STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495093	A. BUILDING _____ B. WING _____	C 04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISONBURG HLTH & REHAB CNTR	1225 RESERVOIR STREET HARRISONBURG, VA 22801

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 4/17/18 through 4/19/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced onsite Medicare/Medicaid standard survey was conducted 04/17/2018 through 04/19/2018. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. The Life Safety Code survey/report will follow. The census in this 180 certified bed facility was 175 at the time of the survey. The final survey sample consisted of thirty-five current Residents and three closed record reviews.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of	F 580		5/29/18

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

Electronically Signed | 05/07/2018

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

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F 580	Continued From page 1 treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on family interview and clinical record review, the facility staff failed to notify the Responsible Party of a change in condition for one of 38 residents, Resident # 109.	F 580	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain incompliance with all state and federal	

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F 580	Continued From page 2 A suspected deep tissue injury was assessed on Resident #109's left leg on 03/26/2018. The family was not notified of the change in condition. Findings were: Resident #109 was admitted to the facility on 03/09/2018 following a fall at home with resulting fracture. Her diagnoses included, but were not limited to: femur fracture, diabetes mellitus, aspiration pneumonia, acute cystitis, hypertension and Atrial fibrillation. Resident #109 was assessed on her most recent MDS (minimum data set) with an ARD (assessment reference date of 03/16/2018 as having difficulty with both long and short term memory and moderately impaired in her daily decision making skills. On 04/17/2018, Resident #109 was observed sitting in a chair in her room. Her daughter was visiting. A family interview was conducted. The daughter was asked if she was the person to be notified if there were changes in Resident #109's status. She stated, "Yes, either me or my brother who lives in Florida." She was asked if they had received notifications of any changes. She stated, "No, they didn't call either one of us about her leg." She was asked to elaborate. She stated, "She [Resident #109] developed a place on her leg underneath her leg brace...they didn't call me and they didn't call my brother...they told her [Resident #109] about it...they didn't tell me anything until I came in here and she was complaining of pain in her leg, I asked her [Resident #109] what was wrong and she said she didn't know. I asked the nurses and they said she had gotten a pressure ulcer from the	F 580	regulations, the center has taken or will take the actions set forth in this Plan of Correction. In addition, the following plan constitutes the center□s allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated. F580 1. The responsible party for R109 was notified of the new pressure ulcer site prior to survey being onsite. 2. An audit will be conducted of current residents with acquired pressure ulcers to ensure the responsible parties have been notified appropriately. 3. Licensed staff will be educated by the staff development coordinator or designee on appropriate notification of responsible parties for acquired pressure ulcers. 4. The unit manager or designee will review documentation of new acquired pressure ulcers to ensure the responsible party has been notified weekly for 8 weeks.	

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F 580	Continued From page 3 brace....they didn't call me or my brother about that, but hey did call me after 10:00 last night to tell me about a skin tear she got on her shin...does that make sense to you?" The clinical record was reviewed on 04/17/2018 at approximately 2:30 p.m. The wound record contained the following: "Date Family/NOK [next of Kin]/POA [power of attorney] Notified/last Updated: 03/26/2017. Details (Who, how, what and by whom?): pt is aware" The face sheet was reviewed, Resident #109 was listed as her own responsible party with her daughter and son listed as emergency contacts. On 04/18/2018 at approximately 5:45 p.m., a meeting was held with the administrator, the DON (director of nursing), and the corporate nurse consultant. The above information was discussed. On 04/19/2018 at approximately 9:00 a.m., the corporate nurse consultant brought information to the survey team. She presented information on Resident #109. She stated, "She was listed as her own RP, I would expect the staff to notify the family of any changes because of her cognitive status." No further information was obtained prior to the exit conference on 04/19/2018.	F 580		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656		5/29/18

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F 656	Continued From page 4	F 656		

care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:

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F 656	Continued From page 5 Based on clinical record review and staff interview, the facility failed for one of 38 residents in the survey sample (Resident # 79) to develop a plan of care to address unwanted sexual advances/contact with other residents. Resident # 79's care plan for adverse behavioral symptoms only addressed sexually inappropriate actions with staff members. The findings were: Resident # 79 in the survey sample, a 77 year-old male, was admitted to the facility on 2/19/18, and most recently readmitted on 4/2/18 with diagnoses that included congestive heart failure, generalized muscle weakness, benign lipomatous neoplasm of skin and right leg, Alzheimer's Disease, dementia with behavioral disturbance, hypertension, hyperlipidemia, acute kidney failure, and chronic obstructive pulmonary disease. According to the most recent Minimum Data Set, a Medicare 5-Day with an Assessment Reference Date of 4/9/18, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 13 out of 15. Review of the Progress (Nurses) Notes in the resident's Electronic Health Record (EHR) revealed the following entries: 4/5/18 - 7:47 a.m. "Was then brought up to the desk, started obtaining VS (vital signs) for Neuro checks, told him would have to get them because he fell, stated 'I did not fall.' While sitting at the desk, was talking to resident in (room number), rubbing her arm and trying to get her to kiss him." 4/13/18 - 1:00 p.m. "Patient is alert and	F 656	F656 1. The careplan for R79 was updated to reflect his behavior of being sexually inappropriate with another resident. 2. An audit will be conducted of current residents with a known history of being sexually inappropriate with another resident to ensure the careplan reflects the behavior. 3. Licensed staff will be educated by the staff development coordinator or designee on the process for updating a careplan to reflect a resident being sexually inappropriate with another resident. 4. The unit manager or designee will review careplan documentation of a new behavior of being sexually inappropriate with another resident weekly for 8 weeks.	

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F 656	Continued From page 6 oriented...Patient demonstrated sexually inappropriate behaviors with staff this shift, attempts to kiss staff on the mouth, grabbing, asking repeatedly for hugs...Will continue to monitor." Further review of Resident # 79's EHR revealed the following care plan problem, dated 4/15/18, after the inappropriate behaviors with staff, "The resident exhibits adverse behavioral symptoms such as being sexually inappropriate with staff (wants to hug and kiss in mouth)." The goal for the problem was, "The resident will have fewer episodes of behavior by review date." The interventions to the stated problem were, "Administer medications as ordered. Monitor/document for side effects and effectiveness; Educate the resident/family/caregivers on successful coping and interaction strategies as needed. The resident needs encouragement and active support by family/caregivers when the resident use these strategies; If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident." The care plan addressed inappropriate behaviors with the staff, but did not address the same behaviors with other residents. The survey team discussed the findings with the facility's administrative staff prior to the exit conference.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		5/29/18

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F 657	Continued From page 7 §483.21(b) Comprehensive Care Plans §483.21(b)(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) 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, facility staff failed to review and revise a CCP (comprehensive care plan) for two of 38 residents in the survey sample, Resident #85 and Resident #69. 1. Facility staff failed to include tracheostomy (trach) care every (q) shift on the CCP for Resident #85.	F 657	F657 1. The careplan for R85 was updated to reflect trach care every shift. The careplan for R69 was updated to reflect weight loss. The careplan for R125 was updated to reflect self-feeding. 2. An audit will be conducted of current residents with trach□s to ensure trach care every shift is careplanned appropriately. An audit will be conducted	

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F 657	Continued From page 8 2. Resident #125's care plan included inaccurate information that she needed to be fed and also did not include interventions for the use of Red foam handled silverware. 3. The facility staff failed to revise the plan of care for Resident # 69 to address her weight loss of 40 pounds, a 16.1% weight loss over a period of 70 days. Findings included: 1. Facility staff failed to include tracheostomy (trach) care every (q) shift on the CCP for Resident #85. 1. Resident #85 was originally admitted to the facility on 04/01/2014 and readmitted on 10/04/2017 with diagnoses including, but not limited to: Bronchitis, Chronic Obstructive Pulmonary Disease, Respiratory Failure, Obstructive Sleep Apnea, Tracheostomy with Oxygen (O2) dependence and Morbid Obesity. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 03/07/18. Resident #85 was assessed as cognitively intact with a total cognitive score of 15 out of 15. Resident #85's clinical record was reviewed on 04/18/18 at approximately 9:00 a.m. During this review the following orders were noted on the current POS (physician order sheet) dated April 2018: "...change trach gauze qs every shift...Order Date: 10/04/2017...Oxygen Therapy - Oxygen at 8 liters per minute via trach every shift...Order Date: 10/04/2017, Oxygen tubing change weekly on 11-7 shift every night shift	F 657	of current residents with weight loss for the month of April to ensure careplan has been appropriately updated to reflect actual weight loss. An audit will be conducted of current residents who are careplanned as being a feeder to ensure that the information is accurate. 3. Licensed staff will be educated by the staff development coordinator or designee on the process for updating a careplan to reflect trach care every shift, weight loss, and feeders. 4. The unit manager or designee will review careplans for new trach□s to ensure trach care every shift is careplanned and feeders to ensure careplanned information is accurate weekly for 8 weeks. The unit manager of designee will review actual weight loss each month to ensure it is careplanned accurately monthly for 2 months.	

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F 657	Continued From page 9 every Sun...Order Date: 10/04/2017...trach care q shift every shift...Order Date: 10/04/2017..." Subsequent review of Resident #85's CCP included the following regarding her tracheostomy: "...Interventions: Ensure that trach ties are secured at all times...Monitor/document respiratory rate, depth and quality...Oxygen Settings: O2 via trach as ordered. Suction as necessary..." No Interventions regarding actual trach care (cleaning of insertion site of trach, dressing changes, or care and cleaning of the inside of Resident #85's trach) were included in the CCP. The Administrator, DON (director of nursing) and Corporate Nurse were informed of the above findings during a meeting with the survey team on 04/18/18 at approximately 5:45 p.m. The Corporate Nurse stated, "This is just an oversight. We will get this corrected." No further information was received by the survey team prior to the exit conference on 04/19/18. 2. Resident #125's care plan included inaccurate information that she needed to be fed and also did not include interventions for the use of Red foam handled silverware. Resident #125 was admitted to the facility on 02/10/2017 with the following diagnoses, but not limited to: cerebrovascular disease, arthritis, hemiplegia, depressive disorder, and aphasia. The most recent MDS (minimum data set) was a	F 657		

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5 day assessment (completed after a hospital stay) with an ARD (assessment reference date of 02/15/2018. Resident #125 was assessed as being moderately impaired, with a cognitive summary score of "09".

On 04/17/2018 during lunch observation, Resident #125 was observed in her room eating lunch. Her food was in individual bowls, she had two spouted cups and was using red foam handled silverware. Her tray card was observed and the afore mentioned assistive devices were listed on the card. Resident #125 was feeding herself, there were no staff in her room with her.

On 04/18/2018 during breakfast, Resident #125 was observed in her chair eating breakfast. Her food was in individual bowls, her drinks were in spouted cups but she had regular long handled silverware. Her tray card was observed, the red foam handled silverware was listed. CNA (certified nursing assistant) #7 was in the hallway and was asked about the utensils. She stated, "I set up her tray...the utensils come from the kitchen, they must have forgotten to put them on there...I'll go get them." Resident #125 was observed feeding herself with no staff in the room.

On 04/18/2018 the clinical record was reviewed. There were no orders on the POS (physician order sheet) regarding the red foam handled utensils or orders for Resident #125 to be fed by staff.

The care plan contained the following interventions for the focus area "Resident has an ADL [activities of daily living] self-care performance deficit... EATING: The resident

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needs to be fed." The were no interventions listed for the red foam handle eating utensils.

During an end of the day meeting on 04/18/2018 the above information was discussed with the administrator and the corporate nurse consultant.

At approximately 9:00 a.m. on 04/19/2018, this surveyor went to the kitchen and spoke with the dietary manager regarding the use of the red foam handled utensils. She stated she would find the information and bring it to this surveyor.

At approximately 10:30 a.m., the corporate dietitian came to the conference room and presented information. She stated that Resident #109 had started using the red foam handled utensils with OT (occupational therapy) in August. She stated, " We don't need a physician's order to put them on the tray if OT has requested them, but they should probably be on the care plan..."

At approximately 11:30 a.m., the corporate nurse consultant came to the conference room to present additional information to the survey team. She stated, "[Name of Resident #125] does not need to be fed...I talked to [name of unit manager]...that is an error on her care plan and we corrected it...The utensils should have also been care planned."

No further information was obtained prior to the exit conference on 04/19/2018.

3. The facility staff failed to revise the plan of care for Resident # 69 to address her weight loss of 40 pounds, a 16.1% weight loss over a period of 70 days.

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F 657	Continued From page 12	F 657		

Resident # 69 in the survey sample, a 76 year-old female, was admitted to the facility on 2/8/18, and readmitted on 4/11/18 with diagnoses that included hypertension, diabetes mellitus, hyperlipidemia, Non-Alzheimer's dementia, depression, obstructive sleep apnea, and morbid obesity. According to the most recent Minimum Data Set, a Medicare 5-Day with an Assessment Reference Date of 4/15/18, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 10 out of 15.

Under Section K (Swallowing/Nutritional Status), the resident's weight at Item K0200 (Height and Weight), was listed at 229 pounds. Under Item K0300 (Weight Loss), the resident was identified as having no weight loss.

Review of the weights for Resident # 69, as listed in the Weights and Vital Signs portion of the Electronic Health Record (EHR), noted her most recent weight, recorded at 5:56 a.m. on 4/18/18, was 2209 pounds. The record also noted that the resident's weight on 2/8/18 was 249 pounds, and that she had a weight gain of 1960 pounds, or a 787.1% weight gain. The Director of Nursing (DON) was asked for and provided and printout of Resident # 69's weights from the date of admission (2/8/18) up to and including the date of record review (4/18/18)..

At approximately 10:30 a.m. on 4/18/18, the printout of Resident # 69's weights was reviewed with the DON who said that the 4/18/18 weight of 2209 pounds was incorrect. The DON subsequently provided a revised printout that noted the resident's weight at 1:39 p.m. on 4/18/18 was 209 pounds. The revised printout

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F 657	Continued From page 13 noted the resident's weight on 2/8/18 was 249 pounds, and that she had a weight loss of 40 pounds, or a 16.1% weight loss. Review of Resident # 69's care plan, dated 2/9/18, revealed the following problem in the area of nutrition, "Nutrition risk d/t (due to) recent hospitalization for AMS (Altered Mental Status). PMH (Past Medical History) DM II (Diabetes Mellitus Type II), CHF (Congestive Heart Failure), HTN (Hypertension), morbid obesity. Potential for further significant weight changes Weight change noted 4/12/18." The goal for the problem was, "Will avoid significant weight change through next review. Gradual weight loss appropriate." The interventions for the stated problem were, "Provide diet as ordered. Monitor intake and record each meal. Offer substitutes when intake less than 50%; Weights as ordered." The resident's care plan was not revised to include interventions to prevent further weight loss, or to provide a plan for planned weight loss. The findings were discussed with the administrative staff by the survey team prior to the exit conference.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 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	F 684		5/29/18

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F 684	Continued From page 14 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to follow physician's orders one of 38 resident's, Resident #361. R 361 did not have TED hose applied as ordered. The Findings Include: R 361 was admitted to the facility on 04/05/18. The most current MDS (minimum data set) was an initial assessment dated 4/12/18. R 361 was assessed with a cognitive score of 15, indicating cognitively intact. Diagnoses for R 361 included fractured left femur. During a Resident interview conducted on 04/17/18 03:21 PM bruising was observed on both arms, R 361 verbalized that he bruises easily when ever he bumps his arms, when asked if he was on anticoagulants, R 361 verbalized he didn't think so. During the interview R 361 was observed wearing shorts and without socks or TED hose. On 4/18/18 a record review was conducted. An order was written on 4/6/18 for TED hose to be applied every morning and taken off during hours of sleep. On 04/18/18 11:27 AM again observed TED hose not being worn and talked with R 361 regarding TED hose. R 361 verbalized that staff have not been putting them on.	F 684	F684 1. TED hose were placed on R361 while surveyors were onsite. 2. An audit will be conducted of current residents with a careplanned intervention of TED hose to ensure they are on the residents□ body as indicated. 3. Nursing staff will be educated by the staff development coordinator or designee on ensuring residents who have a careplanned intervention of TED hose have them on appropriately. 4. The unit manager or designee will view each resident who has a careplanned intervention of TED hose to ensure they are on appropriately 5 days a week for 8 weeks.	

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F 684	Continued From page 15 04/18/18 11:41 AM LPN #3, verbalized that she didn't know why the TED hose were not on. This surveyor explained that according to R 361's TAR (treatment administration record) that the TED hose were being signed off as if the TED hose were in place. LPN #3 verbalized that she was unsure why that it was documented indicating the TED hose were in place. 04/18/18 05:45 PM the above information was provided to the director of nursing and administrator, the administrator nodded head in understanding. No other information was provided prior to exit conference on 4/19/18.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(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 from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to follow the comprehensive care plan for treatment and care	F 686	F686 1. The careplan for R45 was updated to remove the inaccurate intervention of glen	5/29/18

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F 686	Continued From page 16 of skin integrity for one of 38 resident's, Resident #45. R 45 did not have arm protective sleeves, air mattress was not turned on, and feet were not floated on a cushion as indicated in the care plan. The Findings Include: R 45 was admitted to the facility on 08/04/13. The most current MDS (minimum data set) was a quarterly assessment dated 2/08/18. R 45 was assessed with a cognitive score of 3, indicating severe cognitive status. Diagnoses for R 45 included: Osteomyelitis, diabetes, and stage 2 pressure ulcer of the sacrum. R 45 was on hospice at the time of the survey. On 4/18/18 R 45's clinical record was reviewed and documented in the current care plan, "The resident has potential for pressure ulcers r/t impaired mobility and incontinence. The resident has two left upper arm abscesses. Created on: 06/09/2014 Revision on: 02/15/2018 [... interventions for R 45 included] Heels up cushion, turn and reposition self frequently. , ATMOS 9000 Air mattress, Glen sleeves to BUE [both upper extremities...]." On 4/19/18 between 8:45 AM and 11:15 AM R 45 was observed three times laying in bed in the same position (on back), heels were laying on mattress (not cushioned), no arm protective sleeves in place, and air mattress was not turned on. On 04/19/18 at 11:20 AM license practical nurse (LPN #4) was asked to observed R 45. LPN #4 entered the room as this surveyor was pointing	F 686	sleeves while surveyors were onsite. 2. An audit will be conducted of current residents with a careplanned intervention of glen sleeves to ensure that information is accurate. 3. Licensed staff will be educated by the staff development coordinator or designee on ensuring a careplanned intervention for glen sleeves is accurate. 4. The unit manager or designee will review newly careplanned intervention for glen sleeves to ensure it is accurate weekly for 8 weeks.	

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out concerns regarding the air mattress, arm sleeve protectors, and feet not being cushioned, LPN #4 verbalized that she had been in R 45's room earlier, but did not realize that the air mattress was not turned on. LPN #4 then went to R 45's head of the bed, realized that the electric plug was not completely plugged into the wall and plugged the air mattress in, turning on the air mattress. LPN #4 also observed R 45's heels laying on the mattress with the heel cushion under R 45's knees allowing R 45's heels to rest directly on the bed.

At this time this surveyor and LPN #4 left the room. During the interview with LPN #4, LPN #4 verbalized was not aware that R 45 was supposed to have protective sleeves. At this time, this surveyor asked LPN #4 to review R 45's care plan. After reviewing the care plan LPN # 4 verbalized that she would get everything in place.

On 04/19/18 11:30 AM certified nursing assistant (CNA #6) was interviewed (CNA #6 was assigned to R 45). CNA #6 verbalized that she was also unaware that R 45's bed was not plugged in and that R 45 was supposed to have arm protectors on.

On 04/19/18 11:35 AM the Central supply manager was interviewed (OS #3). OS #3 showed this surveyor that Glen sleeves (arm protectors) were in the supply room and available.

On 04/18/18 05:00 PM the above information was provided to the director of nursing and administrator.

No other information was provided prior to exit conference on 4/19/18.

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F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to ensure a safe bed environment for one of 38 residents in the survey sample. There was no assessment for Resident #260's bed safety prior to placement on a specialty air mattress with bed rails. Resident #260 rolled out of bed less than 24 hours after the air mattress was placed. The resident's left arm was entangled in the bed rail during the fall, resulting in a fractured left arm and dislocated left shoulder (harm). The findings include: Resident #260 was admitted to the facility on 6/21/16, was re-admitted on 5/2/17 and was discharged from the facility on 7/22/17. Diagnoses for Resident #260 included Alzheimer's, cerebrovascular disease, cervical disc degeneration, aortic valve disorder, anemia, high blood pressure and heart failure. The minimum data set (MDS) dated 6/21/17 assessed Resident #260 with severely impaired cognitive skills. Resident #260's clinical record documented the resident was re-admitted to the facility following a	F 689	F689 1. R260 is no longer a resident in the facility. 2. An audit will be conducted of current residents with an atmos air 9000 mattress to ensure a device assessment has been completed to include the mattress. 3. Licensed staff will be educated by the staff development coordinator or designee on completing a new device assessment for any resident receiving a new atmos air 9000 mattress. 4. The unit manager or designee will review documentation on residents with a new atmos air 9000 mattress to ensure a new device assessment has been completed weekly for 8 weeks.	5/29/18

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hospital stay on 3/20/17. A nursing note dated 3/24/17 documented, "daughter called and requesting that res [resident] have an air mattress. order received from [physician] and asked 3-11 to get mattress for res."

Resident #260's clinical record documented a nursing note dated 3/27/17 at 3:30 p.m. stating, "cna [certified nurses' aide] note res [resident] had his left arm through the assist bar and was on his knees at bedside. staff assist to remove arm from assist rail and lowered to floor. res c/o [complained of] left arm pain/discomfort, res assessed by [nurse practitioner]. res lifted back to bed x 5 staff and lift. with staff supporting head and left arm. orders received to send res to [emergency room] for eval. [evaluation]. instructed by np [nurse practitioner] to give res pain med [medication]..." (sic)

The emergency room report dated 3/27/17 documented the resident was diagnosed with a left humerus (upper arm) fracture and left shoulder dislocation.

A fall committee meeting note dated 3/27/17 at 4:00 p.m. documented, "...The resident is at risk for further falls r/t [due to] Unaware of safety needs...Resident sustained a roll out of bed today...Resident had left arm through assist bar on left side of bed and rolled onto the floor. Resident has cognitive impairment - Alzheimer's disease...received verbal order to send to ER [emergency room] for evaluation. Resident returned same evening with sling in place to L [left] arm due to L [left] humerus fx [fracture] and L shoulder dislocation and orders to follow up with Ortho [orthopedics]...assist bars and atmos 9k [9000 air mattress] were interventions in place

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before fall. New interventions post fall include concave air mattress and bilateral fall mats..."

The nurse practitioner's (NP's) progress note dated 3/28/17 documented, "The resident fell last evening and was noted to have some deformity and significant pain in his left shoulder/arm...Notes returned which showed a left impaction type fracture of the humeral head he was also noted to have a anterior sub-coracoid dislocation of the left humerus from the glenoid [shoulder blade cavity]. He had the dislocation reduced and he was sent back for continued care...Will schedule Norco 3 times a day also add as needed Norco discontinuing the Xanax staff stated that they are concerned that this may have contributed to his agitation and fall that occurred yesterday afternoon..."

Resident #260's clinical record documented prior to the fall of 3/27/17, the resident had severe cognitive impairment, required the extensive assistance of one person for bed mobility and was totally dependent upon one person for transfers. The resident's plan of care in place during March 2017 documented the resident was at risk of falls due to poor safety awareness. Interventions for fall/injury prevention included anticipate needs, assistive devices, call light in reach, encouragement to use call light and encouragement to participate in activities.

A device assessment dated 3/21/17 listed the resident's use of "assist bars" as non-restrictive and listed the bars were in place to promote bed mobility. There was no re-assessment of Resident #260's bed safety and bed rail use when the specialty air mattress (model 9000) was installed.

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The facility's investigation report to the state agency of Resident #260's fall dated 3/31/17 documented, "...found kneeling on the floor next to his bed with his wrist tangled in the assist bar on his bed. Staff did not witness how the resident arrived on his knees...Based on his injuries of a fractured clavicle and how he was observed we determined that he had rolled out of bed. After a root cause analysis and discussing with staff, we had given him an air mattress 15 hrs [hours] prior which we believe is why he rolled out of bed..."

On 4/19/18 at 10:55 a.m., the registered nurse (RN) consultant was interviewed about Resident #260's fall/fracture on 3/27/17. The RN consultant stated the device assessment for assist bars dated 3/21/17 was with a standard 4000 model mattress. The RN consultant stated that on 3/24/17 the resident's family member demanded the resident be placed on an air mattress following his recent hospitalization. The RN consultant stated the resident did not have pressure ulcers but since the family member was adamant about the mattress, the physician entered an order for an Atmos 9000 model mattress. The RN consultant stated there was no additional assessment for the use of the assist bars prior to placing the 9000 model air mattress. The RN consultant stated the mattresses had the same dimensions but the Atmos 9000 provided different air distribution as compared to the standard Atmos 4000 model. A copy of the safety precautions and installation instructions for the Atmos 9000 mattress was requested at this time.

On 4/19/18 at 12:21 p.m., the licensed practical nurse (LPN #2) unit manger caring for Resident #260 at the time of the fall was interviewed. LPN

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#2 stated she was called to the room and found the resident on his knees with his left arm through the center of the assist rail. LPN #2 stated the resident's family member requested the air mattress to protect the resident's skin. LPN #2 stated the physician ordered the mattress after the family member's request. LPN #2 stated there was no re-assessment at the time of Resident #260's use of the Atmos 9000 air mattress with the assist rails. LPN #2 stated she had a physician's order and added the air mattress to the care plan as part of preventing skin breakdown.

On 4/19/18 at 2:51 p.m., the RN consultant presented a sheet listing the 9000 model mattress dimensions and product specifications. The sheet listed no safety precautions or installation instructions. The RN consultant stated she did not have a copy of the safety and/or installation instructions but thought they were available online.

The manufacturer's user guide for the AtmosAir mattress replacement system stated, "...Use or non-use of restraints, including side rails, can be critical to patient safety. Serious or fatal injury can result from the use (potential entrapment) or non-use (potential falls) of side rails or other restraints...Bed frame and side rails (if used) must be properly sized relative to the mattress to help minimize any gaps that might entrap a patient's head or body. It is recommended that bed and side rails (if used) comply with all applicable regulations and protocols...Caregivers should assess risks and benefits of side rail/restraint use (including entrapment and patient falls from bed) in conjunction with individual patient needs, and should discuss use

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F 689	Continued From page 23 or non-use with patient and/or family. Consider not only the clinical and other needs of the patient but also the risks of fatal or serious injury from falling out of bed and from patient entrapment in or around the side rails, restraints or other accessories...refer to FDA's Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment..." (1) These findings were reviewed with the administrator, nurse consultant and director of nursing during a meeting on 4/19/18 at 3:15 p.m. (1) AtmosAir Mattress Replacement System User Guide Instructions for Use. Revised 4/2015. Arjohuntleigh Getinge Group. 4/20/18. www.arjohuntleigh.com.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(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. §483.25(e)(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	F 690		5/29/18

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F 690	Continued From page 24 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. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is 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 observation, staff interview, family interview and clinical record review the facility staff failed to provide clinical justification for the use of an indwelling catheter for one of 38 res, Res #109. Resident #109 was admitted to the facility with an indwelling catheter on 03/09/2018. Per a family interview on 04/17/2018, Resident #109 had not had an indwelling catheter prior to being admitted to the hospital and coming to the nursing home. Findings were: Resident #109 was admitted to the facility on 03/09/2018 following a fall at home with resulting fracture. Her diagnoses included, but were not limited to: femur fracture, diabetes mellitus, aspiration pneumonia, acute cystitis, hypertension and Atrial fibrillation.	F 690	F690 1. The foley catheter for R109 was removed per physician order while surveyors were onsite. 2. An audit will be conducted of current residents with a foley catheter to ensure they have an appropriate diagnosis documented in the medical record. 3. Licensed staff will be educated by the staff development coordinator or designee on ensuring any resident with a foley catheter has an appropriate diagnosis documented in the medical record. 4. The unit manager or designee will review careplan documentation of any new foley catheter to ensure they have an appropriate diagnosis documented in their medical record weekly for 8 weeks.	

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F 690	Continued From page 25	F 690		

Resident #109 was assessed on her most recent MDS (minimum data set) with an ARD (assessment reference date) of 03/16/2018 as having difficulty with both long and short term memory and moderately impaired in her daily decision making skills.

On 04/17/2018, Resident #109 was observed sitting in a chair in her room. Her daughter was visiting. A family interview was conducted. The daughter was asked why Resident #109 had an indwelling catheter. She stated, "That's what we want to know...she didn't have one before she went to the hospital. She wears a brief at home."

The clinical record was reviewed on 04/17/2018 at approximately 2:30 p.m. The current POS (physician order sheet) was reviewed and contained the following order: "Foley Cath...every shift for obstructed uropathy". Review of the hospital discharge summary dated 03/09/2018 contained the following information: "Foley Catheter while fracture is healing". There was no mention of urinary obstruction in any of Resident #109's documentation.

On 04/17/2018 at approximately 3:00 p.m. the unit manager was interviewed regarding Resident #109's catheter. She was asked why Resident #109 had one. She stated, "She came in with it...I thought about that yesterday that we should contact the doctor and see if we can get it out."

On 04/18/2018 the corporate nurse consultant was in the conference room speaking with the survey team. She was asked about the indwelling catheter for Resident #109. The corporate nurse consultant was asked where the diagnosis for "urinary obstruction" was obtained as this

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F 690	Continued From page 26 surveyor had been unable to locate it in the clinical records other than as a reason on the POS for the catheter. The corporate nurse returned to the conference room and stated, "The nurse who entered the orders in for the catheter chose that diagnosis as a reason for the catheter...[Name of Resident #109], doesn't have an obstruction...we are contacting the physician to get an order to try to remove it." On 04/18/2018 at approximately 5:45 p.m., a meeting was held with the administrator, the DON (director of nursing), and the corporate nurse consultant. The above information was discussed. The corporate nurse consultant stated that the doctor had been contacted and stated he would like to keep the catheter in until Resident #109's fracture healed. The corporate nurse was asked if the physician had shared his rationale for the continued catheterization since Resident #109 was getting up in a chair, and being turned side to side for repositioning and to be changed when she had a bowel movement. The corporate consultant stated she would look into it. On 04/19/2018, during an end of the day meeting, the corporate nurse consultant stated that an order had been obtained to do a trial reduction for Resident #109 and the catheter had been removed. No further information was obtained prior to the exit conference on 04/19/2018.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration.	F 692		5/29/18

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F 692	Continued From page 27 (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed for one of 38 residents in the survey sample (Resident # 69) to maintain acceptable parameters of weight. The resident, who was not on a physician ordered weight loss program, had a weight loss of 40 pounds, or a 16.06 % weight loss over a period of 70 days. The findings were: Resident # 69 in the survey sample, a 76 year-old female, was admitted to the facility on 2/8/18, and readmitted on 4/11/18 with diagnoses that included hypertension, diabetes mellitus, hyperlipidemia, Non-Alzheimer's dementia, depression, obstructive sleep apnea, and morbid	F 692	F692 1. R69 has returned to her usual body weight presently. 2. An audit will be conducted of current residents with actual weight loss for the month of April to ensure the weight is accurate and ensure appropriate actions have been taken to intervene. 3. Nurse management will be educated by the staff development coordinator or designee on the importance of ensuring accurate weights and placing appropriate interventions for actual weight loss. 4. The unit manager or designee will review weights to ensure accuracy and interventions have been placed appropriately monthly for 2 months.	

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F 692	Continued From page 28	F 692		

obesity. According to the most recent Minimum Data Set, a Medicare 5-Day with an Assessment Reference Date of 4/15/18, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 10 out of 15.

Under Section K (Swallowing/Nutritional Status), the resident's weight at Item K0200 (Height and Weight), was listed at 229 pounds. Under Item K0300 (Weight Loss), the resident was identified as having no weight loss.

Review of the weights for Resident # 69, as listed in the Weights and Vital Signs portion of the Electronic Health Record (EHR), noted her most recent weight, recorded at 5:56 a.m. on 4/18/18, was 2209 pounds. The record also noted that the resident's weight on 2/8/18 was 249 pounds, and that she had a weight gain of 1960 pounds, or a 787.1% weight gain. The Director of Nursing (DON) was asked for and provided and printout of Resident # 69's weights from the date of admission (2/8/18) up to and including the date of record review (4/18/18)..

At approximately 10:30 a.m. on 4/18/18, the printout of Resident # 69's weights was reviewed with the DON who said that the 4/18/18 weight of 2209 pounds was incorrect. The DON subsequently provided a revised printout that noted the resident's weight at 1:39 p.m. on 4/18/18 was 209 pounds. The revised printout noted the resident's weight on 2/8/18 was 249 pounds, and that she had a weight loss of 40 pounds, or a 16.1% weight loss.

A thorough review of Resident # 69's EHR failed to reveal any orders for dietary supplements, or

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F 692	Continued From page 29 any documentation of a physician ordered weight loss program. The only reference to the resident's diet was an order, dated 4/12/18, for a "Heath Healthy Diabetic Diet, Mechanical Soft, Regular liquids consistency." The survey team discussed the findings with the administrative staff during an end of day meeting at 5:00 p.m. on 4/18/18.	F 692		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review,	F 700	F700 1. The side rails and bedrail cushions on	5/29/18

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F 700	Continued From page 30 facility staff failed to properly assess one of 38 residents in the survey sample, Resident #52, for the use of siderails and bed rail cushions. The facility staff failed to properly assess Resident #52 for the use of siderails and bed rail cushions. Findings included: Resident #52 was originally admitted to the facility on 12/01/2012 and readmitted on 04/30/2013 with diagnoses including, but not limited to: Down's Syndrome, Paraplegia, Schizoaffective Disorder, Osteoporosis and Seizures. The most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 02/05/2018. Resident #52 was assessed as severely impaired in his short and long term memory and daily decision making skills. During the initial tour conducted 04/17/18 at approximately 2:45 p.m., Resident #52 was observed lying in the bed with four siderails up and a rail cushion in place on both sides of the bed. Throughout the remainder of the survey conducted 04/17/18 through 04/19/18, Resident #52's bed was observed with four siderails up and rail cushions in place at all times. Review of Resident #52's clinical record on 04/18/18 at approximately 11:00 a.m. included the discovery of a "Device Assessment" dated 02/03/2018, a "Restraint-Physical (Quarterly/Annual Evaluation)" dated 02/05/2018 and a "Restraint Reduction Committee Meeting"	F 700	the bed for R52 were evaluated and were not identified as a risk of entrapment, while surveyors were onsite. 2. The maintenance director or designee will complete an inspection of all current bed frames, mattresses, and/or bedrails to identify areas of possible entrapment. 3. Nursing staff, maintenance staff, housekeeping staff, and central supply staff will be educated by the staff development coordinator or designee on the protocol for the regular maintenance program to inspect bed frames, mattresses, and/or bedrails to identify areas of possible entrapment. 4. The maintenance director or designee will complete the regular maintenance program to inspect bed frames, mattresses, and/or bedrails to identify areas of possible entrapment annually and for any new specialty bed/mattress as needed.	

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F 700	Continued From page 31 progress note dated 04/12/2018. No dimensions or distances of various parts of the bed or specialty mattress, or Resident #52's size and weight were included in any of the assessments or notes. The Corporate Nurse was interviewed on 04/19/18 at approximately 10:50 a.m. The Corporate Nurse stated regarding the new regulations governing the use of siderails, "[Name] Maintenance Assistant did a sweep of the facility. He focused on siderails, bed frames and assist bars. He looked for gaps and any other potential problems. Unfortunately, I don't think he wrote any of it down. Let me check with him again to make sure." The Maintenance Man was interviewed on 04/19/18 at approximately 1:00 p.m. regarding bed rails and safety. The Maintenance Man stated, "Monthly room rounds are done. We have a work order system in the computer that is completed weekly/monthly. The questions are all yes/no. You check one or the other. There isn't any space for measurements." When asked specifically about Resident #52's bed, specialty mattress and any measurements or dimensions, the Maintenance Man stated, "I don't think I have been asked to do anything with that bed." The Administrator and DON (director of nursing) were informed of the above findings during a meeting with the survey team on 04/19/18 at approximately 5:00 p.m. No further information was received by the survey team prior to the exit conference on 04/19/18.	F 700		
F 756	Drug Regimen Review, Report Irregular, Act On	F 756		5/29/18

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F 756 SS=D	Continued From page 32 CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		

§483.45(c) Drug Regimen Review.
§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

§483.45(c)(2) This review must include a review of the resident's medical chart.

§483.45(c)(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.

§483.45(c)(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

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F 756	Continued From page 33 requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility document review, the facility staff failed to ensure a pharmacy recommendation for two of 38 residents in the survey sample were acted upon, R 47 (Resident # 47) and R313 (Resident # 313). 1. R47 had a pharmacy recommendation to decrease Ambien 5 mg (milligrams) every night on 02/08/18 and another pharmacy recommendation to decrease Ambien 5 mg every night on 03/19/18; the pharmacy recommendation was not addressed until 04/05/18. 2. The facility staff failed to ensure a pharmacy recommendation for R313 regarding a lipid panel was not completed. Findings include: 1. R47 had a pharmacy recommendation to decrease Ambien 5 mg (milligrams) every night on 02/08/18 and another pharmacy recommendation to decrease Ambien 5 mg every night on 03/19/18; the pharmacy was not addressed until 04/05/18. During the resident's clinical record review for unnecessary medications, the resident's pharmacy recommendations were reviewed. A pharmacy recommendation dated 02/08/18 documented, "...Zolpidem Tartrate [Ambien] 5 mg at bedtime for insomnia....Please consider a GDR [gradual dose reduction], with eventual goal of	F 756	F756 1. R313 had a lipid panel drawn on 5/3/2018. Ambien was decreased for R47 on 4/5/2018. 2. An audit will be conducted of current residents with a pharmacy recommendation for the month of April to ensure it has been completed as recommended. 3. Nurse management and medical staff will be educated by the staff development coordinator or designee on the process for completing pharmacy recommendations. 4. The director of nursing or designee will review pharmacy recommendations to ensure they have been completed monthly for 2 months.	

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F 756	Continued From page 34	F 756		

discontinuation..."

Another pharmacy review dated 03/19/18 documented, "...Zolpidem Tartrate [Ambien] 5 mg at bedtime for insomnia....Please consider a GDR [gradual dose reduction], with eventual goal of discontinuation..."

The physician signed the pharmacy review dated 02/08/18 on 04/05/18 (nearly two months later). The physician did not check the box to either accept the recommendation or decline, but documented in the accept recommendation response area to: "[change] to PRN [as needed] at 2.5 mg." This was signed and addressed by the physician on 04/05/18.

The corporate nurse consultant was made aware of the above information and was asked for a policy at this time.

A facility policy was presented and documented, "...facility staff should ensure that the attending physician, medical director and director of nursing are provided with copies of the MMRs [monthly medication reviews]...facility should alert the medical director when the MMRs are not addressed by the attending physician in a timely manner...If an irregularity does not require urgent action but should be addressed before the consultant pharmacist's next monthly MMR...The attending physician should address the consultant pharmacist's recommendation no later that their next scheduled...per applicable regulation..."

No further information and/or documentation was presented prior to the exit conference on 04/19/18 at approximately 6:00 p.m.

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F 756	Continued From page 35	F 756		

2. The facility staff failed to ensure a pharmacy recommendation for R313 regarding a lipid panel was not completed.

During the resident's clinical record review for unnecessary medications, the resident's pharmacy recommendations were reviewed.

A pharmacy recommendation dated 11/09/17 documented, "...[name of resident] receives lipid-lowering therapy with Atorvastatin Calcium...and does not have a fasting lipid profile documented in the resident record...Please consider monitoring a fasting lipid panel on the next lab day..."

The PA (physician's assistant) accepted the recommendation and documented, "will ask for lipids with any labs." DON (director of nursing) signed the form on 12/04/17.

The resident's laboratory results were reviewed and revealed that the resident has labs drawn in late November 2017, February 2018 twice and twice in March 2018 without any lipid panel/profile completed.

The corporate nurse consultant was asked about the above information and asked for assistance in locating the pharmacy recommended lab test for R313.

The corporate nurse consultant confirmed that the lipid profile had not been completed at the facility or at the hospital and the resident was still receiving the medication at the same dose.

A facility policy was presented and documented,

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F 756	Continued From page 36 "...facility staff should ensure that the attending physician, medical director and director of nursing are provided with copies of the MMRs [monthly medication reviews]...facility should alert the medical director when the MMRs are not addressed by the attending physician in a timely manner...If an irregularity does not require urgent action but should be addressed before the consultant pharmacist's next monthly MMR...The attending physician should address the consultant pharmacist's recommendation no later that their next scheduled...per applicable regulation..." No further information and/or documentation was presented prior to the exit conference on 04/19/18 at approximately 6:00 p.m.	F 756		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(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. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of	F 761		5/29/18

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F 761	Continued From page 37 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 staff failed to properly label and store medications on one of three units in the facility: East wing medication room. A bottle of liquid Lorazepam was located in the refrigerator with no date to indicate when it had been opened. Findings include: On 4/18/18 at 11:00 a.m. an inspection of the medication room on the East wing was conducted with the ADON (assistant director of nursing). An open bottle of Lorazepam was observed in the locked narcotic box in the refrigerator. The bottle was not dated with an "open" date by staff. The ADON was asked about the bottle, and if was known when the bottle had been opened. The ADON stated "No; it should have been dated when it was opened. Is the box still in there?" The ADON checked the lock box, but there was no box for the Lorazepam. The ADON was asked for the facility policy for storage/labeling of medications. The ADON then stated "I am from another state, so I'm not sure how things are done here, but I will check!" The regional nurse consultant presented this surveyor with a copy of the facility policy "Storage and Expiration of Medications, Biologicals, Syringes, and Needles" 4/18/18 at 11:30 a.m.	F 761	F761 1. Opened Lorazepam with no expiration date in the East medication room refrigerator was discarded and re-ordered while surveyors were onsite. 2. An audit will be conducted of medication room refrigerators to ensure all opened medications have an expiration date labeled. 3. Licensed staff will be educated by the staff development coordinator or designee on the process of labeling opened medications with an expiration date that are placed in the medication room refrigerator. 4. The unit manager or designee will check medication room refrigerators to ensure any opened medications have an expiration date 5 times a week for 8 weeks.	

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F 761	Continued From page 38 The policy directs under "Procedure : 5. Once any biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened." The package insert for the Lorazepam provided by the manufacturer directed "Discard opened bottle after 90 days." The administrator, DON (director of nursing), and regional nurse consultant were informed of the above findings during an end of the day meeting 4/18/18 at 5:45 p.m.	F 761		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation staff interview,and tray card review, the facility staff failed to ensure one of 38 residents, Resident #125 was provided with proper eating utensils. Resident #125 did not have red foam handled utensils during breakfast on 04/18/2018. Findings were: Resident #125 was admitted to the facility on	F 810	F810 1. Specialized utensils were provided to R125 while surveyors were onsite. 2. Current residents who are to receive specialized utensils were reviewed to ensure they are provided for meals. 3. Nursing and dietary staff will be educated by the staff development coordinator or designee on the process for providing specialized utensils to residents for meals. 4. The kitchen manager or designee will	5/29/18

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F 810	Continued From page 39 02/10/2017 with the following diagnoses, but not limited to: cerebrovascular disease, arthritis, hemiplegia, depressive disorder, and aphasia. The most recent MDS (minimum data set) was a 5 day assessment (completed after a hospital stay) with an ARD (assessment reference date of 02/15/2018. Resident #125 was assessed as being moderately impaired, with a cognitive summary score of "09". On 04/17/2018 during lunch observation, Resident #125 was observed in her room eating lunch. Her food was in individual bowls, she had two spouted cups and was using red foam handled silverware. Her tray card was observed and the afore mentioned assistive devices were listed on the card. On 04/18/2018 during breakfast, Resident #125 was observed in her chair eating breakfast. Her food was in individual bowls, her drinks were in spouted cups but she had regular long handled silverware. Her tray card was observed, the red foam handled silverware was listed. CNA (certified nursing assistant) #7 was in the hallway and was asked about the utensils. She stated, "I set up her tray...the utensils come from the kitchen, they must have forgotten to put them on there...I'll go get them." On 04/18/2018 the clinical record was reviewed. There were no orders on the POS (physician order sheet) or entries on the care plan regarding the red foam handled utensils for Resident #105. During an end of the day meeting on 04/18/2018 the above information was discussed with the administrator and the corporate nurse consultant.	F 810	observe trays for residents who are to receive specialized utensils to ensure they are present 5 times a week for 4 weeks, then weekly for 4 weeks.	

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F 810	Continued From page 40 At approximately 9:00 a.m. on 04/19/2018, this surveyor went to the kitchen and spoke with the dietary manager regarding the use of the red foam handled utensils. She stated she would find the information and bring it to this surveyor. At approximately 10:30 a.m., the corporate dietitian came to the conference room and presented information. She stated that Resident #109 had started using the red foam handled utensils with OT (occupational therapy) in August. She stated, " We don't need a physician's order to put them on the tray if OT has requested them, but they should probably be on the care plan..." No further information was obtained prior to the exit conference on 04/19/2018.	F 810		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		5/29/18

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F 880	Continued From page 41 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 42 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on medication pass and pour observation, staff interview, and facility document review the facility staff failed to ensure proper handwashing during medication pass. RN (registered nurse) # 3 performed an incorrect technique for handwashing. Findings include: On 4/18/18 a medication pass and pour observation was conducted with RN # 3 beginning at 7:45 a.m. After administering medications to a resident, RN # 3 went to the sink in the resident's room and proceeded to wash her hands. RN # 3 then turned off the faucet with her wet hands, obtained a paper towel, and dried her hands. RN # 3 was asked about the handwashing technique observed. RN # 3 stated "I'm not sure what the policy here is, but I do remember from nursing school it's a big step; I should have used paper towel to turn off the faucet." On 4/18/18 at 9:30 a.m. the regional nurse consultant gave this surveyor a copy of the facility policy "Hand Hygiene." The regional nurse consultant stated "Handwashing is more a standard of practice; but we use this handout as our guide." The policy handout directed	F 880	F880 1. RN3 was educated about proper handwashing while surveyors were onsite. 2. Current licensed staff will be observed to ensure proper handwashing is being practiced. 3. Nursing staff will be educated by the staff development coordinator or designee on the practice of proper handwashing. 4. The staff development coordinator or designee will observe one nursing staff wash their hands in the patient care setting 5 times a week for 8 weeks.	

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F 880	Continued From page 43 "Handwashing: Wet hands with water, apply soap..... Rinse and dry with a disposable towel.....Use a towel to turn off the faucet." The administrator, DON (director of nursing), and regional nurse consultant were informed of the above findings during an end of the day meeting 4/18/18 at 5:45 p.m.	F 880		
F 909 SS=F	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on facility document review and staff interview, the facility staff failed to develop and implement an inspection protocol for bed frames, mattresses and bed rails to identify areas of possible entrapment. Current checklists for resident room inspections included no specific inspections for potential entrapment risks associated with bed frames, mattresses and/or bed rails. There were no established procedures for checking compatibility of separately purchased mattresses with bed frames and/or bed rails to minimize entrapment risks. The findings include: On 4/19/18 at 12:52 p.m., the facility's maintenance director was interviewed about	F 909	F909 1. The facility developed and implemented a regular maintenance program to inspect bed frames, mattresses, and/or bedrails to identify areas of possible entrapment, including separately purchased specialty mattresses and bed frames. 2. The maintenance director or designee will complete an inspection of all current bed frames, mattresses, and/or bedrails to identify areas of possible entrapment. 3. Nursing staff, maintenance staff, housekeeping staff, and central supply staff will be educated by the staff development coordinator or designee on the protocol for the regular maintenance	5/29/18

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F 909	Continued From page 44 safety inspections for beds, mattresses and bed rails regarding potential entrapment risks. The maintenance director stated he performed "monthly room rounds" and the bed was part of the room inspection. The maintenance director stated the bed check involved checking for missing and loose parts. The maintenance director stated the bed was part of a checklist for the entire room. When asked if gap measurements were performed to identify areas of potential entrapment, the maintenance director stated the bed was just looked at "in general." The maintenance director stated no measurements were done during the monthly inspection. The maintenance director stated the room was marked on his checklist as a pass or fail and he had no specific documentation related to the beds, mattresses or rails. Concerning specialty mattresses, the maintenance director stated specialty mattresses were ordered by supply. The maintenance director stated sometimes a vendor representative came for installation of a new mattress. The maintenance director stated he did not perform any assessments or do any kind of measurements for specialty mattresses. The maintenance director presented a copy of the monthly room checklist. The checklist made no reference to any measurements or criteria for assessment of potential entrapment risks related specifically to the bed frame, mattress and/or bed rails in use. The checklist documented the following regarding bed safety, "Inspect beds (bed locks, coasters/wheel guards to ensure	F 909	program to inspect bed frames, mattresses, and/or bedrails to identify areas of possible entrapment. 4. The maintenance director or designee will complete the regular maintenance program to inspect bed frames, mattresses, and/or bedrails to identify areas of possible entrapment annually and for any new specialty bed/mattress as needed.	

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F 909	Continued From page 45 resident safety) and other furnishings for proper operation secured for resident safety. Repair as needed... Assure that nuts, screws bolts, cranks, handles and headboards/footboards are tightly fitted and that mechanically all cranks and position devices properly function...Inspect connectors on rails and tighten as necessary. Remove any burs or rough edges to prevent injury..." This finding was reviewed with the administrator, nursing consultant and director of nursing during a meeting on 4/19/18 at 3:15 p.m.	F 909		