, the MDS coordinator. When asked the purpose of the comprehensive care plan, LPN #6 stated the purpose of the care plan was to guide patient care, problems, and how to take care of problems. When asked who had access to the comprehensive care plan, LPN #6 stated nurses and nurse management had access to the care plan. When asked when the comprehensive care plan would be updated, LPN #6 stated that the care plan would be updated for things such as falls, acute illnesses, skin related issues such as bruises, pressure sores or skin tears, etc. When asked who would be responsible for updating the comprehensive care plan for skin areas, LPN #6 stated she was responsible.

On 7/26/17 at 11:13 a.m., LPN #6 stated she had

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forgotten to resolve the stage two pressure sore to Resident #5's coccyx on the care plan. LPN #6 stated she just realized that the pressure area was still on the care plan so she had just resolved it. LPN #6 stated that it (the pressure sore on Resident #5's coccyx) should have been taken off the care plan on 6/29/17 when the area was healed.

On 7/27/17 at 6:32 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing), and ASM #3, the corporate nurse were made aware of the above concerns. No further information was presented prior to exit.

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

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

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2. The facility staff failed to update Resident #8's comprehensive care plan after an 8/11/16 resident-to-resident altercation.

Resident #8 was admitted to the facility on 6/10/11 and most recently readmitted on 9/15/16 with diagnoses including, but not limited to: history of a stroke, dementia, depression and difficulty swallowing. On the most recent MDS (minimum data set), an annual assessment with the assessment reference date of 7/14/17, Resident #8 was coded as being severely cognitively impaired for making daily decisions. She was coded as not having received pain medications during the look back period.

During the time of the survey, Resident #8 was not observed demonstrating any behaviors toward any other residents or staff.

A review of Resident #8's nurses' notes revealed the following: 8/11/16 at 3:23 a.m. "S/P (status/post - after) aggressive behaviors towards another resident. No further episodes noted. Resting quietly in bed with resp (respirations) even and nonlabored. No unusual behaviors noted."

A review of the facility's investigation of the incident mentioned above revealed that Resident #8 kicked another resident on 8/11/16. Further review of Resident #8's clinical record failed to reveal evidence that interventions were put into place to prevent Resident #8 from injuring others or to protect Resident #8 from retaliation by other residents.

A review of Resident #8's comprehensive care plan most recently updated 7/14/17 failed to

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reveal information related to the 8/11/16 incident.

On 7/27/17 at 11:00 a.m., LPN (licensed practical nurse) #6, the MDS nurse, was interviewed. She stated the social worker usually is responsible for any interventions necessary after a resident-to-resident incident related to behaviors. She stated the facility social worker was currently on vacation. LPN #6 stated that she could not find any evidence that Resident #8's care plan was updated for the 8/11/16 incident.

On 7/27/17 at 4:05 p.m., LPN (licensed practical nurse) #7 (who wrote the 8/11/16 nurse's note referenced above) was interviewed. She stated she separated the residents involved in the altercation and wrote the nurse's note. She stated she was not certain what other interventions were put into place for Resident #8. LPN #7 stated: "[Resident #8] can be difficult.

On 7/27/17 at 6:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate nurse, were informed of these concerns.

On 7/28/17 at 9:25 a.m., LPN #1, the QA (quality assurance) nurse was interviewed. She stated she used to work the floor all the time, and now works the floor when needed. She stated in the case of a resident to resident altercation, the most immediate concern is separating the residents and assessing both for injuries. Beyond this immediate action, she stated the incident should be documented in the nurses' notes and on an incident report. LPN #1 stated resident to resident incidents are discussed at weekly risk meetings, and at those meetings, further interventions are discussed. She stated the

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interventions should be documented clearly in the resident's care plan, and that the care plan should reflect that the incident occurred. LPN #1 stated the social worker is responsible for updating care plans for resident to resident altercations, and for documenting any new interventions put into place.

No further information was presented prior to exit.

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

(b)(3) Comprehensive Care Plans

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

(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:
Based on 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 five of 25 residents in the survey sample, Residents #2, #8, #3, #11 and #7.

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

2. The facility staff failed to clarity Resident #8's orders for as-needed pain medication. Resident #8 had orders for two different as needed pain medications, with no clarification as to when to

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Corrective Action(s):
Resident #2, #8, #3, and #11's attending physicians have been notified that the facility staff failed to clarify the resident's multiple as needed pain medication orders and did not have clear instructions as to when to administer which pain medication. Resident's #2, #8, #3 and #11 have had their comprehensive care plan updated to reflect their current pain management needs. A Facility Incident & Accident Form was completed for this incident.

Resident #7's attending physician has been notified that the facility staff failed to keep HOB elevated during incontinence care. A Facility

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give either medication.

3. The facility staff failed to clarity Resident #3's orders for as-needed pain medication. Resident #3 had orders for two different as needed pain medications, with no clarification as to when to give either medication.

4. The facility staff failed to clarity Resident #11's orders for as-needed pain medication. Resident #11 had orders for multiple as needed pain medications, with no clarification as to when to give the medications.

5. The facility staff failed to keep Resident #7's head of bed elevated during incontinence care when his tube feed was running.

The findings include:

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

Resident #2 was admitted to the facility on 12/20/16 and most recently readmitted on 5/30/17 with diagnoses including, but not limited to: history of a stroke, epilepsy, diabetes, and difficulty swallowing. On the most recent MDS (Minimum Data Set), a 30-day Medicare assessment with an assessment reference date of 6/25/17, Resident #2 was coded as having no cognitive impairment for making daily decisions. He was coded as having received pain medication during the look back period.

During the course of the survey, the surveyor was

Incident & Accident Form was completed for this incident.

Identification of Deficient Practices/Corrective Action(s):
All other residents may have been potentially affected. The DON, ADON and/or designee will conduct a 100% review of all resident's pain medication orders to identify any residents at risk. All residents identified at risk will be corrected at time of discovery and an Incident & Accident form will be completed for each negative finding. The attending physician will be notified of each incorrect pain medication order for clarification.
All Tube feeding residents may have potentially been affected. The DON or designee will conduct 100% review of all tube feeding residents during incontinent care to monitor for proper positioning during care delivery to ensure the HOB is not lowered below 45 degrees. All residents identified at risk will be corrected at time of discovery and staff involved will

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unable to obtain an interview with Resident #2.

A review of Resident #2's clinical record revealed the following orders, written 5/30/17 and signed by the physician most recently on 7/24/17: "Acetaminophen (Tylenol (1)) 325 mg (milligrams) tablet. Take two tablets by mouth every 4 hours as needed pain/fever....Norco (Hydrocodone/Acetaminophen (2)) 5-325 (mg) tablet. Give 1 tab (tablet) PO (by mouth) q 6 hours (every six hours) prn (as needed). Dx (diagnosis) pain." Review of the clinical record revealed no further clarification for when to administer these medications.

A review of Resident #2's comprehensive care plan dated 5/23/17 revealed, in part, the following: "Assess and establish the level of pain. Medicate per order and monitor for effectiveness. Reposition for comfort."

On 7/27/17 at 6:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate nurse, were informed of these concerns.

On 7/28/17 at 9:25 a.m., LPN (licensed practical nurse) #1, the QA (quality assurance) nurse was interviewed. She stated she used to work the floor all the time, and now works the floor when needed. When asked to review Resident #2's prn pain medication orders and to tell the surveyor which pain medication should be given under which circumstances, LPN #1 stated: "I think you would have to ask the resident. I would have to use my nursing judgment." When asked what she would do if the resident could not or would not participate in the assessment, LPN #1 stated: "We really should get clarification. This is the

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receive one-on-one inservice training.

Systemic Change(s):
The facility policy and procedure has been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report, documentation in the medical record and physician orders remains the source document for the development and monitoring of the plan care which includes, obtaining, transcribing and administering physician ordered medications and treatments, revising and completing interim care plans. Licensed staff will be inserviced by the DON and/or regional nurse consultant on the procedure for obtaining and transcribing physician accurate medication & treatment orders. All C.N.A. staff will be inserviced on the proper delivery of incontinence care to Tube Feeding residents to ensure proper positioning is maintained.

Monitoring:

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F 281	Continued From page 66	F 281	The DON is responsible for maintaining compliance. The DON, Unit Manager and/or designee will performs chart audits weekly coinciding with the care plan calendar in order to maintain compliance with as needed pain medication orders. The Unit manager will perform 2 random weekly incontinence audits of Tube Feeding residents to maintain compliance. Any/all negative findings from these audits will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 9/11/17	

doctor's order. It should not be up to the nurse. It should be up to the doctor." LPN #1 stated that the way the orders are written, it would be technically possible for the resident to receive both medications at one time. LPN #1 stated: "This would not be safe, and it wouldn't be what the doctor intended. We need clarification."

On 7/28/17 at 9:39 a.m., ASM #3, the corporate nurse, informed the survey team that the facility staff uses their own policies as their professional standard of practice.

A review of the facility policy "Medication and Treatment Orders" revealed, in part, the following: "Orders for medications must include: Name and strength of the drug; quantity or specific duration of therapy; dosage and frequency of administration; route of administration; and reason or problem for which given."

No further information was provided prior to exit.

(1) "Acetaminophen is used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body." This information is taken from the website https://medlineplus.gov/druginfo/meds/a681004.html.

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(2) "Hydrocodone is available in combination with other ingredients, and different combination products are prescribed for different uses. Some hydrocodone combination products are used to relieve moderate-to-severe pain. Other hydrocodone combination products are used to relieve cough. Hydrocodone is in a class of medications called opiate (narcotic) analgesics and in a class of medications called antitussives. Hydrocodone relieves pain by changing the way the brain and nervous system respond to pain. Hydrocodone relieves cough by decreasing activity in the part of the brain that causes coughing." This information is taken from the website https://medlineplus.gov/druginfo/meds/a601006.html.

The following information is provided in Fundamentals of Nursing, 6th edition (Potter and Perry, 2005, p.846): "A medication order is required for any medication to be administered by a nurse...If the medication order is incomplete, the nurse should inform the prescriber and ensure completeness before carrying out any medication order."

2. The facility staff failed to clarity Resident #8's orders for as-needed pain medication. Resident #8 had orders for two different as needed pain medications, with no clarification as to when to give either medication.

Resident #8 was admitted to the facility on 6/10/11 and most recently readmitted on 9/15/16 with diagnoses including, but not limited to: history of a stroke, dementia, depression and difficulty swallowing. On the most recent MDS

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(minimum data set), an annual assessment with the assessment reference date of 7/14/17, Resident #8 was coded as being severely cognitively impaired for making daily decisions. She was coded as not having received pain medications during the look back period.

A review of Resident #8's clinical record revealed the following orders, written 9/15/16 and most recently signed by the physician on 7/24/17: "Norco 5-325 tablet. Take 1 tab (tablet) po q4 (by mouth every four) hours prn (as needed) dx (diagnosis) pain...Acetaminophen 325 mg tablet take 2 tablets = 650 mg PO q 4 hrs (hours) prn. Not to exceed 3 gms (grams) in 24 hour period. Dx. pain and/or fever." Review of the clinical record revealed no further clarification for when to administer these medications.

A review of Resident #8's comprehensive care plan dated 7/20/17 revealed, in part, the following: "Assess and establish the level of pain. Medicate per order and monitor for effectiveness. Reposition for comfort."

On 7/27/17 at 6:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate nurse, were informed of these concerns.

On 7/28/17 at 9:25 a.m., LPN #1, the QA (quality assurance) nurse was interviewed. She stated she used to work the floor all the time, and now works the floor when needed. When asked to review Resident #8's prn pain medication orders and to tell the surveyor which pain medication should be given under which circumstances, LPN #1 stated: "I think you would have to ask the resident. I would have to use my nursing

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judgment." When asked what she would do if the resident could not or would not participate in the assessment, LPN #1 stated: "We really should get clarification. This is the doctor's order. It should not be up to the nurse. It should be up to the doctor." LPN #1 stated that the way the orders are written, it would be technically possible for the resident to receive both medications at one time. LPN #1 stated: "This would not be safe, and it wouldn't be what the doctor intended. We need clarification."

No further information was provided prior to exit.

3. The facility staff failed to clarity Resident #3's orders for as-needed pain medication. Resident #3 had orders for two different as needed pain medications, with no clarification as to when to give either medication.

Resident #3 was admitted to the facility on 6/23/10 and most recently readmitted on 11/12/15 with diagnoses including, but not limited to: rhabdomyolysis (3), arthritis, diabetes and dementia. On the most recent MDS (minimum data set), an annual assessment with the assessment reference date of 7/18/17, Resident #3 was coded as being moderately impaired for making daily decisions. She was coded as having received pain medication during the look back period.

A review of Resident #3's clinical record revealed the following orders, dated 8/2/16 and most recently signed by the physician on 7/24/17: "Morphine sulfate (4) 100mg/5 ml (milliliters) soln (solution). Give 0.5 ml (10 mg) SL (sublingual - under the tongue) q 30 min (every 30 minutes)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL FRONT ROYAL REVISED COPY	400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630

(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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prn Dx pain, dyspnea (difficulty breathing) or resp (respiratory rate) greater than 30...MAPAP (Tylenol) 325 mg tablet. Give two tabs by mouth every 4 hours as needed pain/fever greater than 101." Review of the clinical record revealed no further clarification for when to administer these medications.

A review of Resident #3's comprehensive care plan dated 12/14/16 revealed, in part, the following: "Encourage resident to describe the pain. Assess and establish the level of pain. Medicate per order and monitor for effectiveness."

On 7/27/17 at 6:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate nurse, were informed of these concerns.

On 7/28/17 at 9:25 a.m., LPN #1, the QA (quality assurance) nurse was interviewed. She stated she used to work the floor all the time, and now works the floor when needed. When asked to review Resident #3's prn pain medication orders and to tell the surveyor which pain medication should be given under which circumstances, LPN #1 stated: "I think you would have to ask the resident. I would have to use my nursing judgment." When asked what she would do if the resident could not or would not participate in the assessment, LPN #1 stated: "We really should get clarification. This is the doctor's order. It should not be up to the nurse. It should be up to the doctor." LPN #1 stated that the way the orders are written, it would be technically possible for the resident to receive both medications at one time. LPN #1 stated: "This would not be safe, and it wouldn't be what the doctor intended.

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We need clarification."

No further information was provided prior to exit.

(3) "Rhabdomyolysis is the breakdown of muscle tissue that leads to the release of muscle fiber contents into the blood. These substances are harmful to the kidney and often cause kidney damage." This information was taken from the website https://medlineplus.gov/ency/article/000473.htm.

(4) "Morphine is used to relieve moderate to severe pain. Morphine extended-release tablets and capsules are only used to relieve severe (around-the-clock) pain that cannot be controlled by the use of other pain medications. Morphine extended-release tablets and capsules should not be used to treat pain that can be controlled by medication that is taken as needed. Morphine is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain." This information is taken from the National Institutes of Health website https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682133.html.

4. The facility staff failed to clarity Resident #11's orders for as-needed pain medication. Resident #11 had orders for multiple as needed pain medications, with no clarification as to when to give the medications.

Resident #11 was admitted to the facility on 4/23/10 with diagnoses including, but not limited to: Cerebral palsy (5), high blood pressure, and depression. On the most recent MDS (minimum

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data set), an annual assessment with the assessment reference date of 5/17/17, Resident #11 was coded as having no cognitive impairment for making daily decisions. He was coded as having received pain medications during the look back period.

A review of the clinical record revealed the following orders:
- "Norco 5-325 (mg) tablet. 1 po q 6 hrs (every six hours) prn for HA (headache)." This order was written 1/28/17 and most recently signed by the physician on 7/24/17.
- "Butalb-ASA-Caff (Butalbital-Aspirin-Caffeine) (6) Cap (capsule). Take 1 cap by mouth every 6 hours as needed." This order was written 7/17/17 and signed by the physician on 7/24/17.
- "Butalbital-Acetaminophen-Caff-Codein (Butalbital-Acetaminophen-Caffeine-Codeine) 1 or 2 q 6 hrs prn for HA." This order was written 6/12/17 and signed by the physician on 7/24/17.
- "Tylenol 325 mg tablet. Take two tablets by mouth every 6 hours as needed [for] pain." This order was written 5/18/17 and signed by the physician on 7/24/17. Review of the clinical record revealed no further clarification for when to administer these medications.

A review of Resident #11's comprehensive care plan dated 5/23/17 revealed, in part, the following: "Assess and establish the level of pain. Medicate per order and monitor for effectiveness. Reposition for comfort. Ask if he would like to lay (sic) down."

On 7/27/17 at 6:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate nurse, were informed of these concerns.

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On 7/28/17 at 9:25 a.m., LPN #1, the QA (quality assurance) nurse was interviewed. She stated she used to work the floor all the time, and now works the floor when needed. When asked to review Resident #11's prn pain medication orders and to tell the surveyor which pain medication should be given under which circumstances, LPN #1 stated: "I think you would have to ask the resident. I would have to use my nursing judgment." When asked what she would do if the resident could not or would not participate in the assessment, LPN #1 stated: "We really should get clarification. This is the doctor's order. It should not be up to the nurse. It should be up to the doctor." LPN #1 stated that the way the orders are written, it would be technically possible for the resident to receive both medications at one time. LPN #1 stated: "This would not be safe, and it wouldn't be what the doctor intended. We need clarification."

No further information was provided prior to exit.

(5) "Cerebral palsy refers to a group of neurological disorders that appear in infancy or early childhood and permanently affect body movement and muscle coordination Cerebral palsy (CP) is caused by damage to or abnormalities inside the developing brain that disrupt the brain's ability to control movement and maintain posture and balance. The term cerebral refers to the brain; palsy refers to the loss or impairment of motor function." This information was taken from the website https://www.ninds.nih.gov/Disorders/Patient-Caregiver-Education/Hope-Through-Research/Cerebral-Palsy-Hope-Through-Research.

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(6) "This combination of drugs is used to relieve tension headaches." This information is taken from the website https://medlineplus.gov/druginfo/meds/a601009.html.

5. The facility staff failed to keep Resident #7's head of bed elevated during incontinence care when his tube feeding was running.

Resident #7 was admitted to the facility on 7/17/17 with diagnoses that included but were not limited to cerebral infarction due to occlusion (stroke), Parkinson's disease, dementia with behavioral disturbance, GERD (gastro-esophageal reflux disease), high blood pressure, and dysphagia (difficulty swallowing). Resident #7 was documented in an admission note dated 7/17/17 as being alert and oriented to self and needing an assist of two persons with ADLs (activities of daily living). Resident #7 did not have a completed MDS (minimum data set) assessment.

On 7/26/17 at 8:37 a.m., observation of incontinence care was conducted with CNA (certified nursing assistant) #7, the CNA assigned to Resident #7 and CNA #10. CNA #7 was observed lowering Resident #7's head of bed all the way flat. CNA #7 then proceeded to start incontinence care. Resident #7's peg feeding was observed hooked up to his peg (percutaneous endoscopic gastrostomy (1)) tube and running the entire time incontinence care was provided. Resident #7's head was observed flat on the bed the entire time incontinence care was provided. Incontinence care lasted fifteen minutes.

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Resident #7's nutrition care plan dated 7/18/17, documented the following: "At nutrition risk related to recent CVA (stroke) and PEG placement. Enteral feeding dependent...Will experience no s/sx (signs/symptoms) of intolerance of TF (tube feed)...Maintain resident in upright position during feedings and one hour after each feeding."

On 7/27/17 at 9:15 a.m., an interview was conducted with CNA (certified nursing assistant) #11. CNA #11 was asked about the process for providing incontinence care to a resident with a tube feeding running. CNA #11 stated she would ask the nurse to shut it (the tube feeding) off and to make sure that the HOB (head of bed) was not all the way flat. When asked how the HOB should be, CNA #11 stated, "At least at 45 degrees."

On 7/27/17 at 9:20 a.m., an interview was conducted with CNA #3, regarding the process followed for providing incontinence care to a resident with a tube feeding running. CNA #3 stated she would ask the nurse to turn the feeding off and she would make sure the resident's head was not all the way flat during care. CNA #3 stated she would keep the HOB (head of bed) elevated.

On 7/27/17 at 2:11 p.m., an interview was conducted with CNA #7, the CNA who lowered Resident #7's head of bed during incontinence care. CNA #7 stated resident's with tube feeds should not have the head of the bed flat. When asked why residents who are on tube feedings should not have their HOB flat while the tube feeding is running or for an hour after their feeding has been completed, CNA #7 stated, "It

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F 281	Continued From page 76 can come up into their throat." CNA #7 stated she had made a mistake and forgot to keep his (Resident #7's) head elevated. CNA #7 stated she was nervous. On 7/27/17 at 6:32 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing), and ASM #3, the corporate nurse were made aware of the above concerns. ASM #2 stated they (the facility) use their policy as a professional standard. The facility policy titled, "Enteral Feeding- Safety precautions," documents in part, the following: "...Preventing aspiration...Always elevate the head of the bed (HOB) at least 30 degrees-45 degrees during the tube feed and at least 1 hour after. " (1) "Percutaneous endoscopic gastrostomy tube - a tube placed in the stomach for the purpose of temporary or permanent nutrition." This information is taken from the website: https://medlineplus.gov/ency/article/002937.htm.	F 281		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (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:	F 282	**F282** **Corrective Action(s):** Resident #7's attending physician has been notified that facility staff failed to provide incontinent care to a Tube feeding resident per the written plan of care. A facility incident and accident form has been completed for this incident.	

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F 282	Continued From page 77 Based on observation, staff interview, facility document review, and clinical record review it was determined that facility staff failed to follow the written plan of care for two of 25 residents in the survey sample, Resident # 7 and #4. 1. The facility staff failed to follow the written plan of care and lowered Resident #7's head all the way flat in bed during incontinence care while his tube feeding was running. 2. The facility staff failed to implement Resident #4's "Heelz up" cushion per the resident's care plan. The findings include: 1. Resident #7 was admitted to the facility on 7/17/17 with diagnoses that included but were not limited to cerebral infarction due to occlusion (stroke), Parkinson's disease, dementia with behavioral disturbance, GERD (gastro-esophageal reflux disease), high blood pressure, and dysphagia (difficulty swallowing). Resident #7 was documented in an admission note dated 7/17/17 as being alert and oriented to self and needing an assist of two persons with ADLs (activities of daily living). Resident #7 did not have a completed MDS (minimum data set) assessment. On 7/26/17 at 8:37 a.m., observation of incontinence care was conducted with CNA (certified nursing assistant) #7, the CNA assigned to Resident #7 and CNA #10. CNA #7 was observed lowering Resident #7's head of bed all the way flat. CNA #7 then proceeded to start incontinence care. Resident #7's peg feeding was observed hooked up to his peg	F 282	Resident #4's attending physician has been notified that the facility staff failed to ensure placement of Resident #4's Heelz Up Cushion while in bed per written plan of care. **Identification of Deficient Practices/Corrective Action(s):** All other residents may have been potentially affected. The DON, ADON and/or Unit Managers will conduct a 100% review of all resident physician orders and care plans to identify residents at risk for not following and/or implementing physician ordered plan of care. All residents identified at risk will be corrected at time of discovery and an Incident & Accident form will be completed for each negative finding. The attending physician will be notified of each incident. **Systemic Change(s):** The facility policy and procedure for following and implementing physician ordered laboratory and the use of specialty equipment have been reviewed and no revisions are warranted at this time. The DON	

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(percutaneous endoscopic gastrostomy (1)) tube and running the entire time incontinence care was provided. Resident #7's head was observed flat on the bed the entire time incontinence care was provided. Incontinence care lasted fifteen minutes.

Resident #7's nutrition care plan dated 7/18/17, documented the following: "At nutrition risk related to recent CVA (stroke) and PEG placement. Enteral feeding dependent...Will experience no s/sx (signs/symptoms) of intolerance of TF (tube feed)...Maintain resident in upright position during feedings and one hour after each feeding."

On 7/27/17 at 9:15 a.m., an interview was conducted with CNA (certified nursing assistant) #11. CNA #11 was asked about the process for providing incontinence care to a resident with a tube feeding running. CNA #11 stated she would ask the nurse to shut it (the tube feeding) off and to make sure that the HOB (head of bed) was not all the way flat. When asked how the HOB should be, CNA #11 stated, "At least at 45 degrees." CNA #11 stated that all nurses should know the head of bed should be elevated for a resident with a tube feeding.

On 7/27/17 at 9:20 a.m., an interview was conducted with CNA #3, regarding the process followed for providing incontinence care to a resident with a tube feeding running. CNA #3 stated she would ask the nurse to turn the feeding off and she would make sure the resident's head was not all the way flat during care. CNA #3 stated she would keep the HOB (head of bed) elevated.

and/or regional nurse consultant will inservice all Nursing staff on following the physician ordered plan of care and the comprehensive care plan.

Monitoring:
The DON is responsible for maintaining compliance. The DON, ADON, and/or Unit Manager will perform weekly chart audits coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these reviews will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.

Completion Date: **9/11/17**

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On 7/27/17 at 2:11 p.m., an interview was conducted with CNA #7, the CNA who lowered Resident #7's head of bed during incontinence care. CNA #7 stated resident's with tube feeds should not have the head of the bed flat. When asked why residents who are on tube feedings should not have their HOB flat while the tube feeding is running or for an hour after their feeding has been completed, CNA #7 stated, "It can come up into their throat." CNA #7 stated she had made a mistake and forgot to keep his (Resident #7's) head elevated. CNA #7 stated she was nervous.

On 7/27/17 at 6:32 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing), and ASM #3, the corporate nurse were made aware of the above concerns.

The facility policy titled, "Care Plans" did not address the above concerns. The facility policy titled, "Enteral Feeding- Safety precautions," documents in part, the following: "...Preventing aspiration...Always elevate the head of the bed (HOB) at least 30 degrees-45 degrees during the tube feed and at least 1 hour after. "

According to Potter and Perry's, Fundamentals of Nursing, 7th Edition, page 269 states "A written care plan communicates nursing care priorities to other health care professionals. The nursing care plan enhances the continuity of care by listing specific nursing interventions needed to achieve the goals of care. The complete care plan is the blueprint for nursing action. It provides direction for implementation of the plan plus the framework for evaluation of the client's response to nursing actions."

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(1) "Percutaneous endoscopic gastrostomy tube - a tube placed in the stomach for the purpose of temporary or permanent nutrition." This information is taken from the website: https://medlineplus.gov/ency/article/002937.htm.

2. The facility staff failed to implement Resident #4's "Heelz up" cushion (a cushion used to prevent an individual's heels from touching the mattress) per the resident's written plan of care.

Resident #4 was admitted to the facility on 3/24/11. Resident #4's diagnoses included but were not limited to: dementia (1), high blood pressure and dysphagia (2). Resident #4's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 6/2/17, coded the resident's cognitive skills for daily decision making as severely impaired. Section M coded Resident #4 as not having a pressure injury (3).

Resident #4's clinical record revealed a wound assessment report dated 7/27/17 that documented Resident #4 developed a pressure injury on the right heel on 7/18/17 that was documented as unstageable due to suspected deep tissue injury (3).

A physician's order summary signed by the physician on 7/24/17 documented an order dated 7/18/17 for a "Heelz up cushion to bed for protection and prevention QS (every shift)."

Resident #4's July 2017 TAR (treatment administration record) documented, "Heelz up

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cushion to bed for protection and prevention QS."

Resident #4's comprehensive care plan initiated on 5/3t/t7 documented, "At risk for pressure ulcers due to decrease (sic) mobility & incont (incontinence). 7/t8/t7 DTI (deep tissue injury) right heel...Approaches: Heelz up when in bed..." Resident #4's CNA (certified nursing assistant) care plan documented, "Heels up cushion in bed..."

On 7/26/t7 at 3:2t p.m. Resident #4 was observed lying in bed on her back. The resident's feet were sticking out of the bottom of the blanket that was covering her. Resident #4 had socks on her feet and her heels were lying on the mattress. No "Heelz up" cushion was observed.

On 7/27/t7 at 9:45 a.m. an interview was conducted with CNA #7 (the CNA caring for Resident #4). CNA #7 was asked how she was made aware of the types of pressure injury interventions each resident required. CNA #7 stated nurses and other CNAs make her aware during report/shift change and there is a care plan located in each resident's closet. CNA #7 was asked to describe a "Heelz up" cushion. CNA #7 stated a "Heelz up" cushion was a bigger version of a pillow and she usually puts it under residents' calves so their heels are not touching the bed. CNA #7 was asked if Resident #4 presented with any pressure injuries and stated, "Not that I know of." When asked if Resident #4 required any pressure injury prevention devices such as a "Heelz up" cushion, CNA #7 stated, "Not that I know of." At this time, CNA #7 was asked to show this surveyor Resident #4's feet. Resident #4 was lying in bed. CNA #7 removed the bottom portion of the resident's blanket. Resident #4 had

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socks on her feet and her heels were lying on the mattress. No "Heelz up" cushion was observed.

On 7/27/17 at 3:05 p.m. an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 was asked how she was made aware of the types of pressure injury interventions each resident required. LPN #5 stated if there was a new order then the order would be documented on the 24 hour report and the new order would be verbally passed on during the nursing report. LPN #5 stated pressure injury interventions were also signed off on the TAR. LPN #5 was asked if Resident #4 required any pressure injury interventions. LPN #5 stated, "She has a Heelz up." LPN #5 stated the night shift had cleaned the cushion and didn't put it back in the resident's room.

On 7/27/17 at 6:32 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

On 7/28/17 at 8:50 a.m. an interview was conducted with LPN #1 regarding the purpose of the care plan. LPN #1 stated the purpose of the care plan was to capture the resident in his/her entirety. LPN #1 stated each resident's care plan contains care and services that are going to be provided by all disciplines. LPN #1 stated the facility staff try to develop care plans that are personalized to each resident. When asked how staff ensures each resident's care plan is followed, LPN #1 stated each resident's care plan is in the computer in case staff needs to reference it. LPN #1 stated CNA service care plans are also located in each resident's closet.

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The facility policy titled, "Care Planning-Interdisciplinary Team" documented, "Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive person centered care plan for each resident." The policy did not document specific information regarding staff following the care plan.

No further information was presented prior to exit.

(1) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dementia&_ga=2.205672787.1977489418.1501503571-139120270.1477942321

(2) Dysphagia is difficulty swallowing. This information was obtained from the website: https://medlineplus.gov/swallowingdisorders.html

(3) A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue...

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F 282	Continued From page 84 Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface..." This information was obtained from the website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/	F 282		
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:	F 309	**F309** **Corrective Action(s):** Residents #4's attending physician was notified that the facility failed to provide the left lateral support to wheelchair as ordered by the attending physician. A facility incident & Accident form was completed for this incident. Resident #7, #2, #8, #3 & #5's attending physicians were notified that the facility staff failed to assess the location of the resident's pain and failed to offer non-pharmacological interventions prior to administering as needed pain medication per physician order. A	

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(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, staff interview, facility document review and clinical record review it was determined that the facility staff failed to provide treatment and care to promote and maintain the highest level of well-being for seven of 25 residents in the survey sample, Residents #4, #7, #2, #8, #3, #5 and #6.

1. The facility staff failed to provide Resident #4's left lateral support as prescribed by the physician.

2. The facility staff failed to assess the location of the resident's pain and failed to offer non-pharmacological interventions prior to administering as needed pain medication to Resident #7 in June and July 2017.

3. The facility staff failed to assess the location of the resident's pain and failed to offer non-pharmacological interventions prior to administering as needed pain medication to Resident #2 in June and July 2017.

facility Incident & Accident form was completed for this incident.

Residents #6's attending physician was notified that the facility failed to attempt non-pharmacological interventions prior to the administration of Norco 5-325mg on four different occasions. A facility Incident and Accident form was completed for this incident.

Identification of Deficient Practices/Corrective Action(s):
All other residents may have been potentially affected. The DON, ADON, and Unit Managers will conduct a 100% audit of all resident's physician orders and MAR's to identify resident at risk. Residents identified at risk will be corrected at time of discovery and their comprehensive plans of care updated to reflect their resident specific needs. The attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding.

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4. The facility staff failed to assess the location of the resident's pain and failed to offer non-pharmacological interventions prior to administering as needed pain medication to Resident #8 in June and July 2017.

5. The facility staff failed to assess the location of the resident's pain and failed to offer non-pharmacological interventions prior to administering as needed pain medication to Resident #3 in June and July 2017.

6. The facility staff failed to attempt non-pharmacological pain relief interventions and failed to assess the location of Resident #5's pain prior to the administration of Tylenol 650 mg on: 3/13/17, 3/16/17, 3/18/17, 3/23/17, 4/1/17, 4/18/17 and 7/6/17.

7. The facility staff failed to attempt non-pharmacological pain relief interventions prior to the administration of Norco 5-325 mg to Resident #6 on 3/29/17, 4/19/17, 4/26/17, and 5/20/17.

The findings include:

1. The facility staff failed to provide Resident #4's left lateral support as prescribed by the physician.

Resident #4 was admitted to the facility on 3/24/11. Resident #4's diagnoses included but were not limited to: dementia (1), high blood pressure and dysphagia (2). Resident #4's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 6/2/17, coded the resident's cognitive skills for daily decision making as severely impaired. Section G documented Resident #4

Systemic Change(s):
The facility policy and procedures have been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hour Report and documentation in the medical record /physician orders remains the source document for the development and monitoring of the provision of care, which includes, obtaining, transcribing and completing physician orders, medication orders, treatment orders. This includes assessing the location of a resident's pain and attempting non-pharmacological interventions prior to pain medication administration. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders. As well as performing physician ordered monitoring and follow up per physician orders.

Monitoring:
The DON will be responsible for maintaining compliance. The DON,

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Completion Date: **9/11/17**

was totally dependent on two or more staff with bed mobility and transfers.

Review of Resident #4's clinical record revealed a physician's order summary signed by the physician on 7/24/17 that documented an order dated 6/1/17 for left lateral support and Posey posterior leg support while up in the wheelchair.

Resident #4's July 2017 TAR (treatment administration record) documented, "L (Left) lateral support and Posey posterior leg support while up in w/c (wheelchair)."

Resident #4's comprehensive care plan initiated on 5/31/17 and CNA (certified nursing assistant) care plan current as of "June 2017" failed to document information regarding left lateral support or Posey posterior leg support while up in the wheelchair.

On 7/26/17 at 3:42 p.m., 5:15 p.m. and 7/27/17 at 8:35 a.m. Resident #4 was observed in the wheelchair. No left lateral support was observed while the resident was in the wheelchair. The posterior leg support was observed.

On 7/27/17 at 9:45 a.m. an interview was conducted with CNA (certified nursing assistant) #7 (the CNA caring for Resident #4). CNA #7 was asked how she was made aware of the positioning devices required for each resident. CNA #7 stated nurses and other CNAs make her aware during report/shift change and there is a care plan located in each resident's closet. CNA #7 was asked if Resident #4 required any positioning devices. CNA #7 stated, "Not that I know of. I haven't heard of any in report."

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On 7/27/17 at 3:05 p.m. an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 was asked how she was made aware of the positioning devices required for each resident. LPN #5 stated the devices were documented on the TAR and if the order for the device was new then she was made aware during the nursing report. LPN #5 was asked to describe the left lateral support that was supposed to be implemented for Resident #4. LPN #5 stated the left lateral support was an "L" shaped cushion that is supposed to be placed beside the resident in the wheelchair so the resident doesn't lean.

On 7/27/17 at 6:32 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

The facility policy titled, "Medication and Treatment Orders" documented, "Orders for medications and treatments will be consistent with principles of safe and effective order writing." The policy failed to document information pertaining to the implementation of left lateral support.

No further information was presented prior to exit.

(1) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dementia&_ga=2.205

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(2) Dysphagia is difficulty swallowing. This information was obtained from the website: https://medlineplus.gov/swallowingdisorders.html

2. The facility staff failed to assess the location of the resident's pain and failed to offer non-pharmacological interventions prior to administering as needed pain medication to Resident #7 on 7/26/17.

Resident #7 was admitted to the facility on 7/17/17. Resident #7's diagnoses included but were not limited to: stroke, high cholesterol and dementia. Resident #7 did not have a completed MDS (minimum data set). On his admission nursing assessment dated 7/17/17, he was documented as being "alert" and "confused." He was documented as being fed by "tube."

On 7/26/17 at 9:50 a.m., LPN (licensed practical nurse) #5 was observed as she assessed Resident #7 for pain. LPN #5 asked Resident #7 if he was experiencing pain. Resident #7 stated that he was. LPN #5 asked Resident #7 to rate the pain on a scale from one to ten. Resident #7 stated: "Seven." LPN #5 prepared the resident's medication by crushing two 325 mg (milligram) tablets of Tylenol (2), mixing the crushed medication with water, and administering the medication through Resident #7's PEG tube. LPN #5 did not ask Resident #7 the location of his pain, or offer any non-pharmacological interventions prior to administering the medication.

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A review of the physician's orders for Resident #7, revealed the following order: "Change Tylenol to give 2 tabs (tablets) 325 mg (milligram) (650 mg Acetaminophen) via g-tube q (every) 4 hours prn (as needed). [Note: This was given as a verbal order on 7/26/17 at 9:45 a.m.]."

A review of Resident #7's comprehensive care plan initiated 7/18/17 and updated most recently on 7/26/17 revealed no information related to pain medication assessment.

On 7/27/17 at 6:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate nurse, were informed of these concerns.

On 7/28/17 at 9:25 a.m., LPN (licensed practical nurse) #1, the QA (quality assurance) nurse was interviewed. She stated she used to work the floor all the time, and now works the floor when needed. When asked what assessments should be performed prior to administering an as needed pain medication to a resident, LPN #1 stated: "I do a visual observation. I ask them what kind of pain it is. I ask where it's located. I ask them to rate the pain." She stated these are important factors in helping other staff members know why a medication was administered. When asked if she would document this information, LPN #1 stated: "Yes, I would. I would write a note. Our system does not give you the chance to document the location." When asked for clarification, LPN #1 stated: "There is nowhere in the computer system to document the location of the pain. I always write a note. There should be a note." When asked if she attempts non-pharmacological interventions prior to administering an as-needed pain medication,

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LPN #1 stated: "Sometimes." She stated if she does offer these interventions, it might include turning, repositioning, ice pack, or a different level for the head of the bed. LPN #1 stated: "Ideally, I would offer something. I might not always document it."

A review of the facility policy "Administering Pain Medications" revealed, in part, the following: "The purpose of this procedure is to provide guidelines for assessing the resident's level of pain prior to administering analgesic pain medication...The pain assessment consists of gathering both subjective and objective data...Conduct a pain assessment as indicated...Evaluate and document the effectiveness of non-pharmacologic interventions...Administer pain medications as ordered."

No further information was provided prior to exit.

(1) "Percutaneous endoscopic gastrostomy tube - a tube placed in the stomach for the purpose of temporary or permanent nutrition." This information is taken from the website: https://medlineplus.gov/ency/article/002937.htm.

(2) "Acetaminophen is used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body

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senses pain and by cooling the body." This information is taken from the website https://medlineplus.gov/druginfo/meds/a681004.html.

Fundamentals of Nursing, 6th Edition, Potter and Perry, 2005, pages 1239-1287, "Nurses need to approach pain management systematically to understand a client's pain and to provide appropriate intervention....it is necessary to monitor pain on a consistent basis....Assessment of common characteristics of pain helps the nurse form an understanding of the type of pain, its pattern, and types of interventions that may bring relief....Onset and duration....Location....Intensity....Quality....Pain Pattern....Relief Measures....Contributing Symptoms....Pain therapy requires an individualized approach....Nurses administer and monitor interventions ordered by physicians for pain relief and independently use pain-relief measures that complement those prescribed by a physician....Effective communication of a client's assessment of pain and his or her response to intervention is facilitated by accurate and thorough documentation. This communication needs to transpire from nurse to nurse, shift to shift, and nurse to other health care providers. It is the professional responsibility of the nurse caring for the client to report what has been effective for managing the client's pain. The client is not responsible for ensuring that this information is accurately transmitted. A variety of tools such as a pain flow sheet or diary will help centralize the information about pain management."

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3. The facility staff failed to assess the location of the resident's pain and failed to offer non-pharmacological interventions prior to administering as needed pain medication to Resident #2 in June and July 2017.

Resident #2 was admitted to the facility on 12/20/16 and most recently readmitted on 5/30/17 with diagnoses including, but not limited to: history of a stroke, epilepsy, diabetes, and difficulty swallowing. On the most recent MDS (Minimum Data Set), a 30-day Medicare assessment with an assessment reference date of 6/25/17, Resident #2 was coded as having no cognitive impairment for making daily decisions. He was coded as having received pain medication during the look back period.

During the course of the survey, the surveyor was unable to obtain an interview with Resident #2.

A review of Resident #2's clinical record revealed the following orders, written 5/30/17 and signed by the physician most recently on 7/24/17: "Acetaminophen (Tylenol) 325 mg (milligrams) tablet. Take two tablets by mouth every 4 hours as needed pain/fever....Norco (Hydrocodone/Acetaminophen (3)) 5-325 (mg) tablet. Give 1 tab (tablet) PO (by mouth) q 6 hours (every six hours) prn (as needed). Dx (diagnosis) pain."

A review of Resident #2's MARs (medication administration records), MAR notes, and nurses' notes revealed that Resident #2 received Tylenol and Norco as follows:
- Norco: 6/2/17, 6/4/17, 6/5/17, 6/6/17, 6/9/17, 6/12/17, 6/18/17 X 2; 6/21/17, 6/22/17, 6/29/17, 6/30/17, 7/2/17 X 2, 7/4/17, 7/6/17, 7/9/17, and

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7/26/17
- Tylenol: 6/17/17
According to the documentation, the facility nurse failed to assess the location of the resident's pain and failed to attempt non-pharmacological interventions prior to administering the medications to Resident #2 on each of these occasions.

A review of Resident #2's comprehensive care plan dated 5/23/17 revealed, in part, the following: "Assess and establish the level of pain. Medicate per order and monitor for effectiveness. Reposition for comfort."

On 7/27/17 at 6:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate nurse, were informed of these concerns.

On 7/28/17 at 9:25 a.m., LPN #1, the QA (quality assurance) nurse was interviewed. LPN #1 stated she used to work the floor all the time, and now works the floor when needed. When asked to review Resident #2's medication administration records as indicated above, LPN #1 stated she did not see evidence that Resident #2's pain location was assessed or that the nurse attempted non-pharmacological interventions prior to administering the pain medications.

No further information was provided prior to exit.

(3) "Hydrocodone is available in combination with other ingredients, and different combination products are prescribed for different uses. Some hydrocodone combination products are used to relieve moderate-to-severe pain. Other hydrocodone combination products are used to

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relieve cough. Hydrocodone is in a class of medications called opiate (narcotic) analgesics and in a class of medications called antitussives. Hydrocodone relieves pain by changing the way the brain and nervous system respond to pain. Hydrocodone relieves cough by decreasing activity in the part of the brain that causes coughing." This information is taken from the website https://medlineplus.gov/druginfo/meds/a601006.html.

4. The facility staff failed to assess the location of the resident's pain and failed to offer non-pharmacological interventions prior to administering as needed pain medication to Resident #8 in June and July 2017.

Resident #8 was admitted to the facility on 6/10/11 and most recently readmitted on 9/15/16 with diagnoses including, but not limited to: history of a stroke, dementia, depression and difficulty swallowing. On the most recent MDS (minimum data set), an annual assessment with the assessment reference date of 7/14/17, Resident #8 was coded as being severely cognitively impaired for making daily decisions. She was coded as not having received pain medications during the look back period.

A review of Resident #8's clinical record revealed the following order, written 9/15/16 and most recently signed by the physician on 7/24/17: "Norco 5-325 tablet. Take 1 tab po q4 (tablet by mouth every four) hours prn (as needed) dx (diagnosis) pain."

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A review of Resident #8's MARs (medication administration records), MAR notes, and nurses' notes revealed that Resident #8 received Norco as follows: 6/24/17, 7/6/17, and 7/19/17. According to the documentation, the facility nurse failed to assess the location of Resident #8's pain and failed to attempt non-pharmacological interventions prior to administering the medications to Resident #8 on each of these occasions.

A review of Resident #8's comprehensive care plan dated 7/20/17 revealed, in part, the following: "Assess and establish the level of pain. Medicate per order and monitor for effectiveness. Reposition for comfort."

On 7/27/17 at 6:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate nurse, were informed of these concerns.

On 7/28/17 at 9:25 a.m., LPN #1, the QA (quality assurance) nurse was interviewed. LPN #1 stated she used to work the floor all the time, and now works the floor when needed. When asked to review Resident #8's medication administration records as indicated above, LPN #1 stated she did not see evidence that the resident's pain location was assessed or that the nurse attempted non-pharmacological interventions prior to administering the medications.

No further information was provided prior to exit.

5. The facility staff failed to assess the location of the resident's pain and failed to offer non-pharmacological interventions prior to

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administering as needed pain medication to Resident #3 in June and July 2017.

Resident #3 was admitted to the facility on 6/23/10 and most recently readmitted on 11/12/15 with diagnoses including, but not limited to: rhabdomyolysis (4), arthritis, diabetes and dementia. On the most recent MDS (minimum data set), an annual assessment with the assessment reference date of 7/18/17, Resident #3 was coded as being moderately impaired for making daily decisions. She was coded as having received pain medication during the look back period.

A review of Resident #3's clinical record revealed the following order, dated 8/2/16 and most recently signed by the physician on 7/24/17: "MAPAP (Tylenol) 325 mg tablet. Give two tabs (tablets) by mouth every 4 hours as needed pain/fever greater than 101."

A review of Resident #3's MARs (medication administration records), MAR notes, and nurses' notes revealed that Resident #3 received Tylenol as follows: 6/3/17, and 7/13/17. According to the documentation, the facility nurse failed to assess the location of Resident #3's pain and failed to attempt non-pharmacological interventions prior to administering the medications to Resident #3 on each of these occasions.

A review of Resident #3's comprehensive care plan dated 12/14/16 revealed, in part, the following: "Encourage resident to describe the pain. Assess and establish the level of pain. Medicate per order and monitor for effectiveness."

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On 7/27/17 at 6:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate nurse, were informed of these concerns.

On 7/28/17 at 9:25 a.m., LPN #1, the QA (quality assurance) nurse was interviewed. LPN #1 stated she used to work the floor all the time, and now works the floor when needed. When asked to review Resident #3's medication administration records as indicated above, LPN #1 stated she did not see evidence that the resident's pain location was assessed or that the nurse attempted non-pharmacological interventions prior to administering the medications.

No further information was provided prior to exit.

(4) "Rhabdomyolysis is the breakdown of muscle tissue that leads to the release of muscle fiber contents into the blood. These substances are harmful to the kidney and often cause kidney damage." This information was taken from the website https://medlineplus.gov/ency/article/000473.htm.

6. The facility staff failed to attempt non-pharmacological pain relief interventions and failed to assess the location of Resident #5's pain prior to the administration of Tylenol 650 mg on: 3/13/17, 3/16/17, 3/18/17, 3/23/17, 4/1/17, 4/18/17 and 7/6/17.

Resident #5 was admitted to the facility on 9/14/13 with diagnoses that included but were not limited to: Alzheimer's disease, age-related osteoporosis, and dementia with behavioral disturbance. Resident #5's most recent MDS (minimum data set) assessment was a quarterly

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assessment with an ARD (assessment reference date of 6/28/17. Resident #5 was coded as being severely cognitively impaired in the ability to make daily decisions scoring 00 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #5 was coded as requiring total dependence on two staff members with bed mobility, transfers, toileting, and personal hygiene; and total dependence on one staff member with dressing, and eating.

Review of Resident #6's most recent POS (Physician Order Sheet) dated August 2017, documented the following order: "Norco [1] 5/325 mg tablet 1 tab (tablet) p.o. (by mouth) q (every) 8 hours prn (as needed dx (diagnosis) pain."

Review of Resident #5's March, April, and July 2017 MARs (Medication Administration Record) documented the following order: "Tylenol [1[325 MG (milligram) Caplet 2 tabs (tablets) = 650 mg PO (by mouth) Q (every) 6 hours PRN (as needed) pain/fever."

Further review of Resident #5's March, April, and July 2017 MARs (Medication Administration Record) revealed that Resident #5 received Tylenol 650 mg on the following dates: 3/13/17, 3/16/17, 3/18/17, 3/23/17, 4/1/17, 4/18/17 and 7/6/17.

Review of Resident #5's most recent physician orders dated August 2017, documented the following order: "Tylenol [1] 325 mg (milligram) caplet 2 tabs (tablets) = 650 mg p.o. (by mouth) q (every) six hours) as needed pain/fever."

Review of the March, April, and July 2017 MAR note sheets revealed that non-pharmacological

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pain interventions were not documented as being attempted and the location of pain was not documented as being assessed for all of the above dates.

Review of the nursing notes dated March through July 2017 revealed no evidence that non-pharmacological pain interventions were attempted prior to the administration of Tylenol on the above dates. Further review of the nursing notes failed to reveal assessments for the location of pain on the above dates.

On 7/27/17 at 2:30 p.m., an interview was conducted with LPN (licensed practical nurse) #9. When asked the process of assessing and administering pain medication, LPN #9 stated that she would first ask the resident their pain level and the location. LPN #9 stated that she would attempt other things to relieve pain (non-pharmacological) pain relief interventions. When asked if non-pharmacological interventions should always be attempted, LPN #9 stated, "I do, yes." LPN #9 stated that if the resident continues to have pain, she would the administer pain medication. When asked if the location of pain is assessed and documented anywhere, LPN #9 stated that it is usually documented on the MAR with the pain scale and should always be documented. When asked if it is documented anywhere that non-pharmacological interventions were attempted, LPN #9 stated that the nursing staff did not usually document non-pharmacological interventions attempted, but sometimes it was in a nursing note. When asked how a nurse would know if non-pharmacological pain relief interventions were attempted if there is no documentation in the clinical record, LPN #9 stated that she didn't know.

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On 7/27/17 at 2:32 p.m., an interview was conducted with LPN #10. When asked the process of assessing and administering pain medication, LPN #10 stated she would ask the resident their pain level and the location. LPN #10 stated that she would attempt other things to relieve pain (non-pharmacological) pain relief interventions. When asked if nursing should be documenting that non-pharmacological interventions were attempted, LPN #10 stated that nursing can document in a nursing note but she didn't think nursing staff was required to document non-pharmacological interventions attempted. LPN #10 stated that she would administer pain medication if non-pharmacological interventions were not effective and then follow up after one hour. LPN #10 could not determine if Resident #5 was offered non-pharmacological pain interventions.

On 7/27/17 at 6:32 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #3, the corporate nurse were made aware of the above concerns.

[1] Tylenol Tablet 325 mg (Acetaminophen) - Treats minor aches and pains and also reduces fever. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008785/?report=details.

7. The facility staff failed to attempt non-pharmacological pain relief interventions prior to the administration of Norco 5-325 mg to

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Resident #6 on: 3/29/17, 4/19/17, 4/26/17, and 5/20/17.

Resident #6 was admitted to the facility on 7/13/12 and readmitted on 12/17/15 with diagnoses that included but were not limited to post right mastectomy, major depressive disorder, polyarthritis, type two diabetes mellitus, and dementia without behavioral disturbance. Resident #6's most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 7/7/17. Resident #6 was coded as being moderately impaired of cognition, scoring 08 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #6 was coded as requiring total dependence on two staff members with transfers; and extensive assistance with two staff members with bed mobility, dressing, toileting, and personal hygiene.

Review of Resident #6's March, April, and May 2017 MARs (medication administration record) documented the following order: "Norco [1] 5-325 Tablet Take one tab po (by mouth) Q (every) 8 hours PRN (as needed)."

Further review of Resident #6's March, May, April and May 2017 MARS revealed that Resident #6 had received Norco on the following dates: 3/29/17, 4/19/17, 4/26/17, and 5/20/17.

Review of the note sheets on the March, April, and May 2017 MARs failed to evidence that non-pharmacological pain relief interventions were attempted prior to the administration of Norco for the above dates.

Review of the March, April, and May 2017 nursing

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notes failed to reveal that non-pharmacological pain relief interventions were attempted prior to the administration of Norco for the above dates.

On 7/27/17 at 2:30 p.m., an interview was conducted with LPN (licensed practical nurse) #9. When asked the process of assessing and administering pain medication, LPN #9 stated that she would first ask the resident their pain level and the location. LPN #9 stated that she would attempt other things to relieve pain (non-pharmacological) pain relief interventions. When asked if non-pharmacological interventions should always be attempted, LPN #9 stated, "I do, yes." LPN #9 stated that if the resident continues to have pain, she would the administer pain medication. When asked if it is documented anywhere that non-pharmacological interventions were attempted, LPN #9 stated that the nursing staff did not usually document non-pharmacological interventions attempted, but sometimes it was in a nursing note. When asked how a nurse would know if non-pharmacological pain relief interventions were attempted if there is no documentation in the clinical record, LPN #9 stated that she didn't know.

On 7/27/17 at 2:32 p.m., an interview was conducted with LPN #10. When asked the process of assessing and administering pain medication, LPN #10 stated that she would ask the resident their pain level and the location. LPN #10 stated that she would attempt other things to relieve pain (non-pharmacological) pain relief interventions. When asked if nursing should be documenting that non-pharmacological interventions were attempted, LPN #10 stated that nursing can document in a nursing note but she didn't think nursing staff was required to

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F 309	Continued From page 104 document non-pharmacological interventions attempted. LPN #10 stated that she would administer pain medication if non-pharmacological interventions were not effective and then follow up after one hour. LPN #10 could not determine if Resident #6 was offered non-pharmacological pain interventions. On 7/27/17 at approximately 3:15 p.m., an interview was attempted with Resident #6. When asked if staff attempted other things before giving her pain medications, Resident #6 could not respond to the question. On 7/27/17 at 6:32 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #3, the corporate nurse were made aware of the above concerns. [1] Norco is an 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=aaef2d01-126d-4aab-9b2a-eee31a769150.	F 309		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure	F 314	**F- 314** **Corrective Action(s):** Resident #4's physician was notified that the physician ordered Heelz Up cushion was not applied as ordered by the physician. Resident #4 has been re-assessed by nursing for compromised skin integrity and the Heelz Up order has been reviewed. The comprehensive care plans have	

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ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and

(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to implement pressure injury interventions to prevent the development and promote healing of pressure sores for one of 25 residents in the survey sample, Resident #4.

The facility staff failed to implement Resident #4's "Heelz up" cushion (a cushion used to prevent an individual's heels from touching the mattress) as prescribed by the physician and per the resident's plan of care.

The findings include:

Resident #4 was admitted to the facility on 3/24/11. Resident #4's diagnoses included but were not limited to: dementia (1), high blood pressure and dysphagia (2). Resident #4's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 6/2/17, coded the resident's cognitive skills for daily decision making as severely impaired. Section M coded Resident #4 as not having a pressure injury (3).

Resident #4's clinical record revealed a wound assessment report dated 7/27/17 that documented Resident #4 developed a pressure

been updated to reflect the current preventative skin care approaches and interventions to prevent pressure injuries.

Identification of Deficient Practice(s) and Corrective Action(s):
All other residents with pressure relieving devices may have been potentially affected. A 100% body audit of all residents with pressure relieving devices will be completed to identify any skin or pressure related issues. Any negative findings will be addressed at the time of discovery, the attending physician notified and a facility incident and accident form will be completed.

Systemic Change(s):
The facility Policy and Procedure for Wound Care has been reviewed and no changes are warranted at this time. The nursing staff will be inserviced by the DON and/or regional nurse consultant(s) on the facility's Pressure Ulcer Treatment and Prevention Policy and Procedure. Training will include,

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F 314	Continued From page 106 injury on the right heel on 7/18/17 that was documented as unstageable due to suspected deep tissue injury (3). A physician's order summary signed by the physician on 7/24/17 documented an order dated 7/18/17 for a "Heelz up cushion to bed for protection and prevention QS (every shift)." Resident #4's July 2017 TAR (treatment administration record) documented, "Heelz up cushion to bed for protection and prevention QS." Resident #4's comprehensive care plan initiated on 5/31/17 documented, "At risk for pressure ulcers due to decrease (sic) mobility & incont (incontinence). 7/18/17 DTI (deep tissue injury) right heel...Approaches: Heelz up when in bed..." Resident #4's CNA (certified nursing assistant) care plan documented, "Heels up cushion in bed..." On 7/26/17 at 3:21 p.m. Resident #4 was observed lying in bed on her back. The resident's feet were sticking out of the bottom of the blanket that was covering her. Resident #4 had socks on her feet and her heels were lying on the mattress. No "Heelz up" cushion was observed. On 7/27/17 at 9:45 a.m. an interview was conducted with CNA #7 (the CNA caring for Resident #4). CNA #7 was asked how she was made aware of the types of pressure injury interventions each resident required. CNA #7 stated nurses and other CNAs make her aware during report/shift change and there is a care plan located in each resident's closet. CNA #7 was asked to describe a "Heelz up" cushion. CNA #7 stated a "Heelz up" cushion was a bigger version	F 314	performing weekly body audits, assessing risk for pressure ulcers using Braden scale, preventative measures, and implementation of physician ordered preventive interventions as ordered. **Monitoring:** The DON is responsible for maintaining compliance. The DON and/or designee will complete weekly audits of all resident Pressure Ulcer preventative orders to ensure they are being implemented per physician order. Any negative findings will be corrected at the time of discovery and disciplinary action will be taken as needed. All weekly audits will be reviewed weekly by the Risk Management Committee for appropriate implementation of prevention orders. The results of these audits will be provided to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** **9/11/17**	

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of a pillow and she usually puts it under residents' calves so their heels are not touching the bed. CNA #7 was asked if Resident #4 presented with any pressure injuries and stated, "Not that I know of." When asked if Resident #4 required any pressure injury prevention devices such as a "Heelz up" cushion, CNA #7 stated, "Not that I know of." At this time, CNA #7 was asked to show this surveyor Resident #4's feet. Resident #4 was lying in bed. CNA #7 removed the bottom portion of the resident's blanket. Resident #4 had socks on her feet and her heels were lying on the mattress. No "Heelz up" cushion was observed.

On 7/27/17 at 3:05 p.m. an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 was asked how she was made aware of the types of pressure injury interventions each resident required. LPN #5 stated if there was a new order then the order would be documented on the 24 hour report and the new order would be verbally passed on during the nursing report. LPN #5 stated pressure injury interventions were also signed off on the TAR. LPN #5 was asked if Resident #4 required any pressure injury interventions. LPN #5 stated, "She has a Heelz up." LPN #5 stated the night shift had cleaned the cushion and didn't put it back in the resident's room.

On 7/27/17 at 6:32 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

The facility policy titled, "Wound Care" failed to document information regarding the implementation of pressure injury interventions.

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No further information was presented prior to exit.

(1) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dementia&_ga=2.205672787.1977489418.1501503571-139120270.1477942321

(2) Dysphagia is difficulty swallowing. This information was obtained from the website: https://medlineplus.gov/swallowingdisorders.html

(3) A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue...
Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration
Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear

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F 314	Continued From page 109 differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface..." This information was obtained from the website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/	F 314		
F 322 SS=D	483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE EATING SKILLS (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and (5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide the appropriate treatment and services for a feeding tube to prevent complications for one of 25 residents in the survey sample, Resident #7.	F 322	**F322** **Corrective Action(s):** Residents #7's attending physician has been notified that facility staff did not position resident #7 correctly during incontinent care while administering resident #7's tube feeding per physician order. A facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practice(s) & Corrective Action(s):** All other tube-feeding residents may have been potentially affected. A 100% review of all tube-feeding residents was performed to identify those at risk. Any negative findings will be corrected at the time of discovery and a facility Incident & Accident form will be completed for any/all negative findings. **Systemic Change(s):**	

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The facility staff kept Resident #7's head of bed flat while providing incontinence care. Resident #7's tube feed was hooked up to his peg tube (Percutaneous endoscopic gastrostomy (1)) and was running during the entire observation of incontinence care.

The findings include:

Resident #7 was admitted to the facility on 7/17/17 with diagnoses that included but were not limited to cerebral infarction due to occlusion (stroke), Parkinson's disease, dementia with behavioral disturbance, GERD (gastro-esophageal reflux disease), high blood pressure, and dysphagia (difficulty swallowing). Resident #7 was documented in an admission note dated 7/17/17 as being alert and oriented to self and needing an assist of two persons with ADLs (activities of daily living). Resident #7 did not have a completed MDS (minimum data set) assessment.

On 7/26/17 at 8:37 a.m., observation of incontinence care was conducted with CNA (certified nursing assistant) #7, the CNA assigned to Resident #7 and CNA #10. CNA #7 was observed lowering Resident #7's head of bed all the way flat. CNA #7 then proceeded to start incontinence care. Resident #7's peg feeding was hooked up to his peg tube and running the entire time incontinence care was provided. Resident #7's head was observed to be flat on the bed the entire time incontinence care was provided. Incontinence care lasted fifteen minutes.

The facility Policy and Procedure was reviewed and no changes are warranted at this time. All nursing staff will be inserviced by the DON and/or the Regional Nurse Consultant on the facility policy and procedure for positioning, tube feeding administration, changing and flushing of gastrostomy tubes, as well as proper documentation for tube-feedings.

Monitoring:
The Director of Nursing is responsible for compliance. The DON and or Unit Manager will perform random documented rounds on all tube feeding residents weekly to monitor for compliance. All negative findings identified during the audit will be corrected at time of discovery and appropriate disciplinary action taken. Detailed findings of these reviews will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.

Completion Date: **9/11/17**

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Resident #7's nutrition care plan dated 7/18/17, documented the following: "At nutrition risk related to recent CVA (stroke) and PEG placement. Enteral feeding dependent...Will experience no s/sx (signs/symptoms) of intolerance of TF (tube feed)...Maintain resident in upright position during feedings and one hour after each feeding."

On 7/27/17 at 9:15 a.m., an interview was conducted with CNA (certified nursing assistant) #11. CNA #11 was asked about the process for providing incontinence care to a resident with a tube feeding running. CNA #11 stated she would ask the nurse to shut it (the tube feeding) off and to make sure that the HOB (head of bed) was not all the way flat. When asked how the HOB should be, CNA #11 stated, "At least at 45 degrees."

On 7/27/17 at 9:20 a.m., an interview was conducted with CNA #3, regarding the process followed for providing incontinence care to a resident with a tube feeding running. CNA #3 stated she would ask the nurse to turn the feeding off and she would make sure the resident's head was not all the way flat during care. CNA #3 stated she would keep the HOB (head of bed) elevated.

On 7/27/17 at 2:11 p.m., an interview was conducted with CNA #7, the CNA who lowered Resident #7's head of bed during incontinence care. CNA #7 stated resident's with tube feeds should not have the head of the bed flat. When asked why residents who are on tube feedings should not have their HOB flat while the tube feeding is running or for an hour after their feeding has been completed, CNA #7 stated, "It

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can come up into their throat." CNA #7 stated she had made a mistake and forgot to keep his (Resident #7's) head elevated. CNA #7 stated she was nervous.

On 7/27/17 at 6:32 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing), and ASM #3, the corporate nurse were made aware of the above concerns. ASM #2 stated they (the facility) use their policy as a professional standard.

The facility policy titled, "Enteral Feeding- Safety precautions," documents in part, the following: "...Preventing aspiration...Always elevate the head of the bed (HOB) at least 30 degrees-45 degrees during the tube feed and at least 1 hour after. "

(1) "Percutaneous endoscopic gastrostomy tube - a tube placed in the stomach for the purpose of temporary or permanent nutrition." This information is taken from the website: https://medlineplus.gov/ency/article/002937.htm.

F 323 SS=D 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

(d) Accidents.
The facility must ensure that -

(1) The resident environment remains as free from accident hazards as is possible; and

(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or

F 323

F323
Corrective Action(s):
Resident #3's attending physician has been notified that facility staff failed to place her bed in the lowest position for safety after using the mechanical lift to transfer her from the bed. A facility incident and accident form has been completed for this incident.

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bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.

(1) Assess the resident for risk of entrapment from bed rails prior to installation.

(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide care and services to promote a safe environment free from accident hazards for three of 25 residents in the survey sample, Residents #3, #8, and #5.

1. The facility staff failed to maintain Resident #3's bed at a safe level off the floor. During multiple observations Resident #3 was observed in bed with the bed in an elevated position (approximately 3 1/2 feet off the floor).

2. The facility staff failed to implement interventions to protect Resident #8, and to prevent her from injuring other residents after an altercation with another resident on 8/11/16.

3. The facility staff failed to put interventions in place to keep Resident #5 safe from a resident who had kicked her on 8/11/16.

Resident #8's attending physician has reviewed Resident #8's medical record, medications and current plan of care for modifications to the current plan of care to assist with managing her aggressive behavior. A psychological consult has been ordered to assist with addressing resident #8's aggressive behaviors toward other residents. A facility incident and accident form has been completed for this incident.

Resident #5's attending physician has reviewed her medical record, medications and current plan of care to assist with preventing any future aggressive incidents with other residents. A psychological consult has been ordered to assist with addressing and preventing aggressive behaviors toward or from resident #5.

Identification of Deficient Practices/Corrective Action(s):
All other residents may have potentially been affected. The Administrator will review the last 60 days of Incidents & Accidents

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F 323	Continued From page 114 The findings include: 1. The facility staff failed to maintain Resident #3's bed at a safe level off the floor. During multiple observations Resident #3 was observed in bed with the bed in an elevated position (approximately 3 1/2 feet off the floor). Resident #3 was admitted to the facility on 6/23/10 and most recently readmitted on 11/12/15 with diagnoses including, but not limited to: rhabdomyolysis (1), arthritis, diabetes and dementia. On the most recent MDS (minimum data set), an annual assessment with the assessment reference date of 7/18/17, Resident #3 was coded as being moderately impaired for making daily decisions. She was coded as requiring the extensive assistance of two staff members for bed mobility. At the following times during the survey, Resident #3 was observed lying in her bed. On each of these occasions, the resident's bed was approximately 3 1/2 feet off the floor: 7/25/17 at 2:20 p.m. and 5:30 p.m.; 7/26/17 at 2:30 p.m.; and 7/27/17 at 8:40 a.m. and 2:20 p.m. A review of Resident #3's comprehensive care plan dated 12/14/16 revealed, in part, the following: "At risk for falls due to not being able to ambulate ...Call bell in reach. Up in w/c (wheelchair) daily. Encourage resident to ask for assistance. Re-educate staff on using [mechanical] lift with res (resident. Remind resident to ask for assistance if she can't reach something. Assist with transferring in and out of bed. [Mechanical] lift for transfers." On 7/27/17 at 2:20 p.m., CNA (certified nursing	F 323	forms to identify any residents at risk for aggressive behaviors. Any residents identified will have their medical record reviewed by their attending physician for any changes or revisions to the plan of care to prevent or redirect any further behavior. All staff was inserviced on the correct positioning of all beds when they are occupied by residents throughout the day and at nighttime. **Systemic Change(s):** The facility policy and procedure has been reviewed and no revisions are warranted at this time. The DON and/or regional nurse consultant will inservice all nursing staff on managing and monitoring of residents with aggressive behaviors as well as wandering behaviors. All staff was inserviced on the correct positioning of all beds when they are occupied by residents throughout the day and at nighttime	

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F 323	Continued From page 115	F 323	**Monitoring:** The DON and Administrator are responsible for monitoring compliance. The 24hour report will be reviewed each morning during the stand up meeting for any incidents of aggressive/abusive behavior. The Administrator and/or DON will investigation and follow up on all reports of inappropriate and/or aggressive/abusive behavior and report to the MD & RP and to the appropriate state agencies as required. The Unit Manager will perform daily inspections of all residents beds to monitor for compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these reviews will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** **9/11/17**	

assistant) #3 accompanied the surveyor to Resident #3's bedside. When asked if she observed anything unsafe for Resident #3, CNA #3 stated: "Oh yeah. The bed. We usually keep it at the lowest." When asked if the bed was at its lowest position, CNA #3 stated: "No, it can go a lot lower." When asked if she knew why the bed was at this high position off the floor, CNA #3 stated: "We use the [mechanical] lift on [Resident #3]. It's easier to use it if the bed is higher off the ground. We usually put it back." She added that Resident #3 is a low fall risk for falling out of the bed, but "it still is not the safest position for her."

On 7/27/17 at 6:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate nurse, were informed of these concerns.

On 7/28/17 at 9:25 a.m., LPN (licensed practical nurse) #1, the QA (quality assurance) nurse was interviewed. She stated she used to work the floor all the time, and now works the floor when needed. When asked what position a resident's bed should be kept off the floor, LPN #1 stated: "Unless there is a specific care concern, the resident's bed should always be left at the lowest position to the floor."

On 7/28/17 at 9:39 a.m., policies regarding safe bed height were requested.

No further information was provided prior to exit.

(1) "Rhabdomyolysis is the breakdown of muscle tissue that leads to the release of muscle fiber contents into the blood. These substances are harmful to the kidney and often cause kidney damage." This information was taken from the

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website
https://medlineplus.gov/ency/article/000473.htm.

According to Mosby's Textbook for Long-Term Care Assistants, fourth edition, 2003. Page 144, "Safety is a basic need. Nursing center residents are at great risk for falls and other accidents....You need to know the factors that increase a person's risk of accidents and injury."

2. The facility staff failed to implement interventions to protect Resident #8, and to prevent her from injuring other residents after an altercation with another resident on 8/11/16.

Resident #8 was admitted to the facility on 6/10/11 and most recently readmitted on 9/15/16 with diagnoses including, but not limited to: history of a stroke, dementia, depression and difficulty swallowing. On the most recent MDS (minimum data set), an annual assessment with the assessment reference date of 7/14/17, Resident #8 was coded as being severely cognitively impaired for making daily decisions. She was coded as not having received pain medications during the look back period.

During the time of the survey, Resident #8 was not observed demonstrating any behaviors toward any other residents or staff.

A review of Resident #8's nurses' notes revealed the following: 8/11/16 at 3:23 a.m. "S/P (status/post - after) aggressive behaviors towards another resident. No further episodes noted. Resting quietly in bed with resp (respirations) even and nonlabored. No unusual behaviors noted."

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A review of the facility's investigation of the incident mentioned above revealed that Resident #8 kicked another resident on 8/11/16. Further review of Resident #8's clinical record failed to reveal evidence that interventions were put into place to prevent Resident #8 from injuring others or to protect Resident #8 from retaliation by other residents.

A review of Resident #8's comprehensive care plan most recently updated 7/14/17 failed to reveal information related to the 8/11/16 incident.

On 7/27/17 at 11:00 a.m., LPN (licensed practical nurse) #6, the MDS nurse, was interviewed. She stated the social worker usually is responsible for any interventions necessary after a resident-to-resident incident related to behaviors. LPN #6 stated the facility social worker was currently on vacation.

On 7/27/17 at 4:05 p.m., LPN (licensed practical nurse) #7 (who wrote the 8/11/16 nurse's note referenced above) was interviewed. She stated she separated the residents involved in the altercation and wrote the nurse's note. She stated she was not certain what other interventions were put into place for Resident #8. LPN #7 stated: "[Resident #8] can be difficult."

On 7/27/17 at 6:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate nurse, were informed of these concerns.

On 7/28/17 at 9:25 a.m., LPN (licensed practical nurse) #1, the QA (quality assurance) nurse was interviewed. She stated she used to work the

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floor all the time, and now works the floor when needed. LPN #1 stated in the case of a resident to resident altercation, the most immediate concern is separating the residents and assessing both for injuries. Beyond this immediate action, she stated the incident should be documented in the nurses' notes and on an incident report. She stated resident to resident incidents are discussed at weekly risk meetings, and at those meetings, further interventions are discussed. LPN #1 stated the interventions should be documented clearly in the resident's care plan, and that the care plan should reflect that the incident occurred. LPN #1 stated the social worker is responsible for updating care plans for resident to resident altercations, and for documenting any new interventions put into place.

A review of the facility policy Resident-to-Resident Altercations revealed, in part, the following:
"Facility staff will monitor residents for aggressive/inappropriate behaviors towards other residents, family members, visitors and other staff. Occurrences of such incidents shall be promptly reported to the Nurse Supervisor, Director of Nursing Services, and to the Administrator. 2. If two residents are involved in an altercation, staff will:
a. Separate the residents, and institute measures to calm the situation;
b. Identify what happened, including what might have led to aggressive conduct on the part of one or more of the individuals involved in the altercation;
c. Notify each resident's representative and Attending physician of the incident;
d. Review the events with the Nursing Supervisor and Director of Nursing, including interventions to

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try to prevent additional incidents;
e. Consult with the Attending Physician to identify treatable conditions such as acute psychosis that may have caused or contributed to the problem;
f. Make any necessary changes in the care plan approaches to any or all of the involved individuals;
g. Document in the resident's clinical record all interventions and their effectiveness;
h. Consult psychiatric services as needed for assistance in assessing the resident, identifying causes, and developing a care plan for intervention and management as necessary or as may be recommended by the Attending physician or Interdisciplinary Planning team;
i. Complete an Report of Incident/Accident form and document the incident. findings, and any corrective measures taken in the resident's medical/clinical record.;
j. If, after carefully evaluating the situation, it is determined that care cannot be readily given within the facility, transfer the resident; and
k. Report incidents, findings, and corrective measures to appropriate state agencies as outlined in our facility's abuse reporting policy."

No further information was presented prior to exit.

3. The facility staff failed to put interventions in place to keep Resident #5 safe from a resident who had kicked her on 8/11/16.

Resident #5 was admitted to the facility on 9/14/13 with diagnoses that included but were not limited to Alzheimer's disease, age-related osteoporosis, and dementia with behavioral disturbance. Resident #5's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference

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date) of 6/28/17. Resident #5 was coded as being severely cognitively impaired in the ability to make daily decisions scoring 00 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #5 was coded as requiring total dependence on two staff members with bed mobility, transfers, toileting, and personal hygiene; and total dependence on one staff member with dressing, and eating.

Review of Resident #5's nursing notes revealed the following note dated 8/11/16 at 1:38 a.m. that documented the following: "S/P (status post) recipient (sic) by another resident kicked in L (left shin), no unusual bruising noted, no s/s (signs/symptoms) pain or discomfort, Moved LLE (left lower extremity) without difficulty. Noted awake at times shaking grab bars, no s/s of distress/discomfort noted. VS (vital signs) -97.1 (temperature) -76 (pulse)- 20 (respirations)- 139/77 (blood pressure), SPO2 (oxygen saturation) 98 % RA (room air)." No additional nursing notes could be found regarding the incident.

Review of Resident #5's care plans dated 6/29/16 and 8/19/16 failed to reveal that the care plan was reviewed or revised after this incident.

Review of Resident #5's incident report dated 8/11/16, did not evidence any interventions to keep the resident safe from the resident who kicked her.

On 7/26/17 at 9:30 a.m., an interview was conducted with LPN (licensed practical nurse) #6, the MDS coordinator. When asked the purpose of the comprehensive care plan, LPN #6 stated that the purpose of the care plan was to guide

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patient care, problems, and how to take care of problems. When asked who had access to the comprehensive care plan, LPN #6 stated nurses and nurse management had access to the care plan. When asked when the comprehensive care plan would be updated, LPN #6 stated that the care plan would be updated for things such as falls, acute illnesses, skin related issues such as bruises, pressure sores or skin tears, etc. When asked if the comprehensive care plan would be updated for a resident to resident altercation, LPN #6 stated that the social worker would make a behavior care plan for the aggressor, or they would update the care plan for the victim of the resident to resident altercation if there was an injury. When asked how nursing staff are keeping Resident #5 safe from the resident who kicked her on 8/11/16, LPN #6 stated, "Well we know (Name of aggressor) gets agitated very quickly. We would tell nursing staff verbally to keep them separated. We let the staff know so we can be prepared." When asked how a new nurse would know to keep the two residents separated if it is not documented on Resident #5's care plan, LPN #6 stated that she wasn't sure, that she would hope a nurse would inform this new nurse. LPN #6 stated the social worker was currently on vacation and could not be reached for an interview. LPN #6 confirmed that she could not find a care plan regarding the resident to resident altercation for Resident #5.

On 7/27/17 at 9:35 a.m., an interview was conducted with LPN #1, the QA (quality assurance) nurse. When asked about the process followed for a resident to resident altercation, LPN #1 stated that typically the residents would be separated and then assessed

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for injuries. LPN #1 stated if the residents were in the right state of mind and cognitively intact, she would educate the residents on appropriate behavior at the facility. LPN #1 stated an incident report would be completed and notification of both residents' responsible parties and the physician would be notified. LPN #1 stated that the incident would be discussed in the weekly risk management meetings to determine if additional interventions would be appropriate such as a psych (psychiatric) consult. LPN #1 stated both (resident) care plans (the victim and the aggressor) should be updated to reflect the incident and the intervention put into place to prevent future altercations. LPN #1 stated the nursing notes should also reflect the incident and any follow up monitoring. LPN #1 stated social services usually updates the behavior care plan when a resident to resident altercation occurs. LPN #1 stated that the MDS coordinator can also update the care plan.

On 7/27/17 at 6:32 p.m., ASM (administrator staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the corporate nurse were made aware of the above findings. Evidence that interventions were in place to keep Resident #5 safe from the resident who had kicked her could not be provided.

No further information was presented prior to exit.

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

F 329

F 329
Corrective Action(s):
Resident #3's attending physician was notified that resident #3 received Ativan on 3 occasions in

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F 329	Continued From page 123 drug when used– (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that– (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to ensure	F 329	June and July 2017 without first attempting non-pharmacological interventions. Resident #3's physician reviewed resident #3's medication orders and no adjustments were needed. A facility Incident & Accident form and a medication error form was completed for this incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents receiving anti-anxiety medications may have been potentially affected. The DON, Unit Manager and/or Pharmacy consultant will review the medication orders of all residents to ensure that no unnecessary medications or duplicate medication therapy has been ordered and that non-pharmacological interventions are attempted prior to administering PRN anti-anxiety medications. Any/all negative findings will be communicated to the attending physicians for corrective action. A Facility Incident & Accident form	

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the drug regimen for one of 25 residents in the survey sample, (Resident #3), was free from unnecessary drugs.

The facility staff administered as needed Lorazepam (Ativan (1)) to Resident #3 on three occasions during June and July 2017 without first attempting nonpharmacological interventions.

The findings include:

Resident #3 was admitted to the facility on 6/23/10 and most recently readmitted on 11/12/15 with diagnoses including, but not limited to: rhabdomyolysis (2), arthritis, diabetes and dementia. On the most recent MDS (minimum data set), an annual assessment with the assessment reference date of 7/18/17, Resident #3 was coded as being moderately impaired for making daily decisions. She was coded as not having received anti-anxiety medications during the look back period.

A review of Resident #3's clinical record revealed the following order, written 4/5/17 and most recently signed by the physician on 7/24/17: "Ativan 0.5 mg (milligram) tablet. Take 1 tab (tablet) po (by mouth) q6 hours (every six hours) prn (as needed). Dx (diagnosis) anxiety."

A review of Resident #3's MARs (medication administration records), MAR notes, and nurses' notes revealed that Resident #3 was administered Ativan as follows: 6/20/17, 7/3/17, and 7/19/17. According to the documentation, the facility nurse did not attempt non-pharmacological interventions prior to administering Ativan to Resident #3 on each of the occasions listed above.

will be completed for each negative finding.

Systemic Change(s):
The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. All nursing staff will be inserviced by the DON and/or regional nurse consultant and issued a copy of the facility policy and procedure for proper administration and monitoring of all medications. This includes attempting non-pharmacological interventions prior to administration of PRN anti-anxiety medication.

Monitoring:
The DON is responsible for maintaining compliance. The DON, Unit Manager and/or designee will complete weekly physician orders and MAR audits coinciding with the Care plan calendar to monitor compliance. All negative findings will be corrected immediately and appropriate disciplinary action will be taken as necessary. Aggregate findings of these audits

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A review of Resident #3's comprehensive care plan dated 12/14/16 revealed, in part, 1he following: "Potentially at risk for periods of anxiety and depression: Praise resident for demonstrating desired behavior. Encourage resident to verbalize through one-to-one interactions. Provide emotional support to resident when needed. Encourage resident to attend activities of interest. Administer medications as ordered."

On 7/27/17 at 6:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate nurse, were informed of these concerns.

On 7/28/17 at 9:25 a.m., LPN (licensed practical nurse) #1, 1he QA (quality assurance) nurse was interviewed. She stated she used to work the floor all the time, and now works the floor when needed. LPN #1 stated she would "always" try other interventions before giving a resident an as-needed dose of Ativan. She stated she would attempt interventions such as redirection, offering an activity, offering a snack, or sitting with the resident to give her some one-on-one attention. When asked if she would document these interventions, LPN #1 stated: "Yes. If it's not documented, it's not done. You have to document for the Ativan." When asked to review Resident #3's medication administration records as indicated above, LPN #1 stated she did not see evidence that the nurse attempted non-pharmacological interventions prior to administering the Ativan to Resident #3.

No further information was provided prior to exit.

will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.

Completion Date: 9/11/17

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F 329	Continued From page 126 (1) "Lorazepam is used to relieve anxiety. Lorazepam is in a class of medications called benzodiazepines. It works by slowing activity in the brain to allow for relaxation." This information is taken from the National Institutes of Health website https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682053.html. (2) "Rhabdomyolysis is the breakdown of muscle tissue that leads to the release of muscle fiber contents into the blood. These substances are harmful to the kidney and often cause kidney damage." This information was taken from the website https://medlineplus.gov/ency/article/000473.htm.	F 329		
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (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 observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to administer medications in a manner to prevent a medication error rate greater than 5% for one of four residents in the medication administration observation, Resident #21. The staff made two errors out of 31 opportunities. The medication error rate was 6.5%. On 7/26/17, the facility staff failed to administer Gabapentin (1) with breakfast, as ordered by the	F 332	**F332** **Corrective Action(s):** Resident #21 involved in Medication Pass Observation has had their attending physicians notified of the medication errors that occurred. LPN #4 involved in the medication pass observation has received one-on-one inservice training on medication administration and the 5 rights of medication administration. A facility Incident & Accident form was completed for each medication error.	

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F 332	Continued From page 127	F 332	**Identification of Deficient Practices & Corrective Actions(s):**	

physician. The facility staff failed to have Resident #21, rinse her mouth with water and spit after administering Spiriva (2).

The findings include:

Resident #21 was admitted to the facility on 6/7/17 and most recently readmitted on 7/12/17 with diagnoses including, but not limited to: diabetes, COPD (chronic obstructive pulmonary disease (3)), and heart failure. On the most recent MDS (minimum data set), a significant change assessment with the assessment reference date of 7/19/17, Resident #21 was coded as having no cognitive impairment for making daily decisions.

On 7/26/17 at 8:50 a.m., LPN (licensed practical nurse) #4 was observed administering the following medications to Resident #21. At the time of the medication administration, Resident #21 was sitting in the chair beside her bed. She stated she had been to the dining room, eaten breakfast, and had already returned to her room:
- Aspirin (4) 81 mg (milligrams)
- Iron (5) 325 mg
- Folic Acid (6) 1 mg
- Multivitamin (7)
- Vitamin B-12 (8) 500 mcg (micrograms)
- Gabapentin 300 mg
- Amiodarone (9) 200 mg
- Diltiazem ER (extended release) (10) 240 mg
- Metolazone (11) 2.5 mg
- Paroxetine (12) 40 mg
- Spiriva 2.5 mcg inhaler
- Breo Ellipta (13) inhaler
- Lasix (14) 80 mg

After LPN #4 administered two puffs of Spiriva to

All residents may have potentially been affected. A 100% medication pass audit of all licensed nurses within the facility will be conducted to identify those nurses at risk for Medication Administration and/or technique errors. A facility Incident & Accident form will be completed for each negative finding as well as one-on-one inservice training and appropriate disciplinary action if warranted for nursing staff observed.

Systemic Change(s):
The facility Policy and Procedure for medication administration and has been reviewed and no changes are warranted at this time. All Licensed nursing staff will be inserviced by the DON or ADON on the facility policy and procedure for medication administration. Inservices will include administering medication per physician order and the 5 rights of medication administration and

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Resident #21, she immediately administered one puff of Breo Ellipta. LPN #4 did not instruct Resident #21 to rinse her mouth and spit after the Spiriva.

A review of the physician's orders for Resident #21 revealed, in part, the following:
- "Gabapentin 300 mg capsule - One cap by mouth every morning with breakfast." This order was written 7/12/17 and signed by the physician on 7/24/17.
- "Spiriva Respimat 2.5 mcg INH Inhale 2 puffs into lungs QD (daily). Dx (diagnosis) COPD. Rinse mouth after." This order was written 7/12/17 and signed by the physician on 7/24/17.

A review of the manufacturer's instructions for Spiriva Respimat revealed, in part, the following: "After administration, instruct patient to dispose of the used capsule prior to storing the inhaler and to rinse mouth with water to minimize dry mouth."

A review of Resident #21's comprehensive care plan dated 7/25/17 revealed, in part, the following: "Medication per order."

On 7/16/17 at 1:05 p.m., LPN #4 was interviewed. When asked to check Resident #21's order for Gabapentin, she pulled the order up on the computer. LPN #4 read the order and stated: "No. I guess I didn't give it with breakfast. She already had breakfast. I guess I should have given it to her when she was going to the dining room." When asked to check Resident #21's order for Spiriva, she pulled the order up on the computer. When asked if she followed the order, LPN #4 stated she did. When asked if she remembered whether or not she had asked Resident #21 to rise her mouth after the Spiriva

proper procedure to be followed when administering inhalers.

Monitoring:
The Director of Nursing is responsible for maintaining compliance. The DON, Unit Manager and/or designee will conduct two random weekly medication pass observations of licensed nurses to monitor for compliance. Any negatives findings will be addressed at the time of discovery and appropriate disciplinary action will be taken. All discrepancies found in these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.

Completion Date: **9/11/17**

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inhalation, LPN #4 stated: "Oh, no. I didn't. I thought it would be enough to just rinse it once after all the inhalers. I didn't know I had to have her rinse her mouth after each [inhaler]."

On 7/27/17 at 6:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate nurse, were informed of these concerns.

A review of the facility policy "Medication and Treatment Orders" revealed, in part, the following: "Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state."

No further information was provided prior to exit.

(1) "Gabapentin capsules, tablets, and oral solution are used to help control certain types of seizures in people who have epilepsy. Gabapentin capsules, tablets, and oral solution are also used to relieve the pain of postherpetic neuralgia (PHN; the burning, stabbing pain or aches that may last for months or years after an attack of shingles)." This information is taken from the website https://medlineplus.gov/druginfo/meds/a694007.html.

(2) "Tiotropium (Spiriva) is used to prevent wheezing, shortness of breath, coughing, and chest tightness in patients with chronic obstructive pulmonary disease (COPD, a group of diseases that affect the lungs and airways) such as chronic bronchitis (swelling of the air passages that lead to the lungs) and emphysema (damage to air sacs in the lungs)." This information is

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taken from the website https://medlineplus.gov/druginfo/meds/a604018.html.

(3) "COPD, or chronic obstructive pulmonary (PULL-mun-ary) disease, is a progressive disease that makes it hard to breathe."Progressive" means the disease gets worse over time." This information is taken from the website http://www.nhlbi.nih.gov/health/health-topics/topics/copd.

(4) "Prescription aspirin is used to relieve the symptoms of rheumatoid arthritis (arthritis caused by swelling of the lining of the joints), osteoarthritis (arthritis caused by breakdown of the lining of the joints), systemic lupus erythematosus (condition in which the immune system attacks the joints and organs and causes pain and swelling) and certain other rheumatologic conditions (conditions in which the immune system attacks parts of the body). Nonprescription aspirin is used to reduce fever and to relieve mild to moderate pain from headaches, menstrual periods, arthritis, colds, toothaches, and muscle aches. Nonprescription aspirin is also used to prevent heart attacks in people who have had a heart attack in the past or who have angina (chest pain that occurs when the heart does not get enough oxygen). Nonprescription aspirin is also used to reduce the risk of death in people who are experiencing or who have recently experienced a heart attack. Nonprescription aspirin is also used to prevent ischemic strokes (strokes that occur when a blood clot blocks the flow of blood to the brain) or mini-strokes (strokes that occur when the flow of blood to the brain is blocked for a short time) in

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people who have had this type of stroke or mini-stroke in the past." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682878.html.

(5) "Iron is a mineral that our bodies need for many functions. For example, iron is part of hemoglobin, a protein which carries oxygen from our lungs throughout our bodies. It helps our muscles store and use oxygen. Iron is also part of many other proteins and enzymes." This information is taken from the website https://medlineplus.gov/iron.html.

(6) "Folic acid is a B vitamin. It helps the body make healthy new cells. Everyone needs folic acid. For women who may get pregnant, it is really important. Getting enough folic acid before and during pregnancy can prevent major birth defects of her baby's brain or spine." This information was taken from the website https://medlineplus.gov/folicacid.html.

(7) "Dietary supplements are vitamins, minerals, herbs, and many other products. They can come as pills, capsules, powders, drinks, and energy bars. Supplements do not have to go through the testing that drugs do. Some supplements can play an important role in health. For example, calcium and vitamin D are important for keeping bones strong. Pregnant women can take the vitamin folic acid to prevent certain birth defects in their babies." This information was taken from the website https://medlineplus.gov/dietarysupplements.html.

(8) "Vitamin B12, like the other B vitamins, is important for protein metabolism. It helps in the

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formation of red blood cells and in the maintenance of the central nervous system." This information is taken from the website https://medlineplus.gov/ency/article/002403.htm.

(9) "Amiodarone is used to treat and prevent certain types of serious, life-threatening ventricular arrhythmias (a certain type of abnormal heart rhythm when other medications did not help or could not be tolerated. Amiodarone is in a class of medications called antiarrhythmics. It works by relaxing overactive heart muscles." This information is taken from the website https://medlineplus.gov/druginfo/meds/a687009.html.

(10) "Diltiazem is used to treat high blood pressure and to control angina (chest pain). Diltiazem is in a class of medications called calcium-channel blockers. It works by relaxing the blood vessels so the heart does not have to pump as hard. It also increases the supply of blood and oxygen to the heart." This information was taken from the website https://medlineplus.gov/druginfo/meds/a684027.html.

(11) "Metolazone is used to reduce the swelling and fluid retention caused by heart failure or kidney disease. It also is used alone or with other medications to treat high blood pressure. Metolazone is in a class of medications called diuretics ('water pills'). It causes the kidneys to reduce the amount of water and salt in the body by increasing the amount of urine." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682345.html.

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(12) "Paroxetine tablets, suspension (liquid), and extended-release (long-acting) tablets are used to treat depression, panic disorder (sudden, unexpected attacks of extreme fear and worry about these attacks), and social anxiety disorder (extreme fear of interacting with others or performing in front of others that interferes with normal life). Paroxetine tablets and suspension are also used to treat obsessive-compulsive disorder (bothersome thoughts that won't go away and the need to perform certain actions over and over), generalized anxiety disorder (GAD; excessive worrying that is difficult to control), and posttraumatic stress disorder (disturbing psychological symptoms that develop after a frightening experience)." This information is taken from the website https://medlineplus.gov/druginfo/meds/a698032.html.

(13) "The combination of fluticasone and vilanterol (Breo Ellipta) is used to control wheezing, shortness of breath, coughing, and chest tightness caused by chronic obstructive pulmonary (COPD; a group of diseases that affect the lungs and airways, that includes chronic bronchitis and emphysema). Fluticasone is in a class of medications called steroids. It works by reducing swelling in the airways. Vilanterol is in a class of medications called long-acting beta-agonists (LABAs). It works by relaxing and opening air passages in the lungs, making it easier to breathe." This information is taken from the website https://medlineplus.gov/druginfo/meds/a613037.html.

(14) "Furosemide (Lasix) is used alone or in

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F 332	Continued From page 134 combination with other medications to treat high blood pressure. Furosemide is used to treat edema (fluid retention; excess fluid held in body tissues) caused by various medical problems, including heart, kidney, and liver disease. Furosemide is in a class of medications called diuretics ('water pills'). It works by causing the kidneys to get rid of unneeded water and salt from the body into the urine." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682858.html. In Fundamentals of Nursing, 6th edition, 2005, Patricia A. Potter and Anne Griffin Perry, Mosby, Inc; Page 419: "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."	F 332		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 371	**F 371** **Corrective Action(s):** 1. The other staff member #2 involved in the observation of the coffee preparation has been inserviced on the proper use of a hair net anytime they enter the kitchen food preparation area. A facility Incident and Accident form was completed for this incident. 2. Other Staff members #4 & #5 involved in the tray line observation obtaining and serving	

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F 371	Continued From page 135 (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that the facility failed to prepare and serve food in a safe, sanitary manner. 1. The facility staff failed to wear a hair net in a food preparation area. 2. The facility staff failed to obtain temperatures of multiple food items before serving the items to residents. 3. The facility staff failed use serving utensils to serve bread to residents. The facility staff used contaminated gloved hands to serve bread. Only one resident in the entire facility was receiving tube feeding for the majority of his nutrition. The findings include: 1. On 7/26/17 at 7:15 a.m., observation of coffee preparation was conducted in the kitchen. The coffee maker was positioned adjacent to the door between the kitchen and the dining room. Four freshly-poured, open carafes of hot coffee were on a cart next to the door to the dining room. OSM (other staff member) #2, the receptionist, entered the kitchen through the dining room	F 371	food without taking temperatures have received one-on-one inservice training regarding the proper procedure to obtaining and recording temperatures prior to serving food from the kitchen. A facility Incident and Accident form was completed for this incident. 3. Other Staff members #4 & #5 involved in the tray line observation obtaining and serving food without changing gloves after touching steam table and microwave have received one-on-one inservice training regarding the proper procedure to preparing and serving food from the kitchen in a sanitary fashion. A facility Incident and Accident form was completed for this incident **Identification of Deficient Practices & Corrective Action(s):** All other residents may have been potentially affected. The Food Service Manager, and/or Registered Dietician will randomly monitor the kitchen preparation area before, during	

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doors. She was not wearing a hair net. She approached the coffee maker, poured a cup of coffee into a mug she had brought into the kitchen, and left.

On 7/26/17 at 8:35 a.m., OSM #2 was interviewed. When asked if it is her practice to go into the kitchen while coffee is being poured for resident carafes, OSM #2 stated: "I always go in and pour myself some coffee. But the carafes are not normally there. The carafes are usually already on the carts." When asked if she ever wears a hair net when she enters the kitchen, OSM #2 stated: "No. We have an area we can go in and not have to put on a hair net. We have to stay in our little box." When asked if she should have worn a hair net when she saw the open carafes of coffee, OSM #2 stated she should have.

On 7/27/17 at 9:40 a.m., OSM #1, the dietary manager, was interviewed. She stated OSM #2 should have put on a hair net when she entered the kitchen and observed the open coffee carafes in the area. OSM #1 stated: "I explained it to her. The lids were not on the carafes. She (OSM #2) should have put on a hair net."

A review of the facility policy "Safety and Sanitation" revealed, in part, the following: "The following rules will apply to dietary safety operations: Personal Hygiene: Hair nets and/or caps should be worn."

On 7/27/17 at 6:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate nurse, were informed of these concerns.

and after meals to identify any negative findings. Any negative findings will be corrected and time of discovering and disciplinary action will be taken as need. A facility Incident and Accident form will be completed for each negative finding identified.

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Systemic Change(s):
Current facility policy & procedure has been reviewed and no changes are warranted at this time. The CDM and dietary staff on the proper sanitation, storage, cleaning and transportation of dietary products per established policy and procedure. In addition the inservice will cover the procedure for proper hair/beard net application at all times while in the kitchen area. The inservice will include all aspects of infection & sanitation control measures.

Monitoring:
The Dietary Manager is responsible for maintaining compliance. The Dietary manager

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F 371	Continued From page 137 No further information was provided prior to exit. 2. On 7/26/17 at 11:35 a.m., observation was made of the tray line service for resident lunches. On four occasions, OSM (other staff member) #5, a cook, was observed obtaining a grilled cheese sandwich from a pan containing multiple sandwiches and placing it on a resident's lunch tray without first obtaining the temperature of the sandwich. On 7/26/17 at 4:55 p.m., OSM #4, a cook, was observed serving residents, four individual serving bowls of leftover vegetables which had been spooned into the bowls ahead of time and microwaved at the time of service. OSM #4 did not obtain the reheated temperature of any of the bowls of vegetables prior to serving them. On 7/26/17 at 1:15 p.m., OSM #5 was interviewed. When asked if all foods served to residents should be assessed for temperature before being served, OSM #5 stated: "Yes." When asked if she remembered serving any foods without obtaining temperatures at lunch, she stated she could not remember doing so. When asked if she took the temperatures of the grilled cheese sandwiches before serving them to residents, OSM #5 stated: "Oh my goodness. No. I did not. I didn't even think of it." On 7/27/17 at 9:40 a.m., OSM #1, the dietary manager, was interviewed. When asked which foods required temperature taking before being served, OSM #1 stated: "All perishable food." When informed of the above observations of the grilled cheese sandwiches and the individual leftover vegetable bowls, OSM #1 stated: "They	F 371	will complete the Dietary Food preperation tool daily to monitor for compliance. Any negative findings will be corrected at time of discovery and disciplinary action will be taken as warranted. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** **9/11/17**	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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all should have had temperatures taken before being served."

A review of the facility policy "Food Temperatures" revealed, in part, the following: "Food temperatures will be obtained and recorded prior to meal service, and any inappropriate temperatures will be corrected to ensure proper serving temperature. Using a food thermometer, obtain final temperatures for all menu items, hot and cold, prior to serving."

A review of the facility policy "Reheating Foods" revealed, in part, the following: "All leftovers will be reheated in a safe and sanitary manner to maintain food quality...Bring all leftovers quickly to temperature of 165 degrees throughout item."

On 7/27/17 at 6:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate nurse, were informed of these concerns.

No further information was provided prior to exit.

3. On 7/26/17 at 11:35 a.m., observation was made of the tray line service for resident lunches. On multiple occasions, OSM (other staff member) #5 was observed touching the steam table, microwave handle, and various serving utensils with her gloved hands. She used her gloved hands to directly serve rolls to residents in between touching these other surfaces.

On 7/26/17 at 4:55 p.m., OSM #4, a cook, was observed touching the steam table, microwave handle, and various serving utensils with her gloved hands. She used her gloved hands to directly serve rolls to residents in between

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touching these other surfaces.

On 7/26/17 at 1:15 p.m., OSM #5 was interviewed. When asked the most sanitary method to serve individual rolls to residents, OSM #5 stated: "I think you can wear gloves." When asked if she remembered touching any other objects with gloved hands in between placing rolls on resident trays, OSM #5 stated: "Well, yes, I guess I did. It would probably be better to use some tongs."

On 7/27/17 at 9:40 a.m., OSM #1, the dietary manager, was interviewed. When asked if facility staff members should use gloved hands to directly serve rolls on resident trays, OSM #1 stated: "No. They should be using tongs."

A review of the facility policy "Glove Use" revealed, in part, the following: "Proper utensils will be used for food handling...Change gloves whenever you change an activity, the type of food being worked with, or whenever you leave the work station."

On 7/27/17 at 6:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate nurse, were informed of these concerns.

No further information was provided prior to exit.

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

(a) Infection prevention and control program.

The facility must establish an infection prevention and control program (IPCP) that must include, at

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F 441
Corrective Action(s):
Resident #1 has had their torn wheelchair seat cushion replaced. Resident #7 has had their torn and cracked wheelchair arm rests

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(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEOED BY FULL REGULATDRY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PRDVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEO TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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a minimum, the following elements:

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions 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.

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replaced. A facility Incident & Accident form has been completed for each of these incidents.

The attending physician for Residents #1 was notified that the facility failed to administer a dietary supplement in a sanitary way. A facility Incident & Accident form has been completed for this incident.

The attending physician for Resident #7 was notified that a staff nurse touched the resident's medications prior to administration. A facility Incident & Accident form has been completed for each of this incident.

The air gap for the ice machine in the kitchen was corrected to maintain a one inch gap between the drain pipe and the waste water drain. A facility Incident & Accident form has been completed for each of this incident.

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F 441	Continued From page 141	F 441	The 100 Hall Shower room has been deep cleaned and sanitized to include the shower floor. A facility Incident & Accident form has been completed for each of this incident.	

(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, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain infection control practices for two of 25 residents in the survey sample, (Residents #1 and #7); and failed to maintain infection control practices to prevent the spread of infection for two of four residents in the medication administration observation (Residents #1 and #7), and for one of two facility ice machines (the kitchen ice machine), and for one of two facility shower rooms (the shower room on the 100 hall).

1. The facility staff failed to maintain Resident #1's wheelchair cushion free from torn areas, exposing foam that was unable to be sanitized.

Identification of Deficient Practice(s) and Corrective Action(s):
All residents may have the potential to be affected by improper infection control and hand washing techniques. The DON and/or Unit Manager will conduct medication pass audits on all licensed staff to observe proper infection control practices and proper hand washing during medication administration procedures.
A 100% audit of all resident wheelchairs, Ice Machines and shower rooms will be completed to ensure that all equipment and rooms are in a clean, sanitary working order. Any negative findings will be addressed immediately and a facility Incident and Accident form will

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2. The facility staff failed to maintain Resident #7's wheelchair armrests free from torn areas, exposing foam that was unable to be sanitized.

3. The facility staff nurse administered a dietary supplement to Resident #1 after the nurse had touched the liquid supplement with her gloved finger.

4. The facility staff nurse placed her fingers inside the medication cups and the pouches containing crushed medications prior to administering the medications to Resident #7.

5. The facility staff failed to maintain a one inch air gap between the 1/2 inch diameter drain pipe and waste water drain in the ice machine in the kitchen.

6. The facility staff failed to clean the shower room floors (of the shower room located on the 100 unit hall) after a resident who was given a shower was incontinent of feces. Resident #5 was showered with the feces on the bathroom floor from a previous resident.

The findings include:

1. The facility staff failed to maintain Resident #1's wheelchair cushion free from torn areas, exposing foam that was unable to be sanitized.

Resident #1 was admitted to the facility on 3/1/17. Resident #1's diagnoses included but were not limited to: diabetes, high blood pressure and anxiety disorder. Resident #1's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 5/2/17, coded the resident's cognition as

be completed for each negative finding.

Systemic Change(s):
The facility Infection Control policy and procedure has been reviewed and no changes are warranted at this time. The DON and/or Regional Nurse Consultant will inservice all staff on the infection Control Policy to include the standard for cleaning and sanitizing resident shower rooms, maintenance of Ice Machines with the proper Air gap, proper medication administration and hand washing and the proper care and maintenance of resident equipment to prevent the spread or infections.

Monitoring:
The Administrator and DON are responsible for maintaining compliance. The DON and/or designee will perform 2 random Medication pass audits to monitor for compliance with medication administration and supplement administration. Any negative findings will be corrected at the

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F 441	Continued From page 143 severely impaired. On 7/26/17 at 5:15 p.m. Resident #1 was observed sitting in a wheelchair in the dining room. The front left corner of Resident #1's wheelchair cushion was torn approximately one and a half inches and foam was exposed. The other corners of the cushion were not observed. On 7/27/17 at 8:36 a.m. Resident #1 was in the bathroom and the wheelchair was observed outside of the bathroom door. The front left corner of Resident #1's wheelchair cushion was torn approximately one and a half inches and foam was exposed; the front right corner of the cushion was torn approximately one half inch and foam was exposed. On 7/27/17 at 8:39 a.m. an interview was conducted with CNA (certified nursing assistant) #5. When asked who was responsible for ensuring wheelchairs and cushions are in good repair, CNA #5 stated all staff is responsible but night shift usually notices any issues. CNA #5 stated if anything is wrong then staff has to fill out a slip and turn it into the maintenance department. CNA #5 was shown Resident #1's wheelchair cushion. When asked if the cushion should contain the torn areas, CNA #5 stated, "No." CNA #5 stated Resident #1 used to have a different cushion and she thought the rehab (rehabilitation) department gave her a new one. When asked how the torn cushion could be properly cleaned, CNA #5 stated she would clean the cushion good with sanitizing wipes. When asked if that would be sufficient to kill germs since the cushion was torn with foam exposed, CNA #5 stated, "No." CNA #5 stated the cushion would have to be replaced.	F 441	time of discovery and disciplinary action taken as needed. The Administrator will perform bi-weekly facility rounds to monitor for compliance of cleaning shower rooms, that wheelchairs are in proper functional working order and that all Ice Machine Ice gaps are appropriate. Any negative findings will be corrected at time of discover. Aggregate findings of the reports will be submitted to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in the facility policy and procedure. **Compliance Date:** **9/11/17**	

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On 7/27/17 at 3:05 p.m. an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated the night shift staff is responsible for cleaning wheelchairs and should let the day shift employees know when there is an issue so the day shift staff can talk to the therapy staff who can order new cushions. When asked how it was possible to clean torn cushions to kill bacteria, LPN #5 stated, "It needs to be addressed." LPN #5 stated the cushion would get wet and would not be able to be properly cleaned.

On 7/27/17 at 6:32 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

The facility policy titled, "Policies and Practices-Infection Control" documented, "This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections..."

No further information was presented prior to exit.

2. The facility staff failed to maintain Resident #7's wheelchair armrests free from torn areas, exposing foam that was unable to be sanitized.

Resident #7 was admitted to the facility on 7/17/17. Resident #7's diagnoses included but were not limited to: stroke, high cholesterol and dementia (1). Resident #7 did not have a completed MDS (minimum data set). On his admission nursing assessment dated 7/17/17, he

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was documented as being "alert" and "confused."

On 7/25/17 at 2:45 p.m., 7/26/17 at 3:21 p.m. and 7/27/17 at 8:49 a.m. Resident #7 was observed lying in bed. The following was observed on the resident's wheelchair during the above dates/times:
-One torn area (approximately 0.5 inch [length] by 0.5 inch [width]) on the left armrest with foam exposed.
-One torn area (approximately 0.75 inch [length] by 1.25 inch [width]) on the right armrest with foam exposed.
-Another torn area (approximately 0.5 inch [length] by 1 inch [width]) on the right armrest with foam exposed.

On 7/27/17 at 8:39 a.m. an interview was conducted with CNA (certified nursing assistant) #5. When asked who was responsible for ensuring wheelchairs and cushions are in good repair, CNA #5 stated all staff is responsible but night shift usually notices any issues. CNA #5 stated if anything is wrong then staff has to fill out a slip and turn it into the maintenance department.

On 7/27/17 at 3:05 p.m. an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated the night shift staff is responsible for cleaning wheelchairs and should let the day shift employees know when there is an issue so the day shift staff can talk to the therapy staff who can order new arm rests. When asked how it is possible to clean torn wheelchair armrests to kill bacteria, LPN #5 stated, "It needs to be addressed." LPN #5 stated the armrests will get wet and will not be able to be properly cleaned. At this time, LPN #5 was asked to observe

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Resident #7's wheelchair armrests. During this observation, the right armrest was replaced and did not contain any torn areas. LPN #5 was asked to observe the left armrest. LPN #5 confirmed the armrest should not have been torn and stated, "They should fix that."

On 7/27/17 at 6:32 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

No further information was presented prior to exit.

(1) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dementia&_ga=2.205672787.1977489418.1501503571-139120270.1477942321

3. The facility staff nurse administered Med Pass (1), a dietary supplement to Resident #1 after the nurse had touched the liquid supplement with her gloved finger.

Resident #1 was admitted to the facility on 3/1/17. Resident #1's diagnoses included but were not limited to: diabetes, high blood pressure and anxiety disorder. Resident #1's most recent MDS (minimum data set), was a significant change in status assessment with an ARD (assessment reference date) of 5/2/17, and coded Resident

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#1's cognition as severely impaired.

On 7/25/17 at 4:00 p.m., LPN (licensed practical nurse) #3 was observed preparing to give Resident #1 a liquid dietary supplement, Med Pass. LPN #3 set four small (30 milliliter [ml] each) medication cups on top of the med (medication) cart. She poured 30 mls of Med Pass into each of the four medication cups. She checked the order on the computer. As she did this, one of her gloved fingers came into contact with the Med Pass in one of the cups. LPN #3 then poured the contents of all four small medication cups into a larger cup. She took the large cup of Med Pass in Resident #1's room, handed the cup to Resident #1, and Resident #1 drank all the Med Pass in the cup.

A review of the physician's orders for Resident #1 revealed the following order, written on 4/27/17 and most recently signed by the physician on 7/24/17: "Med Pass 120 cc (cubic centimeters/milliliters) po (by mouth) TID (three 1imes a day)."

On 7/26/17 at 4:25 p.m., LPN #3 was interviewed. When asked what should be done if a nurse's gloved finger comes in direct contact with a medication or dietary supplement she is preparing1o give a resident. LPN #3 stated: "It should be thrown out. You shouldn't give the resident anything you have touched." When asked if she remembered her gloved finger coming into contact with Resident #1's Med Pass on the previous afternoon, she stated she had no memory of this happening. LPN #3 stated: "If I had realized it, I would have thrown it away. Absolutely."

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F 441	Continued From page 148 On 7/27/17 at 6:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate nurse, were informed of these concerns. On 7/28/17 at 9:25 a.m., LPN #1, the QA (quality assurance) nurse was interviewed. She stated she used to work the floor all the time, and now works the floor when needed. When asked what should be done if a nurse's gloved finger comes into contact with any liquid medication/supplement poured for a resident, LPN #1 stated: "It should be thrown out. It is contaminated. You should discard and re-pour it." A review of the facility policy "Infection Control Guidelines for All Nursing Procedures" revealed no information related to disposal of medications/supplements contaminated by staff gloves. A review of the facility policy "Infection Control" revealed, in part, the following: "All personnel will be trained on our infection control policies and practices upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control. The depth of employee training shall be appropriate to the degree of direct resident contact and job responsibilities." No further information was provided prior to exit. (1) "Med Pass 2.0 Balanced Fortified Nutrition provides a convenient way to supplement calories and protein...Designed to be used as a medication pass drink (Unless milk or food is contraindicated with medication), delivers more	F 441		

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nutrition than water, juice or milk...Additional intake can mean weight maintenance or weight gain." This information is taken from the manufacturer's website https://www.medline.com/product/Med-Pass-20-Nutritional-Supplement/Oral-Supplements/Z05-PFt 0974.

4. The facility staff nurse placed her fingers inside the medication cups and the pouches containing crushed medications prior to administering the medications to Resident #7.

Resident #7 was admitted to the facility on 7/t7/t7. Resident #7's diagnoses included but were not limited to: stroke, high cholesterol and dementia. Resident #7 did not have a completed MDS (minimum data set). On his admission nursing assessment dated 7/t7/t7, he was documented as being "alert" and "confused."

On 7/26/t7 at 9:t5 a.m., LPN (licensed practical nurse) #5 was observed preparing the following medications for administration to Resident #7:
- Norvasc (3) 5 mg (milligrams)
- Atorvastatin (4) 80 mg
- Aspirin (5) 8t mg
- Finasteride (6) 5 mg
- Multivitamin (7)
- Sinemet t0-t00 mg (8)
- Tylenol 650 mg (9)

Each of these medications was in pill form. LPN #5 poured each individual medication listed above into a separate medication cup. Each time she touched the medication cups, she placed her finger inside the cup. She poured each medication into a separate small plastic pouch in order to crush the medication. As she pulled

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each individual pouch from the stack prior to placing the pill/s in the pouch, she touched the inside of each pouch with her finger. She crushed each pill and poured the contents from the pouch back into the medication cup. She mixed each pill with water, and administered the medication through the Resident's PEG tube.

A review of the physician's orders for Resident #7, signed by the physician on 7/18/17, revealed, in part, the following:
- "Amlodipine Besylate (Norvasc) 5 mg tab (tablet) give one tab via g-tube QD (daily).
- Atorvastatin 80 mg tablet give one tab via g-tube QD.
- Proscar (Finasteride) 5 mg tablet give one tab via g-tube QD.
- Carbidopa-Levo (Sinemet) 10-100 mg give via g-tube 5X (five times) a day.
- Aspirin 81 mg tablet give one tab via g-tube QD
- Multivitamin one tab QD."

On 7/27/17 at 6:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate nurse, were informed of these concerns.

On 7/28/17 at 9:25 a.m., LPN #1, the QA (quality assurance) nurse was interviewed. She stated she used to work the floor all the time, and now works the floor when needed. The surveyor demonstrated to LPN #1 how LPN #5 had placed her fingers in the medication cups and in the crushed pill pouches. When asked if this was an appropriate way to prepare medications for a resident, LPN #1 stated: "You just contaminated the med (medication) cups with your fingers. You can't do that. You can only touch the outside of the pill cups." LPN #1 stated: "It is never okay to

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put your fingers anywhere inside the pouches for the crushed pills, either before or after you have crushed the medicine." She stated both practices were infection control concerns.

A review of the facility policy "Infection Control Guidelines for All Nursing Procedures" revealed no information related to sanitary practices during medication administration.

A review of the facility policy "Infection Control" revealed, in part, the following: "All personnel will be trained on our infection control policies and practices upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control. The depth of employee training shall be appropriate to the degree of direct resident contact and job responsibilities."

No further information was provided prior to exit.

(2)"Percutaneous endoscopic gastrostomy tube - a tube placed in the stomach for the purpose of temporary or permanent nutrition." This information is taken from the website http://www.asge.org/patients/patients.aspx?id=394.

(3) "Amlodipine is used alone or in combination with other medications to treat high blood pressure and chest pain (angina). Amlodipine is in a class of medications called calcium channel blockers. It lowers blood pressure by relaxing the blood vessels so the heart does not have to pump as hard. It controls chest pain by increasing the supply of blood to the heart. If taken regularly, amlodipine controls chest pain, but it does not stop chest pain once it starts." This information is

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HERITAGE HALL FRONT ROYAL REVISED COPY	400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630

(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 APPRDPRIATE DEFICIENCY)	(X5) COMPLETION OATE
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taken from the website https://medlineplus.gov/druginfo/meds/a692044.html.

(4) "Atorvastatin is used together with diet, weight loss, and exercise to reduce the risk of heart attack and stroke and to decrease the chance that heart surgery will be needed in people who have heart disease or who are at risk of developing heart disease. Atorvastatin is also used to decrease the amount of fatty substances such as low-density lipoprotein (LDL) cholesterol ('bad cholesterol') and triglycerides in the blood and to increase the amount of high-density lipoprotein (HDL) cholesterol ('good cholesterol') in the blood." This information is taken from the website https://medlineplus.gov/druginfo/meds/a600045.html.

(5) "Prescription aspirin is used to relieve the symptoms of rheumatoid arthritis (arthritis caused by swelling of the lining of the joints), osteoarthritis (arthritis caused by breakdown of the lining of the joints), systemic lupus erythematosus (condition in which the immune system attacks the joints and organs and causes pain and swelling) and certain other rheumatologic conditions (conditions in which the immune system attacks parts of the body). Nonprescription aspirin is used to reduce fever and to relieve mild to moderate pain from headaches, menstrual periods, arthritis, colds, toothaches, and muscle aches. Nonprescription aspirin is also used to prevent heart attacks in people who have had a heart attack in the past or who have angina (chest pain that occurs when the heart does not get enough oxygen). Nonprescription aspirin is also used to reduce the

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risk of death in people who are experiencing or who have recently experienced a heart attack. Nonprescription aspirin is also used to prevent ischemic strokes (strokes that occur when a blood clot blocks the flow of blood to the brain) or mini-strokes (strokes that occur when the flow of blood to the brain is blocked for a short time) in people who have had this type of stroke or mini-stroke in the past." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682878.html.

(6) "Finasteride (Proscar) is used alone or in combination with another medication (doxazosin [Cardura]) to treat benign prostatic hypertrophy (BPH, enlargement of the prostate gland). Finasteride is used to treat symptoms of BPH such as frequent and difficult urination and may reduce the chance of acute urinary retention (sudden inability to urinate)." This information is taken from the website https://medlineplus.gov/druginfo/meds/a698016.html.

(7) "Dietary supplements are vitamins, minerals, herbs, and many other products. They can come as pills, capsules, powders, drinks, and energy bars. Supplements do not have to go through the testing that drugs do. Some supplements can play an important role in health. For example, calcium and vitamin D are important for keeping bones strong. Pregnant women can take the vitamin folic acid to prevent certain birth defects in their babies." This information was taken from the website https://medlineplus.gov/dietarysupplements.html.

(8) "The combination of levodopa and carbidopa

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(Sinemet) is used to treat the symptoms of Parkinson's disease and Parkinson's-like symptoms that may develop after encephalitis (swelling of the brain) or injury to the nervous system caused by carbon monoxide poisoning or manganese poisoning. Parkinson's symptoms, including tremors (shaking), stiffness, and slowness of movement, are caused by a lack of dopamine, a natural substance usually found in the brain." This information is taken from the website https://medlineplus.gov/druginfo/meds/a601068.html.

(9) "Acetaminophen is used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body." This information is taken from the website https://medlineplus.gov/druginfo/meds/a681004.html.

5. The facility staff failed to maintain a one inch air gap between the 1/2 inch diameter drain pipe and waste water drain in the ice machine in the kitchen.

On 7/25/17 at 11:40 a.m., observation was made of the facility kitchen. OSM (other staff member) #1, the dietary manager, accompanied the

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surveyors. The ice machine drain was observed. The drain pipe draining excess water from the machine was observed to be less than one inch from the floor drain. From a distance of two feet, the drain pipe appeared to be nearly in direct contact with the floor drain.

On 7/26/17 at 1:55 p.m., OSM #3, the maintenance director, accompanied the surveyor to observe the ice machine in the kitchen, and was interviewed. OSM #3 stated: "There is supposed to be a gap between the ice machine drain line and the floor drain. [The drain line] broke recently. I'm honestly not sure if it's correct now. I put a temporary pipe on here." OSM #3 stated the ice machine drain was "not at code right now." He stated the drain pipe should always be twice the amount of the diameter of the drain pipe off the floor. When asked how often he checks the ice machine drain, OSM #3 stated: "I check it monthly. I think I checked it mid-July. Since it's not a permanent fix, it's easy for it to get moved or hit." When asked why the distance between the drain pipe and the floor drain is important, OSM #3 stated: "In case there is a clog in the floor drain. You don't want dirty water to filter back into the ice machine."

On 7/27/17 at 6:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate nurse, were informed of these concerns.

On 7/28/17 at 12:10 p.m., ASM #1 provided the surveyor with a copy of the manufacturer's instructions for the ice machine. A review of these instructions revealed no information related to the required distance between the drain pipe and the floor drain.

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No further information was provided prior to exit.

According to the 2015 International Plumbing Code, Chapter 8, Section 802.2.1 Air gap: "The air gap between the indirect waste pipe and the floor level rim of the waste receptor shall not be less than twice the effective opening of the indirect waste pipe."
6. The facility staff failed to clean the shower room floors (of the shower room located on the 100 unit hall) after a resident who was given a shower was incontinent of feces. Resident #5 was showered with the feces on the bathroom floor from a previous resident.

On 7/26/17 at 3:00 p.m., an observation of the shower room located on the 100 hall was conducted with OSM (other staff member) #3, the maintenance director. Brown feces were observed in the drain and on the floor of the shower room. An Allevyn dressing [1] was also observed in the drain of the shower room. The shower room floor appeared to be wet.

On 7/26/17 at 3:00 p.m., an interview was conducted with OSM #3. When asked how often the shower rooms were cleaned, OSM #3 stated that he was not sure when the CNAs cleaned up the room. When asked what was in the drain, OSM #3 stated that it appeared to be feces in the drain. On 7/26/17 at approximately 3:03 p.m., CNA (certified nursing assistant) #10 walked into the shower room. When asked how often shower rooms were cleaned, OSM #10 stated that CNAs should be cleaning any mess after each resident uses the shower room. When asked the last time she was in the shower room, CNA #10 stated that her last shower given was at 10:25 that morning.

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CNA #10 stated that the dressing and feces were not in the drain at that time or after her shower. CNA #10 did not know who used the shower room last.

On 7/26/17 at 3:40 p.m., an interview was conducted with CNA #9, a 3-11 shift CNA. When asked who was responsible for cleaning the shower room, CNA #9 stated that CNAs are supposed to clean the shower room after each use. When asked if it was ever ok to leave feces and dressings in the shower drain, CNA #9 stated, "Absolutely not. No ma'am."

On 7/26/17 at approximately 4:00 p.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). ASM #2 stated, "I want to talk to you about the stuff that was left in the drain." ASM #2 stated the CNA who was assigned to Resident #5, was giving Resident #5 a shower when she became combative with the CNA. The CNA then decided to quickly get the resident back to her room safely before her behaviors escalated. ASM #2 stated that the CNA was on her way back to clean the bathroom when this writer had already observed the dressing and feces in the drain. When asked what time the CNA gave Resident #5 her shower, ASM #2 stated that she was not sure but Resident #5 was usually the last shower of the day shift.

On 7/26/17 at approximately 4:29 p.m., an interview was conducted with CNA #7, the CNA who gave Resident #5 her shower. When asked when she had given Resident #5 her shower, CNA #7 stated that she went into the shower room around 2:35 p.m. CNA #5 stated that she brought the resident back to her room around

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2:50-2:55 p.m. because the resident was becoming restless. CNA #5 stated, "I was getting ready to go back to the shower room when you all discovered my mess."

On 7/28/17 at 8:30 a.m., an interview was conducted with LPN (Licensed practical nurse) #10. When asked the process of giving a shower to a resident with a dressing in place, LPN #10 stated that if dressings get wet then the CNAs would alert the nurse and the nurse would re-dress the affected area. LPN #10 stated that allevyn dressings (the dressing that was in the drain) were able to get wet. LPN #10 stated that if the allevyn dressing were to come off during the shower, she would re-dress after the shower.

On 7/28/17 at 8:30 a.m., an interview was conducted with LPN (Licensed practical nurse) #10. When asked about the process for showering a resident with a dressing in place, LPN #10 stated if dressings get wet, then the CNAs would alert the nurse, and the nurse would re-dress the affected area. LPN #10 stated that allevyn dressings were able to get wet. LPN #10 stated if an allevyn dressing were to come off during a shower, she would re-dress (reapply a dressing) after the shower.

On 7/28/17 at approximately 10:54 a.m., further interview was conducted with CNA #7. When asked about the process followed for showering a resident with a dressing such as allevyn, CNA #7 stated that allevyn dressings can get wet and she would notify the nurse if the dressing were to come off during the shower. When asked about the process followed for showering an incontinent resident, CNA #7 stated CNA's were supposed to put a bucket underneath the shower chair in case

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the resident has an incontinent episode in the shower room. When asked if Resident #5 was incontinent, CNA #7 stated that she was. When asked if she had used a bucket underneath Resident #5 while giving her a shower on 7/26/17, CNA #7 stated, "I didn't use a bucket that day but she (Resident #5) did not have an incontinent episode in the shower with me. She doesn't usually go to the bathroom during showers." CNA #7 was asked where the feces observed in the shower drain came from, if Resident #5 did not have an incontinence episode. CNA #7 stated the feces, was on the floor and in the drain prior to her giving Resident #5 a shower. CNA #7 stated the dressing in the drain was from her (Resident #5) but not the feces. When CNA #7 was asked if she brought Resident #5 into the shower room with feces on the floor, CNA #7 confirmed the feces was on the floor when she brought Resident #5 into the shower room for her shower. CNA #7 could not recall who used the shower room prior to her.

Resident #5 was admitted to the facility on 9/14/13 with diagnoses that included but were not limited to Alzheimer's disease, age-related osteoporosis, and dementia with behavioral disturbance. Resident #5's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date of 6/28/17. Resident #5 was coded as being severely cognitively impaired in the ability to make daily decisions scoring 00 out of 15 on the BIMS (Brief Interview for Mental Status) exam.

On 7/28/17 at approximately 12 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the corporate nurse were

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made aware of the above findings.

The facility policy titled, "Infection Control" did not address the above concerns.

No further information was presented prior to exit.

[1] Allevyn dressing is waterproof and requires no secondary dressing, tape or bandages. It is able to conform to the most awkward body areas such as the sacrum, heels and elbows. It is suitable for use on a variety of exuding wounds and can be used in conjunction with a hydrogel for sloughy wounds. This information was obtained from the National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmed/8845677.

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F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 7/25/17 through 7/28/17. Corrections are required for compliance with the following with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 60 certified bed facility was 58 at the time of the survey. The survey sample consisted of 15 current resident reviews (Residents #1 through #14 and Resident #21) and ten closed record reviews (Residents #15 through #20 and Residents #22 through #25).	F 000	F 001 12 VAC 5-371-180 Infection Control Cross References to F-441 Cross Reference POC for F- 441 12 VAC 5-371-250 Resident Assessment and Care Planning Cross Reference to F-279 Cross Reference POC for F-279 12 VAC 5-371-220 Nursing Services Cross Reference to F-309 Cross Reference POC for F-309 12 VAC 5-371-220 Nurse Services Cross Reference to F-314 Cross Reference POC for F-314	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12VAC5-371-180. Infection control cross reference to F441 12VAC5-371-250. Resident assessment and care planning cross reference to F279 12VAC5-371-220. Nursing services cross reference to F309 12VAC5-371-220. Nursing services cross reference to F314 12VAC5-371-370. Maintenance and housekeeping cross reference to F252 12VAC5-371-250. Resident assessment and care planning Cross reference to F-278	F 001	12 VAC 5-371-370 Maintenance and Housekeeping Cross Reference to F-252 Cross Reference POC for F-252 12 VAC 371-250 Resident Assessment and Care Planning Cross Reference to F-278 Cross Reference POC for F-278 12 VAC 371-200B. Director of Nursing Cross Reference to F-281 Cross Reference POC for F-281 12 VAC 5-371-220A Nurse Services Cross Reference to F-323 Cross Reference POC for F-323 12 VAC 5-371-140 Policies and Procedures Cross Reference to F-329 Cross Reference POC for F-329 12 VAC 5-371-220B Nurse Services Cross Reference to F-332 Cross Reference POC for F-332	

LABORATORY OIRECTOR'S OR PROVIOER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 001	Continued From Page 1 12VAC5-371-200B. Director of Nursing Cross reference to F-281 12VAC5-371-220A. Nursing services. Cross reference to F-323 12VAC5-371-140. Policies and procedures Cross reference to F-329 12VAC5-371-220B. Nursing services. Cross reference to F-332 12VAC5-371-340. Dietary and food service program. Cross reference to F371 12VAC5-371-220. Nursing Services cross references to F157, F280 12VAC5-371-130B. Resident Rights cross references to F167, F157 12VAC5-371-110 B1, 2 cross references to F225 12VAC5-371-110 B1, 2, 3, cross references to F226 12VAC 5-371-200. Director of Nursing cross references to F282 12VAC5-371-140. Policies and Procedures cross references to F322.	F 001	12 VAC 5-371-340 Dietary and Food Services Program Cross Reference to F-371 Cross Reference POC for F-371 12 VAC 5-371-220 Nurse Services Cross Reference to F-157, F-280 Cross Reference POC for F-157 & F-280 12 VAC 5-371-130B Resident Rights Cross Reference to F-167, F-157 Cross Reference POC for F-167, F-157 12 VAC 5-371-110 B1, 2 Cross Reference to F-225 Cross Reference POC for F-225 12 VAC 5-371-110 B1, 2, 3 Cross Reference to F-226 Cross Reference POC for F-226 12 VAC 5-371-220 Director of Nursing Cross Reference to F-282 Cross Reference POC for F-282 12 VAC 5-371-140 Policies and Procedures Cross Reference to F-322 Cross Reference POC for F-322 Completion Date: 9/11/17	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 495301	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 7/28/2017

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F 278	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-

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

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

(2) Clinical disagreement does not constitute a material and false statement.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to complete an accurate MDS (minimum data set) assessment for one of 25 residents in the survey sample, Resident #8.

The facility staff inaccurately coded Resident #8's bathing status on the 7/14/17 annual MDS assessment.

The findings include:

Resident #8 was admitted to the facility on 6/10/11 and most recently readmitted on 9/15/16 with diagnoses including, but not limited to: history of a stroke, dementia, depression and difficulty swallowing. On the most recent MDS (minimum data set), an annual assessment with the assessment reference date of 7/14/17, Resident #8 was coded as being severely cognitively impaired for making daily decisions. She was coded as not having a bath of any kind during the look back period.

A review of Resident #8's ADL (activities of daily living) record during the seven day look back period for the 7/14/17 MDS assessment, revealed that she received a sponge bath in bed on 7/12/17.

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	Continued From Page 1 On 7/28/17 at 9:25 a.m., LPN (licensed practical nurse) #1, the QA (quality assurance) nurse was interviewed. LPN #1 stated she had helped to complete the above referenced MDS assessment for Resident #8. When shown Resident #8's ADL records for 7/12/17 and the coding for bathing on the 7/14/17 MDS assessment, LPN #1 stated: "Oh that is my mistake. Actually, it is the computer's mistake. The computer pre-populates those areas so I don't normally go back and re-check them. I'm not sure how this mistake was made." A review of the facility policy "Resident Assessment Instrument" revealed, in part, the following: "The purpose of the assessment is to describe the resident's capability to perform daily life functions and to identify significant impairment in functional capacity. Information derived from the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practicable level of functioning." On 7/27/17 at 6:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the corporate nurse, were informed of these concerns. No further information was provided prior to exit.