STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495266	A. BUILDING _____ B. WING _____	02/23/2017

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HANOVER HEALTH AND REHABILITATION CENTER	8139 LEE DAVIS ROAD MECHANICSVILLE, VA 23111

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/21/17 through 2/23/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code Survey/Report will follow. No complaints were investigated during the survey. The census in this 120 certified bed facility was 99 at the time of the survey. The survey sample consisted of 17 current Resident reviews (Residents #1 through #17) and 3 closed records (Residents #18 through #20).	F 000		
F 172 SS=E	483.10(f)(4)(i)-(vi) RIGHT TO/FACILITY PROVISION OF VISITOR ACCESS (f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (i) The facility must provide immediate access to any resident by: (A) Any representative of the Secretary, (B) Any representative of the State, (C) Any representative of the Office of the State long term care ombudsman, (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq.), (D) The resident's individual physician, (E) Any representative of the protection and	F 172		3/20/17

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

Electronically Signed | 03/16/2017

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advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq),

(F) Any representative of the agency responsible for the protection and advocacy system for individuals with mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000 (42 U.S.C. 10801 et seq.), and

(G) The resident representative.

(ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time;

(iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time;

(iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and

(v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may

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F 172	Continued From page 2 need to place on such rights and the reasons for the clinical or safety restriction or limitation. (vi) A facility must meet the following requirements: (A) Inform each resident (or resident representative, where appropriate) of his or her visitation rights and related facility policy and procedures, including any clinical or safety restriction or limitation on such rights, consistent with the requirements of this subpart, the reasons for the restriction or limitation, and to whom the restrictions apply, when he or she is informed of his or her other rights under this section. (B) Inform each resident of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse (including a same-sex spouse), a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time. (C) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability. (D) Ensure that all visitors enjoy full and equal visitation privileges consistent with resident preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and facility documentation review, the facility staff failed, for 1 resident (Resident #13) of the survey sample of 20 residents, to ensure that the	F 172	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is	

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F 172	Continued From page 3 resident was not subject to visiting hour limitations. For Resident #13, the facility staff limited visiting hours to 8:00 P.M. The Findings included: Resident #13 was a 72 year old who was admitted to the facility on 6/15/16. Her diagnoses included Muscle Weakness - Generalized, Adult Failure to Thrive, and Multiple Sclerosis. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 1/14/17, coded Resident #15 as having a Brief Interview of Mental Status score of 13, indicating that she was independent in decision making ability. On 2/22/17 at 10:30 A.M. a Group Interview was conducted. Five residents attended the meeting. When asked if there were any facility rules that they were concerned about, the group unanimously stated that they didn't agree with the facility limiting visitation hours to 8:00 P.M. They said that the receptionist makes a daily announcement at 7:30 P.M. before she leaves that visiting hours are over at 8:00 P.M. and that the door will be locked. Resident #13 stated that she thought that the "8:00 P.M. rule was very unfair" to her because her main visitor worked until 6:00 P.M. and that their visits was always "too rushed". On 2/22/17 a review was conducted of facility documentation. The Guidelines for Visitors policy (undated) read, "Any hours that may be	F 172	completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F172 1. During the survey, the Administrator was notified of a deficient practice related to the visitation access announcement made at 8 pm nightly. 2. All residents are at risk and may be affected by the deficient practice. 3. Staff Development Coordinator or designee will educate facility staff on open visitor access, and door security. 4. All Current residents have been informed that facility doors will automatically lock for security at 8 pm but access is maintained by using the doorbell. Activity staff will audit 30% of patients weekly times 3 weeks, monthly times one month and will review in QA & A meeting .	

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F 172	Continued From page 4 suggested or that may be posted in the Center for visitation are reflective only of the Center's general business hours and in no way restricts or limits resident visitation at any other hours." On 2/24/17 at 11:00 A.M. an interview was conducted with the Clinical Consultant (Employee B), who stated, "I was here last night. I heard the receptionist announce that visiting hours are over at 8:00 P.M., the front door would be locked, and you'll have to ring the bell to get back into the building." Employee B then stated that the receptionist would be instructed to stop announcing that visiting hours would be over at 8:00 P.M. She would only announce that the front door would be locked. The facility Administrator (Employee A) was also present, and verbalized agreement with the statement made by the Clinical Consultant.	F 172		
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 (iii) Have a disciplinary action in effect against his or her professional license by a state licensure	F 225		3/20/17

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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 investigation is in progress.

(4) Report the results of all investigations to the

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F 225	Continued From page 6 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, clinical record review, and facility documentation review, the facility staff failed to investigate and report to the state agency (SA) an injury of unknown origin (IUO) for one Resident (Resident #4) in a survey sample of 20 Residents. For Resident #4, an IUO (a maroon red bruise under left nipple) was identified on 2/5/17. No investigation was conducted nor was the IUO reported to the SA. The findings included: Resident #4, a male, was admitted to the facility 1/18/17. His diagnoses included left hip replacement, fractured left femur without repair, chronic kidney disease stage IV, hypertension, arteriosclerotic cardiovascular disease, anemia, hyperlipidemia, and gout. Resident #4's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1/25/17 was coded as an admission, five day assessment. He was coded as having minimal memory deficits and required some assistance with making daily life decisions. Resident #4 was coded as requiring limited to total assistance of one to two staff members to perform his activities of daily living. He was coded as having one unable to stage pressure ulcer upon admission.	F 225	F 225 1. Resident # 4 has been discharged from the facility 2. All residents are at risk. 3. Education will be completed with all licensed staff to include investigation / reporting all injuries of an unknown etiology. 4. The DON / designee will review any incident reports weekly x 3 weeks and then monthly x 1 month to ensure injuries are reported as per regulation. Review in quarterly QA & A meeting.	

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Review of Resident #4's clinical record revealed an entry:

"2/5/17 00:05 (12:05 a.m.) Resident was in bed sleeping with bed in lowest position, floor mat in place, and call bell within reach. Resident brief changed and repositioned in bed. Resident noted having a maroon red bruise to the left chest area under left nipple. Asked resident what happen and he said "I don't know" and resident denies pain or discomfort."

Review of the FRIs (facility reported incident) submitted by the facility, revealed no FRI for the IUO for Resident #4. ADM D, a corporate consultant, stated 2/23/17 at 9:43 a.m., he would find the investigation of Resident #4's IUO. ADM D stated the previous DON (director of nursing) would have investigated the injury and he would have to look through her information. 2/23/17 at 10:25 a.m., ADM D stated he was unable to find any investigation had been conducted regarding Resident #4's IUO. He was also unable to determine if the injury had been reported to the DON.

Review of the facility's policy entitled Abuse/Investigative Reporting/Injuries of Unknown Origin" included:

"Injuries of unknown origin (injuries not witnessed or patient cannot state what happened) will be handled the same as an allegation of mistreatment, neglect, or abuse and must be reported to the Center Administrator.

PROCEDURE:

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F 225	Continued From page 8 1. Any and all injuries of unknown origin to a patient are to be reported to a licensed nurse. 2. A licensed nurse will assure patient safety. 3. A licensed nurse will notify the Administrator and/or Director of Nursing immediately. 4. A licensed nurse will closely monitor and document thoroughly the behavior and condition of the patient involved to evaluate any injury. 5. For all patients involved in the incident with injury, a licensed nurse must notify the following: a. Attending Physician b. Responsible Party. 6. A licensed nurse is responsible for completing an Incident Record. 7. The Director of Nursing is responsible for immediately notifying the Administrator of the injury of unknown origin. An initial report to the State Agency will be initiated. 8. Investigative protocols will be immediately initiated. Corporate Nurse Consult and/or Vice President of Clinical Services is to review investigation prior to submitting the final report to the State Agencies. 9. If the injury of unknown origin is administratively deemed unusual or may lead to litigation, the Office of General Counsel must be notified and will instruct the Center as to whether to complete the (corporate name) Report to Counsel in Anticipation of Litigation packet." The administrator, ADON (assistant DON), and corporate consultants were advised of the failure of the staff to report and investigate an IUO to the SA for Resident #4, 2/23/17 at 1:05 p.m.	F 225		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment	F 278		3/20/17

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F 278	Continued From page 9 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 and clinical record review, the facility staff failed to complete an accurate MDS (minimum data set) RAI (Resident Assessment Instrument) for one Resident (Resident #11) in a survey sample of 20	F 278	F 278 1. Resident # 11 has been discharged from facility 2. All residents are at risk and may be	

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F 278	Continued From page 10 Residents. For Resident #11, the facility staff failed to code that a fall on 2/1/17 included an injury. The findings included: Resident #11, a female, was admitted to the facility 2/1/17. Her diagnoses included metabolic encephalopathy, anasarca, left renal calculus, hepatitis C, cirrhosis, ascites, hypertension, chronic kidney disease stage III, diabetes mellitus, and pancytopenia. Resident #11's most recent (minimum data set) MDS with an (assessment reference date) ARD of 2/9/17 was coded as an admission assessment. She was coded as having no memory deficits and was able to make her own daily life decisions. She was coded as needing limited assistance of one staff member to perform her activities of daily living with the exception of bathing. For bathing she was coded as requiring extensive assistance of one staff member. She was coded as having one fall with no injury since admission. Review of Resident #11's clinical record revealed on the day of admission, 2/1/17, Resident #11 was found on the floor of her bedroom. The "Progress Note" included: "2/1/17 22:40 (10:40 p.m.) Situation: transfer to the hospital after fall w/injury (with) Assessment (RN-registered nurse)/Appearance (LPN-licensed practical nurse): Pt (patient) found on floor at bedside lying supine, w/minimal amount of blood observed to back of head. Assessment shows small abrasion (sp) to	F 278	affected by the deficient practice. 3. Data Verification Analyst or designee will educate MDS staff of requirement to code fall with injury. 4. MDS staff or designee will complete 100% audit to ensure all MDS assessments from February 23rd, 2017 have been coded per regulation related to fall with injury. Then will audit residents with falls to ensure accurate coding weekly times 3 weeks, monthly times one month, and review in QA & A meeting	

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occipital region, pt shows no cognitive changes. Neurochecks completed and w/in normal limits. VS (vital signs) 159/79 98% RA (room air), 22, 88, 96.0. Pt is confused and alert to herself at baseline. When asked about fall pt states that she got up to use the bathroom and R (right) knee gave out on her. MD/RP (responsible party) notified of fall."

A thorough review of Resident #11's clinical record revealed the fall on 2/1/17 was the only fall Resident #11 experienced during the look back period for the assessment in question.

When interviewed, 2/22/17 at 2:16 p.m., RN (registered nurse) B, an MDS coordinator, stated she would check on the coding, however she knew that the coding was inaccurate. She stated the fall should have been coded as a fall with injury.

Guidance was provided in "Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.14 October 2016 p. J-32,
Coding Instructions for J1900B, Injury (Except Major)
· Code 0, none: if the resident had no injurious fall (except major) since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
· Code 1, one: if the resident had one injurious fall (except major) since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).October 2016 Page J-33
· Code 2, two or more: if the resident had two or more injurious falls (except major) since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS)."

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F 278	Continued From page 12 The administrator, ADON (assistant director of nursing), and corporate consultants were informed of the failure of the staff to accurately code a fall with injury on Resident #11's admission MDS assessment, 2/22/17 at 1:05 p.m.	F 278		
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. (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--	F 280		3/20/17

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F 280	Continued From page 13 (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 280		

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F 280	Continued From page 14 (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, and clinical record review, the facility staff failed to review and revise the comprehensive plan of care for two Residents (Residents' #4 and #12) in a survey sample of 20 Residents. 1. For Resident #4, the facility staff failed to review and revise the comprehensive plan of care for pressure ulcers; and 2. For Resident #12, a wheel chair seat cushion for skin protection, dysem to prevent sliding from the wheelchair and use of a psychoactive medication were not care planned. Dycem is a non-skid material that can be placed in the seat of a wheelchair. Dycem is designed to prevent objects from sliding. The findings included: 1. For Resident #4, the facility staff failed to review and revise the comprehensive plan of care for pressure ulcers. Resident #4, a male, was admitted to the facility 1/18/17. His diagnoses included left hip replacement, fractured left femur without repair, chronic kidney disease stage IV, hypertension,	F 280	F 280 1. Resident # 4 has been discharged from facility. Resident # 12 deficiency has been corrected and intervention is in place. 2. All residents may be at risk for deficient practice. 3. Staff Development Coordinator or designee will educate all licensed staff in Development and review of resident Care Plan related to Fall intervention, and skin integrity (prevention of skin breakdown). 4. Staff Development Coordinator or designee will review 100% Care Plans for all residents with: A. Pressure Ulcers, to ensure appropriate intervention and review. B. Residents who are using Dysom to prevent sliding in the wheelchair, as an intervention will be Care Planned. C. Audit 30 % Care plans weekly times 3 weeks, monthly times one month, and review in quarterly QA & A meeting.	

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arteriosclerotic cardiovascular disease, anemia, hyperlipidemia, and gout.

Resident #4's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1/25/17 was coded as an admission, five day assessment. He was coded as having minimal memory deficits and required some assistance with making daily life decisions. Resident #4 was coded as requiring limited to total assistance of one to two staff members to perform his activities of daily living. He was coded as having one unable to stage pressure ulcer upon admission.

Resident #4 was observed 2/22/17 at 1:40 p.m. during wound care observation. Resident #4 was observed to have an unable to stage pressure ulcer that covered the entire right heel. His left heel was also observed. The left heel appeared to be covered with discolored tissue. No odor, redness, edema, or discharge was observed on either heel. Resident #4 was also observed during initial tour 2/21/17 at 2:55 p.m., 2/21/17 at 4:25 p.m., and 2/22/17 at 8:06 a.m. At all observations (except for during wound care observation) he was out of bed and in a wheelchair and a black specialty positioning boot was on his right foot.

Review of Resident #4's clinical record revealed that upon admission, he was assessed as having an unable to stage pressure ulcer on his right heel. Treatment was initiated to the right heel. On 1/31/17 (13 days after admission), Resident #4 was noted to have developed a "blister" on his left heel. The area was assessed as being an "Other" on the facility's wound care tracking and within two weeks was assessed and coded as a Stage II pressure ulcer on the wound tracking.

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www.npuap.com defines pressure ulcers:

"Stage II:
Partial-thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.
Further description:
Presents as a shiny or dry shallow ulcer without slough or bruising.* This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration, or excoriation.
*Bruising indicates suspected deep tissue injury

Unstageable:
Full-thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, or black) in the wound bed.
Further description:
Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined.
Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed."

Review of Resident #4's care plan revealed an entry on his initial interim care plan that included:

"1/20/17 The resident has pressure related actual impairment to skin integrity of the right heel. Risk for further skin breakdown due to decreased mobility and episodes of incontinence.

Interventions:
Encourage good nutrition and hydration in order

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to promote healthier skin.
Keep skin clean and dry. Use lotion on dry skin
Obtain labs as ordered
Use a draw sheet or lifting device to move resident
Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface.
Weekly skin assessment ."

The interim care plan was developed on 1/20/17 and revised on 1/31/17 when a "blister" was diagnosed on his left heel.

The revised care plan only included:

"E encourage good nutrition and hydration in order to promote healthier skin.
Keep skin clean and dry. Use lotion on dry skin
Obtain labs as ordered
Use a draw sheet or lifting device to move resident
Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface.
Weekly skin assessment .
Wound care per MD orders."

By 2/14/17 the care plan was again revised and at that time only included:

"Potential for skin impairment

Goal:
Resident will have no evidence of skin impairment through next review

Interventions:
Keep skin clean and dry.

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Lotion to dry skin.
Pericare with incontinence episodes.
Pressure reduction mattress.
Weekly skin assessment."

While no order was evident for Resident #4 to wear the black boot, upon admission information was on his discharge orders from the facility he had been at:

"(R) heel-Apply Allevyn Multisite dressing change every other day-Prevalon boot (R) heel at all times."

A thorough review of the entire care plan (revised and current) revealed no entry for Resident #4 to wear the Prevalon boot at all times to his right heel.

From the time of his admission his care plan failed to address the care of his unable to stage pressure ulcer to his right heel. No preventative measures were developed within the interim care plan nor when it was revised on 1/31/17 nor at the time of the second revision 2/14/17. After the care plan was revised on 2/14/17, no strategies were developed to care for either pressure ulcer (both right and left heels).

When interviewed, ADM D, a corporate consultant, stated no interventions were included in the care plan for prevention or for the actual care of the pressure ulcers, 2/23/17 at 12:10 p.m.

Guidance for the creation of an individualized care plan is provided by "Fundamentals of Nursing 7th Edition, Potter-Perry, page 268:

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In any health care setting a nurse is responsible for providing a written pan of care for all clients. The plan of care sometimes takes several forms...In hospitals and community-based settings, the client often receives care from more than one nurse, physician, or allied health professional. A written nursing care plan makes possible the coordination of nursing care, subspecialty consultations, and scheduling of diagnostic tests...You design a written plan to direct clinical nursing care and to decrease the risk of incomplete, incorrect, or inaccurate care. As the client's problems and status change, so does the plan. A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care, and listing outcome criteria to be used in evaluation. The written plan communicates nursing care priorities to other health care professionals. The nursing care plan enhances the continuity of nursing care by listing specific nursing interventions needed to achieve the goals of care. All nurses who care for a given client will then carry out these nursing interventions throughout a given day during a client's length of stay. A correctly formulated nursing care plan makes it easier to continue care from one nurse to another."

The administrator, ADON (assistant director of nursing) and corporate consultants were advised of the failure of the staff to develop strategies for prevention of pressure ulcers formation and care of the actual pressure ulcers for Resident #4, 2/23/17 at 1:05 p.m.

2. For Resident #12, a wheel chair seat cushion for skin protection, dysem to prevent sliding from the wheelchair and use of a psychoactive medication were not care planned. Dycem is a

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non-skid material that can be placed in the seat of a wheelchair. Dycem is designed to reduce friction and prevent objects from sliding.

Resident #12 was readmitted to the facility on 11/15/16. His diagnoses included seizures, peripheral vascular disease, malnutrition, dementia, and osteoarthritis.

On 2/21/17 at 4:42 p.m., Resident #12 was observed in his room sleeping on an air mattress. On 2/22/17 at 8:15 a.m., Resident #12 was observed sitting in the doorway of his room in his wheelchair. He had just completed his breakfast when he stated, "I'm going back to bed soon". Resident #12 was observed to be very thin, had some food from his breakfast on his left hand and the left side of his face and he was slightly sliding from the seat of the wheelchair. There was no cushion or dysem observed in the wheelchair. During this observation, the regional cooperate nurse, Adm D, approached Resident #12, rolled his wheelchair further into his room, and asked a staff member to clean his hand and face.

On 2/21/17 at 4:50 p.m., a review of Resident #12's clinical record was initiated.

Resident #12's most recent MDS (minimum data set) with an ARD (assessment reference date) of 11/22/16 was coded as an admission assessment. He was coded as having long and short term memory deficits and was moderately impaired to make his own daily life decisions. Resident #12 was coded as requiring extensive to total assistance of one staff member to perform his activities of daily living, except for eating, he required limited assistance. Resident #12 was coded for a weight of 100 pounds and a height of

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5 feet 7 inches. He was coded incontinent of bowel and bladder and was coded at risk for pressure ulcers. He was admitted with one unstageable pressure ulcer and no falls. In Section N, Medications Received, Resident #12 was coded for the use of an anti-depressant for seven days of the ARD period.

The corresponding MDS Care Assessment Worksheet coded the following to be included in the comprehensive care plan:
a. Under Pressure Ulcers read, "Needs special mattress or seat cushion to reduce or relieve pressure".
b. Under Falls read, "Yes, Falls Functional Status will be addressed to Minimize Risks. Resident finding for risk of falls included impaired balance during transition and use of Antidepressants".
c. Under Psychotropic Drug Use read, Antidepressant, "Yes, Functional Status will be addressed in the care plan to avoid complications".

Review of Resident #12's Comprehensive Care Plan did not include interventions for the use of a seat cushion to reduce pressure, or interventions to avoid complications related to the use of a psychotropic drug.

Review of Progress Notes revealed the following:
a. On 12/18/16 -"Resident was found to have three small open areas to his sacrum."
b. On 12/28/16 - "Resident was found on floor in his room. He had slid himself out of his wheelchair. Resident now has dysem to the seat of his chair to provide friction."
c. On 2/19/17 - "Resident observed in on floor in his room beside the sink. Resident was able to acknowledge he hit his face on the sink."

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Review of the Physician Orders revealed an order dated 11/15/16 , "Trazodone 50 mg. (milligrams) Give .5 tablet by mouth at bedtime for sleep dose is 25 mg."

Review of the Medication Administration Records (MARs) revealed Resident #12 was administered Trazodone 25 mg. from 11/15/16 through 2/13/17.

Resident #12's Comprehensive Care Plan did not reflect a wheelchair seat cushion, the application of dycem to prevent slipping and friction, or the use of a psychotropic drug.

On 2/22/17 at 2:00 p.m., an interview was conducted with the Adm D regarding the Resident #12's wheelchair cushion and the dycem. Adm D said Resident #12 did look thin to him and would benefit from a wheelchair cushion and Adm D stated Resident #12 did not have the dycem in his wheelchair earlier in the day.

On 2/23/17 at 9:00 a.m., the administrator was informed that Resident #12 was observed without a cushion in his wheelchair and no dycem in place. The administrator was also informed the comprehensive care plan did not include interventions for a wheelchair seat cushion, dycem or the use of a psychotropic medication.

On 2/23/17 at 11:50 a.m., an interview was conducted with the MDS coordinator, RN (registered nurse) B, regarding the development and revision of Resident #12's comprehensive care plan. RN B said the MDS coordinator would prepare the initial comprehensive care plan and she added, "If something triggers for careplanning, it would be put on the care plan."

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F 280	Continued From page 23 On 2/23/17 at 2:45 p.m., the administrator, ADON (assistant director of nursing) and corporate consultants were informed of the failure of the staff to review and revise Resident #12's comprehensive care plan for a wheelchair seat cushion, dysem and the use of a psychotropic medication. No additional information was provided.	F 280		
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 staff interview, facility documentation review and clinical record review the facility staff failed for 8 residents (Resident # 10, 6, 3, 17, 18, 4, 11 and 19) of 20 residents in the survey sample to ensure facility staff performed within the scope of their practice and failed to follow professional standards of nursing for medication administration. 1. For Resident # 10, the Dietetic Technician, Registered performed nutrition assessments outside the scope of practice. 2. For Resident #6, the Dietetic Technician, Registered performed nutrition assessments outside the scope of practice.	F 281	F 281 1. Residents # 10, # 6, # 3, # 17, # 18, # 19 deficient practice has been corrected. Residents # 4 and # 11 have been discharged from facility. 2. All residents receiving dietary assessment, dietary interventions including weight loss may be at risk for deficient practice. A. Residents receiving Claritin may be at risk for deficient practice. 3. Registered Dietitian or designee will educate registered dietary tech on capabilities within her scope of practice, specific to those requiring dietary assessment, and intervention including	3/20/17

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F 281	Continued From page 24 3. Resident #3 had significant weight changes that were not addressed by the RD (registered dietician). 4. Resident #17's admission dietary assessment was completed by a DTR (dietary technician, registered) instead of the RD. 5. Resident #18's admission dietary assessment was completed by a DTR (dietary technician, registered) instead of the RD. 6. For Resident #4, the Dietetic Technician, Registered performed nutrition assessments outside the scope of practice. 7. For Resident #11, the Dietetic Technician, Registered performed nutrition assessments outside the scope of practice. 8. For Resident #19, the facility staff failed to complete a verbal physician's order for Claritin to be administered for 10 days as the physician ordered the Claritin. The findings included: 1. For Resident # 10, the Dietetic Technician, Registered performed nutrition assessments outside the scope of practice. Resident #10, a 91 year old, was admitted to the facility on 9/12/16. Her diagnoses included dementia, dysphagia, failure to thrive, hypertension and depression. Her most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 2/2/17. She was coded with a	F 281	weight loss. A. Staff Development Coordinator or Designee will in-service all licensed staff on duration time for Claritin use per Doctor□s Orders. 4. Audit 100% of residents high nutrition risk to determine a need for Registered Dietitian referral is completed as required. 30% audit weekly times 3 weeks, then monthly times one month, and review in quarterly QA & A meeting. A. Audit 100% of residents with orders for Claritin to determine completion date per Doctor□s orders is in intact. 30% audit weekly times 3 weeks, monthly times one month, and review in quarterly QA & A meeting.	

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Brief Interview of Mental Status score of 6 indicating severe cognitive impairment. She required extensive assistance with her activities of daily living. She was coded to have weight loss that was not physician prescribed.

Resident #10 was observed on 2/22/17 at 8:45 a.m. eating breakfast in her room. She ate a small amount of scrambled eggs with the remainder of the food left untouched.

Resident #10's clinical record was reviewed for weight loss. The first "Nutrition/Dietary Note" documented in the clinical record was dated 9/20/16. This note was titled "Nutrition Assessment (A)" and was completed by the Dietetic Technician, Registered (DTR). In addition to the collection of diet and health related data, the DTR wrote the following note in the assessment "Weight: 100.2 #(pound)/ 45 kg (kilogram) IBW (Ideal Body Weight) 135#/ 61 kg IBWR (Ideal Body Weight Range) 121-149#. Resident is currently at 74% IBW. Resident alert to self. Unable to make needs known. mech soft diet ordered, no noted chewing/ swallowing difficulty. dependent on staff for meals. Skin noted as intact, no facility labs. Resident with dx (diagnosis) of dementia weight loss may be unavoidable as disease process progresses. Varied intake to date. Well below IBW of 135#. Recommend adding fortified foods. Med plus 120cc's BID (two times per day) for nutritional support. Follow residents weight trends, intake, labs."

The next Nutrition/Dietary Note was written by the DTR on 1/13/17. The note read, "Weight Committee: Suspected past incorrect weights. Reevaluated baseline weight of 76.5#. Resident

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has been on Fortified foods, Medplus 120 cc's BID (twice per day) ordered 9/20/16 for nutritional support. Intake remains unchanged at 50-75% of most meals. Resident enjoys sweets, and all food related activities. Most meals in dining room, feeds self, resists help with feeding. Requested labs from MD (doctor). Weight stable x 10 days. Resident will continue with weekly weights till stable. Will reevaluate at that time."

All of Resident #10's Nutrition/Dietary Notes were completed by the DTR. There were no assessments in the record written by the Corporate Registered Dietitian (RD).

On 2/22/17 at 1:45 p.m., an interview was held with the Corporate RD. She was asked to review the 1/13/17 note written by the DTR regarding the re-establishment of Resident #10's baseline weight. When asked if she knew why the baseline weight was changed, the Corporate RD stated she did not know. When asked if she reviewed the clinical records of the residents in the facility who had weight loss, the Corporate RD stated no. When asked for which residents she reviewed clinical records, the Corporate RD stated she reviewed the residents with tube feedings, wounds when the DTR notified her of a wound that was not healing and other residents brought to her attention by the DTR.

On 2/22/17 around 2:15 p.m., the DTR (in the presence of the Corporate RD) stated that Resident #10's baseline weight had been changed because Resident #10 moved from the skilled unit to the non-skilled unit and the scales from each unit produced very different weights. The concern regarding the weight discrepancy in the scales between the units was reviewed with

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the Administrator and corporate staff at the end of day meeting on 2/22/17.

Another interview was held with the DTR on 2/23/17 at 10:30 a.m. The DTR stated that she had worked at the facility about one year. She stated that a dietitian did not work with her in the building but the Corporate RD was available if needed. She stated that the Corporate RD was in the building every 2-3 weeks and was available by phone or email. When asked if the Corporate RD met with her when at the facility, the DTR stated yes. When asked if all the residents with wounds and weight loss were reviewed during the meeting with the Corporate RD, the DTR stated no. The DTR stated that she knew which residents she wanted to review with the Corporate RD during the meetings. When asked if she kept a written list, the DTR stated that she did not have a written list. When asked what types of nutritional situations she would bring up to the Corporate RD, the DTR stated anything out of her own scope of practice. When asked if the Corporate RD documented in the clinical record regarding the concerns issued by the DTR, the DTR stated yes, the Corporate RD would document in the clinical record. The DTR stated that the Corporate RD was consulted for all tube feeding residents. The DTR was asked what she was responsible for at the facility. She stated she completed the Minimum Data Set, care plans and weights. When asked if she completed all the initial nutrition assessments, she stated not for everyone.

On 2/23/17 at 11:10 a.m., the Corporate RD was interviewed by phone. The Corporate RD stated that she was at the facility every month. She stated she was available to the DTR by phone

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and email. She stated she had remote access to the electronic clinical records. The Corporate RD stated that she met with the DTR when at the facility. The Corporate RD stated that during the meetings, the DTR brings her up to date and reviewed any concerns that she (DTR) may have about a resident. When asked if she reviewed residents with weight loss, the Corporate RD stated that the DTR handled weight loss. When asked if she ever reviewed the work of the DTR, the Corporate RD stated it was rare for her to review a clinical record. When asked if she had ever read the scope of practice for a DTR, the Corporate RD stated that she had but it had been awhile. It was reviewed with the Corporate RD that the survey team had a concern about the lack of supervision regarding the DTR's work.

The Academy of Nutrition and Dietetics is the professional organization for food and nutrition professionals. This organization established the standards of practice for registered dietitians (RD) and dietetic technicians, registered (DTR). The following standards of practice titled "Academy of Nutrition and Dietetics: Revised 2012 Standards of Practice in Nutrition Care and Standards of Professional Performance for Dietetic Technicians, Registered" was accessed on 2/27/17 at 11:30 a.m. at the website http://www.andjrnl.org/article/S2212-2672(12)01939-9/pdf.

"Standard 1: Participates in the Nutrition Screening and Provides Support to Nutrition Assessment. The dietetic technician, registered (DTR) participates in the nutrition screening of patients/ clients and populations and obtains and verifies relevant data and information for support of nutrition assessment under the supervision of

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the registered dietitian (RD). Rationale: Nutrition screening is the preliminary step that precedes the first step of the Nutrition Care Process-nutrition assessment. Although nutrition assessment and reassessment is the responsibility of the RD, the DTR takes an active role in obtaining and verifying relevant data and information for the RD to complete the assessment."

"Standard 2: Provides Support to Nutrition Diagnosis. The dietetic technician, registered (DTR) obtains, verifies, and documents relevant data and information to support the registered dietitian (RD) in determining the nutrition diagnosis(es) of patients/ clients or nutrition problems and etiology for populations. DTRs observe and communicate signs and symptoms/ defining characteristics, and other relevant information in a timely and accurate manner. Rationale: Nutrition diagnosis is the second of four steps in the Nutrition Care Process. DTRs contribute to nutrition diagnosis by obtaining, verifying, documenting, and communicating relevant data and information about problem, etiology, signs, and symptoms for the RD to effectively cluster, analyze, and synthesize information to determine a nutrition diagnostic category(ies). Timely appropriate nutrition diagnosis by the RD leads to timely appropriate nutrition intervention/ plan of care."

"Standard 3: Provides Support to Nutrition Intervention as Directed by the Registered Dietitian. The dietetic technician, registered (DTR) works under the supervision of the registered dietitian (RD) and assists by contributing to the implementation of nutrition intervention/ plan of care developed by the RD."

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"Rationale: Nutrition intervention/ plan of care is the third of four steps in the Nutrition Care Process. The DTR contributes to nutrition intervention/ plan of care by assisting the RD with implementation of individualized patient-/client-centered nutrition interventions/ plans of care and education with the goal of positively influencing the nutrition diagnosis/problem."

"Standard 4: Provides Nutrition Monitoring and Supports Nutrition Evaluation. The dietetic technician, registered (DTR) participates in the nutrition monitoring of patients/clients and populations under the supervision of the registered dietitian (RD). The DTR uses selected indicators as established by or in communication with the RD that are relevant to the patient's/client's defined needs, nutrition diagnosis/ problem, nutrition goals, and health status. Rationale: Nutrition monitoring and evaluation is the fourth step in the Nutrition Care Process. By obtaining nutrition data and information at scheduled (preplanned) follow-up points, the DTR assists the RD in nutrition monitoring to support evaluation of the patient/ client-centered nutrition interventions/ plan of care and tailoring the nutrition intervention/ plan of care to the patient's/ client's needs."

A second document titled "Academy of Nutrition and Dietetics: Scope of Practice for the Dietetic Technician, Registered" was accessed on 2/27/17 at 3:01 p.m. at http://www.andjrnl.org/article/S2212-2672(12)01935-1/pdf.
This document is used together with the standards of practice document referenced above.

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The section titled "RD/DTR Team and Guidelines for RD Supervision of the DTR, Patient/ Client Direct Care Settings" read "According to the 2012 Standards of Practice in Nutrition Care for Dietetic Technician, Registered, the DTR and other support staff work under the supervision of the RD when engaged in direct patient/ client nutrition care activities in any setting. The primary patient/ client populations include individuals with medical conditions or diseases as well as at-risk individuals receiving personalized nutrition guidance as part of preventative health."

Figure 1 in the document outlines the roles of the RD and DTR as part of the Nutrition Care Process as follows:
"Nutrition Assessment"
RD role= "Perform"
DTR role= "Assist with or initiate data collection as directed by the RD or per standard operating procedures, and begin documenting elements of the nutrition assessment for finalization by the RD."

"Nutrition Diagnosis"
RD role= "Perform"
DTR role= "Per RD assigned task, communicate and provide input to the RD, when applicable."

"Nutrition Intervention"
RD Role= "Determine/ recommend or per established and approved disease- specific and condition -specific protocol orders from the referring practitioner, if applicable, initiate interventions; may assign to appropriate support, administrative, and technical (DTR) staff."
DTR role= "Implement/ oversee standard operating procedures; assist with implementation

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of individualized patient/ client interventions and education as assigned by the RD."

"Nutrition Monitoring"
RD role: "Monitoring: determine/approve, may assign elements of monitoring to appropriate support, administrative, and technical staff. Evaluation: document outcome of interventions reflecting input from all sources to recognize contribution of DTR/ nutrition care team members to patient/ client experience and quality outcomes."
DTR role: "Implement/ oversee (duties performed by other nutrition, foodservice staff) standard operating procedures; complete, document, and report to the RD and others the results and observations of patient/ client specific assigned monitoring activities."

The facility provided a copy of the Dietetic Technician job description dated March 2016. The "Job Summary" read "Responsible for providing technical assistance in identifying and meeting the nutritional needs of the patient. Works with the Dining Services Manager and the Registered Dietitian in providing quality food service and nutritional care."
Under the section titled "Job Specific Duties" the following duties were listed:
- Prepares and manages implementation of nutritional care plans according to dietary orders from physicians, and in collaboration with a Registered Dietitian.
- Alerts the Registered Dietitian to unusual nutritional situations as observed or perceived.
- Interact and participate with other disciplines by actively participating in the care plan process, weight variance committee, and wound care teams.

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F 281	Continued From page 33 According to the standards and scope of practice for the Dietetic Technician, Registered, the facility DTR worked outside of her scope of practice by: - completing nutrition assessments - determining nutritional diagnoses - developing the nutritional plan of care - evaluating data collected through monitoring At the end of the day meeting on 2/23/17, the Administrator and Corporate staff were notified that the survey team was concerned that the DTR performed outside of the DTR scope of practice. 2. For Resident #6, the Dietetic Technician, Registered performed nutrition assessments outside the scope of practice. Resident #6, a 69 year old, was admitted to the facility on 4/22/16. Her diagnoses included diabetes, depression, restless leg syndrome, and elevated lipids. Her most recent Minimum Data Set assessment was a annual assessment with an assessment reference date of 1/11/17. She was coded with a Brief Interview of Mental Status score of 14 indicating no cognitive impairment. She required assistance with her activities of daily living. She was not coded to have weight loss. Resident #6's Nutrition/ Dietary Notes were reviewed. According to the notes, Resident #6 had experienced weight loss. Her initial Nutrition Assessment was completed 4/27/16 and was signed by the DTR. All ten Nutrition/ Dietary Notes in Resident #6's clinical record were completed by the DTR.	F 281		

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The DTR completed the nutrition assessment and developed the nutrition plan of care, both of which are outside the scope of practice for the DTR.

3. Resident #3 had significant weight changes that were not addressed by the RD (registered dietician).

Resident #3, was initially admitted to the facility 6/16/16. Diagnoses included stroke with left sided hemiparesis, aphasia, high blood pressure, seizure disorder, anemia and chronic kidney disease, stage 2.

Resident #3's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1/14/17 was coded as a quarterly assessment. Resident #3 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. Resident #3 was coded as needing extensive assistance of one to two staff members to perform activities of daily living with the exception of eating.

On 2/23/17 at 9:00 AM, Resident #3 was observed in his room, eating breakfast. He was feeding himself and had consumed all of his breakfast.

On 2/22/17, review of the clinical record was conducted. On 9/14/16, a nutrition/dietary note was written by the DTR for a weight committee meeting. The note read: "CBW (current body weight) 207.8 pounds 16.8 pound times one month (gain) (history of weight fluctuations). Current diet: Heart Healthy. Percentage intake 50-100%.... Reasons why weight change may have occurred: Resident continues on current diet

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with good intake. No concerns with dietary intake. Resident continues to take Furosemide (Lasix) 20 mg (milligrams) 3 times daily for edema. Decrease contributed to edema/diuresis. Remains well above IBW (ideal body weight) of 142 pounds. Recommendations: continue with current dietary poc (plan of care)."

On 1/11/17 a dietary note was written by the DTR. The note contained the following: "CBW 200.1 pounds. Decrease of 14 pounds in one month. .... Reasons why weight change may have occurred: Continues on current diet with excellent intake. Meals noted at 75-100%. Meals in dining room with no dietary issues. Continues on diuretic therapy. History of edema bilateral lower legs. TX (treatment) in place. Decrease contributed to edema/diuresis. Recommendations: Continue with current dietary interventions."

There was no documented RD involvement regarding the significant weight changes.

4. Resident #17's admission dietary assessment was completed by a DTR (dietary technician, registered) instead of the RD.

Resident #17's admission dietary assessment was completed by a DTR (dietary technician, registered) instead of the RD.

Resident #17, was initially admitted to the facility 2/9/17. Diagnoses included stroke with left sided hemiparesis, dysphagia, high blood pressure, atrial fibrillation, anemia, and diabetes.

Resident #17's most recent MDS (minimum data

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set) with an ARD (assessment reference date) of 2/11/17 was coded as an admission assessment. Resident #17 was coded as having a BIMS (brief interview of mental status) of "15" out of a possible 15, or no cognitive impairment. Resident #17 was coded as needing extensive assistance of one to two staff members to perform activities of daily living with the exception of eating.

On 2/23/17 at 8:40 AM, Resident #17 was observed in the room in a wheel chair. A left elbow protector was in place.

On 2/23/17, a clinical record review was conducted. On 1/10/17, a nutrition assessment was completed by the DTR. The note contained the following: "Weight: 165 pounds/75 kg (kilograms) IBW 178/81 kg IBWR 160-196 pounds. Currently at 93% IBW. Alert, verbal able to express needs. Observed resident at lunch day of admit, accompanied by wife. Mechanical soft diet with adequate intake to date, being followed by speech therapy. Cold beverages are to be in sip cup, hot beverages in regular coffee mug, staff aware, meals to date in dining room. Participating in therapy. No changes at this time to dietary poc. Following labs weights, intake." There was no documented RD involvement in the admission assessment.

5. Resident #18's admission dietary assessment was completed by a DTR (dietary technician, registered) instead of the RD.

Resident #18's admission dietary assessment was completed by a DTR (dietary technician, registered) instead of the RD.

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Resident #18 was initially admitted to the facility 1/3/17. Diagnoses included chronic obstructive pulmonary disease (COPD), high blood pressure, congestive heart failure, anemia, and hyperlipidemia.

Resident #18's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1/10/17 was coded as an admission assessment. Resident #18 was coded as having a BIMS (brief interview of mental status) of "13" out of a possible 15, or no cognitive impairment. Resident #18 was coded as needing standby to limited assistance of one staff member to perform activities of daily living.

On 2/23/17, a closed clinical record review was conducted. On 1/10/17, an admission dietary assessment was completed by the DTR. The note read: "Diet: Heart Healthy/Diabetic. ... Weight 213 pounds/97 kg (kilograms) IBW 126-154. Currently at 152 % IBW. Alert with confusion, able to express needs. Heart Healthy/Diabetic diet 1500 cc (cubic centimeters) fluid restriction diet with intake noted as adequate, 50-100%. Eats independently, no known food allergies. No noted chewing/swallowing difficulty. Noted edema +1 to bilateral lower extremities. Receiving 40 mg Furosemide., Spironalctone 25 mg. At risk for weight fluctuations. Blood sugar levels may be altered related to resident with orders for Prednisone. No changes at this time to dietary poc. Following weights/labs/intake." There was no RD (registered dietician) involvement documented in the clinical record.

On 2/23/17 at 10:35 AM, an interview was conducted with the DTR. She included in her

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scope of practice the following duties: "all weights, MDS, care plans and initial assessments. She also stated that "tube feedings" were not in her scope of practice.

On 2/23/17 at 11:10 AM, a phone interview with the RD of the company was conducted. The RD explained that she was in the facility once a month and was available by phone and email at all times. She also stated that she could remotely access the the electronic medical record from home as well as from other facilities on the company. She added that the weight /wounds and tube feedings meeting members, to include the DTR would "put interventions in place. " The RD went on to state that she would see any residents the DTR asked her to see, or residents she (DTR) "is not comfortable with." She also stated that (name of company) policy is "The team (weight) committee is to review weights and if any issues, to refer to RD."

6. For Resident # 4, the Dietetic Technician, Registered performed nutrition assessments outside the scope of practice.

Resident #4, a male, was admitted to the facility 1/18/17. His diagnoses included left hip replacement, fractured left femur without repair, chronic kidney disease stage IV, hypertension, arteriosclerotic cardiovascular disease, anemia, hyperlipidemia, and gout.

Resident #4's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1/25/17 was coded as an admission, five day assessment. He was coded as having minimal memory deficits and required some assistance with making daily life decisions. Resident #4 was

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coded as requiring limited to total assistance of one to two staff members to perform his activities of daily living. He was coded as having one unable to stage pressure ulcer upon admission. Resident #4 had been coded as "being at risk" for the development of pressure areas. His weight was coded as 173 pounds and height 68 inches.

Review of Resident #4's clinical record revealed he had been admitted to the facility with an unable to stage pressure ulcer. During his stay at the facility he developed another pressure ulcer on his left heel and experienced a significant weight loss.

Review of the nutrition notes revealed he was not assessed by a nutritionist during his stay at the facility. On 1/25/17 Other A, a dietary tech, entered a note (one week after admission). Included in the note, Other A referenced laboratory work, medications, medical diagnoses and height and weight. Included were recommendations: "Resident is alert to self. HOH (hard of hearing). Regular diet w (with)/NKFA (no known food allergies). Intake noted as adequate, requires meal set up. Advanced age of 91 yr (year). Noted pressure areas, tx in place. labs noted, nursing aware of abnormal labs. Staff to encourage foods/fluids and dining room participation. Recommend mvi/mn (multivitamin with minerals)." No order was obtained for multivitamins with minerals even though the dietary tech made the recommendation.

The weight committee meeting was held on 2/10/17 and Resident #4 was discussed as by that time he had experienced a 5.1% weight loss with a weight of 163.9 pounds (down 9 pounds

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from an admission weight of 173.2 pounds). The dietary tech again addressed Resident #4's intake, medications, labs. Her synopsis included:

"Reasons why weight change may have occurred: weight has decreased 9.3 # (pounds) x 2 weeks Continues on regular diet w/adequate intake, meals in dining room able to verbalize nutritional needs. NO dietary issues at this time. Continues/fluctuating edema to BLE (bilateral lower extremities) and both feet. Diuretics increased. Weight fluctuations expected r/t (related to) changes in fluid status. Nursing is aware of abnormal labs. Nursing to notify MD. Recommendations: (none entered)."

Resident #4 had developed a second pressure area, there was no mention made of a second pressure ulcer development within the diet techs note.

The only other nutrition assessment was on 2/16/17 by the dietary tech. The note addressed Resident #4's current weight of 164.3 pounds. She wrote, "Continue w/current dietary interventions."

While Resident #4 was at high risk for nutritional needs, including weight loss and the development of a second pressure ulcer, he was not seen nor assessed by the dietitian. When interviewed 2/23/17 at 11:07 a.m., ADM E (the dietitian) stated she had not been involved in the management of Resident #4's nutritional needs. ADM E stated she would have only been involved if the dietary tech had informed her of Resident #4's needs.

The administrator, ADON (assistant director of

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nursing) and corporate consultants were informed of the failure of the staff to ensure Resident #4's nutritional needs were addressed by a staff member acting within the scope of their practice, 2/23/17 at 1:05 p.m.

7. For Resident # 11, the Dietetic Technician, Registered performed nutrition assessments outside the scope of practice.

Resident #11, a female, was admitted to the facility 2/1/17. Her diagnoses included metabolic encephalopathy, anasarca, left renal calculus, hepatitis C, cirrhosis, ascites, hypertension, chronic kidney disease stage III, diabetes mellitus, and pancytopenia.

Resident #11's most recent MDS (minimum data set) with an ARD (assessment reference date) of 2/9/17 was coded as an admission assessment. She was coded as having no memory deficits and was able to make her own daily life decisions. She was coded as needing limited assistance of one staff member to perform her activities of daily living with the exception of bathing. For bathing she was coded as requiring extensive assistance of one staff member. She was coded as having one fall with no injury since admission. Section O, Special Treatments, Procedures, Programs, indicated she did not receive oxygen therapy during the look back period. Resident #11's weight was coded as 181 pounds and her height as 65 inches.

Review of Resident #11's clinical record revealed no nutritional assessment was completed by the dietary tech until 2/7/17, seven days after admission. The note addressed Resident #11's weight, lab work, medications, and diet. Included

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within the note was an entry that included:

"Currently at 145% Ibw (ideal body weight), alert w/confusion. able to express simple nutritional needs. Regular diet w/no restrictions, intake adequate, NKF, meals in dining room. receiving Lasix (diuretic) 20 mg (milligram) x 2 daily, potential for weight changes. Continue w/current dietary interventions."

By the next time the dietary tech had assessed Resident #11 2/21/17, she had a significant weight loss of 13.6 pounds in two weeks. Included in her note was:

"Resident w/poor po (by mouth) intake at this time. Med plus 120 cc's (cubic centimeters) Bid (twice daily) added 2/14/17 r/t to poor po. Med plus providing an additional 480 kcal (calories) and 15 g (grams) pro (protein) daily. Continues on Lasix 20 mg twice daily which may have also contributed to decrease. 3 day weights in process to reestablish baseline. Recommendation: Continue to follow weights/labs/intake."

While by 2/22/17 Resident #11 had experienced a 13.6 pound, significant weight loss (7.5% in two weeks) no documentation was evident Resident #11 was seen or assessed by the dietitian. Other A stated 2/22/17 at 10:35 a.m., the dietitian was only involved when there is a problem "I don't feel comfortable with..." Other A also stated she only "touched base" with the dietitian for things, "I think she needs to know..."

The administrator, ADON (assistant director of nursing) and corporate consultants were informed of the failure of the staff to ensure Resident #11's

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nutritional needs were addressed by a staff member acting within the scope of their practice, 2/23/17 at 1:05 p.m.

8. For Resident #19, the facility staff failed to enter a correct verbal order for Claritin, per physician's wishes. The staff entered Claritin to be administered daily, when the physician verbally ordered it to be administered daily for 10 days.

Resident #19, a female, was admitted to the facility 12/27/16. She was discharged home 2/3/17. Her diagnoses included hemiplegia status post cerebral infarction, muscle weakness, cognitive communication deficit, acute diastolic congestive heart failure, cough, hypertension, and hyperlipidemia.

Resident #19's most recent MDS with an ARD of 1/3/17 was coded as an admission assessment. Resident #19 was coded as having no memory deficits and was able to make her own daily life decisions. Resident #19 was coded as requiring limited to extensive assistance of one to two staff members to perform her activities of daily living.

Review of Resident #19's clinical record revealed an entry in the interdisciplinary "Progress Notes":

"1/13/17 15:46 (3:46 p.m.) Skilled for left sided weakness r/t stroke, HTN (hypertension), CHF (congestive heart failure), hyperlipidemia, resident alert x 2/3 (two to three), resident able to make needs known, resident requires extensive assist with bed mobility, transfers, and toileting. resident has MD in to visit N.O. (new order) clartin (sp) 10 mg (milligram) x (for) 10 days, resident has no distress noted will continue to

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monitor." The note was signed by LPN B.

Review of the physician's orders revealed a verbal order was entered into the computer by LPN B that included:

"1/13/17 Claritin tablet (Loratadine) Give 1 tablet by mouth one time a day for Allergies."

An entry was placed on the eMAR (electronic medication administration record) for Claritin to be administered daily (not just for 10 days). Nurses initials were evident indicating Claritin 10 mg was administered daily from 1/14/17 until her discharge on 2/3/17. The order was not electronically signed by the physician until 1/31/17.

LPN A was unable to be interviewed to discern how the order was entered for Claritin to be administered continually from 2/13/17 and not for 10 days as her note indicated and the physician desired.

Other C, the physician, was interviewed 2/23/17 at 11:28 a.m. Other C stated he would have only ordered for Claritin be be administered 10 days to two weeks, not on an unending basis. Other C stated he did not want his Residents to be administered unnecessary medications such as allergy medications, etc for an unending time.

LPN H stated 2/23/17 at 1:25 p.m., a verbal order that is entered into the computer system has an area on the screen that ending dates are calculated. LPN H said the calendar has to be clicked to enter the start and stop dates for medications that are to be administered for a limited time (such as the Claritin to be

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F 281	Continued From page 45 administered for 10 days). Guidance for nursing practice for the administration of medications is included in, "Fundamentals of Nursing 7th Edition, p 336, The physician is responsible for directing medical treatment. Nurses follow physician's orders unless they believe the orders are in error or harm clients." Same source, p. 699, "The physician, nurse practitioner, or physician's assistant prescribes medications by writing a medication order on a form in the client's medical record. Sometimes a prescriber orders a medication by talking directly to the nurse or by telephone...When a verbal or telephone order is received, the nurse who took the order writes the complete order or enters it into a computer and then reads it back and receives confirmation from the prescribe to confirm accuracy. " The administrator, ADON (assistant director of nursing), and corporate consultants were informed of the failure of LPN A to enter a verbal order for Claritin correctly (10 days as opposed to unending) for Resident #19, 2/23/17 at 1:05 p.m.	F 281		
F 309 SS=D	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	F 309		3/20/17

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F 309	Continued From page 46 comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, hospital documentation, and clinical record review, the facility staff failed for 3 residents (Residents #12, #16 and #10) in the survey sample of 20 residents, to provide physician ordered care and services. 1. For Resident #12, the facility staff failed to implement a physician approved pharmacy recommendation for the gradual dose reduction (GDR) of Trazodone, an anti-depression	F 309	F 309 1. Resident # 16 has been discharged from facility. Resident # 12 and # 10 deficient practice has been corrected. 2. All residents requiring a gradual dose reduction and clarification of insulin as sliding scale. Requiring suture removal may be at risk for deficient practice. 3. Staff Development Coordinator or designee will educate all licensed staff on	

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F 309	Continued From page 47 medication. 2. For Resident #16, the facility staff failed to obtain clarification of a sliding scale insulin order and failed to obtain and document a blood sugar measurement on 2/22/17. Sliding scale insulin is a dose of insulin administered based on predetermined parameters as ordered by the physician. 3. For Resident #10, an order was written on 11/22/16 to remove sutures to the forehead in 5-7 days. The sutures were not removed until 12/22/16. The Findings Included: 1. Resident #12, was readmitted to the facility on 11/15/16. His diagnoses included seizures, peripheral vascular disease, malnutrition, dementia, and osteoarthritis. On 2/21/17 at 4:42 p.m., Resident #12 was observed in his room sleeping on an air mattress. On 2/22/17 at 8:15 a.m., Resident #12 was observed sitting in the doorway of his room in his wheelchair. He had just completed his breakfast when he stated, "I'm going back to bed soon". Resident #12 was observed to be very thin, had some food from his breakfast on his left hand and the left side of his face and he was slightly sliding from the seat of the wheelchair. On 2/21/17 at 4:50 p.m., a review of Resident #12's clinical record was initiated. Resident #12's most recent MDS (minimum data set) with an ARD (assessment reference date) of 11/22/16 was coded as an admission	F 309	Policy / procedure related to Gradual Dose reduction. B. Documentation of Insulin in Medication record. Clarification of insulin sliding scale orders. C. Removal / Documentation of sutures per Doctor□s Orders. 4. DON or designee will audit 30% gradual dose reduction recommendation, insulin orders for clarification, documentation of insulin in Medication admin record. Audit weekly times 3 week, monthly times one month, and review in quarterly QA & A meeting.	

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assessment. He was coded as having long and short term memory deficits and was moderately impaired to make his own daily life decisions. Resident #12 was coded as requiring extensive to total assistance of one staff member to perform his activities of daily living, except for eating, he required limited assistance. In Section N, Medications Received, Resident #12 was coded for the use of an anti-depressant for the seven days of the seven day ARD look back period.

Review of Resident #12's Comprehensive Care Plan did not include interventions related to the use of a psychotropic drug. ("Psychotropic medications are drugs that effect brain activities associated with mental processes and behavior. Psychotropic medications are divided into four broad categories: anti-psychotic; anti-depressant; anti-anxiety; and hypnotic medication." www.oig.hhs.gov)

Review of the Physician Orders revealed an order dated 11/15/16 , "Trazodone 50 mg. Give .5 tablet by mouth at bedtime for sleep dose is 25 mg."

Review of a Pharmacy Consultation Review dated 1/18/17 read, "[Resident's Name] has an order for Trazodone 25 mg hs (at bedtime) for Insomnia. If clinically appropriate, please evaluate for gradual dose reduction." Hand written on the consultation was, "Resident is on 25 q (every) HS." Under Physician Response was checked, "I accept the recommendation above, please implement as written." Hand written was, [an arrow pointing downward] decrease to 1/2 Pill." Signed by the physician (Other C) on 1/28/17, which was 10 days after the pharmacy recommendation was made. Also of note, was Other C's signature on the line

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designated for the DON (Director of Nursing).

Review of the Medication Administration Records (MARs) revealed Resident #12 was administered Trazodone 25 mg from 11/15/16 through 2/13/17. The physician's approved pharmacy recommendation to reduce the Trazodone by 1/2 was not implemented.

On 2/22/17 at 11:a.m., an interview was conducted with the regional nurse consultant, Adm D, regarding the Pharmacy Consultation Report for a gradual dose reduction. After reviewing the report, Adm D said, "Looks to me like it should have been reduced to 12.5 mg. Adm D said the physician's approval of the recommendation on 1/28/17 was the same as a written order.

On 2/22/17 at 4:15 p.m., during an end of day meeting, the administrator, assistant director of nursing and the nurse consultants were informed of the order for the reduction of Resident #12's Trazodone that was not implemented. Resident #12 continued to receive 25 mg of the Trazodone for 15 days after it was ordered for a reduction to 12.5 mg.

Review of the facility's pharmacy policy entitled, Monthyl Medication Review (MMR), included the following under Procedure:
"6. The pharmacist will address of resident's MMRs to the Director of Nursing and/or the attending physician and to the Medical Director.
7. Facility should encourage Physician/Prescriber or other Responsible Parties receiving the MMR and the Director of Nursing to act upon the recommendations contained in the MMR.
8. Facility should alert the Medical Director where

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MMRs are not addressed by the attending physician in a timely manner."

The nurse consultant, Adm B, cited Mosby's Fundamentals of Nursing as one of the facility's reference for professional standard of nursing.

"Fundamentals of Nursing, 7th Edition" by Potter-Perry, provided nursing guidance for medication administration. Page 336 read, "The physician is responsible for directing medical treatment. Nurses follow physicians' orders unless they believe the orders are in error or harm clients."

On 2/23/17 at 2:45 p.m., the administrator, ADON (assistant director of nursing) and corporate consultants were informed of the failure of the staff to follow the physician's order to reduce Resident #12's Trazodone. No additional information was provided.

2. For Resident #16, the facility staff failed to obtain clarification of a sliding scale insulin order and failed to obtain and document a blood sugar measurement on 2/22/17. Sliding scale insulin is a dose of insulin administered based on predetermined parameters as ordered by the physician.

Resident #16 was initially admitted to the facility 2/21/17. Diagnoses included high blood pressure, osteomyelitis of the foot, chronic renal failure and diabetes.

Resident #16 was observed on 2/23/17 at 8:15 a.m. He was resting quietly in his room in his bed.

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On 2/23/17 at 9:00 a.m., a review of Resident #16's clinical record was initiated.

Resident #16 was recently admitted to the facility and was assessed by nursing staff as being alert and oriented x 3 with periods of confusion. Resident #16 was assessed to be able to ambulate short distances and continent of bowel and bladder.

Review of Resident #16's Comprehensive Care Plan created on 2/22/17 revealed a focus for Diabetes Mellitus and an intervention to administer diabetes medication as ordered by the physician

Review of Resident #16's physician orders revealed the following Sliding Scale Insulin order dated 2/21/17, "Insulin Regular Human Solution 100 Unit/ml (milliliter). Inject as per sliding scale: If 150-200 =18 units 15 units before meals add 3 more units for every 30 points above 150; 201-250 units = 21 units subcutaneously before meals for diabetes."

Resident #16's most recent hemoglobin A1c (HA1c) dated 2/17/17 was 13.6. The hemoglobin A1c is a blood test that measures average level of blood sugar over the past 2 to 3 months. Normal range is between 4-5.6

Review of the February 2017 MAR (Medication Administration Record) revealed a corresponding order entry dated 2/21/17 at 6:25 p.m. There was no entry or documentation of a blood sugar measurement for 6:30 a.m. on 2/22/17.

On 2/23/17 at 9:00 a.m., an interview was

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conducted with unit nurse, LPN (licensed practical nurse) A, regarding the sliding scale order. After reviewing the order, LPN A said the order was a little confusing but it was the order that came with Resident #16's hospital discharge orders.

On 2/23/17 at 9:30 a.m., Resident #16's hospital discharge sliding scale orders were reviewed and read, "Insulin Regular 100 Unit/ml. injection 15 units before meals add 3 more units for every 50 points above 150 (milligrams/decliter). 150-200-18 units, 201-250 units = 21 units." The hospital discharge orders were not the same as the facility admission orders.

On 2/23/17 at 10:15 a.m., the ADON (Assistant Director of Nursing)- Adm C, was asked to review Resident #16's sliding scale orders. After reviewing the orders, Adm C said the orders needed clarification. Adm C said she would follow up with the physician.

On 2/23/17 at 12:00 p.m., a follow-up interview was conducted with Adm C regarding Resident #16's SSI orders and the blood sugar measurement on 2/22/17, which was not documented as having been obtained.

On 2/23/17 at 1:15 p.m., during an end of day meeting with the administration, Adm C said she had spoken with a nurse that said she did obtain Resident #16's blood sugar measurement on 2/22/17 and insulin coverage wasn't required. There was no evidence provided of the blood sugar measurement or any written statement from the nurse.

On 2/23/17 at 2:45 p.m., the administration was

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informed of the facility staff's failure to obtain clarification of a sliding scale insulin order and failed to obtain and document Resident #16's blood sugar measurement on 2/22/17. No additional information was given.

3. For Resident #10, an order was written on 11/22/16 to remove sutures to the forehead in 5-7 days. The sutures were not removed until 12/22/16.

Resident #10, a 91 year old, was admitted to the facility on 9/12/16. Her diagnoses included dementia, dysphagia, failure to thrive, hypertension and depression.

Her most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 2/2/17. She was coded with a Brief Interview of Mental Status score of 6 indicating severe cognitive impairment. She required extensive assistance with her activities of daily living.

Resident #10 had a history of falls. On 11/22/16, Resident #10 was found on the floor in her room. She had a laceration to the forehead and was sent to the emergency room.

A skilled nursing note dated 11/22/16 read "skilled for strengthening r/t (related to) falls and debility. Resident alert and orient to self. No sob (shortness of breath)/ resp (respiratory) distress. Resident returns from ER (emergency room) with DX (diagnosis) Acute cystitis without hematuria, fall initial encounter N.O (new order) to remove sutures in 5-7 days."

A health status note dated 12/12/16 read "Spoke

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F 309	Continued From page 54 with (doctor) and asked if Resident's sutures to her forehead could be removed. N.O. (new order) to remove sutures was received and noted on tar (treatment administration record)." Another note dated 12/12/16 read "removed 7 sutures from forehead as ordered. Resident tolerated procedure w/o (without) difficulties. Will continue to monitor." On 2/22/17 at 2:05 p.m., Resident #10's falls were reviewed with the Assistant Director of Nursing (ADON). The ADON was asked if she knew why there was a three week delay in the removal of Resident #10's sutures. The ADON was unsure why the sutures had not been removed in 5-7 days. No further information was provided.	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 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	F 314		3/20/17

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F 314	Continued From page 55 from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to develop preventative strategies for the prevention of pressure ulcer formation for one Resident (Resident #4) in a survey sample of 20 Residents. Resident #4 developed a Stage II pressure ulcer on his left heel 1/3/1/17 and no preventative measures had been developed or implemented by the facility staff to prevent formation of the ulcer. The findings included: Resident #4, a male, was admitted to the facility 1/18/17. His diagnoses included left hip replacement, fractured left femur without repair, chronic kidney disease stage IV, hypertension, arteriosclerotic cardiovascular disease, anemia, hyperlipidemia, and gout. Resident #4's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1/25/17 was coded as an admission, five day assessment. He was coded as having minimal memory deficits and required some assistance with making daily life decisions. Resident #4 was coded as requiring limited to total assistance of one to two staff members to perform his activities of daily living. He was coded as having one unable to stage pressure ulcer upon admission. Resident #4 had been coded as "being at risk" for the development of pressure areas. Resident #4 was observed 2/22/17 at 1:40 p.m.	F 314	F 314 1. Resident # 4 has been discharged from facility. 2. All residents are at risk for deficient practice. 3. Staff Development Coordinator or designee will educate all licensed staff in appropriate strategies to prevent development of pressure ulcer formation. 4. Audit Care Plans on all residents identified as high risk for skin integrity (via Braden scale) for appropriate strategies to prevent ulcer formation. Audit 30% Care Plans weekly times 3 weeks, monthly times one month, and review in quarterly QA & A meeting.	

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during wound care observation. Resident #4 was observed to have an unable to stage pressure ulcer that covered the entire right heel. His left heel was also observed. The left heel appeared to be covered with discolored tissue. No odor, redness, edema, or discharge was observed on either heel. Resident #4 was also observed during initial tour 2/21/17 at 2:55 p.m., 2/21/17 at 4:25 p.m., and 2/22/17 at 8:06 a.m. At all observations (except for during wound care observation) he was out of bed and in a wheelchair and a black specialty positioning boot was on his right foot.

LPN B was present during the wound care observation. LPN B stated she would have to check the clinical record to identify what both heel wounds were assessed as. LPN B did state the floor nurses were responsible for assessing and treating pressure ulcers. LPN B was the floor nurse caring for Resident #4 2/22/17, day shift.

During a weekly skin assessment, Resident #4 was found to have a "serum filled blister" on his left heel. Review of the "Wound Record" completed by LPN (licensed practical nurse) J revealed she had identified the area on his left heel as an "acquired" area and coded the area under the "Type" as "other."

Review of Resident #4's clinical record revealed that upon admission, he was assessed as having an unable to stage pressure ulcer on his right heel. Treatment was initiated to the right heel. On 1/31/17 (13 days after admission), Resident #4 was noted to have developed a "blister" on his left heel. The area was assessed as being an "Other" on the facility's wound care tracking and within two weeks was assessed and coded as a

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Stage II pressure ulcer on the wound tracking. The area was documented as being 2 cm (centimeter) x 0.1 cm, with no depth at the time of discovery. The physician was contacted and ordered "Skin prep Q (every) shift."

www.npuap.com defines pressure ulcers:

"Stage II:
Partial-thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.
Further description:
Presents as a shiny or dry shallow ulcer without slough or bruising.* This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration, or excoriation.
*Bruising indicates suspected deep tissue injury"

LPN J was interviewed 2/22/17 at 3:12 p.m. LPN J stated she had identified the area on 1/31/17 during Resident #4's weekly skin assessment. LPN J stated the area appeared to be a "blister." LPN J stated she was not "confident " about assessing wounds and did not know what else to document the area as being. LPN J stated the only education she had about pressure ulcers was "what I had in school." She also stated the facility had some education on the computer about skin assessments and pressure areas. LPN J stated the MDS staff could be utilized to assist with staging of wounds, however she did not recall if they had been contacted about Resident #4's area on his left heel.

The treatment continued to be "Skin prep every shift" through the time of the survey.

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LPN I, one of the MDS staff, stated 2/22/17 at 3:22 p.m., the MDS could "act as resource" for wound assessment. LPN I was unaware if the MDS staff had assessed Resident #4's left heel after the identification of the area as a "blister."

Review of the wound assessment completed 2/7/17 revealed the area was still assessed as a "blister" and measured 0.2 cm x 0.4 cm with no depth. On 2/14/17 the area had been assessed as a "pressure ulcer" and measured 1.5 cm x 0.5 cm, with no depth.

ADM D stated 2/22/17 at 4:15 p.m., the facility had always utilized the floor nurses to assess and treat wounds. ADM D stated the only education the nurses would have would be what was "from school" and some on line education offered by the facility.

Guidance was provided in "Pressure Ulcer Treatment, U S Department of Health and Human Services, December, 1994, p. 5, Assessment is the starting point in preparing to treat or manage an individual with a pressure ulcer.

Assessment involves the entire person, not just the ulcer and is the basis for starting treatment and evaluating it's effects. Adequate assessment is also essential for communication among caregivers.

(page 23), Emphasizing assessment. Educational programs should emphasize the need for accurate, consistent, and uniform assessment, description, and documentation of the extent of tissue damage. "

Review of Resident #4's care plan revealed an

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entry on his initial interim care plan that included:

"1/20/17 The resident has pressure related actual impairment to skin integrity of the right heel. Risk for further skin breakdown due to decreased mobility and episodes of incontinence.

Interventions:
Encourage good nutrition and hydration in order to promote healthier skin.
Keep skin clean and dry.
Use lotion on dry skin
Obtain labs as ordered
Use a draw sheet or lifting device to move resident
Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface.
Weekly skin assessment ."

The interim care plan was developed on 1/20/17 and revised on 1/31/17 when a "blister" was diagnosed on his left heel.

The revised care plan only included:

"Encourage good nutrition and hydration in order to promote healthier skin.
Keep skin clean and dry.
Use lotion on dry skin
Obtain labs as ordered
Use a draw sheet or lifting device to move resident
Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface.
Weekly skin assessment .
Wound care per MD orders."

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By 2/14/17 the care plan was again revised and at that time only included:

"Potential for skin impairment

Goal:
Resident will have no evidence of skin impairment through next review

Interventions:
Keep skin clean and dry.
Lotion to dry skin.
Pericare with incontinence episodes.
Pressure reduction mattress.
Weekly skin assessment."

ADM B, a corporate consultant, stated 2/23/17 at 1:05 p.m., the staff had determined the area on Resident #4's left heel was due to his rubbing his foot on the floor while attempting to self propel. A thorough review of the clinical record, including the care plan, revealed no documentation of Resident #4 rubbing his foot on the floor while attempting to self propel. No interventions were developed due to that behavior in an attempt to protect his heels.

While no order was evident for Resident #4 to wear the black boot, upon admission information was on his discharge orders from the facility he had been at:

"(R) heel-Apply Allevyn Multisite dressing change every other day-Prevalon boot (R) heel at all times."

A thorough review of the entire care plan (revised and current) revealed no entry for Resident #4 to wear the Prevalon boot at all times to his right

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heel as a preventative measure.

From the time of his admission his care plan failed to address the care of his unable to stage pressure ulcer to his right heel. No preventative measures were developed within the interim care plan nor when it was revised on 1/31/17 nor at the time of the second revision 2/14/17. After the care plan was revised on 2/14/17, no strategies were developed to care for either pressure ulcer (both right and left heels).

Guidance was provided in JAMA January 8 2003 page 223:

"Pressure ulcers develop when persisting pressure on a bony site obstructs healthy capillary flow, leading to tissue necrosis.

Preventing pressure ulcers requires a complex interaction of interventions. Few preventative measures have been rigorously evaluated. However, there is agreement that excessive pressure for a period of time may result in pressure-ulcer development. Thus, major preventive interventions consist of removing or redistributing the pressure sensitive areas of the body."

When interviewed, ADM D, a corporate consultant, stated no interventions were included in the care plan for prevention or for the actual care of the pressure ulcers, 2/23/17 at 12:10 p.m.

The administrator, ADON (assistant director of nursing) and corporate consultants were advised of the failure of the staff to develop strategies on the care plan for prevention of pressure ulcer

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F 314	Continued From page 62 formation and care of the actual pressure ulcers for Resident #4, 2/23/17 at 1:05 p.m.	F 314		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive	F 328		3/20/17

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F 328	Continued From page 63 person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: The Findings included: 1. Resident #1 was an 85 year old who was admitted to the facility on 7/20/16. Resident #1's diagnoses included Pacemaker, Muscle Weakness - Generalized, and Congestive Heart Failure. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 1/16/17, coded Resident #1 as having a Brief Interview of Mental Status Score of 13, indicating that she was moderately independent in daily decision making ability. On 2/21/17 at 2:45 P.M., Resident #1 was observed in her bed awake, with the head of her bed elevated. The outside of her door had a sign on it indicating that oxygen was in use. Resident	F 328	F 328 1. Resident # 1 and # 11 deficient practice has been corrected. 2. All residents receiving oxygen therapy may be at risk. 3. Staff Development Coordinator or designee will educate all licensed staff in: A. Policy / procedure related to oxygen administration / following Doctor□s orders. B. Obtaining Doctor□s order for use of oxygen therapy. 4. Audit 100% of residents receiving oxygen to ensure order and administration is correct, continue with audit weekly times 3 weeks, monthly times one month,	

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F 328	Continued From page 64 #1's oxygen mask was not on her face, and the oxygen concentrator was not on. The charge nurse (Registered Nurse A) was present during the observation. She stated that Resident #1 had a physician's order to receive continuous oxygen. She stated that she didn't know why Resident #1 was not receiving oxygen. On 2/21/17 a review was conducted of Resident #1's clinical record, revealing the following signed physician order, "10/17/16. Oxygen at 2 liters continuously every shift related to Unspecified Diastolic Congestive Heart Failure." On 2/23/17 at 1:30 P.M., an interview was conducted with the Clinical Consultant (Employee B). When asked about the importance of administering Resident #1's oxygen per physician's order, she stated, "You have to because she needs it. It's a physician order and we follow physician's orders." The facility Administrator (Employee A) was present during the interview. No further information was provided. Based on observation, resident interview, staff interview, facility documentation review, and clinical record review, the facility staff failed, for 1 resident (Resident #11) in the survey sample of 20 residents, to ensure that they received the proper treatment and care for the administration of oxygen. 1. For Resident #11, the facility staff administered oxygen without a physician's order. Resident #11, a female, was admitted to the facility 2/1/17. Her diagnoses included metabolic	F 328	and review in Quarterly QA & A meeting.	

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encephalopathy, anasarca, left renal calculus, hepatitis C, cirrhosis, ascites, hypertension, chronic kidney disease stage III, diabetes mellitus, and pancytopenia.

Resident #11's most recent MDS (minimum data set) with an ARD (assessment reference date) of 2/9/17 was coded as an admission assessment. She was coded as having no memory deficits and was able to make her own daily life decisions. She was coded as needing limited assistance of one staff member to perform her activities of daily living with the exception of bathing. For bathing she was coded as requiring extensive assistance of one staff member. She was coded as having one fall with no injury since admission. Section O, Special Treatments, Procedures, Programs, indicated she did not receive oxygen therapy during the look back period.

Resident #11 was observed during initial tour of the facility 2/21/17 at approximately 2:53 p.m. She was lying on her back in bed with the head of bed slightly elevated. Resident #11 was alert and verbally responsive. She was receiving oxygen at 1.5 lpm (liters per minute) via nasal cannula. Resident #11 was also observed 2/21/17 at 4:40 p.m. She was in therapy, standing folding clothes. She was receiving oxygen 1.5 lpm. Resident #11 was also observed 2/22/17 at 8:15 a.m. Resident #11 was sitting on the side of her bed and was alert, oriented and verbally responsive. She was receiving oxygen at 1.5 lpm.

A nasal cannula is a soft flexible plastic tube that delivers oxygen directly into the nostrils.

A thorough review of the clinical also revealed no

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physician's order for oxygen to be administered from the time of admission until the observation during the survey. Additionally, no documentation was included in the clinical record that Resident #11 was receiving oxygen, including the care plan or nursing notes.

LPN (licensed practical nurse) B, the nurse caring for Resident #11, was interviewed 2/22/17 a 11:20 a.m. LPN B stated that upon admission, Resident #11 was receiving oxygen at night only. LPN B stated as Resident #11 was active in therapy, she became more short of breath and oxygen was started during the day. LPN B stated, "She uses oxygen all the time now." LPN B reviewed Resident #11's clinical record and stated she "didn't see an order."

Review of the facility's policy entitled, "General Dose Preparation and Medication Administration" revealed:

"4.1.1 Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident, as set forth..."

Additionally, guidance for the administration of oxygen is provided within "Fundamentals of Nursing Potter Perry 7th Edition, p. 951, Oxygen therapy is cheap, widely available, and used in a variety of setting to relieve or prevent tissue hypoxia. The goal of oxygen therapy is to prevent or relieve hypoxia (Hypoxia (www.medicaldictionary.thefreedictionary.com decreased availability of oxygen to the tissues). Oxygen is not a substitute for other treatment, however, and is used only when indicated.

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F 328	Continued From page 67 Oxygen is a medication. It has dangerous side effects, such as atelectasis (www. medicaldictionary.thefreedictionary.com -partial or total collapse of the lung) or oxygen toxicity. As with any medication, the dosage or concentration of oxygen is continuously monitored. Routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration." The administrator, ADON (assistant director of nursing) and corporate consultants were informed of Resident #11 being administered oxygen without a physician's order 2/22/17 at 4:20 p.m. and 2/23/17 at 1:05 p.m.	F 328		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 329		3/20/17

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F 329	Continued From page 68 (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 observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure two Residents (Residents' #4 and #12) in a survey sample of 20 Residents were free from unnecessary medication. 1. For Resident #4, Midodrine was administered on 1/20/17, 1/29/17, 1/30/17, and 2/4/17 when his systolic blood pressure was greater than 160 mmHg (millimeters of mercury) or his blood pressure was not obtained. The physician's order was to not administer the medication if Resident #4's systolic blood pressure (sbp) was greater than 160 mmHg; and 2. For Resident #12, the facility staff failed to implement the physician approved pharmacy	F 329	F 329 1. Resident # 4 has been discharged from facility. Resident # 12 deficient practice has been corrected. 2. All residents with parameters related to B/P medication or change in medication dosage may be at risk. 3. Staff Development Coordinator or designee will in-service all licensed staff in: A. Identification of blood pressure medication parameters. B. Identification in change of medication dosage per Doctor□s orders. 4. 100% Audit of Residents receiving medications requiring parameter documentation, those residents with	

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F 329	Continued From page 69 recommendation to reduce a 25 mg (milligram) dose of Trazodone (an anti-depressant) in half, 12.5 mg. Resident #12 continued to receive 25 mg of the Trazodone for 15 days after the physician's order to reduce to 12.5 mg. The findings included: 1. For Resident #4, Midodrine was administered on 1/20/17, 1/29/17, 1/30/17, and 2/4/17 when his systolic blood pressure was greater than 160 mmHg (millimeters of mercury) or his blood pressure was not obtained. The physician's order was to not administer the medication if Resident #4's systolic blood pressure (sbp) was greater than 160 mmHg. Resident #4, a male, was admitted to the facility 1/18/17. His diagnoses included left hip replacement, fractured left femur without repair, chronic kidney disease stage IV, hypertension, arteriosclerotic cardiovascular disease, anemia, hyperlipidemia, and gout. Resident #4's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1/25/17 was coded as an admission, five day assessment. He was coded as having minimal memory deficits and required some assistance with making daily life decisions. Resident #4 was coded as requiring limited to total assistance of one to two staff members to perform his activities of daily living. He was coded as having one unable to stage pressure ulcer upon admission. Resident #4 had been coded as "being at risk" for the development of pressure areas. Resident #4 was observed 2/22/17 at 1:40 p.m. during wound care observation. Resident #4 was	F 329	ordered change in medication dosage will be reviewed for accuracy. Continue audit weekly times 3 weeks, monthly times one month, and review in quarterly QA & A meeting.	

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observed to have an unable to stage pressure ulcer that covered the entire right heel. His left heel was also observed. The left heel appeared to be covered with discolored tissue. No odor, redness, edema, or discharge was observed on either heel. Resident #4 was also observed during initial tour 2/21/17 at 2:55 p.m., 2/21/17 at 4:25 p.m., and 2/22/17 at 8:06 a.m. At all observations (except for during wound care observation) he was out of bed and in a wheelchair and a black specialty positioning boot was on his right foot. At all observations, Resident #4 was noted to be alert and verbally responsive, however confused.

Review of Resident #4's clinical record revealed a signed physician's order that included:

"1/18/17 Midodrine HCL Tablet 5 mg (milligram) Give 1 tablet by mouth one time a day for maintain BP. Hold for SBP higher than 160. Do not recline or lay back for 4 hours after dose."

www.drugs.com indicates Midodrine:

"Midodrine hydrochloride tablets, USP are indicated for the treatment of symptomatic orthostatic hypotension (OH). " Orthostatic hypotension is when a Resident's blood pressure drops when standing.

An accompanying entry was placed on the eMAR (electronic medication administration record). Nurses initials were evident indicating the medication had been administered daily at 6 a.m. from 1/19/17 until the medication was discontinued 2/7/17. On 1/20/17 and 1/29/17 Resident #4's blood pressure was not obtained prior to administering the medication. Resident

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#4's blood pressure was obtained and was documented as being 188/58 mmHg (millimeters of Mercury) on 1/30/17 and 166/61 mmHg on 2/4/17.

Guidance was provided at www.drugs.com for administration of Midodrine:

"Because Midodrine hydrochloride tablets can cause marked elevation of supine blood pressure, it should be used in patients whose lives are considerably impaired despite standard clinical care. The indication for use of Midodrine hydrochloride tablets in the treatment of symptomatic orthostatic hypotension is based primarily on a change in a surrogate marker of effectiveness, an increase in systolic blood pressure measured one minute after standing, a surrogate marker considered likely to correspond to a clinical benefit. At present, however, clinical benefits of Midodrine hydrochloride tablets, principally improved ability to carry out activities of daily living, have not been verified."

Review of the facility's policy entitled "General Dose Preparation and Medication Administration" included:

"4.1.1 Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident, as set forth...

4.1.5 If necessary, obtain vital signs."

The administrator, ADON (assistant director of nursing) and corporate consultant were informed of the failure of the staff to obtain Resident #4's

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blood pressure prior to administering Midodrine on 1/20 and 1/29/17 and to refrain from administering Midodrine 1/30 and 2/4/17 when Resident #4's SBP was greater than 160 mmHg, 2/23/17 at 1:05 p.m. ADM D stated he had not been able to determine if Resident #4's blood pressure had been obtained and not documented on 1/20 and 1/29/17 at 6 a.m.

2. For Resident #12, the facility staff failed to implement the physician approved pharmacy recommendation to reduce a 25 mg (milligram) dose of Trazodone (an anti-depressant) in half, 12.5 mg. Resident #12 continued to receive 25 mg of the Trazodone for 15 days after the physician's order to reduce to 12.5 mg.

Resident #12 was readmitted to the facility on 11/15/16. His diagnoses included seizures, peripheral vascular disease, malnutrition, dementia, and osteoarthritis.

On 2/21/17 at 4:42 p.m., Resident #12 was observed in his room sleeping on an air mattress. On 2/22/17 at 8:15 a.m., Resident #12 was observed sitting in the doorway of his room in his wheelchair. He had just completed his breakfast when he stated, "I'm going back to bed soon". Resident #12 was observed to be very thin, had some food from his breakfast on his left hand and the left side of his face and he was slightly sliding from the seat of the wheelchair.

On 2/21/17 at 4:50 p.m., a review of Resident #12's clinical record was initiated.

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Resident #12's most recent MDS (minimum data set) with an ARD (assessment reference date) of 11/22/16 was coded as an admission assessment. He was coded as having long and short term memory deficits and was moderately impaired to make his own daily life decisions. Resident #12 was coded as requiring extensive to total assistance of one staff member to perform his activities of daily living, except for eating, he required limited assistance. In Section N, Medications Received, Resident #12 was coded for the use of an anti-depressant for seven days of the ARD period.

Review of Resident #12's Comprehensive Care Plan did not include interventions related to the use of a psychotropic drug. ("Psychotropic medications are drugs that effect brain activities associated with mental processes and behavior. Psychotropic medications are divided into four broad categories: anti-psychotic; anti-depressant; anti-anxiety; and hypnotic medication." www.oig.hhs.gov)

Review of the Physician Orders revealed an order dated 11/15/16 , "Trazodone 50 mg. Give .5 tablet by mouth at bedtime for sleep dose is 25 mg."

Review of a Pharmacy Consultation Review dated 1/18/17 read, "[Resident's Name] has an order for Trazodone 25 mg hs (at bedtime) for Insomnia. If clinically appropriate, please evaluate for gradual dose reduction." Hand written on the consultation was, "Resident is on 25 q (every) HS." Under Physician Response was checked, "I accept the recommendation above, please implement as written." Hand written was, [an arrow pointing downward] decrease to 1/2 Pill." Signed by the physician

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(Other C) on 1/28/17, which was 10 days after the pharmacy recommendation was made. Also of note, was Other C's signature on the line designated for the DON (Director of Nursing).

Review of the Medication Administration Records (MARs) revealed Resident #12 was administered Trazodone 25 mg from 11/15/16 through 2/13/17. The physician's approved pharmacy recommendation to reduce the Trazodone by 1/2 was not implemented.

On 2/22/17 at 11:a.m., an interview was conducted with the regional nurse consultant, Adm D, regarding the Pharmacy Consultation Report for a gradual dose reduction. After reviewing the report, Adm D said, "Looks to me like it should have been reduced to 12.5 mg. Adm D said the physician's approval of the recommendation on 1/28/17 was the same as a written order.

On 2/22/17 at 4:15 p.m., during an end of day meeting, the administrator, assistant director of nursing and the nurse consultants were informed of the order for the reduction of Resident #12's Trazodone that was not implemented. Resident #12 continued to receive 25 mg. of the Trazodone for 15 days after it was ordered for a reduction to 12.5 mg.

Review of the facility's pharmacy policy entitled, Monthly Medication Review (MMR), included the following under Procedure:
"6. The pharmacist will address of resident's MMRs to the Director of Nursing and/or the attending physician and to the Medical Director.
7. Facility should encourage Physician/Prescriber or other Responsible Parties receiving the MMR

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F 329	Continued From page 75 and the Director of Nursing to act upon the recommendations contained in the MMR. 8. Facility should alert the Medical Director where MMRs are not addressed by the attending physician in a timely manner." The nurse consultant, Adm B, cited Mosby's Fundamentals of Nursing as one of the facility's reference for professional standard of nursing. "Fundamentals of Nursing, 7th Edition" by Potter-Perry, provided nursing guidance for medication administration. Page 336 read, "The physician is responsible for directing medical treatment. Nurses follow physicians' orders unless they believe the orders are in error or harm clients." On 2/23/17 at 2:45 p.m., the administrator, ADON (assistant director of nursing) and corporate consultants were informed of staff's failure to ensure Resident #12 did not receive unnecessary medication. No additional information was provided.	F 329		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the	F 425		3/20/17

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F 425	Continued From page 76 provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure medications were available for administration for one Resident (Resident #4) in a survey sample of 20 Residents . Physician ordered Procrit was not available for administration on 2/8/17. The findings included: Resident #4, a male, was admitted to the facility 1/18/17. His diagnoses included left hip replacement, fractured left femur without repair, chronic kidney disease stage IV, hypertension, arteriosclerotic cardiovascular disease, anemia, hyperlipidemia, and gout. Resident #4's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1/25/17 was coded as an admission, five day assessment. He was coded as having minimal memory deficits and required some assistance with making daily life decisions. Resident #4 was coded as requiring limited to total assistance of one to two staff members to perform his activities of daily living. He was coded as having one unable to stage pressure ulcer upon admission. Resident #4 had been coded as "being at risk" for the development of pressure areas. Review of Resident #4's clinical record revealed a signed physician's order that included: "2/1/17 Procrit Solution 10000 units/ml (milliliter). Inject 1 ml intramuscularly one time a day every	F 425	F 425 1. Resident # 4 has been discharged from facility. 2. All residents are at risk for deficient practice. 3. Staff Development Coordinator or designee will educate all licensed staff related to medication administration. 4. 100% audit completed on all residents with orders for Procrit to ensure administration. Continue 30% audit weekly times 3 weeks, monthly times one month, and review in quarterly QA & A meeting.	

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(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
F 425	Continued From page 77	F 425		

Wed (Wednesday)."

An accompanying entry was placed on the eMAR (electronic medication administration record) with nurses' initials indicating the medication was administered on 2/1/17 and 2/15/17. A "9" was in the space for 2/8/17 with the key of the eMAR indicating a "9" referred the reader to the nursing notes. An entry in the nursing notes for 2/8/17 indicated the medication was not administered as it was not available. Included in the note was "awaiting pharmacy." No further information was available indicating the medication had been delivered from the pharmacy or administered at a later time.

Procrit was a medication utilized to treat anemia, a decrease in red blood cells. Procrit will increase the number of red blood cells.

A CBC (complete blood count) was obtained from Resident #4 on 2/9/17. Results indicated Resident #4's hemoglobin was 7.5 and his hematocrit was 22.4. Hemoglobin is the protein that makes blood red. It is responsible for transporting oxygen to the cells. The hematocrit is the ratio of red blood cells to serum in the blood.

https://www.google.com/?gws_rd=ssl#q=range+of+hemoglobin+in+male&*

"The normal range for hemoglobin is: For men, 13.5 to 17.5 grams per deciliter. For women, 12.0 to 15.5 grams per deciliter."

Documentation was evident the next dose of Procrit that was administered to Resident #4 was

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	495266	A. BUILDING _____ B. WING _____	02/23/2017

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F 425	Continued From page 78 2/14/17. Review of the facility's policy entitled, "General Dose Preparation and Medication Administration" revealed: "4.1.1 Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident, as set forth..." The administrator, ADON (assistant director of nursing) and corporate consultant were informed of the failure of the staff to ensure Procrit was available for administration to Resident #4, 2/23/17 at 1:05 p.m. ADM D stated the nurse that was to administer the medication on 2/8/17 stated she thought she gave the medication, however no evidence was available to verify that the medication was administered.	F 425		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 431		3/20/17

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F 431	Continued From page 79 (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility	F 431	F 431	

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F 431	Continued From page 80 documentation, and manufacturer's recommendations, the facility staff failed to store insulin under refrigeration on two of seven medication carts. Two Novolog vials, one Lantus vial, and one Novolog flex pen was stored on medication carts prior to be opened and accessed. Manufacturer's recommendations are for insulin to be stored in the refrigerator until opened and accessed. The findings included: The north hall medication cart on west wing was observed 2/22/17. Located within the medication cart were two vials of Novolog insulin and one vial of Lantus insulin that were unopened and had not been accessed. LPN (licensed practical nurse) B, the nurse administering medication from the cart, stated one vial of Novolog insulin would have been delivered to the facility on 2/15/17 and the other vial of Novolog insulin would have been delivered on 2/17/17. LPN B also stated the vial of Lantus insulin was delivered to the facility on 2/16/17. LPN B stated she was able to determine the dates by the delivery dates on the pharmacy labels. LPN B stated the insulins had been stored in the medication cart since they had been delivered to the facility. LPN B stated she did not know why they were not put into the refrigerator when delivered to the facility. LPN B stated she thought the vials of insulin were stored in the refrigerator for "easy accessibility." Review of the facility's policy entitled "Insulin Storage Recommendations" included:	F 431	1. All insulin has been placed in appropriate storage location per manufacturer guidelines. 2. All residents may be at risk for deficient practice. 3. Staff Development Coordinator or designee will educate all licensed staff on appropriate storage of insulin. 4. Pharmacy consultant will audit for appropriate storage of insulin. Continue with audit of facility med carts 3 times week for 3 weeks, monthly for one month, and review quarterly in QA & A meeting.	

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F 431	Continued From page 81	F 431		

Lantus Unopened Refrigerated: Until expiration date Room Temperature: 28 days

Novolog unopened Refrigerated: Until expiration date Room Temperature: 28 days

Guidance was also provided at www.novolog.com:

"Store NovoLog® in the refrigerator-between 36°F and 46°F (2°C and 8°C)-until first use. Do not freeze. NovoLog® FlexPen® and PenFill® cartridges that are in use must be kept at room temperature-below 86°F (30°C)-for up to 28 days and must not be refrigerated. Vials, once in use, can be kept at either room temperature or in the refrigerator. Do not store NovoLog® in areas of extreme moisture and where there may be very hot or cold temperatures, such as in a freezer or car."

ADM B, a corporate consultant stated 2/23/17 at 1:05 p.m., all insulins should be stored in the refrigerator until opened and accessed. She stated the insulin could be used until the expiration date if kept in the refrigerator and unopened.

The 300 East hall medication cart was observed 2/22/17 at 1:36 p.m. Within the medication cart was one Novolog flex pen that had not been opened or accessed. LPN C stated the flex pen had been delivered to the facility 2/21/17 and been stored in the medication cart since being delivered to the facility.

Review of the facility's policy entitled "Insulin Storage Recommendations" included:

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F 431	Continued From page 82 "Novolog cartridge or pen Unopened Refrigerated Until expiration date Room temperature 28 days (refrigeration recommended) Guidance was also provided at www.novolog.com: "NovoLog® FlexPen® and PenFill® cartridges that are in use must be kept at room temperature-below 86°F (30°C)-for up to 28 days and must not be refrigerated. Vials, once in use, can be kept at either room temperature or in the refrigerator." The administrator, ADON (assistant director of nursing), and corporate consultants were advised of the failure of the staff to store unopened/unaccessed Novolog insulin vials, a Lantus insulin vial, and Novolog FlexPen in the refrigerator prior to opening and accessing per manufacturer's recommendations, 2/23/17 at 1:05 p.m.	F 431		