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	495372	A. BUILDING _____ B. WING _____	C 06/08/2017

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SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 6/6/17 through 6/8/17. Significant corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. One complaint was investigated during the survey. The Life Safety Code survey/report will follow. The census in this 216 certified bed facility was 202 at the time of the survey. The survey sample consisted of twenty-seven current resident reviews (Residents 1 through 27) and three closed record reviews (Residents 28 through 30).	F 000		
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-	F 278		7/19/17

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

Electronically Signed | 06/26/2017

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F 278	Continued From page 1 (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure an accurate minimum data set (MDS) for one of 30 residents in the survey sample. Resident #11's quarterly MDS dated 4/13/17 inaccurately assessed the resident as always incontinent of urine. The findings include: Resident #11 was admitted to the facility on 5/25/11 with a re-admission on 12/21/15. Diagnoses for Resident #11 included high blood pressure, congestive heart failure, COPD (chronic obstructive pulmonary disease), neuropathy, renal failure and chronic pain. The MDS dated 4/13/17 assessed Resident #11 as cognitively intact. Resident #11's clinical record documented the most recent MDS dated 4/13/17. Section H0300 of this MDS documented the resident was always incontinent of urine. Previous MDS assessments dated 1/31/17, 11/15/16 and 8/23/16 listed the	F 278	Corrective Action: An MDS modification was completed and submitted for Resident #11, Section H, by MDS Coordinator on 6/7/17. Identification: MDS Assessments completed within the past quarter that identified a change in urinary continence will be audited to ensure accurate coding in Section H, 0300 Urinary Continence. Changes: MDS Coordinators will be re-educated on MDS Section H Bladder and Bowel, with specific attention given to 0300 Urinary Continence pages H-7 through H-9. Monitoring: QA Coordinator or designee will audit 15	

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F 278	Continued From page 2 resident as only occasionally incontinent of urine. On 6/7/17 at 10:15 a.m. the certified nurses' aide (CNA #3) that routinely cared for Resident #11 was interviewed about the resident's incontinence. CNA #3 stated the resident was not always incontinent. CNA #3 stated Resident #11 always told her when she needed to go to the bathroom. CNA #3 stated the resident had some bladder leaks when she had coughing spells but routinely requested to use the restroom. CNA #3 stated Resident #11 was very aware if she had bladder leaks and immediately asked for assistance with toileting as needed. On 6/7/17 at 10:25 a.m. the registered nurse responsible for MDS assessments (RN #7) was interviewed about the accuracy of Resident #11's bladder continence. RN #7 stated Resident #11 was not always incontinent. RN #7 reviewed the continence data used for Resident #11's MDS dated 4/13/17. RN #2 stated the coding of "3" indicating always incontinent was inaccurate. RN #7 stated Resident #11 should have been listed as frequently incontinent of bladder for the 4/13/17 MDS. Resident #11's continence data report used for the MDS dated 4/13/17 documented the resident was continent of bladder on 14 out of 25 toileting entries during the look back period from 4/7/17 through 4/13/17. Page H-8 of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual states concerning assessment of bladder continence, "...Review the medical record for bladder or incontinence records or flow sheets, nursing assessments and progress notes,	F 278	MDS assessments monthly to ensure accurate coding of Section H, 0300 Urinary Continence. If variances are found, the responsible MDS Coordinator will be required to complete additional education and submit modified assessments when necessary. Audit findings will be reported to the Quality Assurance & Performance Improvement (QAPI) Committee for additional oversight and recommendation. The QAPI Committee will determine when to discontinue this practice.	

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F 278	Continued From page 3 physician history, and physical examination... Interview the resident if he or she is capable of reliably reporting his or her continence... Ask direct care staff who routinely work with the resident on all shifts about incontinence episodes... Code 2, frequently incontinent: if during the 7-day look-back period, the resident was incontinent of urine during seven or more episodes but had at least one continent void. This includes incontinence of any amount of urine, daytime and nighttime... Code 3, always incontinent: if during the 7-day look-back period, the resident had no continent voids." (1) These findings were reviewed with the administrator and director of nursing during a meeting on 6/7/17 at 1:30 p.m. (1) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.14, Centers for Medicare & Medicaid Services, Revised October 2016.	F 278		
F 280 SS=E	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the	F 280		7/19/17

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expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

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

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

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

483.21
(b) Comprehensive Care Plans

(2) A comprehensive care plan must be-

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

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

(A) The attending physician.

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F 280	Continued From page 5 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to review and revise the CCP (comprehensive care plan) for 5 of 30 residents in the survey sample, Resident # 12, 13, 8, 24, and 9. 1. The facility staff failed to review and revise the CCP for Resident # 12 in the area of falls. 2. The facility staff failed to review and revise the CCP for Resident # 13 in the area of pressure ulcers.	F 280	Corrective Action: Resident #12's care plan was updated 6/9/17 to address fall interventions. Resident #13's care plan was updated on 6/19/17 to address pressure ulcer interventions, i.e. use of cushion. Resident #8's care plan was updated to address open wound on 6/9/17. Resident #24's care plan was updated 6/8/17 to address urinary output. Resident #9's care plan was updated	

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F 280	Continued From page 6 3. Resident #8's care plan was not revised to address an opened wound from his Foley catheter. 4. The facility staff failed to review and revise the CCP for Resident # 24 related to urinary output. 5. Facility staff failed to review and revise Resident #9's CCP (comprehensive care plan) to remove the application of tubigrips to the resident's bilateral lower legs when out of bed. The physician order to discontinue the use of tubigrips was dated 03/28/17. Findings include: 1. The facility staff failed to review and revise the CCP for Resident # 12 in the area of falls. Resident # 12 was admitted to the facility on 08/11/16 after a fall at home, which resulted in a hip fracture. Additional diagnoses for Resident # 12 included, but were not limited to: anemia, a history of a stroke with left sided weakness, fall at home with resulting a hip fracture and insomnia. The most current MDS (minimum data set) was a quarterly assessment dated 04/12/17. This MDS assessed the resident as having a cognitive score of 12, indicating the resident had moderate impairment in daily decision making skills. The resident was additionally assessed as requiring extensive assistance from at least one staff person for all ADL's (activities of daily living), including transfers, ambulation and toileting. Resident # 12's admission MDS dated 08/18/16	F 280	6/9/17 to discontinue tubigrips. Identification: The Nurse Managers will review facility's fall tracking log from the past 30 days to ensure that the care plan updates for affected residents has occurred. The Nurse Managers will review residents with cushions to ensure that the care plan updates for affected residents has occurred. The Nurse Managers will assess male residents with Foley catheters for the presence of open wounds to ensure that the care plan updates for affected residents has occurred. The Nurse Managers will review care plans for those residents receiving dialysis to ensure urinary output is addressed. The Nurse Managers will review resident's with orders for tubigrips to ensure that this intervention remains active. Changes: The Nurse Managers and MDS Coordinators will be re-educated on facility's "Comprehensive Person-Centered Care Planning" policy. Monitoring: The interdisciplinary team will initiate and complete updates for the care plan for facility residents. The MDS Coordinator will be responsible for monitoring compliance and will review resident care plans in conjunction with each MDS	

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F 280	Continued From page 7 was reviewed. The resident triggered in the CAAS (care area assessment summary) section of this MDS for falls. During clinical record review the resident's nursing notes were reviewed. A nursing note documented September 29, 2016 documented that the resident fell after attempting to get up unassisted and sustained a laceration to the face/head area. Resident # 12's CCP was reviewed and did not evidence that the resident had a fall on 09/29/17 and did not evidence that any new interventions were implemented after this fall with injury. On 06/07/17 at 10:30 a.m., RN (Registered Nurse) # 1 was asked who updates care plans. RN # 1 stated that MDS and unit managers, but nurses will update too. The RN was then asked for assistance in locating information for Resident # 12 regarding the above fall. RN # 1 stated that the resident was originally on Unit 1, and did not know if unit 1 had a care plan regarding this or not. On 06/08/17 at approximately 8:30 a.m., RN # 1 stated that no additional information could be located to evidence that Resident # 12's CCP had been updated to reflect the fall or any new interventions. The DON (director of nursing) and the administrator were made aware in a meeting with the survey team on 06/07/17 at approximately 1:30 p.m. No further information and/or documentation was	F 280	assessment. Audit findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for additional oversight and recommendation. The QAPI Committee will determine when to discontinue this practice.	

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presented.

2. The facility staff failed to review and revise the CCP for Resident # 13 in the area of pressure ulcers.

Resident # 13 was admitted to the facility on 05/01/15. Diagnoses for Resident # 13 included, but were not limited to: Chronic kidney disease (stage 3), BPH (benign prostatic hypertrophy) with a history of urinary tract infections, urinary retention with chronic Foley catheter.

The most current MDS (minimum data set) was a quarterly assessment dated 04/19/17. This MDS assessed the resident as having a cognitive score of 4, indicating the resident had severe impairment in daily decision making skills. The resident was additionally assessed as requiring extensive assistance from at least one staff person for most ADL's (activities of daily living), including transfers, toileting, and hygiene.

Resident # 13's annual MDS dated 08/10/16 was reviewed. The resident triggered in the CAAS (care area assessment summary) section of this MDS for pressure ulcers.

During clinical record review the resident's physician progress notes were reviewed. A physician progress note (General surgery consult) dated 05/30/17 documented that the resident was being seen for ongoing pain to his right buttock. According the progress note, this was a healed pressure area location, but the resident was complaining of tenderness in this area. The progress note further documented that the resident should 'stay off area' and the use of a

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'donut' cushion may help and it was thought that there may be some scar and/or nerve tissue damage from the prior pressure ulcer area.

The resident was observed on several occasions with a thick cushion in the seat of his wheelchair.

Resident # 13's CCP was reviewed and there was no information on the CCP regarding the resident's complaints of pain in this area, no information regarding the resident being seen for this area nor any information regarding the recommendations to help alleviate pain and discomfort to the site.

On 06/07/17 at approximately 2:00 p.m., RN # 1 was asked about the above information.

RN # 1 stated that the resident was ordered a gel cushion after the consult and then it was discontinued due to the resident refusing it. The RN stated the cushion the resident has now is foam and it came from therapy. The RN did not know when the resident received the foam cushion and did not know why the resident's CCP was not updated to reflect the above information.

On 06/08/17 at approximately 8:30 a.m., RN # 1 stated that no additional information could be located to evidence that Resident # 13's CCP had been updated.

The DON (director of nursing) and the administrator were made aware in a meeting with the survey team on 06/07/17 at approximately 1:30 p.m.

No further information and/or documentation was presented.

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3. Resident #8's care plan was not revised to address an opened wound from his Foley catheter.

Resident #8 was admitted to the facility on 5/9/14 with, but not limited to, the following diagnoses: hypertension, benign prostatic hypertrophy and coronary artery disease. The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/25/17 was a quarterly assessment. The resident was assessed as being a eight (8) for cognitive skills, moderately impaired in decision-making skills.

On 6/7/17 at approximately 11:30 a.m. Resident #8's clinical record was reviewed to include the following Physician's Telephone Order: "5/30/17 1) Schedule urology appt (appointment) for penile erosion & bleeding..."

On 6/7/17 at approximately 10:52 a.m., This Surveyor accompanied a certified nursing assistant, who was caring for the resident and will be identified as CNA #1, into the resident's room. Resident #8 was observed lying in bed. This Surveyor asked Resident #8 for permission to observe the Foley catheter, with the resident's permission this Surveyor observed Resident #8's Foley catheter. A two and a half inch slit was observed to the underside of the resident's shaft and the tubing of the Foley was observed pulled away from the meatus and hanging over onto the resident's scrotum. CNA #1 was interviewed regarding the penile slit and how long the area had been opened. CNA #1 stated, I have been out for a while due to surgery but when I came back in May it was like that." CNA #1 further

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stated that the Stat Lock, adhesive strap with a small white clamp in the center to hold the Foley in place, was "changed because it was barely hanging on and it was not serving its purpose." When interviewed and asked if "serving its purpose" meant preventing the catheter from pulling, CNA #1 stated, "Yes, we try to keep it alternated from leg to leg so that it, Foley tubing, does not lay in one spot."

On 6/7/17 at approximately 11:00 a.m., A Care Plan (CP) updated on 5/5/17 was reviewed, the CP did not address the penile erosion or any treatment plans to heal the area.

On 6/7/17 at approximately 11:02 a.m., the Unit Manager, who was a registered nurse and will be identified as RN #4 was interviewed regarding the CP being updated to reflect the open area to the resident's penis and the treatment plan. RN #4 stated, "I don't know what the plan is to treat but I planned to put it, the open area to the penis, on the care plan but I have not done it yet. I planned to do it when the care plan got back to the floor." When RN #4 was interviewed and asked how long was aware of the area to the resident's penis, RN #4 stated, "Since May thirtieth."

The CP was not updated as of 6/7/17. The Director of Nursing was present during the time of the interview with RN #4.

On 6/7/17 at approximately 1:40 p.m., the administrative staff was made aware of the CP not being updated to reflect the opened area to the resident's penis and the treatment plan. The DON stated that the treatment plan was the Safety Lock. The DON was made aware that the Safety Lock was not updated on the care plan as

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an intervention.

4. Resident #24's care was not updated to reflect her urinary status related to Dialysis.

Resident #24 was admitted to the facility on 5/5/17 with, but not limited to, the following diagnoses: end stage renal disease, diabetes mellitus and congestive heart failure. The resident dialysis days were Tuesday, Thursday and Saturday. The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/22/17 was an admission assessment. The resident was assessed as being a 10 for cognitive skills, moderately impaired in decision-making skills.

On 6/8/17 at approximately 8:00 a.m., Resident #24's Admission MDS was reviewed in the clinical record. Under section V Care Area Assessment, the resident triggered for Urinary Incontinence to be care planned (CP). The current CP dated 5/25/17 was reviewed to include the following: "5/25/17 Problems / Strengths ADLS (activities of daily living) Independent to total assist...Interventions: Toilet use with needed assistance..."

On 6/8/17 at approximately 8:12 a.m., the MDS coordinator, who was a registered nurse and will be identified as RN #9 was interviewed regarding the CP for urinary incontinence. RN #9 reviewed the CP and stated, "she does not have urinary output because she goes to Dialysis." RN #9 was interviewed and asked if the CP should reflect the following, RN #9 stated, "Yes, I will add it to her CP."

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On 6/8/17 at approximately 10: 02 a.m., the administrative staff were made aware of the above findings.

5. Facility staff failed to review and revise Resident #9's CCP (comprehensive care plan) to remove the application of tubigrips to the resident's bilateral lower legs when out of bed. The physician order to discontinue the use of tubigrips was dated 03/28/17.

Resident #9 was admitted to the facility on 04/10/2012 with diagnoses including, but not limited to: Peripheral Vascular Disease, Osteoarthritis, Hypertension, Dementia and Diabetes.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 04/07/17. Resident #9 was assessed as severely impaired in her cognitive skills with a total cognitive score of zero out of 15.

Review of Resident #9's clinical record on 06/07/17 at approximately 8:20 a.m. revealed interventions on the CCP to apply "...Tubigrips to bilateral legs RT [related to] swelling when OOB [out of bed] on 7-3 shift, off 3-11 shift...Start Date: 4/30/2015..." This intervention was included under the problem of "ADL [activities of daily living] Function..." Included under the problem of "Pressure Ulcers/Skin Breakdown...Tubigrips to bilateral legs for edema on 7-3 shift, off on 3-11 shift...Start Date: 04/20/2012..." Included under the problem of "Pain...Tubigrips to bilateral legs for edema on 7-3 shift, off on 3-11 shift, when OOB...Start Date: 07/24/2012..."

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F 280	Continued From page 14 At approximately 9:20 a.m. on 06/07/17 this surveyor spoke with Resident #9 and asked if she had tubigrips on her lower legs. Resident #9 pulled up her pant legs and showed this surveyor she did not have tubigrips in place. Resident #9 stated, "I just didn't put them on." This surveyor reviewed the TAR's (treatment administration records) for Resident #9 and discovered an order that discontinued the use of tubigrips on 03/28/2017. The clinical manager, RN #1 (registered nurse) was interviewed on 06/07/17 at 9:30 a.m. regarding updated care plans. RN #1 stated, "The care plan can be updated by me, MDS or whomever. There doesn't have to be a specific event to change the care plan." This surveyor showed RN #1 the three problems on Resident #9's current CCP that included the use of tubigrips. RN #1 had no explanation why the tubigrip interventions had not been removed from the care plan when the discontinuation order was written on 03/28/17. The Administrator and DON (director of nursing) were informed of the above documentation during a meeting with the survey team on 06/07/17 at approximately 1:35 p.m. No further information was received by the survey team prior to the exit conference on 06/08/17.	F 280		
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 281		7/19/17

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F 281	Continued From page 15 must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow professional standards of nursing practice for one of 30 residents in the survey sample. Unsigned, undated, handwritten changes were made to a current physician's order on Resident #11's medication administration record. There was no clarification prior to administration to Resident #11 regarding a new order that indicated different doses of the medication Neurontin to be administered at the same time each day. The findings include: Resident #11 was admitted to the facility on 5/25/11 with a re-admission on 12/21/15. Diagnoses for Resident #11 included high blood pressure, congestive heart failure, COPD (chronic obstructive pulmonary disease), neuropathy, renal failure and chronic pain. The MDS dated 4/13/17 assessed Resident #11 as cognitively intact. Resident #11's clinical record was reviewed on 6/7/17. The record documented a physician's order date 9/29/16 for the medication Neurontin 100 mg (milligrams) to be administered twice each day (at 8:00 a.m. and 12:00 p.m.) and a physician's order dated 9/29/16 for Neurontin 300 mg to be administered at each bedtime (8:00 p.m.) for the treatment of neuropathy. The record also documented a physician's order dated 6/4/17 stating to increase the Neurontin to 100 mg three times per day.	F 281	Corrective Action: The physician order for Resident #11's Neurontin was clarified by Practitioner and rewritten on Medication Administration Record (MAR) on 6/7/17. No ill effect or adverse reaction noted to resident. Identification: Nurse Managers will review recent (within the past 2 weeks) physician orders for Neurontin to ensure accuracy of written order and its transcription on the MAR. Changes: Facility Nurses will be re-educated on the correct process of appropriately obtaining and writing an order and its transcription onto the MAR. Monitoring: QA Coordinator will conduct monthly audits to ensure accuracy of written order and its transcription onto the MAR for residents with new orders for Neurontin. Audit findings will be reported to the Quality Assurance and Improvement Performance (QAPI) Committee for additional oversight and recommendation. The QAPI Committee will determine when to discontinue this	

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F 281	Continued From page 16 Resident #11's medication administration record (MAR) for June 2017 listed the Neurontin 100 mg twice per day order but with handwritten changes indicating the medication to be given three times per day instead of twice per day. A handwritten note stating "+ 8 pm" was also written on the order entry. On 6/5/17 and 6/6/17 the Neurontin 100 mg was given three times per day (at 8:00 a.m., 12:00 p.m. and 8:00 p.m.). In addition the previously ordered 300 mg bedtime dose was administered on 6/5/17 and 6/6/18 along with the 100 mg dose. This resulted in 400 mg administered at 8:00 p.m. on 6/5/17 and 6/6/17. There were no initials or signatures indicating who changed the Neurontin 100 mg order from twice per day to three times per day. There was no date listed indicating when the order was changed. Neurontin 400 mg was administered on 6/5/17 and 6/6/17 without any prior clarification from the physician indicating if the resident should get Neurontin 100 mg in addition or instead of the 300 mg dose at 8:00 p.m. each day. On 6/7/17 at 10:00 a.m. the licensed practical nurse (LPN #1) administering medications to Resident #11 was interviewed about the Neurontin orders. After reviewing the medication administration record LPN #1 stated the nurses were not supposed to make hand written changes on existing MAR entries. LPN #1 stated the original orders dated 9/29/16 should have been discontinued on 6/4/17 when the new order was received and a new entry entered for the three times per day dose. When asked about the 100 mg and 300 mg doses of Neurontin administered at 8:00 p.m. on 6/5/17 and 6/6/17, LPN #1 stated	F 281	practice.	

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the previous doses of Neurontin should have been discontinued on 6/4/17 after receiving the new order. LPN #1 stated, "Looks like the 300 mg shouldn't have been given (on 6/5/17 and 6/6/17)." LPN #1 was asked to clarify the order with the physician and advise.

On 6/7/17 at 10:10 a.m. the registered nurse unit manager (RN #4) stated she contacted the physician and he wanted the resident to get Neurontin 100 mg twice per day and 400 mg at each bedtime. At this time RN #4 was interviewed about the order and lack of clarification prior to administration. RN #4 stated she was not sure why the order was written with separate orders (100 mg and 300 mg) to be given at the same time each day.

On 6/7/17 at 10:50 a.m. the director of nursing (DON) was interviewed about Resident #11's Neurontin orders and administration. The DON stated nurses were not supposed to make handwritten changes on the MAR entries. The DON stated the Neurontin order should have been discontinued and a new entry made on the MAR regarding the new order and increased frequency. The DON stated that clarifying orders and order entry were part of basic nursing practice.

The Nursing 2017 Drug Handbook on page 683 describes Neurontin (gabapentin) as an anticonvulsant used for the treatment of seizures, restless leg syndrome, diabetic neuropathy, neuralgia and hot flashes. (1)

The Nursing 2017 Drug Handbook on page 1585 states concerning best practices to avoid common drug errors, "A drug order with

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incomplete or unclear information can result in giving the wrong drug or wrong doses, by the wrong route, or at the wrong time...Keep in mind that each order should specify the correct drug name, concentration, dosage, route, and frequency of administration...Clarify all incomplete or unclear orders with the prescriber..." (1)

The Lippincott Manual of Nursing Practice 10th edition on pages 16 and 17 states concerning standards of nursing care, "Legal claims most commonly made against professional nurses include the following departures from appropriate care: failure to assess the patient properly or in a timely fashion, follow physician orders, follow appropriate nursing measures, communicate information about the patient, adhere to facility policy or procedure, document appropriate information in the medical record, administer medications as ordered, and follow physician's orders that should have been questioned or not followed, such as orders containing medication dosage errors..." This reference on page 17 includes in a list of common departures from standards of care, "Altering a medical record without noting it as a correction with signature, date, and time of change... Failure to act as a patient advocate, such as not questioning illegible or incomplete medical orders..." (2)

These findings were reviewed with the administrator and DON during a meeting on 6/7/17 at 1:30 p.m.

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

(2) Nettina, Sandra M. Lippincott Manual of

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F 281	Continued From page 19 Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.	F 281		
F 315 SS=G	NO CATHETER, PREVENT UTI, RESTORE BLADDER CFR(s): 483.25(e)(1)-(3) (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is	F 315		7/19/17

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F 315	Continued From page 20 incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and observation the facility staff failed to assess for complications of a Foley catheter resulting in harm for one of 30 residents in the survey sample: Resident's #8 . Resident #8 was not assessed for skin breakdown related to a Foley catheter. Resident #8, developed an open penile wound without prior assessments or interventions for prevention resulting in harm to the resident. Findings include: Resident #8 was admitted to the facility on 5/9/14 with, but not limited to the following diagnoses: hypertension, benign prostatic hypertrophy and coronary artery disease. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 4/25/17. Resident #8 was assessed as being moderately cognitively impaired total cognitive score of 8 out of 15. Resident #8's clinical record was reviewed on 6/7/17 and evidenced a Physician's Telephone Order dated 5/30/17 indicating for Resident #8 to "schedule urology appt [appointment] for penile erosion & bleeding." This order was written by the Nurse Practitioner (NP).	F 315	Corrective Action: Resident #8 was assessed by Practitioner and Wound Nurse on 5/30/17 when area penis was first identified with new orders generated and noted in medical record. Urologist was consulted regarding Foley catheter and area to penis 6/8/17 with new orders received. Updates to Resident #8's care plan were completed 6/9/17. Foley catheter remains in place with device to secure placement. Identification: Nurse Managers will conduct skin assessment on all male residents with Foley catheters to assess for and record complications related to a Foley catheter. Changes: Re-education will be provided to nursing staff regarding the facility's practice for using a device that secures the placement of the Foley catheter for facility residents that have a physician order for a Foley catheter. The Charge/Medication Nurses will ensure placement of device every shift and will acknowledge by signing the Treatment Administration Record (TAR) Monitoring:	

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F 315	Continued From page 21 Further review of the medical record revealed a Physician's progress note dated 5/30/17 reading in part "patient has foley [sic] catheter; meatus appears to have erosion with small amount of bleeding several dark clots noted..." The following Nursing Notes were reviewed to include: "5/30/17 9 am Bleeding bright red noted around catheter @ tip of penis. Put on FNP [family nurse practitioner] list..." "5/30/17 1005 Apply personal cleanser to perineum area after each brief change & prn [as needed]..." 5/30/17 1235 pm New orders received from [NP named]...(1) Schedule urology appt for penile erosion and bleeding..." "5/30/17 1245 pm Appoint for urology consult c [with] [doctor named] June 12 @10:15 am..." The Skin Assessments dated 5/2-5/29/17 and 6/5/17 was reviewed to include the following: "No new areas to skin noted." A Non-Pressure Ulcer Skin Conditions form dated 6/6/17 was presented to this Surveyor on 6/8/17 was reviewed to include the following: "Date first observed 6/6/17...Condition is: penile erosion...Size in CM [centimeters] 3.3 x 1.0...Treatment / Changes Recommended...continue routine foley [sic] cath care daily." The current June 2017 Physician's Order Sheets (POS's) were reviewed to include the following order: "Tx [treatment] #16 FR [french] Foley w/ [with] 10 ml [milliliters] NS [normal saline] bulb to	F 315	Nurse Managers will monitor skin integrity of male residents with Foley catheters twice weekly. Audit findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for additional oversight and recommendation. The QAPI Committee will determine when to discontinue this practice.	

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straight drainage for urinary retention...Change Foley Cath Q [every] month and prn [as needed] for dysfunction (change on the 20th)...Routine Foley Care Q-shift and prn..."

The last Foley catheter change was documented on 5/20/17.

On 6/7/17 at approximately 10:52 a.m., This Surveyor accompanied a certified nursing assistant, who was caring for the resident and will be identified as CNA #1, into the resident's room. Resident #8 was observed lying in bed. This Surveyor asked Resident #8 for permission to observe the Foley catheter, with the resident's permission this Surveyor observed Resident #8's Foley catheter. A slit approximately two and a half inches was observed to the underside of the resident's shaft and the tubing of the Foley was observed pulled away from the meatus and hanging over onto the resident's scrotum. CNA #1 was interviewed regarding the penile slit and how long the area had been opened. CNA #1 stated, I have been out for a while due to surgery but when I came back in May it was like that." CNA #1 further stated that the Stat Lock, adhesive strap with a small white clamp in the center to hold the Foley in place, was "changed because it was barely hanging on and it was not serving its purpose." When interviewed and asked if "serving its purpose" meant preventing the catheter from pulling, CNA #1 stated, "Yes, we try to keep it alternated from leg to leg so that it, Foley tubing, does not lay in one spot."

On 6/7/17 at approximately 11:00 a.m., A Care Plan (CP) updated on 5/5/17 was reviewed, the CP did not address the penile erosion or any treatment plans to heal the area.

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On 6/7/17 at approximately 11:02 a.m., the Unit Manager, who was a registered nurse and will be identified as RN #4 was interviewed regarding the CP being updated to reflect the open area to the resident's penis and the treatment plan. RN #4 stated, "I don't know what the plan is to treat but I planned to put it, the open area to the penis, on the care plan but I have not done it yet. I planned to do it when the care plan got back to the floor." When RN #4 was interviewed and asked how long she was aware of the area to the resident's penis, RN #4 stated, "Since May thirtieth."

The CP was not updated as of 6/7/17. The Director of Nursing was present during the time of the interview with RN #4.

Resident #8 also had a care plan for skin break down with interventions to include, "pericare after each incontinent episode and prn, notify charge nurse of any changes in skin..."

On 6/7/17 at approximately 1:40 p.m., the administrator and the director of nursing (DON) were made aware of the observation of Resident #8's penis. The DON was interviewed and asked by the survey team and asked if she was aware of how the Resident's penis could have gotten in that condition. The DON stated, "the catheter." When interviewed and asked how long the Foley catheter was in place the DON stated, "I have to get back with you."

The administrator and the DON were made aware that the clinical records did not contain documentation regarding skin assessments, treatments or a care plan for the wound. When asked the treatment for the penile split, the DON

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stated, the safety lock."

On 6/7/17 at approximately 3:03 p.m. the facilities Nurse Practitioner (NP), who will be identified as Other Staff (OS #1) was interviewed concerning the above finding. OS #1 verbalized that she was aware of Resident #8's condition and made a referral to the urologist. When interviewed and asked what could have caused the penile erosion, OS #1 stated, "It's hard to say he has a catheter in place for urinary retention. Things happen without reason or because of no safety lock (the device that anchors the Foley in place to prevent the tubing from moving). OS #1 was asked if she had seen Resident #8, OS #1 verbalized she had seen Resident #8 on 5/31 and maybe the area to his penis was one (1) centimeters in length. OS #1 further stated, "I should have measured it but I didn't but it was only about to right here, measuring with her thumb down to the first joint of her pointer finger." When interviewed and asked if she had seen Resident 8 since 5/31/17, OS #1 stated, "No."

On 6/7/17 at 3:30 p.m., This surveyor accompanied OS #1 and the wound nurse, who was a registered nurse and will be identified as RN #6, into the resident's room. Resident #8 was asked permission to assess his penis. This Surveyor observed as OS #1 and RN #6 assessed the resident's penis. OS #1 lifted the resident's penis and observed the Foley catheter tubing separated from the meatus and hanging partly onto the resident's scrotum. The slit was approximately two and a half inches long. OS #1 stated, "He has good tissue here, pulling apart the residents penis at the slit, and here." OS #1 then stated, "Oh this is new, he has erosion here pointing to the left inside of his penis." The wound

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nurse nor OS #1 was observed measuring the wound during the time of the assessment with this Surveyor.

Resident #8's penis from behind the head of the penis to the base was completely open, there was no intact urethra. According to OS #1 there was some erosion inside the penile shaft. The split of the penis created an opening at the base of the penis where an indwelling catheter was observed to exit the body. The tissue was open to air with pink raw flesh and bloody drainage.

On 6/7/17 at approximately 4:30 p.m., this Surveyor was informed that Resident #8's appointment had been changed from 6/12/17 to 6/8/17 at 10:00 a.m.

On 6/8/17 at approximately 10:02 a.m., during the meeting with the administrator and the DON the administrator stated that the safety lock was reviewed and the safety lock was equipped to swivel in order to prevent the Foley tubing from sliding. The DON in turn stated, "His issue was not the tubing turning his issue was the position of the tubing. We had to move it up so that the tubing wasn't pulling".

A copy of the facility's policy on Foley Catheter care was requested an reviewed to include the following:
"Subject: Catheter /Changing and Prevention of Urinary Tract Infections...Guidance:...Secure catheters to the upper thigh or lower abdomen to avoid bladder and urethral trauma..."

On 6/8/17 at approximately 11:30 a.m., a copy of the consult from the Urologist was presented to this Surveyor. The report was reviewed to include

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F 315	Continued From page 26 the following: "6/8/17 Consultation Request...And to suggest...Penis circumcised-significant meatal erosion with purulent drainage...Consultation Report: (1) Cleanse bid [twice a day] with warm soap water or Antibacterial wash. (2) Apply calmoseptine bid [twice a day]. (3) Could consider SPC [suprapubic catheter] but given poor prognosis, met [metastatic] PrCa [prostate cancer]-poor surgical candidate. No further information was presented prior to exit conference on 6/8/17.	F 315		
F 329 SS=D	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F 329		7/19/17

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F 329	Continued From page 27 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed ensure the medication regimen was adequately monitored for a gradual dose reduction of an psychotropic medication for one of 30 residents in the survey sample, Resident #4. Resident #4 was without a gradual dose reduction (GDR) from an antidepressant (Zoloft) within the proper timeframe and without documented evidence contraindicating a dose reduction. Findings include: Resident #4 was admitted to the facility on 8/16/14 with readmission on 1/15/16 with diagnoses including, but not limited to: Depression. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment	F 329	Corrective Action: The Pharmacist recommended a Gradual Dose Reduction for Resident #4 on 6/7/17. Practitioner reviewed recommendation and disagreed with reduction at this time following interview with Resident #4 on 6/16/17. Identification: The Pharmacist reviewed all facility residents receiving antidepressants and made recommendation for Gradual Dose Reductions where appropriate. Practitioner will review and respond to recommendations made by Pharmacist. Changes: Facility Practitioners will be re-educated	

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F 329	Continued From page 28 reference date) of 3/27/17. Resident #4 was assessed as being cognitively intact with a cognitive score of 15 out of 15. Review of Resident #4's medical chart on 6/6/17 evidenced via physician orders, that Resident #4 had an order for Zoloft 50 milligrams once per day. The original date of the order was 1/15/16. Review of pharmacy medication reviews evidenced that pharmacy had asked for a Zoloft GDR on 1/13/16. Another pharmacy note dated 2/10/16 evidenced that the physician had agreed with the GDR, but then changed the dose back to the original dose of 50 milligrams everyday due to the Resident #4's daughter wanting the dose to remain the same secondary to Resident #4's husband passing away. Further review of the pharmacy monthly reviews did not evidence any other GDR's for Zoloft from 1/13/16 through 6/6/17. On 6/6/17 at 4:00 p.m. the above finding was brought to the attention of the unit manager (registered nurse, RN #1) where Resident #4 resided. RN #1 was asked to review the chart for a GDR of Zoloft. On 6/7/17 at 11:00 a.m. RN #1 was interviewed concerning Resident #4's GDR. RN #1 verbalized that she was unable to find any other GDR for Zoloft since January 2016. At this time RN #1 introduced this surveyor to the pharmacist for the facility and an interview was conducted. The pharmacist (other staff, OS #2) was able review a note in the pharmacist's computer (not part of the medical record and not dated) and	F 329	on F-329 Unnecessary Drugs/¿483.25(1) Unnecessary Drugs, with specific emphasis placed upon Psychoactive Drugs.(ii) Residents who use Psychoactive Drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Monitoring: During monthly medication regimen reviews, the Pharmacist will monitor responses received from the Practitioner following a recommendation for Gradual Dose Reduction. Audit findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for additional oversight and recommendation. The QAPI Committee will determine when to discontinue this practice.	

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F 329	Continued From page 29 verbalized that the nurse practitioner would not consider any GDR for Resident #4 due to Resident #4's responsible party (RP) request and personal issues within the family. OS #2 verbalized after talking with the nurse practitioner, she (OS #2) had stopped requesting a GDR for Zoloft. This surveyor asked again, when had she (OS #2) had this discussion with the nurse practitioner. OS #2 was unable to say when the note was written or when the discussion of a GDR was conducted. On 6/7/17 at 4:00 p.m. the above finding was presented to the administrator and director of nursing. No other information was presented prior to exit conference on 6/8/17.	F 329		
F 371 SS=E	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food	F 371		7/19/17

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F 371	Continued From page 30 service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to properly sanitize pans in the three compartment sink in the main kitchen. Pots and pans were stacked and not submerged in the sanitizer solution in the three compartment sink. The findings include: On 6/6/17 at 1:40 p.m. accompanied by the dietary manager, the main kitchen was inspected. The three compartment sink was in use for cleaning multiple pots and serving/cooking pans. The sanitizer section of the sink was filled with multiple large and mediums sized pots and baking/serving pans. Six pots/pans were stacked on top of submerged pans above the level of the sanitizer solution. On 6/6/17 at 1:50 p.m. the dietary manager was interviewed about the pots/pans not submerged in the sanitizer solution. The dietary manager stated the pans were supposed to be submerged in the sanitizer solution and not positioned above the level of the solution. The dietary manager removed the pots/pans not submerged in the sanitizer and stated they would need to be re-washed. On 6/7/17 at 11:15 a.m. lunch preparation was observed in the kitchen. A large stainless pot	F 371	Corrective Action: Pans that were observed to have been exposed and not fully submerged in sanitizing solution were removed and placed in the wash sink to re-initiate the complete manual dishwashing procedure (wash, rinse, sanitize). Identification: Non-Clinical Support Manager oversee that dishes and cookware are correctly washed after each meal to ensure that all dishes are clean and properly sanitized prior to their return to circulation. Changes: Dietary staff re-educated on facility "Cleaning Dishes/Manual Dishwashing" procedure. Physical demonstration was also performed for dietary staff regarding appropriate manual dishwashing procedure (wash, rinse, sanitize) to ensure ongoing compliance. Monitoring: Non-Clinical Support Manager or designee will perform weekly audits to	

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F 371	Continued From page 31 was observed positioned above the sanitizer solution in the three compartment sink. The pot was stacked on other pots/pans submerged in the sanitizer sink section. The facility's procedure titled Cleaning Dishes Manual Dishwashing (2000) documented dishes should be washed in sink 1 with warm water and dish detergent then rinsed thoroughly in hot water in sink 2. The policy documented the following steps for sanitizing dishes in sink 3: "Measure appropriate amount of sanitizing chemical into appropriate amount of water...Test sanitizing solution in sink using manufacturer's suggested test strips to assure appropriate level... Place dishes in the sanitizing sink. Allow to stand according to manufacturer's guidelines for sanitizer. (chlorine - 10 seconds) (all others - 30 seconds)...Allow dishes to air dry..." These findings were reviewed with the administrator and director of nursing during a meeting on 6/7/17 at 1:30 p.m.	F 371	ensure compliance with "Cleaning Dishes/Manual Dishwashing" procedure. Audit findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for additional oversight and recommendation. The QAPI Committee will determine when to discontinue this practice.	
F 428 SS=D	DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON CFR(s): 483.45(c)(1)(3)-(5) c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F 428		7/19/17

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F 428	Continued From page 32 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 428		

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F 428	Continued From page 33 Based on staff interview and clinical record review, the facility staff failed review a psychotropic medication for a gradual dose reduction for one of 30 residents in the survey sample, Resident #4. The pharmacist did not recommend Resident #4's antidepressant (Zoloft) for a gradual dose reduction (GDR) from 1/13/16 through 6/6/17. Findings include: Resident #4 was admitted to the facility on 8/16/14 with readmission on 1/15/16 with diagnoses including, but not limited to: Depression. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/27/17. Resident #4 was assessed as being cognitively intact with a cognitive score of 15 out of 15. Review of Resident #4's medical chart on 6/6/17 evidenced via physician orders, that Resident #4 had an order for Zoloft 50 milligrams once per day. The original date of the order was 1/15/16. Review of pharmacy medication reviews evidenced that pharmacy had asked for a Zoloft GDR on 1/13/16. Another pharmacy note dated 2/10/16 evidenced that the physician had agreed with the GDR, but then changed the dose back to the original dose of 50 milligrams everyday due to the Resident #4's daughter wanting the dose to remain the same secondary to Resident #4's husband passing away. Further review of the pharmacy monthly reviews	F 428	Corrective Action: The Pharmacist recommended a Gradual Dose Reduction (GDR) for Resident #4 on 6/7/17. Identification: The Pharmacist reviewed all facility residents receiving antidepressants and made recommendations for GDR when appropriate. Changes: The Pharmacist added a computer program that will assist in effort to review the appropriateness for GDR recommendations for facility residents prescribed antidepressants within appropriate timeframe. A GDR should be attempted at least twice in the first year of therapy and at least annually thereafter. Monitoring: The QA Coordinator will review facility monthly pharmacy medication regimen review report generated by pharmacy provider to ensure that a GDR was recommended within appropriate timeframe. Audit findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for additional oversight and recommendation. The QAPI Committee will determine when to discontinue this practice.	

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F 428	Continued From page 34 did not evidence any other GDR's for Zoloft from 1/13/16 through 6/6/17. On 6/6/17 at 4:00 p.m. the above finding was brought to the attention of the unit manager (registered nurse, RN #1) where Resident #4 resided. RN #1 was asked to review the chart for a GDR of Zoloft. On 6/7/17 at 11:00 a.m. RN #1 was interviewed concerning Resident #4's GDR. RN #1 verbalized that she was unable to find any other GDR for Zoloft since January 2016. At this time RN #1 introduced this surveyor to the pharmacist for the facility and an interview was conducted. The pharmacist (other staff, OS #2) was able review a note in the pharmacist's computer (not part of the medical record and not dated) and verbalized that the nurse practitioner would not consider any recommendations for a GDR for Resident #4 due to Resident #4's responsible party (RP) request and personal issues within the family. OS #2 verbalized after talking with the nurse practitioner, she (OS #2) had stopped requesting a GDR for Zoloft. This surveyor asked again, when had she (OS #2) had this discussion with the nurse practitioner. OS #2 was unable to say when the note was written or when the discussion of a GDR was conducted. On 6/7/17 at 4:00 p.m. the above finding was presented to the administrator and director of nursing. No other information was presented prior to exit conference on 6/8/17.	F 428		
F 431 SS=E	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h)	F 431		7/19/17

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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.

(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

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F 431	Continued From page 36 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review the facility failed to ensure expired medications and biologicals were not available for administration on three of five units: Hummingbird 1, Magnolia Trail, and Butterfly Path. Expired tuberculin solution (i.e. PPD solution used to detect presence of tuberculosis) and Mucomyst (a solution used for aerosolized breathing treatments) were included in the refrigerators and available for administration. Findings include: On 6/7/17 beginning at 9:45 a.m., an inspection of the facility's medication rooms and refrigerators was conducted with assigned staff on the units. On Hummingbird 1 unit, one of three vials of PPD solution was opened and did not have a date identified on the vial or box. LPN (licensed practical nurse) # 1 was asked about the open vial. LPN # 1 stated "I'll have to ask the infection control nurse about it; she was probably the one who opened it."	F 431	Corrective Action: All affected neighborhoods (Hummingbird Lane, Magnolia Trail and Butterfly Path) discarded medications on 6/7/17. Identification: The Nurse Managers reviewed all medication and biological items stored in the neighborhood refrigerators to ensure appropriate dating and or discarding once opened. Changes: Two Nurses will be assigned to review neighborhood refrigerators daily 1st shift to ensure open items are dated and or discarded appropriately once opened. New reference listing was also implemented to assist with compliance. Monitoring:	

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F 431	Continued From page 37 This surveyor then continued to Magnolia Trail at 9:55 a.m. and conducted the medication room inspection with RN (registered nurse) # 1, who was the unit manager. One of two vials of PPD solution was open without a date identified on the box or vial. RN # 1 stated That should have been dated when it was opened." RN # 1 then retrieved the vial for disposal. On 6/7/17 at 10:00 a.m. the medication room on Butterfly Path was inspected with RN # 2. One of two vials of Mucomyst was open and dated 5/30/17. This surveyor asked what the date indicated, and RN # 2 stated "That's the date it was opened." This surveyor then read the label affixed to the box containing the unopened vial of Mucomyst; the label directed "......Discard 96 hours after opening.." Also included in the refrigerator was one vial of opened PPD solution. The box had a date of 2/24/17 handwritten on it. RN # 2 was asked about the PPD and she stated "I didn't know that was in there." On 6/7/17 at 10:05 a.m. LPN # 2, the infection control nurse, was interviewed about the opened, undated vials of PPD solution observed in the medication room refrigerators. LPN # 2 stated "I keep my own supply of PPD in my refrigerator here in my office. I date it when I open it and discard 30 days after opened. The vials out on the floor must have been opened by the nurses, I guess." On 6/7/17 at 10:15 a.m. the DON (director of nursing) was asked for a policy on storage and labeling of medications and biologicals. The policy referred the reader to the Appendix, which included classes of medications, storage instructions, and discard dates. Included in the	F 431	The Quality Coordinator and/or Pharmacy Consultant will review neighborhood refrigerators weekly to ensure that all opened items are dated and or discarded appropriately once opened. Audit findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for additional oversight and recommendation. The QAPI Committee will determine when to discontinue this practice.	

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F 431	Continued From page 38 table of medications was the PPD solution which directed to "Discard 30 days after opening." Under "other medications not listed" instructed to follow the manufacturer expiration date (which would include the Mucomyst). On 6/7/17 the administrator and DON (director of nursing) were informed of the above findings during a meeting beginning at 1:30 p.m. No further information was provided prior to the exit conference.	F 431		
F 456 SS=D	ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION CFR(s): 483.90(d)(2)(e) (d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. (e) Resident Rooms Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure the refrigerator in the main kitchen was in proper working order. The external thermometer for the walk-in refrigerator was not functional. The findings include: On 6/6/17 at 1:40 p.m. accompanied by the dietary manager, the kitchen was inspected during the initial tour of the facility. The external temperature gauge on the walk-in refrigerator	F 456	Corrective Action: External Thermometer for the walk-in refrigerator in the main kitchen was ordered on 6/7/17 and was installed on 6/9/17. Internal refrigerator temperatures did not exceed 41 degrees Fahrenheit. Identification: Non-Support Clinical Manager will ensure that the walk-in refrigerator in the main	7/19/17

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F 456	Continued From page 39 was not functional. The gauge indicated no temperature for the walk-refrigerator with the needle on the gauge positioned on the bottom left of the dial below the -40 degree marking. On 6/6/17 at 1:45 p.m. the dietary manager was interviewed about the non-functional temperature gauge on the walk-in refrigerator. The dietary manager stated the gauge was not working and had not worked in "quite awhile." The dietary manager stated she thought the gauge had been replaced before but was no longer working. On 6/7/17 at 11:40 a.m. the dietary manager was asked when the last work order was written to repair the external refrigerator thermometer. The dietary manager stated it had been "several years ago" since a work order was written and she had been told the gauge could not be repaired. The dietary manager stated, "It's (external thermometer) not been looked at in awhile." These findings were reviewed with the administrator and director of nursing during a meeting on 6/7/17 at 1:30 p.m.	F 456	kitchen is present and in proper working order. Changes: The presence of the external thermometer for the walk-in refrigerator in the main kitchen will be checked by dietary staff daily. Dietary staff will be educated on this change in process. Monitoring: Non-Clinical Manager or designee will audit walk-in refrigerator thermometer maintenance log monthly. Audit findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for additional oversight and recommendation. The QAPI Committee will determine when to discontinue this practice.	
F 502 SS=E	ADMINISTRATION CFR(s): 483.50(a)(1) (a) Laboratory Services (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility failed to obtain physician	F 502	Corrective Action:	7/19/17

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F 502	Continued From page 40 ordered labs for one of 30 residents in the survey sample: Resident # 15. Resident # 15 was ordered to have weekly Chem 7 (a lab that measures seven lab values) labs drawn. Findings include: Resident # 15 was admitted to the facility 6/5/15 with a readmission date of 3/28/17 following a below the knee amputation of the right leg. Other diagnoses for Resident # 15 included, but were not limited to: diabetes, dry eye syndrome, high cholesterol, and peripheral vascular disease (limited circulation of blood in small vessels). The most recent MDS (minimum data set) was a significant change assessment dated 4/4/17. Resident # 15 was coded as having moderate impairment in cognition with a total summary score of 11 out of 15. The clinical record was reviewed 6/6/17 at 4:05 p.m. Included on the current POS (physician order summary) was an order carried forward from 4/10/17 for "Chem 7 weekly." The lab section of the chart was then reviewed. The weekly lab results were included in the record until 5/3/17, and no further lab results for the Chem 7 could be located. On 6/6/17 at 4:30, RN (registered nurse) # 2 was asked for assistance in locating the lab results. The facility's nurse practitioner (NP) was present and asked this surveyor "Did you look at the telephone orders to see if maybe it was d/c'd (discontinued)?" This surveyor stated "Yes, but I could have missed it." The NP then reviewed the telephone orders and stated "I don't see an order to d/c the lab; looks like it was ordered starting	F 502	Chem 7 was obtained for Resident #15 on 6/6/17. Lab results were reviewed by Practitioner with an order received to discontinue weekly Chem 7. No ill effect noted to resident. Identification: All residents with physician orders for weekly Chem 7 labs on affected neighborhood (Butterfly Path) were checked for compliance, as ordered by the physician. Changes: Nursing staff will be re-educated on facility process for obtaining labs ordered by the physician. New communication method to assist with organization with specific emphasis placed on lab collection will also be put into place. Monitoring: Nurse Manager or designee will perform a weekly audit on all residents with physician orders for weekly Chem 7 labs to ensure collection and presence of stop date on order. Audit findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for additional oversight and recommendation. The QAPI Committee will determine when to discontinue this practice.	

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F 502	Continued From page 41 4/10/17." RN # 2 then stated "I'm going to have to investigate this a little further." On 6/7/16 at 7:55 a.m. RN # 2 told this surveyor "We reviewed the chart; the weekly lab didn't get carried over to the calendar so it wasn't done. We went ahead and drew it yesterday. The NP will review the lab result and decide if it needs to continue or be d/c'd." This surveyor asked RN # 2 where the lab calendar was, and she showed me a regular desk type calendar. RN # 2 was asked if a schedule of labs to be done was kept in a separate lab book and she stated "No; we just write them on that calendar." On 6/7/17 the administrator and DON (director of nursing) were informed of the above findings during a meeting beginning at 1:30 p.m. No further information was provided prior to the exit conference.	F 502		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F 514		7/19/17

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F 514	Continued From page 42 (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to ensure a complete and accurate clinical record for two of 30 residents in the survey sample, Residents #3 and #9. 1. Resident #3's listed medication allergies on the client allergy report did not match allergies listed on the CCP (comprehensive care plan) and the POS (physician order sheet). 2. Resident #9's listed medication allergies on the client allergy report did not match allergies listed on the CCP and the POS. Findings included:	F 514	Corrective Action: Medical Records/Admissions Department removed inaccurate allergy sheets from Resident #3 and Resident #9 medical record. Identification: Medical Records/Admissions Department audited all facility resident's medical records and removed allergy sheets. Changes: The facility will list and record resident allergy information on Physician Order	

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F 514	Continued From page 43 1. Resident #3 was admitted to the facility on 07/09/2012 with diagnoses including, but not limited to: Dementia, Paranoid Delusions, Anxiety and Hypertension. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 05/17/17. Resident #3 was assessed as severely impaired in her cognitive status with a total cognitive score of 03 out of 15. Resident #3's clinical record was reviewed on 06/07/17 at approximately 7:35 a.m. During this review a "Client Allergy Report" was noted in the front of the chart that listed the following allergies: "Penicillin" and "Sulindac." Review of the current POS (physician order sheet) dated 06/01/17 through 06/30/17 listed Resident #3's allergies as: "PCN [penicillin], Pentazocine, Sulindac." The CCP (comprehensive care plan) listed allergies as: "PCN, Pentazocine, Sulindac." At approximately 9:30 a.m. on 06/07/17 Clinical Manager, RN #1 (registered nurse) was interviewed regarding who updates allergies on the "Client Allergy Report" if allergies change after admission. RN #1 stated, "Medical records updates these." On 06/07/17 at 10:20 a.m., Other Staff #2 (OS#2)-Medical Records was interviewed regarding updates to the "Client Allergy Report." OS #2 stated, "I know this is printed on admission. Admissions updates if there are any changes. I would think the nurse would update allergies and give to admissions so they can send out to everyone like the pharmacy, chart on the floor, etc."	F 514	Sheet (POS) and Medication Administration Record (MAR). The allergy sheet previously printed by Admissions Department will no longer be used or filed on facility resident's medical record. Monitoring: The Medical Records/Admissions Department will audit admissions monthly to ensure compliance with process change, no longer printing allergy sheet and filing on medical record. Audit findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for additional oversight and recommendation. The QAPI Committee will determine when to discontinue this practice.	

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F 514	Continued From page 44	F 514		

2. Resident #9's listed medication allergies on the client allergy report did not match allergies listed on the CCP and the POS.

Resident #9 was admitted to the facility on 04/10/2012 with diagnoses including, but not limited to: Peripheral Vascular Disease, Osteoarthritis, Hypertension, Dementia and Diabetes.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 04/07/17. Resident #9 was assessed as severely impaired in her cognitive skills with a total cognitive score of zero out of 15.

Review of Resident #9's clinical record on 06/07/17 at approximately 8:20 a.m. revealed a "Client Allergy Report" that listed Resident #9's allergies as: "NKDA" [no known drug allergies]. Review of the current POS dated 06/01/17 through 06/30/17 listed Resident #9's allergies as : "Ibuprofen." The CCP listed allergies as: "Ibuprofen."

On 06/07/17 at approximately 1:35 p.m., during a meeting with the survey team, the DON (director of nursing) stated, "The allergy sheet [referring to the Client Allergy Report] isn't even supposed to be in the record. That is placed in the record during the admission process. We decided not to use them anymore because they aren't accurate. We decided that probably a couple months ago."

No further information was provided to the survey team prior to the exit conference on 06/08/17.

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F 518	Continued From page 45	F 518		
F 518 SS=D	TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS CFR(s): 483.75(m)(2) The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on staff interview and abuse investigation interviews, the facility staff failed to ensure one of 8 employees were knowledgeable of the emergency preparedness protocols. The findings include: On 6/7/17 at approximately 6:40 a.m., a certified nursing assistant, who will be identified as CNA #2 was interviewed and asked how often fire drills were conducted, CNA #2 stated, "Can you hold on and let me ask someone." CNA #2 was asked her role in resident care in the event that there was a power outage, CNA #2 again stated, "Let me ask someone." On 6/7/17 at approximately 1:40 p.m., the administrative staff was made aware of the above findings.	F 518	Corrective Action: CNA #2 was re-educated on facility emergency preparedness procedure. Identification: All employees on affected neighborhood (Butterfly Path)will be re-educated on facility emergency preparedness procedures. Changes: Emergency Preparedness discussions will be included in monthly facility staff meetings held by Director of Nursing (DON) or designee with attendance of employees tracked. Monitoring: QA Coordinator will audit attendance tracking and staff meeting agendas monthly. Audit findings will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for additional oversight and recommendation.	7/19/17

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F 518	Continued From page 46	F 518	The QAPI Committee will determine when to discontinue this practice.	