| STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION | (X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) OATE SURVEY COMPLETEO |
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| | 495336 | A. BUILOING _____ B. WING _____ | C 05/09/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| AUGUSTA NURSING & REHAB CENTER | 83 CROSSROADS LANE FISHERSVILLE, VA 22939 |

| (X4) IO PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEOED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION OATE |
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| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 05/02/2017 through 05/04/2017. An extended survey was conducted 05/08/2017 through 05/09/2017. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Five complaints were investigated during the survey.<br><br>Immediate Jeopardy (IJ) was identified in the area of Comprehensive Person-Centered Care Planning on 05/04/2017 at 1:55 p.m. The facility removed the immediacy on 05/04/2017 at 8:55 p.m. After removal of the immediacy the Scope and Severity was lowered to a Level III, isolated.<br><br>Substandard Quality of Care (SQC) was identified in the area of Quality of Care, Level III, Pattern on 05/04/2017 at 1:55 p.m. | F 000 | Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. | |
| F 157 SS=D | 483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br><br>(g)(14) Notification of Changes.<br><br>(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- | F 157 | F157: Notification of Changes<br><br>1. Resident #10 suffered no adverse affects and did not require transfer to a higher level of care. Resident #10 has current physician orders received 05/03/17 for hypo/hyperglycemic parameter to notify physician. | 06/23/17 |

| LABORATORY DIRECTOR'S OR PROVIOER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| [signature] | Executive Director | 05/29/2017 |

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

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| F 157 | Continued From page 1<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br><br>(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);<br><br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br><br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br><br>(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.<br><br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br><br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br><br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br><br>(iv) The facility must record and periodically update the address (mailing and email) and | F 157 | Resident #10's physician notified on 05/03/17 of blood sugar of 25. Resident has not had blood sugar requiring physician notification since 05/03/17.<br>2. A Quality review of current residents with physician orders for sliding scale insulin and/or Insulin dependent was completed to verify finger stick blood sugar (FSBS) checks are in place with high/low parameters, hypo/hyperglycemic protocols and when to contact physician. Physician notification r/t residents with low FSBS per order and/or administration of oral glucose or IM glucagon is present in the medical record.<br>3. Licensed nurses re-educated by the DCS/Designee regarding obtaining orders for FSBS containing high/low parameters, hypo/hyperglycemic PRN physician orders and when to contact physician with documentation in the medical record. Licensed nurses re-educated by the DCS/Designee r/t to physician notification of residents with low FSBS per order and/or administration of oral glucose and/or IM glucagon is present in the medical record. Licensed nurses re-educated by the DCS/Designee regarding location of physician contact information along with hypoglycemic management process. | |

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| F 157 | Continued From page 2 | F 157 | 4. DCS/Designee during morning clinical meeting to conduct quality monitoring of physician orders for new admissions related to FSBS, high/low parameters, when to contact physician, and hypo/hyperglycemic protocols daily x 4, weekly x 4 then monthly, PRN and as indicated. DCS/Designee to conduct quality monitoring related to physician notification of residents who require administration of hypoglycemic protocols per physician with documentation in the medical record as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. | |

phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by:
Based on staff interview, and clinical record review, facility staff failed to notify the physician of a change in condition for one of 25 residents in the survey sample, Resident #10.

Facility staff failed to notify the physician of a blood sugar reading of 25 for Resident #10.

Findings included:

Resident #10 was originally admitted to the facility on 11/19/2011 and readmitted on 04/03/2017 with diagnoses including, but not limited to: Paraplegia, Aspiration Pneumonitis, COPD (Chronic Obstructive Pulmonary Disease), Depression, Anxiety, Diabetes, Hypertension, Neurogenic Bladder, and Chronic UTI (Urinary Tract Infection).

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 04/10/2017. Resident #10 was assessed as moderately impaired in her cognitive status with a total cognitive score of 10 out of 15.

During review of Resident #10's medical record on 05/03/17 at approximately 10:00 a.m. the following documentation was located in the clinical record. "Interdisciplinary Progress Note" dated "5/3/17 0500 [5:00 a.m.] I checked the resident's BS [blood sugar] and it was 25. I gave the resident a glucose tab [tablet] and pudding but she couldn't chew the tab. I then gave her the glucagon shot to raise her BS. The final number was 85. I called her RP [responsible party] and will notify the MD [physician]."

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| F 157 | Continued From page 3 | F 157 | | |

LPN #2 (licensed practical nurse) was interviewed at 10:55 a.m. on 05/03/17. LPN #2 stated, "There are no standing orders for diabetes. I asked that when I got here."

LPN #3 was interviewed at 11:10 a.m. on 05/03/17. LPN #3 stated, "Received in report of low blood sugar this morning. (Name) PA (physician assistant) knows. I rechecked; it was 127. I don't know if the on-call doctor was notified."

PA was interviewed at 11:15 a.m. on 05/03/17. PA stated, "I was notified this morning at 9:08 when I came in. I don't know if the on-call doctor was notified or not. I am going to find out who was on-call last night and ask them myself. I will let you know. She also didn't get her bedtime snack last night."

At approximately 1:00 p.m. on 05/03/17 the PA entered the conference room and handed this surveyor the following note: "5-3-17 Noon To Whom It May Concern: In regard to [(Name) Resident #10], I was notified at 0908 (9:08 a.m.) that her accuchek [blood sugar] was 25. Nursing gave her a glucose tab and pudding. She then was administered a Glucagon injection. I inquired about any input from the on call doctor but no one knew. I called over office (sic) and there was no call made to the on call physician to direct these orders. This incident occurred about 5:30 a.m. today. An accuchek at time of exam was 136..."

The Administrator and DON (director of nursing) were notified of the above findings during a meeting with the survey team on 05/03/2017 at approximately 5:45 p.m. No further information

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| F 157 | Continued From page 4<br>was received by the survey team prior to the exit conference on 05/09/2017. | F 157 | | |
| F 205 SS=D | 483.15(d)(1)(i)-(iv)(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR<br><br>(d) Notice of bed-hold policy and return-<br><br>(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-<br><br>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;<br><br>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;<br><br>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (c)(5) of this section, permitting a resident to return; and<br><br>(iv) The information specified in paragraph (c)(5) of this section.<br><br>(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (e)(1) of this section.<br>This REQUIREMENT is not met as evidenced by: | F 205 | F 205: Notice of Bed-Hold Policy Before/Upon Transfer<br><br>1. Resident #21 no longer resides in the facility.<br>2. Quality review of hospital re-admissions for previous 30 days 4/10-5/10 for room changes to ensure documentation is present in the medical record if indicated.<br>3. Social Services, Licensed Nurses, Admissions, DCS and ED re-educated by the Division Education Specialist/Designee regarding notification of Bed Hold policy prior to hospital discharge and notification of room change before returning to the facility. | 06/23/17 |

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| F 205 | Continued From page 5<br>Based on resident interview, staff interview and clinical record review, the facility staff failed to offer one of 25 residents a bed hold prior to discharge and failed for one of 25 residents to notify of a room change, Resident #21.<br><br>Resident #21 was not offered a bed hold prior to discharging to the hospital and Resident #21's room was changed without notification.<br><br>The findings include:<br><br>Resident #21 was originally admitted to the facility on 1/8/16 and readmitted on 1/9/17 with, but not limited to, the following diagnoses: urine retention, vaginal fistula, unspecified ileus and quadriplegia related to a C5-C6 injury. The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/14/17 was a quarterly assessment. The resident was assessed as being a fifteen (15) for cognitive skills; able to make needs known and independent in decision-making skills.<br><br>On 5/8/17 at approximately 12:45 p.m. during a interview with Resident #21, the resident stated that she was not informed that she was moving from Unit (four) 4 to Unit (three) 3 until she returned to the facility and found her belongings had been moved from "one unit to the next." When interviewed and asked if she was offered a bed hold and notification prior to going out to the hospital, Resident #21 stated, "No, I was admitted to the hospital in January and when I cam back all my stuff was on Unit 3."<br><br>On 5/8/17 at approximately 12:50 p.m., the Administrator in Training (AIT) identified as Other Staff (OS) #5 was interviewed regarding the | F 205 | 4. Social Services Director / Designee during morning meeting to review and discuss with IDT team hospital transfers and room changes to ensure a bed hold was offered and notification of room change if indicated. Social Services to conduct quality monitoring with hospital transfers, room changes, monthly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. | |

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| F 205 | Continued From page 6<br>resident being notified of a room change and if she was offered a bed hold. OS #5 stated, "There should have been a letter, for a bed hold, offered. I have to check and see. If there isn't a letter in the chart, then they probably didn't do one."<br><br>On 5/8/17 at approximately 1:11 p.m. OS #5 entered the conference room and stated, "I am not seeing anything. I see where she was notified of a room change from Unit 2 to Unit 4 but I am not seeing anything where she was moved from Unit 4 to Unit 3." When interviewed and asked if there was a letter provided for a bed hold, OS #5 stated, "No."<br><br>On 5/8/17 a Physician's Telephone order was reviewed in the clinical record to include the following:<br><br>"1/10/17 Resident moved to Unit 3 Rm [room number named]."<br><br>On 5/9/17 at approximately 1:34 p.m., the administrative staff were made aware of the above findings. No further information was provided during the course of the survey regarding notification of a bed hold and a room change prior to discharge. | F 205 | | |
| F 224 SS=G | 483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN<br><br>§483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint | F 224 | F 224: Prohibit Mistreatment/Neglect/ Misappropriation<br>1. Resident #21 no longer resides in the facility. C.N.A identified in 2567 no longer works at the facility. | 06/23/17 |

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| F 224 | Continued From page 7<br>not required to treat the resident's symptoms.<br><br>483.12(b) The facility must develop and implement written policies and procedures that:<br><br>(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,<br><br>(b)(2) Establish policies and procedures to investigate any such allegations, and<br><br>(b)(3) Include training as required at paragraph §483.95,<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, resident interview, clinical record review, Adult Protective Service (APS) review, and facility document review; the facility staff failed to ensure one of 25 residents was free from neglect. Resident #21 was not provided ADL (Activities of Daily Living) during her menstrual cycle. A CNA (certified nursing assistant) stuffed wipes inside the resident's vagina and between her legs during the resident's menstrual cycle resulting in psychological harm. The resident stated in an interview, "I felt awful, humiliated and embarrassed..., I am so happy to be out of there I can't imagine having to go back there."<br><br>The findings include:<br><br>Resident #21 was originally admitted to the facility on 1/8/16 and readmitted on 1/9/17 with, but not limited to, the following diagnoses: urine retention, vaginal fistula, unspecified ileus and quadriplegia related to a C5-C6 injury. The most recent Minimum Data Set (MDS) with an | F 224 | 2. Quality review of residents was completed to determine appropriate ADL care was provided during their menstrual cycle. Peri-care skills competency conducted as indicated.<br>3. Licensed Nurses and C.N.A's re-educated by the Director of Clinical Services (DCS)/Designee regarding providing appropriate ADL care to female resident's during their menstrual cycle along with Abuse/Neglect training per policy.<br>4. DCS / Designee during morning clinical meeting will review and discuss with IDT team newly admitted residents to ensure appropriate ADL care is provided for female residents during their menstrual cycle. DCS/Designee through random monitoring will conduct peri-care skills competencies 3 times weekly x 4 weeks, 2 times weekly x 2 weeks then random monthly and with newly hired C.N.A's to ensure residents receive appropriate ADL and are free from Abuse/Neglect. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. | |

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| F 224 | Continued From page 8 | F 224 | | |

Assessment Reference Date (ARD) of 1/14/17 was a quarterly assessment. The resident was assessed as being a fifteen (15) for cognitive skills; able to make needs known and independent in decision-making skills. The resident was discharged 01/27/17

On 5/8/17 at approximately 11:30 a.m., An APS report was reviewed regarding Resident #21 was not provided ADL care during her menstrual cycle and that the resident was found without care related to bathing and "bloody wipes" were found between the resident's legs.

On 5/8/17 at approximately 1:34 p.m., the administrative staff was made aware of the APS report. The facility staff involved in the APS report were not available for interview. Two of the employees were called multiple times on 5/8/17 at 3:20 p.m. and again at 5:24 p.m., but there was no answer. The remainder of the staff involved were no longer employed at the facility.

On 5/8/17 at approximately 12:45 p.m. during an interview with Resident #21, the resident stated that she was not provided ADL care from the facility staff during her menstrual cycle for approximately three days and that her bed was soaked with urine. Resident #21 stated that when she was finally cleaned a CNA (certified nursing assistant) "found wipes stuffed inside my vagina and between my legs saturated with blood." During the interview Resident #21 stated to this Surveyor, "Can I call you back I have an appointment I have to attend and I can finish telling you what happened when we talk again." This Surveyor agreed to continue the interview at a later time.

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| F 224 | Continued From page 9 | F 224 | | |

On 5/9/17 at approximately 9:07 a.m. Resident #21 was interviewed regarding the above findings of not being provided ADL care during her menstrual cycle and having to lie in bed soaked with urine for three days. Resident #21 stated, "I felt awful, humiliated and embarrassed when the CNA pulled the covers back and discovered blood on the sheets and between my legs" Resident #21 further stated, "When the CNA pulled the covers back to see the look on her face was humiliating." Resident #21 stated, "It is enough to have someone change you because you can't do it yourself but to have someone leave you laying in blood is disgusting. Resident #21 then stated, "The worst part of it all was I had to go to my care plan (CP) meeting and repeat this in front of my parents and my husband, it was degrading. When you are at the mercy of someone else it is just humiliating. I am so happy to be out of there I can't imagine having to go back there."

On 5/9/17 at approximately 9:20 a.m., the CNA involved in the above incident was called three times but no answer.

On 5/9/17 the investigation and witness statement was reviewed to include the following:

Witness Statement:
1/17 LPN-Called by aides doing shower to shower room. Bloody wipes noted, advised by aides they were between Residents legs at vagina area. Resident advised they have been there since 3-11 (second shift). I wasn't changed all night [referring to her menstrual pad] . Resident also states. "My gowns not been changed for 3 days." [ADON-assistant director of nursing named] made aware..."

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| F 224 | Continued From page 10 | F 224 | | |

1/17/17 CNA-On Tuesday January 17th around 1300 (1:00 p.m.) [Resident named] was scheduled for a shower. As I went to her room and got her things I brought her to the shower room. As I was preparing myself, getting all my things together, I noticed something between her legs like a napkin or her brief, I asked her what was between her legs she told me "oh probably the pad I was laying on," So I put gloves on and pulled her in the shower stall and spread her legs apart and pulled a wipe from just sitting between her legs, that had menstrual blood on it. She was telling me she was on her period, and was a little shocked by what she had seen. As I start the water to do perineal care I pulled two or three wipes folded together from between her legs also, about that time I just walked back from the trash the other shower aide walked in. I asked [Aide named] to get the unit manager so I can show her. [Resident named] was concerned so I try to calm her down and informed her I got the unit manager...."

"1/26/17 CNA-...The incident where they said the wipes were left in between her legs. The other aide asked if I would her her (sic) and she placed the wipes there to clean her. I'm not sure if they were left there or not. Because I did see the girl pull them out."

On 5/9/17 at approximately 1:34 p.m., the administrative staff were made aware of the above findings. A copy of the abuse policy was requested and reviewed to include the following:

Policies and Procedures:
Subject: Resident Abuse...Revision Date: 2/1/17

"Neglect: Neglect is the failure of the facility, its

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| F 224 | Continued From page 11<br>employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress...Intentional lack of attention to physical needs including, but not limited to, toileting and bathing. Failure to provide services that result in harm to the resident, such as not turning a bedfast resident or leaving a resident in a soiled bed..." | F 224 | | |
| F 240 SS=E | 483.10(a)(1)(2) CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE<br><br>(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, resident interview, and Group Interview, the facility staff failed for three of 25 residents in the survey sample (Residents # 4, 14, and 25), as well as eight residents in the Group Interview, to promote a living environment that enhanced the quality of life.<br><br>1. Resident # 4 complained about a facility | F 240 | F240: Care and Environment Promotes Quality of Life<br><br>1. Resident #4 concern completed with resolution. Resident #14 and Resident #25 did not have any items taken and/or broken d/t the resident who wandered into their room. Residents #14 and #25 were reinterviewed on 05/26/17 regarding concerns and no further concerns were voiced. Wandering resident remains on close observation by staff for needed redirection away from other resident's rooms. Activities Director has met with Resident Council on 06/01/17 with regards to wandering residents. No concerns at this time.<br>2. Quality review of current residents who wander to determine appropriate interventions was completed after implemented. Care plan updated as indicated with modifications. Transfer/ Discharge for alternate placement as indicated. | 06/23/17 |

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| F 240 | Continued From page 12<br>resident who wanders throughout the facility, who entered her room several times, and who broke one of her ceramic figurines.<br><br>2. Resident # 14 complained about a facility resident who wanders throughout the facility and who has attempted to take some of her personal items from the room.<br><br>3. Resident # 25 complained of a facility resident who wanders, who has attempted to take items belonging to her roommate, and who ignores a facility effort to keep her out of their room.<br><br>4. Eight residents in the Group Interview complained about a facility resident who wanders throughout the facility and who has been identified as taking money and personal items belonging to other residents.<br><br>The findings were:<br><br>1. Resident # 4 complained about a facility resident who wanders throughout the facility, who entered her room several times, and who broke one of her ceramic figurines.<br><br>Resident # 4 in the survey sample, a 66 year-old female, was admitted to the facility on 4/7/15, and most recently readmitted on 4/14/17 with diagnoses that included obstructive sleep apnea, encephalopathy, acidosis, hypertension, restless leg syndrome, diabetes mellitus, asthma, congestive heart failure, bi-polar disorder, anxiety, chronic pain, morbid obesity, acute respiratory failure, chronic renal failure, seizure disorder, anemia, seizure disorder, depression, gastroesophageal reflux disease, chronic obstructive pulmonary disease, and respirator | F 240 | 3. Facility staff re-educated by the Executive Director (ED)/Director of Clinical Services(DCS)/Designee regarding communicating resident behaviors and resident concerns at the time of occurrence to the ED/DCS along with use of the 24 hour report for IDT review of residents who wander and the grievance process to communicate resident concerns. Licensed Nurses and C.N.A's re-educated by the DCS/designee regarding use of Stop and Watch for documenting and communicating changes. Social Services re-educated by the ED regarding alternate placement/transfer process for residents who wander. | |

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| F 240 | Continued From page 13<br>failure. According to the most recent Minimum Data Set (MDS), a Significant Change, with an Assessment Reference Date (ARD) of 4/21/17, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.<br><br>During an interview with Resident # 4 at approximately 2:30 p.m. on 5/3/17, the resident complained of a resident that wanders in the facility and enters residents' rooms. "She scared me half to death one night," Resident # 4 said. "I woke up in the middle of the night and she was in the room." Continuing, Resident # 4 said, "She goes in your things. She broke my favorite angel (ceramic figurine). When I complained, staff told me 'Can't you get another angel?' Staff treat her like she's the most wonderful little thing. They baby her. They are just enabling her."<br><br>NOTE: Residents # 14 and 25 identified in Findings 2 and 3 are roommates.<br><br>2. Resident # 14 complained about a facility resident who wanders throughout the facility and who has attempted to take some of her personal items from the room.<br><br>Resident # 14 in the survey sample, an 80 year-old female, was admitted to the facility on 8/20/10, and most recently readmitted on 10/2/10 with diagnoses that included diabetes mellitus, hypertension, depression, history of alcohol abuse, anemia, gastroesophageal reflux disease, hyperlipidemia, psychotic disorder, contractures, muscle wasting and atrophy. According to the most recent MDS, a Quarterly with an ARD of 2/22/17, the resident was assessed under | F 240 | 4. ED/DCS/Designee through random resident interviews twice weekly x 4 weeks, weekly x 4 weeks then randomly twice monthly, PRN and as indicated to ensure a living environment that promotes and enhances quality of life. DCS/ Designee through morning clinical meeting review the 24 hour report r/t documentation of residents who wander in other residents rooms PRN and/or as indicated with changes/new onset of wandering behaviors. Social Services/ ED/Designee through morning meeting PRN and/or as indicated with changes/new onset of wandering behaviors review residents who wander to determine appropriate transfer/placement as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. | |

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Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.

During an interview with Resident # 14 at approximately 3:15 p.m. on 5/4/17, the resident complained of another resident that wanders the facility and who enters other residents' rooms and takes things. "[Name of wandering resident] keeps coming in our room. She comes in and takes things. I was laying in bed one afternoon and she came in and tried to take my cookies and coke." Resident # 14 keeps several packs of cookies on her night stand, and a case of Coke on the floor next to the night stand. Resident # 14 went on to say, "The staff say they can't do anything."

3. Resident # 25 complained of a facility resident who wanders, who has attempted to take items belonging to her roommate, and who ignores a facility effort to keep her out of their room.

Resident # 25 in the survey sample, a 60 year-old female, was admitted to the facility on 10/3/14 with diagnoses that included anxiety disorder, depression, manic depression, psychotic disorder, spinal stenosis, congenital pondylolisthesis, insomnia, and malaise. According to the most recent MDS, a Quarterly with an ARD of 2/14/17, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.

During an interview with Resident # 25 at approximately 3:15 p.m. on 5/4/17, the resident complained of another resident that wanders the

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facility and who enters other residents' rooms and takes things. Resident # 25 confirmed Resident # 14's remarks about the wandering resident and her attempts to take cookies and Coke. "The staff put a STOP sign up, but she just barges right through it," Resident # 25 said. "It is to keep her out, not to keep us in. This is ridiculous."

NOTE: A STOP sign is a cloth strip with a red STOP sign on it that is affixed to the door jamb of a room with magnets.

4. Eight of nine residents present at the Group Interview complained of a facility resident who wanders and who has been identified as taking money and personal items belonging to other residents.

During the Group Interview the subject of the resident who wanders throughout the facility was discussed. Eight of the residents present complained about the wandering resident. One resident stated, "(Name of wandering resident) came in my room and took $1.50 from a small box on top of my night stand. When I complained to the staff, I was told 'Oh well, it's just a little money.' "

Another member of the group said that when you complain about the wandering resident, you are told, "Oh, leave her alone, she doesn't know what she is doing." Another group member said, "They (staff) just pat her on the head and let her go on her way."

The findings were discussed at a meeting at 3:00 p.m. on 5/8/17 with the Interim Administrator, Director of Nursing, Corporate Nurse Consultant,

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| F 240 | Continued From page 16 and the survey team. | F 240 | | |
| F 241 SS=G | 483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY | F 241 | F241: Dignity and Respect of Individuality | 06/23/17 |

(a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, resident interview, APS (Adult protective services) review and clinical record review, the facility staff failed to promote the dignity and respect for three of 25 residents, which resulted in harm for one of 25 resident's Residents #21. The resident stated in an interview, "I felt awful, humiliated and embarrassed..., I am so happy to be out of there I can't imagine having to go back there."

The remaining residents were Resident #4, and #10 and the facility staff failed to ensure a dignified dining experience in the facility.

1. Resident #21 was left lying in a bed soiled with urine and bloody wipes, from the resident's menstrual cycle, were found between the resident's legs during ADL (activities of daily living) care resulting in psychological harm.

2. The facility staff failed to promote dignity and respect for one of 25 residents in the survey sample: Resident # 4. Resident # 4 was left sitting in urine and feces for approximately two hours, and was also left undressed and uncovered by an open window.

1. Resident #21 no longer resides in the facility. Resident #4 is provided ADL care. Resident #10 is dressed appropriately per resident choice. LPN#7 no longer works at the facility. Plate lids with dining debris were removed from resident's rooms and the restorative dining area during meal service. Resident #4 was provided incontinent care at the time and receives timely incontinent care. Resident # 4 was redressed at the time and is dressed daily appropriately, while honoring resident choice. Resident #10 was redressed at the time and currently is dressed daily appropriately, while honoring choices. Currently the facility has no residents with the potential (within age range) of having menstrual cycles.
2. A Quality Review of current residents was completed to determine appropriate ADL care was provided during their menstrual cycle. Review of current residents to determine ADL care was provided in a dignified and respectful manner completed. Peri-care skills competency conducted as indicated. Review of meal service to ensure plate lids with dining debris are not present in resident's rooms and/or the restorative dining area during meal service completed.

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| F 241 | Continued From page 17<br><br>3. Resident #10 was put to bed on one occasion in only a bra and shirt and on another occasion in only a brief.<br><br>4. The facility failed to ensure a dignified dining experience in 22 resident rooms and the Restorative Dining Room.<br><br>The findings include:<br><br>1. Resident #21 was left lying in a bed soiled with urine and bloody wipes, from the resident's menstrual cycle, were found between the resident's legs during ADL (activities of daily living) care resulting in psychological harm.<br><br>Resident #21 was originally admitted to the facility on 1/8/16 and readmitted on 1/9/17 with, but not limited to, the following diagnoses: urine retention, vaginal fistula, unspecified ileus and quadriplegia related to a C5-C6 injury. The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/14/17 was a quarterly assessment. The resident was assessed as being a fifteen (15) for cognitive skills; able to make needs known and independent in decision-making skills. The resident was discharged 01/27/17<br><br>On 5/8/17 at approximately 11:30 a.m., An APS report was reviewed regarding Resident #21 was not provided ADL care during her menstrual cycle and that the resident was found without care related to bathing and "bloody wipes" were found between the resident's legs.<br><br>On 5/8/17 at approximately 1:34 p.m., the | F 241 | 3. Licensed nurses and C.N.A's re-educated by the Director of Clinical Services (DCS)/designee regarding providing privacy during ADL care to ensure the resident's dignity and privacy are honored. Facility staff re-educated by the DCS/ Executive Director (ED)/ designee to ensure plate lids with dining debris are not present in resident's rooms and the restorative dining area during meal service.<br>4. DCS/ED/designee to conduct quality monitoring of meal service daily x 5 days, 3 times weekly x 4 weeks, weekly x 4 weeks then monthly PRN and as indicated. DCS/designee to conduct peri-care skill competency as indicated. DCS/designee to conduct quality monitoring r/t ADL care provided in a dignified and respectful manner 5 times weekly x 4 weeks, 3 times weekly x 4 weeks, weekly x 4 weeks then monthly PRN and as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. | |

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administrative staff was made aware of the APS report. The facility staff involved in the APS report were not available for interview. Two of the employees were called multiple times on 5/8/17 at 3:20 p.m. and again at 5:24 p.m., but there was no answer. The remainder of the staff involved were no longer employed at the facility.

On 5/8/17 at approximately 12:45 p.m. during an interview with Resident #21, the resident stated that she was not provided ADL care from the facility staff during her menstrual cycle for approximately three days and that her bed was soaked with urine. Resident #21 stated that when she was finally cleaned a CNA (certified nursing assistant) "found wipes stuffed inside my vagina and between my legs saturated with blood." During the interview Resident #21 stated to this Surveyor, "Can I call you back I have an appointment I have to attend and I can finish telling you what happened when we talk again." This Surveyor agreed to continue the interview at a later time.

On 5/9/17 at approximately 9:07 a.m. Resident #21 was interviewed regarding the above findings of not being provided ADL care during her menstrual cycle and having to lie in bed soaked with urine for three days. Resident #21 stated, "I felt awful, humiliated and embarrassed when the CNA pulled the covers back and discovered blood on the sheets and between my legs" Resident #21 further stated, "When the CNA pulled the covers back to see the look on her face was humiliating." Resident #21 stated, "It is enough to have someone change you because you can't do it yourself but to have someone leave you laying in blood is disgusting. Resident #21 then stated, "The worst part of it all was I had to go to my care

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plan (CP) meeting and repeat this in front of my parents and my husband, it was degrading. When you are at the mercy of someone else it is just humiliating. I am so happy to be out of there I can't imagine having to go back there."

On 5/9/17 at approximately 9:20 a.m., the CNA involved in the above incident was called three times but no answer.

On 5/9/17 the investigation and witness statement was reviewed to include the following:

Witness Statement:
1/17 LPN-Called by aides doing shower to shower room. Bloody wipes noted, advised by aides they were between Residents legs at vagina area. Resident advised they have been there since 3-11 (second shift). I wasn't changed all night [referring to her menstrual pad] . Resident also states. "My gowns not been changed for 3 days." [ADON-assistant director of nursing named] made aware..."

1/17/17 CNA-On Tuesday January 17th around 1300 (1:00 p.m.) [Resident named] was scheduled for a shower. As I went to her room and got her things I brought her to the shower room. As I was preparing myself, getting all my things together, I noticed something between her legs like a napkin or her brief, I asked her what was between her legs she told me "oh probably the pad I was laying on," So I put gloves on and pulled her in the shower stall and spread her legs apart and pulled a wipe from just sitting between her legs, that had menstrual blood on it. She was telling me she was on her period, and was a little shocked by what she had seen. As I start the water to do perineal care I pulled two or three

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wipes folded together from between her legs also, about that time I just walked back from the trash the other shower aide walked in. I asked [Aide named] to get the unit manager so I can show her. [Resident named] was concerned so I try to calm her down and informed her I got the unit manager...."

"1/26/17 CNA-...The incident where they said the wipes were left in between her legs. The other aide asked if I would her her (sic) and she placed the wipes there to clean her. I'm not sure if they were left there or not. Because I did see the girl pull them out."

On 5/9/17 at approximately 1:34 p.m., the administrative staff were made aware of the above findings.

2. The facility staff failed to promote dignity and respect for one of 25 residents in the survey sample: Resident # 4. Resident # 4 was left sitting in urine and feces for approximately two hours, and was also left undressed and uncovered by an open window.

Resident # 4 was admitted to the facility 4/7/15 with a readmission date of 4/14/17. The most recent MDS (minimum data set) was a significant change in status review and had Resident # 4 assessed as being cognitively intact.

On 5/9/17 at 10:30 a.m. this surveyor conducted a resident interview with Resident # 4. Resident # 4 was included in the survey sample as part of

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an APS (adult protective services) report. The report included Resident # 4 had called the APS worker to report she had been left sitting in urine for approximately 2 hours. Resident # 4 reported that a CNA (certified nursing assistant) had come into the room earlier, turned off the call light telling the resident she would be right back; however, she did not return, and by this time the resident had a bowel movement (BM) as well. When the APS worker arrived at the facility at 10:45 a.m., staff were just leaving the room after cleaning the resident, but had left her with no briefs on as she was having multiple BM's and staff did not want to put a brief on her. The report also documented the resident had not only been left without a brief on, but was not clothed as well; even though the privacy curtain was pulled, the resident's bed is next to a window, which had no curtains or blinds pulled. Resident # 4 was asked about the event, and she stated yes, it most certainly happened and that it had made her feel "really bad."

Resident # 4 went on to say "I'm sitting in urine right now; I put my call bell on at 7:00 a.m. and I am still waiting to be changed. They [the CNA staff] have left this basin of soap and water and told me to wash my top half; but I can't.....I need help. I am weak in my hands and cannot squeeze the wash cloth out to wash myself. The medication nurse brings my cup of pills in, sets them on the table and leaves the room. I try to take them, but I dropped the cup in between my legs and couldn't reach it. The nurse came back in the room and asked if I had taken my pills and I showed her where they were. She got them and handed me the cup and said 'Here- take your pills.' If I try to tell her I can't, and I need help, she just looks at me and tells me I'm robbing her

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of her joy! I spoke with the unit manager about a week or so ago about the problem of getting someone in here to change me around 7.....she said she would tell the oncoming day shift to come and change me first thing....that has yet to happen.

I take a fluid pill around 5:30 a.m. and by 7:00 a.m., it kicks in and I am soaked! When I put my call bell on, they come in, turn it off, tell me they will be right back, and never come back. When I tried to explain that I am uncomfortable and wet, they tell me how busy they are, they have to deliver breakfast trays, feed other residents, and tell me to just hold it! I can't do that; when that fluid pill kicks in, that's it! They came in one day and took me down to lunch without changing my brief; I felt not only uncomfortable, but felt pretty bad and embarrassed to go to the dining room wet like that!"

Resident # 4 also told this surveyor that morning care wasn't given in time for her to attend activities she would like to attend, most specifically her devotions. Toward the end of the interview, the medication nurse [identified as licensed practical nurse (LPN) # 7] came into the room and asked the resident if she would like her pain medicine. Resident # 4 stated she would.. LPN # 7 was then asked about someone helping the resident finish her bath and get dressed. LPN # 7 looked at Resident # 4 and stated "Doesn't therapy come in and work with you on that?" Resident # 4 stated "Not anymore; I was discharged from therapy last week. And my hands are too weak to squeeze out this washcloth; I need help." LPN # 7 then left the room. This surveyor and Resident # 4 then concluded the interview, and this surveyor was

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behind LPN # 7 as she was walking up the hall. When LPN # 7 got to the nurses' station, she looked at a CNA and stated "Can you go finish [name of resident] bath? She's done the top half; need to finish her bottom half and get her dressed." At that time, this surveyor, who had not been noticed by LPN # 7, spoke up and told the CNA that Resident # 4 had not finished the top half, and repeated what Resident # 4 had told LPN # 7. The CNA then went and helped Resident # 4.

The administrator, DON (director of nursing), and regional nurse consultant were informed of the above findings 5/9/17 during a meeting with facility staff beginning at 1:30 p.m.

No further information was provided prior to the exit conference.

THIS IS A COMPLAINT DEFICIENCY.

3. Facility staff failed to promote dignity and respect while caring for Resident #10's ADL's (activities of daily living). Resident #10 was put to bed on one occasion in only a bra and shirt and on another occasion in only a brief.

Resident #10 was originally admitted to the facility on 11/19/2011 and readmitted on 04/03/2017 with diagnoses including, but not limited to: Paraplegia, Aspiration Pneumonitis, COPD (Chronic Obstructive Pulmonary Disease), Depression, Anxiety, Diabetes, Hypertension, Neurogenic Bladder, and Chronic UTI (Urinary Tract Infection).

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The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 04/10/2017. Resident #10 was assessed as moderately impaired in her cognitive status with a total cognitive score of 10 out of 15.

Resident #10's daughter was interviewed on 05/03/2017 at 1:35 p.m. in regards to concerns voiced in a complaint sent to the OLC (office of licensure and certification). The daughter stated, "On January 27, 2017, Mom was put to bed in only a bra and shirt. She has nightgowns here to wear. On March 03, 2017, Mom's CNA (certified nursing assistant) put her to bed in only a brief. A basin of water was left by the bedside until 1:00 a.m. when the night shift aide found it. The evening aide told me she forgot to come back and dress Mom. I don't know why the aide left in the middle of her nighttime care. Mom was drowsy during that day and at bedtime she got a prn [as needed] pain pill and she was very sleepy. It was two different aides and when I spoke to administration about it, their solution was to move the two aides to another unit instead of addressing the problem."

On 05/08/2017 at 10:30 a.m., Resident #10 was interviewed and confirmed the above information. Resident #10 stated, "They put me to bed around 8:00 p.m. When I get my nighttime medicine and sometimes an extra pain pill I get very sleepy. I don't know why they put me to bed like that. The night I was put to bed in only a brief the nighttime aide found me like that and dressed me for bed."

No reference to either incident was included in the clinical record.

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The Administrator and DON (director of nursing) were informed of the above incidences and interviews during a meeting with the survey team on 05/08/2017 at approximately 1:35 p.m. No further information was received by the survey team prior to the exit conference on 05/09/2017.

This is a complaint deficiency.

4. The facility failed to ensure a dignified dining experience in 22 resident rooms and the Restorative Dining Room.

At approximately 8:10 a.m. on 5/3/16, observation of the Breakfast meal served in the Restorative Dining Room found six residents were seated at three tables. At each of the three tables, staff assisting the seated residents to eat had turned the plate covers upside down and had placed dining debris, including straw sleeves, empty salt and pepper packets, empty sugar packets, empty butter packets, and other items in the plate lids.

Observations on Unit Three found 12 rooms with a plate lid containing dining debris on one of the beds in each of the rooms, and three rooms with plate lids containing dining debris on both beds in each room. In three rooms, plate lids with dining debris were observed on overbed tables where residents were eating.

Observations on Unit Two found six rooms with a plate lid containing dining debris on one of the beds in each of the rooms, and three rooms with plate lids containing dining debris on overbed tables where residents were eating.

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| F 241 | Continued From page 26<br>The findings were discussed at a meeting at 3:00 p.m. on 5/8/17 with the Interim Administrator, Director of Nursing, Corporate Nurse Consultant, and the survey team. | F 241 | | |
| F 246 SS=E | 483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES<br><br>483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:<br><br>(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident interview, family interview, group interview, and in the course of a complaint investigation, facility staff failed to ensure call bells were answered in a timely manner for two of 25 residents in the survey sample, Residents #10 and #4.<br><br>1. In accordance with an interview with Resident #10, Resident #10's daughter and in the group interview conducted during the survey, facility staff failed to answer call lights in a timely fashion.<br><br>2. The facility staff failed to ensure call bells were answered in a timely manner for Resident # 4 which resulted in the resident sitting for extended periods of time in urine and/or feces.<br><br>Findings included: | F 246 | F246: Reasonable Accommodation of Needs/Preferences<br>1. Resident # 4 and Resident #10's call lights are answered timely. Care and Services provided timely upon answering the call light for resident #4 and resident #10.<br>2. Quality review of current residents to ensure call lights are answered timely. Review of current residents to ensure care and services are provided timely upon answering the resident's call light.<br>3. Facility staff re-educated by the Director of Clinical Services (DCS)/ Executive Director (ED) /Designee regarding answering residents call lights in a timely manner. Licensed nurses and C.N.A's re-educated by the DCS/ED/ Designee regarding providing care and services in a timely manner upon answering the resident's call light. | 06/23/17 |

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| F 246 | Continued From page 27 | F 246 | 4. ED/DCS/IDT/designee through Mock Survey Rounds and Resident Interviews ensure residents call lights are answered timely / care and services provided timely, 5 times a week x 4 weeks, 3 times a week x 4 weeks, 2 times a week x 4 weeks then weekly, PRN and as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. | |

1. Resident #10 was originally admitted to the facility on 11/19/2011 and readmitted on 04/03/2017 with diagnoses including, but not limited to: Paraplegia, Aspiration Pneumonitis, COPD (Chronic Obstructive Pulmonary Disease), Depression, Anxiety, Diabetes, Hypertension, Neurogenic Bladder, and Chronic UTI (Urinary Tract Infection).

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 04/10/2017. Resident #10 was assessed as moderately impaired in her cognitive status with a total cognitive score of 10 out of 15.

During an interview with Resident #10's daughter on 05/03/2017 at 1:35 p.m. the issue of call lights was discussed. Resident #10's daughter stated, "Sometimes there is only one aide on the hallway. It can sometimes take ten to fifteen minutes before a light is answered. I will see staff up and down the hall, but they never stop to check on the residents. If the aides are busy the office staff could at least check on the resident and then relay the message if they aren't able to help. Mom is a paraplegic and unable to do a lot things for herself."

During the group interview conducted by another member of the survey team, all participants in the group agreed that call lights being answered is an issue. They stated that call lights can sometimes ring for over an hour before being answered or the aide will come into the room, cut off the light and state, I will be right back, but they never come back.

During Resident #10's interview on 05/08/2017 at

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10:30 a.m., Resident #10 stated, "It depends on the time of day. If you put your light on early in the morning, around meal time or at bed time then the response is lengthy. We are sometimes told I cannot help you right now because I am passing out trays or whatever."

The Administrator and DON (director of nursing) were informed of the above during a meeting with the survey team on 05/09/2017 at 1:35 p.m. No further information was received prior to the exit conference on 05/09/2017.

This is a complaint deficiency.

2. The facility staff failed to ensure call bells were answered in a timely manner for Resident # 4 which resulted in the resident sitting for extended periods of time in urine and/or feces.

Resident # 4 was admitted to the facility 4/7/15 with a readmission date of 4/14/17. The most recent MDS (minimum data set) was a significant change in status review and had Resident # 4 assessed as being cognitively intact.

On 5/9/17 at 10:30 a.m. this surveyor conducted a resident interview with Resident # 4. Resident # 4 was included in the survey sample as part of an APS (adult protective services) report. The report included Resident # 4 had called the APS worker to report she had been left sitting in urine for approximately 2 hours. Resident # 4 reported that a CNA (certified nursing assistant) had come into the room earlier, turned off the call light telling the resident she would be right back; however, she did not return, and by this time the

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resident had a bowel movement (BM) as well. When the APS worker arrived at the facility, the staff were just leaving the room after cleaning the resident, but had left her with no briefs on as she was having multiple BM's and staff did not want to put a brief on her. The report also documented the resident had not only been left without a brief on, but was not clothed as well; even though the privacy curtain was pulled, the resident's bed is next to a window, which had no curtains or blinds pulled. During the interview on 5/9/17 at 10:30 a.m. , Resident # 4 was asked about the event, and she stated yes, it most certainly happened and that it had made her feel "really bad." Resident # 4 went on to say "I'm sitting in urine right now; I put my call bell on at 7:00 a.m. and I am still waiting to be changed. When I put my call bell on, they come in, turn it off, tell me they will be right back, and never come back. When I tried to explain that I am uncomfortable and wet, they tell me how busy they are, they have to deliver breakfast trays, feed other residents, and tell me to just hold it! "

A group interview was conducted 5/3/17 beginning at 1:30 p.m. with nine cognitively intact residents. When the topic of call bells was discussed, the group as a whole stated "Once you press the call bell, it's up to and most often more than an hour before anyone comes to see what you need. Either that, or staff will come in and tell you they'll be right back, and then you never see them again." The group voiced they used to think the facility was short staffed and that was why the delay in call bell response time. They further voiced they no longer thought it was due to not enough staff, but that staff were simply not doing their job.

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| F 246 | Continued From page 30<br>The administrator, DON (director of nursing), and regional nurse consultant were informed of the above findings 5/9/17 during a meeting with facility staff beginning at 1:30 p.m.<br><br>No further information was provided prior to the exit conference.<br><br>This is a complaint deficiency. | F 246 | | |
| F 253 SS=D | 483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and resident interview the facility staff failed to ensure a privacy curtain was clean for one of 25 residents in the survey sample: Resident # 6.<br><br>Findings include:<br><br>Resident # 6 was admitted to the facility 3/28/17. The admission MDS (minimum data set) dated 4/4/17 had Resident # 6 assessed with moderate impairment in cognition.<br><br>On 5/2/17 at 2:20 p.m. this surveyor observed Resident # 6 in bed with two visitors present. After knocking and given permission to enter, this surveyor made introductions with the resident and visitors. Resident # 6 looked at this surveyor and said "You want to see something?" I replied I did. Resident # 6 then instructed me to pull the privacy curtain to the extended length, and stated "Look at that!" This surveyor noted that about | F 253 | F 253: Housekeeping & Maintenance Services<br><br>1. Resident #6 privacy curtain was cleaned and replaced.<br>2. Facility wide quality review of privacy curtains in resident rooms was completed by ED and or Maintenance Director. Curtains cleaned and replaced as indicated.<br>3. Maintenance Director /Environmental Services staff re-educated regarding cleanliness of privacy curtain(s) ensuring residents privacy curtains are clean, free from stains, soiling and replaced as indicated in order to maintain a sanitary, orderly and comfortable interior per regulation Facility staff re-educated regarding communicating when privacy curtain(s) are soiled and need to be cleaned and replaced to Maintenance/ Environmental Services. | 06/23/17 |

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| F 253 | Continued From page 31<br>three-quarters of way down the length of the curtain there was a large area with a thick, brown substance smeared on the curtain. This surveyor asked the resident what that was, and the resident replied "What do YOU think it is?" I stated I was not sure and the resident said "Exactly." I then asked the resident how long the curtain had been soiled and he stated "For some time now." I asked the resident if he had alerted staff to the stain and he said "No; not my job!"<br><br>On 5/3/17 at 7:55 a.m. the area manager for housekeeping was interviewed about who was responsible to ensure the cleanliness of privacy curtains. The manager stated "Housekeeping checks the curtains when they do the daily cleaning of the rooms; if one is soiled it should be changed." This surveyor then asked the housekeeping manager to accompany me to the resident's room. Resident # 6 and the roommate were not in the room, and the manager and this surveyor went in to look at the curtain. The manager, after seeing the stain, stated "I will get someone to change this right now. I agree, I have no idea what that is on the curtain.....chocolate or possibly feces. At any rate it will be changed right now."<br><br>The administrator, DON (director of nursing), and regional nurse consultant were informed of the above findings 5/9/17 during a meeting with facility staff beginning at 1:30 p.m.<br><br>No further information was provided prior to the exit conference.<br><br>THIS IS A COMPLAINT DEFICIENCY. | F 253 | 4. Maintenance Director/Designee to conduct random quality monitoring of privacy curtains in resident's rooms to maintain a sanitary, orderly and comfortable interior per regulation twice weekly x 4 weeks, then weekly times 4 weeks then monthly and PRN. Quality monitoring schedule modified based on findings. Findings to be reported to QAPI committee monthly and updated as indicated. | |
| F 279 | 483.20(d);483.21(b)(1) DEVELOP | F 279 | | |

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| F 279 SS=E | Continued From page 32<br>COMPREHENSIVE CARE PLANS<br><br>483.20<br>(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.<br><br>483.21<br>(b) Comprehensive Care Plans<br><br>(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br><br>(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<br><br>(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).<br><br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR | F 279 | F 279: Develop Comprehensive Care Plans<br><br>1. Resident's #4, 5 and 15 care plan's were updated to reflect non-pharmacological interventions. Resident # 24's Behavior care plan was updated to reflect wandering into other resident's room and taking items belonging to others.<br>2. Quality review of resident's pain care plan to ensure non-pharmacological interventions are in place was completed. Review of resident's who wander/take items belonging to others have interventions in place reflected on the behavior care plan.<br>3. Care plan/MDS staff and Licensed Nurses re-educated by the Director of Nursing (DCS)/Designee regarding Pain Care plans to include non-pharmacological interventions and resident's who wander/take items belonging to others have interventions in place reflected on the behavior care plan. | 06/23/17 |

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| F 279 | Continued From page 33<br>recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br><br>(iv)In consultation with the resident and the resident's representative (s)-<br><br>(A) The resident's goals for admission and desired outcomes.<br><br>(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.<br><br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, resident interview, and staff interview, the facility staff failed for four of 25 residents in the survey sample (Residents # 4, 5, 15, and 24) to develop a care plans to address pain treatment and wandering.<br><br>1. The care plan for Resident # 4 failed to include the use of non-pharmacological interventions to address pain.<br><br>2. The care plan for Resident # 5 failed to include the use of non-pharmacological interventions to address pain.<br><br>3. The care plan for Resident # 15 failed to | F 279 | 4. DCS / Designee during morning clinical meeting to review and discuss with IDT team pain care plans to include non-pharmacological interventions and care plans for resident's who wander/ take items belonging to others are included on the behavior care plan. DCS/Designee to conduct quality monitoring with any newly admitted / re-admitted residents, and/or changes in behaviors and pain and update as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. | |

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include the use of non-pharmacological interventions to address pain.

4. The care plan for Resident # 24 failed to include interventions to address wandering, entering other residents' rooms, and taking items belonging to other residents.

The findings include:

1. The care plan for Resident # 4 failed to include the use of non-pharmacological interventions to address pain.

Resident # 4 in the survey sample, a 66 year-old female, was admitted to the facility on 4/7/15, and most recently readmitted on 4/14/17 with diagnoses that included obstructive sleep apnea, encephalopathy, acidosis, hypertension, restless leg syndrome, diabetes mellitus, asthma, congestive heart failure, bi-polar disorder, anxiety, chronic pain, morbid obesity, acute respiratory failure, chronic renal failure, seizure disorder, anemia, seizure disorder, depression, gastroesophageal reflux disease, chronic obstructive pulmonary disease, and respirator failure. According to the most recent Minimum Data Set (MDS), a Significant Change, with an Assessment Reference Date (ARD) of 4/21/17, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.

Resident # 4 had the following medication orders to address pain:

Oxycodone 10 mg (milligrams) Tablet. 10 mg oral twice daily.
Oxycodone 5 mg Tablet. Take 1 tablet by mouth

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every 8 hours as needed for pain.

Review of the Medication Administration Record (MAR) for the month of March 2016 revealed the as needed Oxycodone was administered 30 times between 3/1/17 and 3/23/17. For the month of April 2017, the as needed Oxycodone was administered 13 times between 4/1/17 and 4/8/17.

Resident # 4's care plan included the following problem in the area of pain, "The resident has alteration in pain/comfort related to GERD (Gastroesophageal Reflux Disease), chronic pain, muscle spasms." The goal for the stated problem was, "The resident will voice/demonstrate no side effects related to the use of analgesics through this review period."

The interventions for the stated problem were, "Administer analgesics per MD's order; Report for side effects of pain medication; Observe for constipation, new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria, nausea, vomiting, dizziness and falls; Report occurrences to the MD; Report to nurse resident complaints of pain or requests for pain treatment."

There were no non-pharmacological interventions in the care plan to address pain treatment.

During an interview at 2:30 p.m. on 5/3/17, the resident was asked about the use of non-pharmacological interventions to address her pain. The resident said staff have use hot and cold packs occasionally. "Sometimes a hot or a cold compress will work. Compresses at night can sometimes get me all relaxed and I can sleep

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through the night without medication," the resident said.

The findings were discussed at a meeting at 3:00 p.m. on 5/8/17 with the Interim Administrator, Director of Nursing, Corporate Nurse Consultant, and the survey team.

2. The care plan for Resident # 5 failed to include the use of non-pharmacological interventions to address pain.

Resident # 5 in the survey sample, a 76 year-old male, was admitted to the facility on 10/29/16, and most recently readmitted on 12/31/16 with diagnoses that included gout, hyperlipidemia, right below the knee amputation stump wound, left great toe wound, diabetes mellitus, hypertension, coronary artery disease, gastroesophageal reflux disease, benign prostatic hyperplasia, depression, and arteriosclerotic heart disease. According to the most recent MDS, a Quarterly with an ARD of 2/5/17, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 12 out of 15.

Resident # 5 had the following medication order to address pain:

Oxycodone 5 mg Tablet. Take 1 tablet by mouth every 4 hours as needed for pain.

Review of the MAR for March 2017 revealed as needed Oxycodone was administered 40 times between 3/1/17 and 3/31/17. Review of the MAR for April 2017 revealed as needed Oxycodone

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was administered 43 times between 4/1/17 and 4/30/17.

Review of Resident # 5's care plan revealed the following problem in the area of pain, "The . resident has alteration in pain/comfort related to postoperative discomfort (recent BKA [below the knee amputation]) AEB (as evidenced by) (surgical wound)." The goal for the problem was, "The resident will not demonstrate decline in overall function related to pain; The resident will not have an interruption in normal activities due to pain through the review date."

The interventions for the stated problem were, "Administer analgesics as per orders and prior to treatments or care prn (as needed); Anticipate the resident's need for pain relief and respond to any complaint of pain; Encourage activity and movement as tolerated."

There were no non-pharmacological interventions in the care plan to address pain treatment.

The findings were discussed at a meeting at 3:00 p.m. on 5/8/17 with the Interim Administrator, Director of Nursing, Corporate Nurse Consultant, and the survey team.

3. The care plan for Resident # 15 failed to include the use of non-pharmacological interventions to address pain.

Resident # 15 in the survey sample, a 63 year-old female, was admitted to the facility on 11/26/14 with diagnoses that included generalized muscle weakness, bi-polar disorder, major depressive disorder, gout, hypertension, chronic pain

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syndrome, anemia, fibromyalgia, hyperlipidemia, gastroesophageal reflux disease, asthma, and anxiety disorder. According to the most recent MDS, a Quarterly with an ARD of 4/19/17, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 14 out of 15.

Resident # 15 had the following medication order to address pain:

Hydrocodone-Acetaminophen 5 mg - 325 mg Tablet. Take 1 tablet by mouth every 4 hours as needed for pain.

Review of the MAR for April 2017 revealed as needed Hydrocodone-Acetaminophen was administered 19 times between 4/1/17 and 4/30/17.

Review of Resident # 15's care plan revealed the following problem in the area of pain: "The resident has alteration in pain/comfort, history of femur fracture, disease process, gout, gastroesophageal reflux, fibromyalgia." The goals for the problem were, "The resident will not demonstrate decline in overall function related to pain; The resident will not have an interruption in normal activities due to pain through the review."

The interventions to the stated problem were, "Administer analgesics per orders and prior to treatment or care prn; Encourage activity and movement as tolerated; Report side effects of pain medication; Observe for constipation, new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria, nausea, vomiting, dizziness and falls; Report occurrences to the physician."

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There were no non-pharmacological interventions in the care plan to address pain treatment.

The findings were discussed at a meeting at 3:00 p.m. on 5/8/17 with the Interim Administrator, Director of Nursing, Corporate Nurse Consultant, and the survey team.

4. The care plan for Resident # 24 failed to include interventions to address wandering, entering other residents' rooms, and taking items belonging to other residents.

Resident # 24 in the survey sample, a 78 year-old female, was admitted to the facility on 12/23/14 with diagnoses that included atrial fibrillation, congestive heart failure, hypertension, gastroesophageal reflux disease, hyperlipidemia, depression, generalized muscle weakness, dysphagia, and non-Alzheimer's dementia. According to the most recent MDS, an Annual with an ARD of 3/13/17, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 3 out of 15.

Under Section E (Behavior), at Item E1000 (Wandering - Presence and Frequency), the resident was assessed as having behaviors of wandering the occurred 4 to 6 days, but less than daily.

Resident # 24's care plan included the following problem addressing wandering: "Resident exhibits signs and symptoms of BPSD (Behavioral and Psychotic Symptoms of Dementia) or behaviors related to dementia, AEB

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(as evidenced by) wandering." The goals for the problem were, "Resident will allow staff to provide care as needed; Resident will demonstrate appropriate verbalizations; Resident will maintain appropriate physical behavior."

The interventions to the stated problem were, "Redirect in appropriate behaviors as needed; Assess behaviors for underlying medical causes; Assess for changes in psychosocial status and/or environment; Assess resident for pain as indicated; Determine precipitating factors and alleviate; Encourage resident to attend group activities; Invite and assist as needed to activities of choice; Labs as ordered by physician; Meds per physician orders; Provide positive feedback when resident is compliant and/or appropriate; Wander guard."

The resident's care plan was silent as to proactive measures to prevent wandering, to address the resident's wandering in to other residents' rooms, and the resident's taking items not belonging to her.

During the course of the survey, several resident interviews and the Group Interview elicited comments about Resident # 24 wandering, entering resident rooms, and taking items belonging to other residents. Some of the remarks included the following:

"She scared me half to death one night, I woke up in the middle of the night and she was in the room."

"She goes in your things. She broke my favorite angel (ceramic figurine). When I complained, staff told me 'Can't you get another angel?' Staff

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| F 279 | Continued From page 41<br>treat her like she's the most wonderful little thing. They baby her. They are just enabling her."<br><br>"(Name of Resident # 24) keeps coming in our room. She comes in and takes things. I was laying in bed one afternoon and she came in and tried to take my cookies and Coke. The staff say they can't do anything."<br><br>"The staff put a STOP sign up, but she just barges right through it. It is to keep her out, not to keep us in. This is ridiculous."<br><br>"(Name of Resident # 24) came in my room and took $1.50 from a small box on top of my night stand. When I complained to the staff, I was told 'Oh well, it's just a little money.' "<br><br>"Oh, leave her alone, she doesn't know what she is doing."<br><br>"They (staff) just pat her on the head and let her go on her way."<br><br>The findings were discussed at a meeting at 3:00 p.m. on 5/8/17 with the Interim Administrator, Director of Nursing, Corporate Nurse Consultant, and the survey team. | F 279 | | |
| F 280 SS=D | 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>483.10<br>(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:<br><br>(i) The right to participate in the planning process, including the right to identify individuals or roles to | F 280 | F280: Right to Participate in Care planning/Care-Revise CP<br><br>1. Resident # 10's indwelling catheter was changed 5/4/17. Resident #6 falls mats were put in place on 05/10/17. | 06/23/17 |

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| F 280 | Continued From page 42<br>be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.<br><br>(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.<br><br>(iv) The right to receive the services and/or items included in the plan of care.<br><br>(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.<br><br>(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--<br><br>(i) Facilitate the inclusion of the resident and/or resident representative.<br><br>(ii) Include an assessment of the resident's strengths and needs.<br><br>(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.<br><br>483.21<br>(b) Comprehensive Care Plans<br><br>(2) A comprehensive care plan must be-<br><br>(i) Developed within 7 days after completion of the comprehensive assessment. | F 280 | 2. Quality review of residents with indwelling catheters to verify physician order(s) for changing catheters are care planned was completed. Orders for frequency of catheter change modified as indicated per physician order.<br>3. Licensed Nurses re-educated by the Director of Clinical Services (DCS)/ Designee regarding following the residents plan of care for indwelling catheter changes. Facility staff re-educated regarding ensuring residents with falls mats are in place per the plan of care.<br>4. ED/DCS/Designee through random Mock Survey Rounds ensure residents who require fall mats are in place per the plan of care 5 times weekly x 4 weeks, 3 times weekly x 4 weeks, 2 times weekly x 4 weeks, randomly 2 x monthly, PRN and as indicated. MDS staff/DCS/Designee through morning clinical meeting review residents who have indwelling catheters to ensure their plan of care reflects catheter changes per physician order randomly twice weekly x 2 weeks, with new admissions/re-admissions and with any new catheter orders, PRN and as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. | |

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(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 comprehensive care plan (CCP) for two of 25 residents in the survey sample, Residents #10 and #6.

1. Facility staff did not review and revise

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Resident #10's CCP to address changes with her Foley catheter.

2. Facility staff did not review and revise Resident #6's CCP to include use of fall mats.

Findings included:

Resident #10 was originally admitted to the facility on 11/19/2011 and readmitted on 04/03/2017 with diagnoses including, but not limited to: Paraplegia, Aspiration Pneumonitis, COPD (Chronic Obstructive Pulmonary Disease), Depression, Anxiety, Diabetes, Hypertension, Neurogenic Bladder, and Chronic UTI (Urinary Tract Infection).

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 04/10/2017. Resident #10 was assessed as moderately impaired in her cognitive status with a total cognitive score of 10 out of 15.

During review of Resident #10's clinical record on 05/02/2017 at 2:15 p.m., the current POS (physician order sheet) dated 05/01/17 through 06/30/17 included an order that stated, "...18 Fr [french] 5cc [cubic centimeter] Foley Cath change every month..."

Resident #10's CCP included an entry that stated, "...Foley Catheter 18Fr. 30cc Balloon size Date Initiated: 02/02/16..."

On 05/03/17 at approximately 11:30 a.m., LPN #1 (licensed practical nurse) was asked to verify Resident #10's catheter size. LPN #1 stated, "I will get back with you." At approximately noon on 05/03/17, LPN #1 stated, [Name Resident #10]

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| F 280 | Continued From page 45<br>actually has in a 16 Fr. 10cc balloon catheter. Her catheter was changed in the ER [emergency room] when she was there in April."<br><br>The DON (director of nursing) was interviewed on 05/03/17 at 5:50 p.m. The DON stated, "CCP are updated by the care plan team, nursing supervisors and nursing has been helping lately. Obviously hers hasn't been updated."<br><br>No further information was received by the survey team prior to the exit conference on 05/09/17.<br><br>2. The facility staff failed to review and revise the comprehensive care plan (CCP) for Resident # 6 to include fall mats as an intervention.<br><br>Resident # 6 was admitted to the facility 3/28/17. The admission MDS (minimum data set) dated 4/4/17 had Resident # 6 assessed with moderate impairment in cognition.<br><br>On 5/2/17 during a conversation with Resident # 6 and his two visitors, it was noted there was a fall mat on each side of the resident's bed. Resident # 6 was asked how long the fall mats had been at the bedside, and he stated he did not know. The female visitor spoke up and stated they visit every two weeks and the mats have been down on each visit.<br><br>The clinical record was reviewed on 5/2/17 at 3:00 p.m. Review of the CCP for falls/safety included interventions including ensuring resident wearing appropriate footwear, call light within reach, and bed in low position. There was no | F 280 | | |

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| F 280 | Continued From page 46 | F 280 | | |

documentation for the fall mats. Resident # 6 had not had any falls documented.

On 5/3/17 at 8:05 a.m. LPN (licensed practical nurse), who was the unit manager, was asked about the fall mats and if a physician order was needed to implement them. LPN # 2 stated "No; no order is needed. It's a nursing intervention." LPN # 2 was then asked who would be responsible for adding the intervention to the care plan and she stated "MDS updates the care plans."

On 5/3/17 at 10:00 a.m. the MDS coordinator was interviewed. RN (registered nurse) # 1 stated "We have been working with nursing to update the care plans, but as of yesterday [5/2/17] they are now in charge of the updates themselves. I did not add the fall mats as I was not made aware he had any."

On 5/3/17 at 10:15 a.m. LPN # 5 was asked when the fall mats had been implemented for Resident # 6. LPN # 5 stated she would see if she could find out that information, and get back to me.

At 10:46 a.m. 5/3/17 LPN # 5 gave this surveyor a copy of an updated care plan and stated "The mats were implemented 4/18/17."

The administrator, DON (director of nursing), and regional nurse consultant were informed of the above findings 5/9/17 during a meeting with facility staff beginning at 1:30 p.m.

No further information was provided prior to the exit conference.

F 281 483.21(b)(3)(i) SERVICES PROVIDED MEET — F 281

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| F 281 SS=K | Continued From page 47<br>PROFESSIONAL STANDARDS<br><br>(b)(3) Comprehensive Care Plans<br><br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medication pass observation, resident interview, staff interview, facility document review, clinical record review and in the course of a complaint investigation, facility staff failed to ensure professional standards of nursing practice were followed at the facility for 1 (one) of 25 residents in the survey sample, Resident #10. Immediate Jeopardy (IJ) was identified in the area of Comprehensive Person-Centered Care Planning on 05/04/2017 at 1:55 p.m. The facility removed the immediacy on 05/04/2017 at 8:55 p.m. After removal of the immediacy the Scope and Severity was lowered to a Level III, isolated.<br><br>Immediate Jeopardy:<br>Concerns were voiced to the State Agency (SA) supervisory team regarding the system wide issue of agency nurses not receiving orientation when coming to work at the facility. This issue created a deficient practice related to medication administration, including actual harm to residents in the survey sample, medications not given on time, wrong medications administered and critical medications not available.<br><br>The SA supervisory staff directed the survey team to speak with facility administration to obtain their policies and procedures regarding how agency | F 281 | F281 Services Provided Meet Professional Standard<br>1. Agency Licensed Nurses completed the Agency Orientation Checklist. Medication error report completed for resident #10 per policy. LPN #2 (facility nurse) no longer works in the facility. LPN #3 (agency nurse) no longer works in the facility. Resident #10 currently resides in the facility and has no s/s of adverse effects.<br>At the time of immediacy, current agency nurses present in the facility received immediate orientation by Nursing Administration using the Agency Orientation Checklist, which included administration of medications, pain management and diabetic management. Current schedule was reviewed by the Director of Clinical Services to identify future confirmed pre-scheduled agency personnel requiring orientation, with such orientation being provided using the Agency Orientation Checklist, prior to assumption of Nurse duties.<br>Potential agency placements were scheduled for orientation upon receipt of their credentials by the facility Human Resources Coordinator (HRC). No agency personnel assumed nursing duties until the Agency Orientation Checklist had been completed and received by the HRC. Notification occurred to all contracted agencies of this process on 05/04/17. | 06/23/17 |

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| F 281 | Continued From page 48<br>nurses were oriented to the facility and educated on facility policies and procedures for pain management, diabetic management, and medication management.<br><br>On 05/04/2017 at 12:40 p.m., a meeting was held with the facility administrative staff, including the administrator, the administrator who would be in charge after 05/04/2017, the director of nursing, the regional director of clinical services, the HR director, and the medical director. The administrative team was asked how agency nurses who came to work at the facility were oriented to facility policies and procedures and what the process was. The process was explained as follows:<br>-Background information received from the agency (License, resume, CPR , background check)<br>- Information put into the system<br>- DON informed that information is in the system<br>- Agency nurse comes to work<br>-Upon arrival the agency nurse receives report from staff nurse and is shown where meds are, medication cart, doctor's book<br><br>The administrative team was asked if there was any type of competency checklist done by the facility prior to the agency nurses starting work. Also requested were policies and procedures regarding pain management, medication administration, diabetic management and facility orientation policies.<br><br>On 05/04/2017 at 1:50 p.m., the administrator informed the team leader that a corporate policy regarding the orientation of agency staff had been obtained and included a competency checklist that was to be completed by the facility prior to | F 281 | The Executive Director/designee will review agency files weekly times 4 weeks, then monthly and report to the QAPI committee to ensure compliance with the plan.<br>2. Quality review of medication cart(s) to ensure medications ordered are available was completed. Review of Agency nurse employee files to ensure the Agency orientation checklist was completed prior to assumption of nurse duties. Potential agency placement(s) to be scheduled for orientation upon receipt of their credentials by the facility Human Resources Coordinator (HRC). No agency personnel will assume nursing duties until the Agency Orientation Checklist has been completed and received by the HRC. Notification to all contracted staffing agencies of this process completed 5/4/17. Medication skills competency checklist completed as indicated. | |

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| F 281 | Continued From page 49<br>the agency nurse beginning work. She stated they had not been aware of the policy or the checklist and that it had not been done for any of the agency nurses currently working at the facility.<br><br>After consultation with the SA supervisor, IJ was called on 05/04/2017 at 1:55 p.m. for the system wide failure of the facility to orient and educate agency nurses on facility practice for the administration of medications, pain management and diabetic management.<br><br>On 05/04/2017 at approximately 2:00 p.m., the survey team again met with the facility staff. They were informed that IJ had been identified as of 1:55 p.m. due to the facility failure to provide orientation to agency staff per facility policy. Directive was given to develop a plan for the removal of IJ.<br><br>A plan for removal of IJ was presented on 05/04/2017 at 3:05 p.m. The plan included the 5 points but did not include how the agency staff would be trained or how the facility would deem the agency nurses competent in the training received.<br><br>On 05/04/2017 at 5:00 p.m., the second plan of correction was presented and accepted.<br><br>The facility staff presented completed competencies and training information to the survey team with IJ lifted on 05/04/2017 at 8:55 p.m.<br><br>For Resident #10, the facility staff medicated | F 281 | 3. Licensed nurses (agency) educated by the Assistant Director of Nursing (ADCS)/designee regarding "5 Rights of Medication Administration." Licensed nurses (agency) re-educated by the ADCS/D\designee regarding availability of mediations per physician order(s). Licensed nurses (agency) re-educated by the ADCS/designee regarding facility systems & processes along with facility policy and procedures utilizing the Agency Orientation Checklist. Human Resources re-educated by the Executive Director (ED) / designee regarding potential agency placements to be scheduled for orientation upon receipt of their credentials by the facility Human Resources Coordinator (HRC). Human Resources, Unit Mangers, ED, DCS and ADCS re-educated by the Divisional Education Specialist/ED/designee regarding no agency personnel will assume nursing duties until the Agency Orientation Checklist has been completed and received by the HRC. Licensed nurses (agency) re-educated by the Assistant Director of Nursing (ADCS)/ Designee regarding location of E-Kit, medication cut-off delivery times and medication re-ordering process. | |

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| F 281 | Continued From page 50<br>Resident #10 with the wrong dose of Morphine which resulted in altered mental status, decreased oxygen saturations, and aspiration pneumonitis which resulted in an overnight stay at the hospital for opioid overdose. Facility staff treated a blood sugar of 25 without notifying the physician and receiving orders to treat.<br><br>Findings included:<br><br>Resident #10 was originally admitted to the facility on 11/19/2011 and readmitted on 04/03/2017 with diagnoses including, but not limited to: Paraplegia, Aspiration Pneumonitis, COPD (Chronic Obstructive Pulmonary Disease), Depression, Anxiety, Diabetes, Hypertension, Neurogenic Bladder, and Chronic UTI (Urinary Tract Infection).<br><br>The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 04/10/2017. Resident #10 was assessed as moderately impaired in her cognitive status with a total cognitive score of 10 out of 15.<br><br>Resident #10's clinical record was reviewed on 05/02/2017 at 2:15 p.m. and again on 05/03/2017 at 11:00 a.m. Included in Resident #10's most recent POS (physician order sheet) dated 05/01/17 through 06/30/17 was an order dated 04/03/17 that stated: "...Morphine Sulfate ER 60 MG (milligrams) Tablet ER (extended release) For MS Contin Take 1 (one) Tab by Mouth Every 12 Hours for Pain..." and an order dated 04/04/17 that stated: "...Morphine Sulfate 15 MG Tablet For Morphine Sulfate Take 1 (one) Tab by Mouth every 4 (four) Hours As Needed for Pain..." | F 281 | 4. The Executive Director (ED)/ Director of Clinical Services (DCS)/designee to review agency nurse files prior to the assumption of duties with new agency nurses. ED to conduct random quality review of agency nurse files 5 times weekly x 4 weeks, 3 times weekly x 4 weeks, 2 times monthly, PRN and as indicated. DCS/designee to conduct quality monitoring of "5 Rights of Medication Administration" 2 times weekly x 4 weeks, weekly x 4 weeks, PRN and as indicated. DCS/designee to conduct random quality monitoring of medication carts to ensure medications are available per physician orders 3 times weekly x 2 weeks, twice weekly x 4 weeks, 2 x monthly, PRN and as indicated. DCS/designee to conduct medication skills competency checklist as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. | |

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| F 281 | Continued From page 51<br>***NOTE: Morphine sulfate extended-release tablets are an opioid agonist product indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.<br><br>WARNING: ADDICTION, ABUSE, and MISUSE; LIFE-THREATENING RESPIRATORY DEPRESSION; ACCIDENTAL INGESTION; ...: Life-Threatening Respiratory Depression: Serious, life-threatening, or fatal respiratory depression may occur with use of morphine sulfate extended-release tablets. Monitor for respiratory depression, especially during initiation of morphine sulfate extended-release tablets or following a dose increase. ... OVERDOSAGE: Clinical Presentation: Acute overdosage with morphine is manifested by respiratory depression, somnolence progressing to stupor or coma, skeletal muscle flaccidity, cold and clammy skin, constricted pupils, and, in some cases, pulmonary edema, bradycardia, hypotension, and death....<br><br>Medication Guide:<br>Important information about morphine sulfate ER tablets:<br>Get emergency help right away if you take too much morphine sulfate ER tablets (overdose). When you first start taking morphine sulfate ER tablets, when your dose is changed, or if you take too much (overdose), serious or life-threatening breathing problems that can lead to death may occur.<br><br>This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=19c7d9cc-6ce2-4c5c-8c3f-c24fd334280 | F 281 | | |

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4 (END OF NOTE***)

An "Interdisciplinary Progress Note" dated "4-6-17 Late Entry" included the following: "On Sunday 4/2, I took report from (Name) RN, (registered nurse) after I was moved from Unit 4, at aprox 1130 and I noticed around 1pm, (Name) Resident #10 falling asleep reading newspaper. I checked her oxygen level was 88% her O2 was placed on and her oxygen came up to normal levels, after being toileted she requested to go to bed. A little after that around 3 pm her daughter called because she had tried to call her on her cell phone and she did not answer. I reported the change of condition to her daughter, she stated 'well she doesn't sound right so I will see you in a little bit.' About an hour later she arrived and she spoke with me. I read her the vital signs which I obtained. I reported her temp was elevated and respirations low, and we both agreed that she appeared the same way she had the last time she had a UTI (urinary tract infection), including facial grimacing and she should be sent out to be checked. I read her the last lab result for U/A (urinalysis) C&S (culture and sensitivity) and it was negative for nitrates. I spoke with (Name) transport and they informed me they had no availability until 9:30 p-10 pm. At that time I called (Name) and obtained claim # for transport at aprox 6:50 pm. (Name) Resident #10's daughter had told me that her 'mother had not felt right since she had taken that extra pain pill.' I went to check the MAR (medication administration sheet) and saw the medication error. I also asked (Name) another RN to do a respiratory assessment. At aprox 1915 (7:15 p.m.) the crew was still not here so I called the (unintelligible word) my ride # for (Name) ambulance service. At aprox 1930-1945

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(7:30-7:45 p.m.) the crew arrived to transport (Name) Resident #10. (Name) Physician, nursing supervisor, (Name) Hospital ER (emergency room) aware of all health issues of said pt. (patient)."

A second "Interdisciplinary Progress Note" dated "4/2/17 1945" (7:45 p.m.) included the following documentation: "Nurse on front hall asked this nurse to assess lung fields of resident d/t (due to) medication error causing respiratory depression. This nurse auscultated all lung fields noting clear lung sounds w/respirations slow and shallow. Low respiratory count of 10-12 breaths per minute w/ periods of apnea...This nurse advised the nurse working front hall to admit resident to ER at (Name) hospital for further evaluation d/t decreased respiratory and the medication given causing the respiratory issues."

History and Physical from the emergency room dated 4/2/17, seen by MD (physician) 21:14 (9:14 p.m.). "...Chief Complaint: Altered Mental State; History of Present Illness: ...She was sent from (Name) nursing home with concern for accidental overdose. Patient reportedly received 60mg (milligrams) long-acting morphine at 9AM and 11AM today. She became less responsive throughout the day and was eventually sent to the ED for evaluation. Patient is unable to provide and history and at best grimaces to pain...Differential Diagnosis: After history and physical exam a differential diagnosis was considered, but was not limited to narcotic overdose...ED Course/Procedures: Patient is a 76-year old female who presents from nursing facility with concern for accidental narcotic overdose. She is somnolent on arrival and, at best, grimaces to sternal rub... Primary

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Diagnosis: Sepsis; Secondary Diagnosis: Pneumonia, urinary tract infection, acute encephalopathy; Condition: Guarded; Disposition: Admitted to (Initials) hospital from ED..."

Hospitalist H&P dated 04/03/17 0312 (3:12 a.m.) "HPI: ....presented to the ED from her nursing facility after she was found to be progressively somnolent.

Briefly, the patient appears to have been in her usual state of health until earlier in the day when she inadvertently received twice the dose of her long-acting morphine which she takes for her chronic pain. It appears that she received 60 mg at 9 AM and a second dose of 60 in lieu of a as needed dose of her immediate release morphine at 11 AM. She was then noted to become increasingly somnolent and less responsive and so was sent to the emergency room...Assessment and Plan: (1) Sepsis: The patient presented with fever and leukocytosis of 17,000 in the setting of some mild hypoxia and what appears to be right lower lobe infiltrate meeting criteria for sepsis. At this time I still suspect that her source is pulmonary and further have clinical suspicion that the patient may have aspirated following and inadvertent morphine overdose resulting in an aspiration pneumonitis... (2) Aspiration pneumonitis: The patient has apparent right lower lobe airspace disease which in the setting of her presentation I believe represents a chemical aspiration pneumonitis... (4) Acute encephalopathy: The patient was reportedly increasingly somnolent at the nursing facility however upon evaluation she is awake, alert and oriented x3 and so I believe that her acute encephalopathy was due to an inadvertent

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morphine overdose which is now resolved..."

Nursing Facility H&P dated 4/4/17 1611 (4:11 p.m.), signed by the physician. "Assessment/Plan: (1) Toxic encephalopathy (2) Aspiration pneumonitis...Discussion: I saw the patient today to readmitted to our facility after a hospitalization for urinary tract infection, aspiration pneumonitis, and unintentional opioid overdose. The day prior to admission, the patient received 120 mg of extended release morphine, which was an extra dose, instead of her 15 mg breakthrough dose. This resulted in lethargy and some respiratory depression, and she was sent to the emergency department. There, she was found have aspiration pneumonitis..."

A "Medication Error Report" dated 4/2/17 1105 AM included, "Medication as ordered: prn Morphine 15mg po (orally) Description of error...PRN Order for Morphine 15mg; took 60mg tablet instead...Outcome to resident and care provided: Resident had a change to respiratory/alertness status. Sent to hospital and admitted for sepsis...Type of Error: Wrong dose; Reason for Error: Misread error..." Signed by RN that administered wrong medication and dose of morphine. This RN was working a mandated overtime of four hours the morning of 4/2/17 from 7:00 a.m. to 11:00 a.m. This RN had worked their scheduled shift the night before starting on 4/1/17 at 7:00 p.m. until 4/2/17 at 7:00 a.m.

The Administrator was asked for a copy of any investigation regarding the above incident. The investigation was received by this surveyor. The Administrator stated, "She was given the wrong dose of her morphine and when the error was realized we sent her to the emergency room."

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Included in the investigation was the policy, "Adverse Drug Reactions & Medication Discrepancy; Effective Date: 11/30/2014; Policy: Medication discrepancies and adverse drug reactions are documented and reported. Medication discrepancy refers to: a) Failure to administer, b) Administered at the wrong time, c) Administered wrong amount of medication, d) Administered to wrong resident, e) Administered through wrong route, f) Administered the wrong Medication. Adverse reaction refers to an unintended/undesirable effect that occurs as a result of giving a medication..."

Fundamentals of Nursing 6th Edition on page 841 states concerning medication administration, "Standards are those actions that ensure safe nursing practice. To ensure safe medication administration the nurse should be aware of a nursing standard called the six rights of medication administration. All medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication 2. The right dose 3. The right client 4. The right route 5. The right time 6. The right documentation." (1)

During review of Resident #10's medical record on 05/03/17 at approximately 10:00 a.m. the following documentation was located in the clinical record. "Interdisciplinary Progress Note" dated "5/3/17 0500 (5:00 a.m.) I checked the resident's BS (blood sugar) and it was 25. I gave the resident a glucose tab (tablet) and pudding but she couldn't chew the tab. I then gave her the glucagon shot to raise her BS. The final number was 85. I called her RP (responsible party) and

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will notify the MD (physician)."

Fundamentals of Nursing 6th Edition on page 419 states concerning notification of the physician with a change in condition, "The physician is responsible for directing medical treatment...one of the most litigated issues is whether the nurse kept the physician informed of the client's condition. To inform a physician properly, nurses must perform a competent nursing assessment of the client to determine the signs and symptoms that are significant in relation to the attending physician's tasks of diagnosis and treatment. Nurses must be certain to document that the physician was notified and document his or her response, the nurse's follow-up, and the client's response...If a verbal order is necessary...it should be written and signed by the physician as soon as possible, usually within 24 hours..." (2)

LPN #2 (licensed practical nurse) (Facility nurse) was interviewed on 05/03/17 at 10:55 a.m. LPN #2 stated, "There are no standing orders for diabetes. I asked that when I got here."

LPN #3 (Agency nurse) was interviewed on 05/03/17 at 11:10 a.m. LPN #3 stated, "Received in report of low blood sugar this morning. (Name) PA (physician assistant) knows. I rechecked; it was 127. I don't know if the on-call doctor was notified."

PA was interviewed on 05/03/17 at 11:15 a.m. PA stated, "I was notified this morning at 9:08 when I came in. I don't know if the on-call doctor was notified or not. I am going to find out who was on-call last night and ask them myself. I will let you know. She also didn't get her bedtime snack last night."

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| F 281 | Continued From page 58<br><br>On 05/03/17 at approximately 1:00 p.m. the PA entered the conference room and handed this surveyor the following note: "5-3-17 Noon To Whom It May Concern: In regard to (Name) Resident #10, I was notified at 0908 (9:08 a.m.) that her accuchek (blood sugar) was 25. Nursing gave her a glucose tab and pudding. She then was administered a Glucagon injection. I inquired about any input from the on call doctor but no one knew. I called over office (sic) and there was no call made to the on call physician to direct these orders. This incident occurred about 5:30 a.m. today. An accuchek at time of exam was 136..."<br><br>The Administrator and DON (director of nursing) were notified of the above findings during a meeting with the survey team on 05/03/2017 at approximately 5:45 p.m. No further information was received by the survey team prior to the exit conference on 05/09/2017.<br><br>(1) and (2) Potter, Patricia A. and Perry, Anne G. Fundamentals of Nursing. St. Louis: Mosby, 2005.<br><br>This is a complaint deficiency. | F 281 | | |
| F 282 SS=E | 483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(ii) Be provided by qualified persons in accordance with each resident's written plan of care. | F 282 | F282: Services By Qualified Persons/Per Care Plan<br><br>1. Resident #10 skin integrity review was completed on 05/09/17 and weekly thereafter. | 06/23/17 |

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| F 282 | Continued From page 59<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, and clinical record review, facility staff failed to implement the care plan for one of 25 residents in the survey sample, Residents #10.<br><br>1. Facility staff did not implenet weekly skin assessments.<br><br>Findings included:<br><br>Resident #10 was originally admitted to the facility on 11/19/2011 and readmitted on 04/03/2017 with diagnoses including, but not limited to: Paraplegia, Aspiration Pneumonitis, COPD (Chronic Obstructive Pulmonary Disease), Depression, Anxiety, Diabetes, Hypertension, Neurogenic Bladder, and Chronic UTI (Urinary Tract Infection).<br><br>The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 04/10/2017. Resident #10 was assessed as moderately impaired in her cognitive status with a total cognitive score of 10 out of 15.<br><br>During review of Resident #10's clinical record on 05/02/2017 at 2:15 p.m., Resident #10's CCP included an entry that stated, "...Weekly Skin Checks Date Initiated: 02/02/16..." Review of "Weekly Skin Integrity Review" sheets revealed skin assessments had been completed, 11/27/16, 12/27/16, 01/09/17, 01/17/17, 01/24/17, 01/30/17, 02/10/17, 03/29/17, 04/05/17, 04/11/17, 04/18/17 and 04/25/17.<br><br>No skin assessments were located in the clinical record for the weeks of 12/04/16, 12/11/16, | F 282 | 2. A quality review was completed on current resident's skin evaluations for being current. Skin evaluations completed as indicated.<br>3. Licensed nurses re-educated by the Director of Clinical Services (DCS)/ designee regarding completion of weekly skin evalutions per policy.<br>4. DCS/Designee through morning clinical meeting review weekly skin evaluations to ensure compliance per policy 5 times weekly x 2 weeks, 3 times weekly x 4 weeks, twice weekly, PRN and as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. | |

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| F 282 | Continued From page 60<br>12/18/16, 01/01/17, 02/12/17, 02/19/17, 02/26/17, 03/05/17, 03/12/17, 03/19/17 and 04/30/17.<br><br>The facility policy for "Skin Evaluation" Effective Date: 11/30/2014; Revision Date: 04/01/2017 included the following: "Policy: A Licensed Nurse will complete a total body evaluation on each resident weekly...Procedure: 1. A Licensed Nurse will complete a total body evaluation on each resident weekly and document the observation on the 'Skin Evaluation' form..."<br><br>The DON (director of nursing) was interviewed on 05/03/17 at 5:50 p.m. The DON stated, "The skin assessments have not been done routinely. We are working on correcting this."<br><br>No further information was received by the survey team prior to the exit conference on 05/09/17. | F 282 | | |
| F 309 SS=H | 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>483.24 Quality of life<br>Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.<br><br>483.25 Quality of care<br>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 | F 309 | F 309: Provide Care/Services for Highest Well-Being<br>1. Resident #10 oxygen saturation rate was obtained on 05/13/17 and 05/15/17. O2 stats were within normal limits. Physician gave order to d/c O2 saturations on 06/01/17. Resident #10 is administered long acting Morphine per physician order. Resident has no failures of administration since 05/09/17. Resident #12 oxygen saturation monitored each shift daily since 05/09/17. O2 saturations within normal limits. Physician ordered to d/c O2 saturations on 06/01/17. Resident #13 oxygen saturation level monitored and recorded every shift every day. Oxygen saturation within normal limits. Oxygen saturation level monitoring d/c per physician on 06/01/17. Resident #21 no longer resides in the facility. Resident #11 expired on 05/16/17. Resident #18 no longer resides in the facility. Resident #6 is administered Vitamin D per physician order without failures to administer occurring since 05/09/17. | 06/23/17 |

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| F 309 | Continued From page 61<br>accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:<br><br>(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br><br>(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident interview, staff interview, facility document review, clinical record review and in the course of a complaint investigation, facility staff failed to provide care and services for the highest practicable well being for 10 of 25 residents in the survey sample resulting in SQC (substandard quality of care), Residents #10, #12, #13, #21, #11, #18, #6, #4, #5 and #15. This resulted in harm to Resident #10, #21, #11, and #18.<br><br>1a) Facility staff failed to monitor and record Resident #10's oxygen saturations every shift as ordered by the physician.<br><br>1b) Facility staff failed to administer long acting morphine per physician order resulting in withdrawal symptoms and subsequent harm due to unavailability of the medication. | F 309 | Resident #4 non-pharmacological pain interventions added to plan of care on 05/05/17. Resident #5 pain level reevaluated on 05/15/17 and documented. Resident #5 non-pharmacological pain interventions added to plan of care on 05/15/17. Resident #5 Fentanyl patch applied per physician order. Resident #15 Cyanocobalamin discontinued 05/09/17.<br>2. Quality review of MAR's/TAR's to ensure medications are administered per physician orders was completed. Quality review of MARs/TARs to ensure oxygen saturation rate is documented per physician order was completed. Quality review of Treatment record to ensure skin / wound treatments are completed per physician order was completed. Quality review of skin / wound documentation is completed per policy. Quality review of residents receiving pain management to ensure mediations available and administered per physician order was completed. Quality review of residents receiving pain management to ensure pain level is documented per policy was completed. Quality reviews of residents receiving pain management have non-pharmacological interventions were completed. Quality review of residents with orders requiring intermittent catheterization are followed per physician order. | |

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| F 309 | Continued From page 62<br><br>2. Facility staff failed to monitor and record Resident #12's oxygen saturations every shift per physician order.<br><br>3. Facility staff failed to monitor and record Resident #13's oxygen saturation every shift per physician order.<br><br>4. Resident #21 was not provided pain medications for the treatment of chronic pain related to a C5-C6 (cervical spine injury at the 5th and 6th vertebrae of the spine), which resulted in harm to the resident.<br><br>5. The facility staff failed to assess non-pressure areas on the foot of Resident #11 and obtain physician ordered wound clinic treatment for Resident #11 with resulting harm. Physician orders for a wound clinic consult written on 02/23/2017 were not implemented by the facility staff until they were re-ordered on 03/27/2017. Resident #11 was not seen at the wound clinic until 04/04/2017. Review of facility documentation included Weekly Skin Integrity forms and per instruction on those forms, "If any skin condition present, proceed to skin condition record for each site identified. On 03/01/2017 the Weekly Skin Integrity Form documented bilateral boggy heels and a blackened area on the left fifth metatarsal. The Non-Pressure Skin Condition Record was reviewed. Measurements of the area on the left fifth metatarsal was measured at .4 cm by .4 cm. on 02/24/2017, 03/02/2017, 03/10/2017 and 03/17/2017. The facility failed to measure the areas after 03/17/2017. Weekly Skin Integrity Reviews on 03/08/2017 and 03/22/2017 documented skin intact and treatment in place. There was no further mention of the bilateral | F 309 | 3. Licensed nurses re-educated by the DCS/designee regarding administration of medications per physician order, documentation on the MARs/TARs without omission and providing skin/ wound treatment per physician orders. Licensed nurses re-educated by the DCS/ designee regarding completion of skin/ wound documentation per policy. Licensed nurses re-educated by the DCS/ designee regarding documenting resident's pain level per policy. Licensed nurses re-educated by the DCS/designee regarding following the plan of care for residents receiving non-pharmacological interventions for pain management. Licensed nurses re-educated by the DCS/ designee regarding residents requiring intermittent catheterization per physician order. | |

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| F 309 | Continued From page 63<br>boggy heels. When Resident #11 was seen at the wound clinic, 40 days after the initial order was placed, wounds were described as follow: Left dorsal fifth toe, .6 am X .9 Cm X .1 cm, full thickness non-healing wound with 76-100 % slough; Right lateral heel, 1.9 X .4 X .2, non-healing wound with undermining, 76-100% eschar covered, 1-25 % slough.<br><br>6. The facility staff failed to follow physician's order's to catheterize one of 25 residents in the survey sample: Resident # 18, and also failed to assess and monitor for urinary retention, leading to the resident being admitted to the hospital which resulted in harm.<br><br>7. The facility staff failed to administer Vitamin D per physician's order for one of 25 residents in the survey sample: Resident # 6.<br><br>8. For Resident # 4, the facility staff failed to attempt the use of non-pharmacological interventions to address pain control.<br><br>9a. For Resident # 5, the facility staff failed to assess the level of pain, and the location of the pain prior to the use of pain medication.<br><br>9b. For Resident # 5, the facility staff failed to attempt the use of non-pharmacological interventions to address pain control.<br><br>9c. For Resident # 5, the facility staff failed to follow physician orders for the application of a Fentanyl pain patch.<br><br>10. For Resident # 15, the facility staff failed follow physician orders for the administration of Cyanocobalamin. | F 309 | 4. DCS/Designee through morning clinical meeting review skin evaluations 5 x weekly x 2 weeks, 3 x weekly x 2 weeks, weekly x 4 weeks, twice monthly, PRN and as indicated. DCS/Unit Managers/designee to conduct random quality review of MARs/TARs for omissions QS x 2 weeks, daily x 2 weeks, 3 times weekly x 2 weeks, 2 times weekly x 2 weeks, twice monthly, PRN and as indicated. DCS/Unit Mangers/designee through morning clinical meeting review skin/ wound documentation 5 x weekly x 2 weeks,, 3 times weekly x 4 weeks, 2 times weekly x 4 weeks, twice monthly, PRN and as indicated. DCS/ Unit Managers/designee to conduct random quality review of MARs/TARs to ensure oxygen saturation rate is documented per physician order 3 times weekly x 2 weeks, 2 times weekly x 2 weeks, weekly x 4 weeks, PRN and as indicated. DCS/Unit Managers/designee to conduct random quality review of Treatment records to ensure skin /wound treatments is completed per physician order 3 times weekly x 2 weeks, 2 times weekly x 2 weeks, weekly x 4 weeks, PRN and as indicated. | |

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| F 309 | Continued From page 64<br><br>Findings included:<br><br>1a) Facility staff failed to monitor and record Resident #10's oxygen saturations every shift as ordered by the physician.<br><br>Resident #10 was originally admitted to the facility on 11/19/2011 and readmitted on 04/03/2017 with diagnoses including, but not limited to: Paraplegia, Aspiration Pneumonitis, COPD (Chronic Obstructive Pulmonary Disease), Depression, Anxiety, Diabetes, Hypertension, Neurogenic Bladder, and Chronic UTI (Urinary Tract Infection).<br><br>The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 04/10/2017. Resident #10 was assessed as moderately impaired in her cognitive status with a total cognitive score of 10 out of 15.<br><br>Resident #10's clinical record was reviewed on 05/02/2017 at 2:15 p.m. The most recent POS (physician order sheet) dated 05/01/17 through 06/30/17 included the following order: "...01/19/17: Check Sats (oxygen saturation) Every Shift, 7A-7P, 7P-7A..." Review of TARS (treatment administration sheets) included the following documentation: March 2017 7A-7P no O2 (oxygen) Sats were recorded on 3/19, 3/20, 3/21, 3/24. 7P-7A no O2 Sats were recorded 3/03, 3/11, 3/22, 3/23, 3/25.<br><br>The DON (director of nursing) was interviewed on 05/03/17 at approximately 5:45 p.m. regarding blanks on the TARS. The DON stated, "If there are no sats recorded then we have to assume they were not done." | F 309 | DCS/Unit Managers/designee to conduct random quality review of residents receiving pain management to ensure mediations available and administered per physician order 3 times weekly x 2 weeks, 2 times weekly x 2 weeks, weekly x 4 weeks, PRN and as indicated. DCS/Unit Managers/designee to conduct random quality review of residents receiving vitamin supplements is administered per physician order 3 times weekly x 2 weeks, 2 times weekly x 2 weeks, weekly x 4 weeks, PRN and as indicated. Medication Skills competency checklist randomly PRN as indicated. DCS/Unit Managers/ designee to conduct random quality review of residents receiving pain management to ensure pain level is documented per policy 3 times weekly x 2 weeks, 2 times weekly x 2 weeks, weekly x 4 weeks, PRN and as indicated. DCS/ Unit Managers/designee to conduct random quality reviews of residents receiving pain management has non-pharmacological interventions 3 times weekly x 2 weeks, 2 times weekly x 2 weeks, weekly x 4 weeks, PRN and as indicated. | |

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| F 309 | Continued From page 65 | F 309 | DCS/Unit Managers/designee to conduct random quality review of residents with orders requiring intermittent catheterization is followed per physician order twice weekly x 2 weeks, weekly x 4 weeks, PRN and as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. | |

1b) Facility staff failed to administer long acting morphine per physician order resulting in withdrawal symptoms and subsequent harm due to unavailability of the medication.

Included in Resident #10's POS was an order dated 04/03/17 that stated: "...Morphine Sulfate ER 60 MG (milligrams) Tablet ER (extended release) For MS Contin Take 1 (one) Tab by Mouth Every 12 Hours for Pain..." and an order dated 04/04/17 that stated: "...Morphine Sulfate 15 MG Tablet For Morphine Sulfate Take 1 (one) Tab by Mouth every 4 (four) Hours As Needed for Pain..."

Review of the MARS (medication administration sheets) for Resident #10 included documentation that Resident #10 did not receive a dose of Morphine Sulfate 60mg ER on 04/30/17 at 8:00 a.m. or 8:00 p.m. and also did not receive a dose on 05/01/17 at 8:00 a.m. The first dose the resident received since 04/29/17 at 8:00 p.m. was on 05/01/17 at approximately 10:00 p.m.

Resident #10 was administered Morphine 15 MG by mouth on 04/29/17 at 7:40 p.m., 04/30/17 at 2:10 a.m. and 9:00 p.m. She received no other prn (as needed) doses according to documentation on the MAR. Resident #10 also received Vistaril 25 MG on 04/30/17 at 1:00 p.m. for anxiety.

Resident #10's daughter was interviewed on 05/03/17 at 1:35 p.m. per her request. During this conversation Resident #10's daughter stated, "...On Friday 4/28 a hard script was needed for Mom's Morphine 60 MG every 12 hours. She

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missed a dose on Saturday, 4/29 at 8:00 p.m., Sunday, 4/30 at 8:00 a.m., 8:00 p.m., and a dose on Monday, 05/01 at 8:00 a.m. (Name) the PA (physician assistant) gave the nurse a prescription at 10:30 a.m. on Monday, 05/01. The medicine came from the pharmacy at 10:30 p.m. Monday night. Her Monday bedtime dose was late. I spoke with the Sunday nurse working 7A-7P and she would not call the doctor. Nurse stated, 'Another doctor will not write a prescription for Morphine.' I, myself called the on-call doctor Sunday evening around 10:00 p.m. The on-call doctor was going to call the nurse at the facility to make sure Mom's Morphine would be delivered on Monday. The nurse working didn't know who the Administrator on-call was for the weekend. They gave Mom her prn Morphine over the weekend every four hours when she would take it. Mom called me Sunday evening, crying and stated: "I can't take this pain much longer.'"

LPN #1 (licensed practical nurse) was interviewed on 05/03/17 at approximately 2:00 p.m. regarding the missed Morphine Sulfate ER doses. LPN #1 stated, "A hard script was needed on Friday and not obtained. She (Resident #10) ran out of Morphine over the weekend."

The Medical Director confirmed Resident #10 went into withdrawal from not having her long acting Morphine over the weekend during a conversation with this surveyor on 05/03/17 at approximately 3:00 p.m.

Resident #10 was interviewed on 05/08/17 at 10:30 a.m. Resident #10 stated, "I ran out of my long acting Morphine that weekend. My legs hurt so bad, they had constant pain, then turned to constant tingling up into my thighs. It was

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miserable. I didn't a take a lot of the other Morphine because it didn't help."

The Administrator and DON (director of nursing) were informed of the above during a meeting with the survey team on 05/03/17 at 5:45 p.m. The DON stated, "The hard script should have been obtained on Friday and the medicine ordered from the pharmacy and received at the facility before (Name) Resident #10 ran out of medicine. I don't know how that happened."

This is a complaint deficiency.

2. Facility staff failed to monitor and record Resident #12's oxygen saturations every shift per physician order.

Resident #12 was originally admitted to the facility on 01/12/10 and readmitted on 03/01/14 with diagnoses including, but not limited to: Heart Disease, Hypertension, Hemiplegia, Anxiety, Depression, COPD (Chronic Obstructive Pulmonary Disease), Stroke, Dysphagia and Macular Degeneration.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 02/01/17. Resident #12 was assessed as moderately impaired in her cognitive skills with a total cognitive score of 12 out of 15.

Resident #12's clinical record was reviewed on 05/04/17 at 7:45 a.m. The most recent POS (physician order sheet) dated 04/09/17 through 05/31/17 included an order: "...06/19/14: Check O2 Sats every shift...03/07/14: O2 at 2L/Min (2 liters per minute) via Nasal Cannula every Shift

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Review of Resident #12's TARS revealed the following dates without O2 Sats documented: January 2017: 7A-7P: 1/5, 1/6, 1/10, 1/15, 1/16, 1/17, 1/20, 1/21, 1/22, 1/23, 1/24, 1/27, 1/31. February 2017: 7A-7P: 2/17, 2/19, 2/22, 2/23, 2/24, 2/25, 2/28; 7P-7A: 2/17, 2/25, 2/28. March 2017: 7A-7P: 3/3, 3/11, 3/15, 3/19, 3/20, 3/21, 3/23, 3/24, 3/25; 7P-7A: 3/3, 3/11, 3/21, 3/23, 3/25.

The DON (director of nursing) was interviewed on 05/03/17 at approximately 5:45 p.m. regarding blanks on the TARS. The DON stated, "If there are no sats recorded then we have to assume they were not done."

This is a complaint deficiency.

3. Facility staff failed to monitor and record Resident #13's oxygen saturation every shift per physician order.

Resident #13 was originally admitted to the facility on 02/22/12 and readmitted on 07/17/15 with diagnoses including, but not limited to: Atrial Fibrillation, Heart Disease, Diabetes, Stroke, Dementia, Parkinson's Disease, Seizures and COPD.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 04/29 17. Resident #13 was assessed as severely impaired in her short and long term memory and daily decision making skills.

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Resident #13's clinical record was reviewed on 05/04/17 at 9:40 a.m. The most recent POS dated 04/01/17 through 05/31/17 included an order: "...07/20/15: O2 Sat Every Shift, 06/07/16: O2 at 2L/Min via Nasal Cannula continuous every shift for shortness of breath..."

Review of Resident #13's TARS revealed the following dates without O2 Sats documented:
January 2017: 7A-7P: 1/2, 1/5, 1/6, 1/10, 1/15, 1/16, 1/17, 1/20, 1/21, 1/22, 1/23, 1/24, 1/31; 7P-7A: 1/20.
February 2017: 7A-7P: 2/19, 2/22, 2/23; 7P-7A: 2/25, 2/28.
March 2017: 7A-7P: 3/1, 3/15, 3/20, 3/21, 3/24; 7P-7A: 3/3, 3/7, 3/11, 3/22, 3/23, 3/25.

The DON (director of nursing) was interviewed on 05/03/17 at approximately 5:45 p.m. regarding blanks on the TARS. The DON stated, "If there are no sats recorded then we have to assume they were not done."

No further information was received by the survey team prior to the exit conference on 05/09/2017.

This is a complaint deficiency.

4. Resident #21 was not provided pain medications for the treatment of chronic pain related to a C5-C6 (cervical spine injury at the 5th and 6th vertebrae of the spine), which resulted in harm to the resident. Resident #21's Fentanyl 125 mcg (micrograms) patch was discontinued abruptly and the resident was not provided any other medications for the relief of breakthrough pain.

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Resident #21 was originally admitted to the facility on 1/8/16 and readmitted on 1/9/17 with, but not limited to, the following diagnoses: urine retention, vaginal fistula, unspecified ileus and quadriplegia related to a C5-C6 injury. The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/14/17 was a quarterly assessment. The resident was assessed as being a fifteen (15) for cognitive skills; able to make needs known and independent in decision-making skills.

On 5/4/17 at approximately 1:00 p.m., An APS (adult protective services) report filed in the State agency's office was reviewed regarding multiple allegations of the resident not being provided care and services while in the nursing facility. During the review of the APS report, Resident #21's clinical record was reviewed and it was documented that the resident frequently complained of pain after a Fentanyl patch was discontinued due to an allegation of drug diversion related to the resident's spouse.

On 5/4/17 at approximately 1:40 p.m., the Medical Director was interviewed regarding the above allegation. The medical director stated that he was aware of the above and that "he would have done differently." The medical director further stated that he "did not want to be responsible if she (the resident) overdosed; she was not my patient." The medical director was made aware that Resident #21 was on Fentanyl for a while and that it was discontinued shortly after the allegation of a drug diversion concerning the Resident's husband. The Medical Director stated that "he was aware of something like that but he could not speak to the situation."

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The Medical Director was also made aware that the resident was not offered any other alternatives for the treatment of her pain and therefore according to the nurse's notes, the resident was unable to perform ADL (activities of daily living) on several occasions.

On 5/8/17 at approximately 11:30 a.m., Resident #21's clinical record was reviewed to include the following nursing notes:

"11/26/16 1800 (6:00 p.m.) Res (resident) was told that husband isn't allowed on grounds until investigation is over for the missing Fentanyl patch..."

"11/30/16 1050 [Physician named] in to see resident. N/O (new order) to d/c Fentanyl patches. Orders for Zofran 4 mg po (by mouth) q (every) 6 hours N/V (nausea and vomiting) & Phenergan 25mg IM (intramuscular) q 6 prn (as needed/necessary) for N/V x (times) 2 weeks. Resident has been notified. Resident was upset about having to remove patches. 100 mcg & 25 mcg /hr (hour). patches wasted..."

"12/2/16 7p-11p Multiple c/o's (complaints) RT (related to) fentanyl DC'd. c/o meds not working for pain. Has had 650 mg Tyl (tylenol), 0.5 mg Xanax, Flexeril is now requesting dilaudid for pain but is aware too early want tyl again but it is too early pt (patient) short and curt c (with) staff. Hostile attitude...(sic)."

"12/4/16 late entry from 12/3/16 7A-7P. Resident frequently c/o generalized pain during shift. Resident would ask for pain medication early and when this nurse would tell pt it was too soon, pt

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would say that this nurse didn't give pt (patient) certain time. Pt stated that at one point to "Give me whatever you can give."

"12/14/16 0300 Has been verbally hostile c (with) nsg (nursing) staff..."

"12/18/16 0600 Sent word by CNA (certified nursing assistant) "Give me anything, I don't care what it is just give me something. "...has nothing left for pain that she hasn't already taken..."

"12/26/16 1700 (5:00 p.m.) Pt refused to turn & rotate stating "I can't roll because my shoulders hurt to bad." This nurse repeatedly said that not rotating can cause sores but loudly said "I told you I'm not rolling on my shoulders because I'm in pain & the doc (doctor) won't give me or care about my pain."

On 5/8/17 at approximately 12:45 p.m. during an interview with Resident #21, the resident stated that she was not provided pain medications due to an "alleged drug diversion that was investigated and unfounded, concerning her husband." Resident #21 stated that the "doctor took me off of 125 mcg of Fentanyl without tapering me off of it and I was unable to get out of bed or turn because of the pain."

On 5/8/17 at approximately 5:49 p.m., the administrative staff was made aware of the above findings. The facility staff involved in the above findings were not available for interview. Two of the employees were called multiple times on 5/8/17 at 3:20 p.m. and again at 5:24 p.m., but did not answer. The remainder of the staff involved were no longer employed at the facility.

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On 5/9/17 at approximately 9:20 a.m. A Witness Statement for Resident #21 was reviewed to include the following: "1/27/17 [CNA-certified nursing assistant] named On 1/10/17...Around 10:30 I saw the shower aide go into her room and offer her a shower [CNA shower aide named] she stated that [Resident named] declined her shower...she stated that she did not want it yet because she was in a lot of pain...I offered one more time before I left at 3:00 p.m. that day and [Resident named] stated that she would take care of it later and was still in pain."

On 5/9/17 at approximately 1:34 p.m., the administrative staff were made aware of the above findings.

5. The facility staff failed to assess non-pressure areas on the foot of Resident #11 and obtain physician ordered wound clinic treatment for Resident #11 with resulting harm.

Physician orders for a wound clinic consult written on 02/23/2017 were not implemented by the facility staff until they were re-ordered on 03/27/2017. Resident #11 was not seen at the wound clinic until 04/04/2017. Review of facility documentation included Weekly Skin Integrity forms and per instruction on those forms, "If any skin condition present, proceed to skin condition record for each site identified. On 03/01/2017 the Weekly Skin Integrity Form documented bilateral boggy heels and a blackened area on the left fifth metatarsal. The Non-Pressure Skin Condition Record was reviewed. Measurements of the area on the left fifth metatarsal was measured at 0.4 cm by 0.4 cm. on 02/24/2017, 03/02/2017, 03/10/2017 and 03/17/2017. The facility failed to

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measure the areas after 03/17/2017. Weekly Skin Integrity Reviews on 03/08/2017 and 03/22/2017 documented skin intact and treatment in place. There was no further mention of the bilateral boggy heels.

When Resident #11 was seen at the wound clinic, 40 days after the initial order was placed, wounds were described as follow: Left dorsal fifth toe, 0.6 am X 0.9 Cm X 0.1 cm, full thickness non-healing wound with 76-100 % slough; Right lateral heel, 1.9 X 0.4 X 0.2, non-healing wound with undermining, 76-100% eschar covered, 1-25 % slough.

Resident #11 was originally admitted to the facility on 11/13/2015. Her diagnoses included but were not limited to: End stage renal disease, encephalopathy, atrial fibrillation, hypertension, wegner's Granulomatosis with renal involvement, peripheral vascular disease and gangrene.

The most recent MDS (minimum data sheet) was a significant change assessment with an ARD (assessment reference date) of 05/05/2017. Resident #11 was assessed as having a problem with both long and short term memory and being severely impaired with daily decision making skills.

The clinical record was reviewed beginning on 05/03/2017. Observed in the physician order section were the following orders: "2-23-17 1213 [12:13 p.m.] Wound care clinic consult for feet..." and "3-27-17 1312 [1:12 p.m.] Wound care clinic Appointment STAT Indication-Dx [diagnosis] cellulitis of feet/toes".

The unit manager, LPN (licensed practical nurse)

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was interviewed at 10:00 a.m., on 05/03/2017 regarding Resident #11's appointment at the wound clinic. She was asked when Resident #11 was first seen at the wound clinic. She stated, "April 4th." She was asked why there was a delay in the length of time the initial order was written and the actual appointment. She stated that she had been at the facility for one month and had not been there at the time of the initial order. She stated she did not know why the appointment had not been made. She directed this surveyor to the staff member who made transportation arrangements and appointments, OS (other staff) #9.

OS #9 was interviewed at approximately 10:15 a.m. on 05/03/2017. She was asked what her role in making appointments for residents was at the facility. She stated that when she received a request from the staff she made appointments for residents and arranged for their transportation to the appointment. She was asked if she knew why Resident #11's appointment for the wound clinic had not been made when originally ordered on 02/23/2017. After looking through her information she informed this surveyor that she had not gotten any information regarding an appointment at the wound clinic for Resident #11 until 03/27/2017 at which time an appointment was scheduled for 04/04/2017 and transportation was arranged.

Review of facility documentation included Weekly Skin Integrity forms and per instruction on those forms, "If any skin condition present, proceed to skin condition record for each site identified. On 03/01/2017 the Weekly Skin Integrity Form documented bilateral boggy heels and a blackened area on the left fifth metatarsal. The

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Non-Pressure Skin Condition Record was reviewed. Measurements of the area on the left fifth metatarsal was measured at 0.4 cm by0 .4 cm. on 02/24/2017, 03/02/2017, 03/10/2017 and 03/17/2017. The facility failed to measure the areas after 03/17/2017. Weekly Skin Integrity Reviews on 03/08/2017 and 03/22/2017 documented skin intact and treatment in place. There was no further mention of the bilateral boggy heels.

A physician progress note date 03/27/2017 was reviewed and included the following information: "I was to see this patient by nursing staff for possible infection to her feet...Apparently the dialysis staff noticed her toes that were erythematous and the left fifth toe apparently was draining some purulent material....Inspection of the feet reveals a erythematous left fifth toe with some purulent material adjacent. There is some mild erythema over the distal portion of the foot and the heel. Similar findings are noted on the right foot...The area is mildly tender with palpation....Impression Cellulitis of both feet.....I will immediately place her on Keflex 500 mg 4 times daily X [times] 7 days. I will have the nursing staff contact the wound clinic and have them see her tomorrow..."

The TAR (treatment administration records) were reviewed. On the TAR for February an order to "Clean right heel with DWC [wound cleanser] and apply optifoam and heel cup for protection" was added on 02/22/2017 and marked as completed on 2/22/2017 and 02/24/2017. All other days were blank. An order for "Foam boot daily" was added on 02/22/2017 and marked as completed on 02/24/2017. The same orders for treatment were on the TAR for March. Cleaning of the heel

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as described was marked as completed on 7 of 31 days and the foam boot either placed or refused by the resident on 25 of 31 days. LPN #1 was asked about the holes on the TAR for February and March. She stated, "I don't know if the treatments were done or not." LPN #1 was asked who would be doing the dressing change for Resident #11 scheduled for that day (05/03/2017). She stated that she would be doing it. This surveyor asked to be present when the dressing change was completed. LPN #1 agreed to the request.

Wound clinic notes from 04/04/2017, 40 days after the initial order was placed, were reviewed. Wounds were described as follow: Left dorsal fifth toe, 0.6 am X0 .9 Cm X 0.1 cm, full thickness non-healing wound with 76-100 % slough; Right lateral heel, 1.9 X 0.4 X 0.2, non-healing wound with undermining, 76-100% eschar covered, 1-25 % slough. Further documentation included: "This is a chronically ill patient with COPD, Coronary disease, renal failure/dialysis and history of Wegener's vasculitis who comes into the wound clinic another time with more wounds on her feet and legs. She has been treated off and on since 8/2015. She says some of her wounds are due to her scuffing her feet on her wheelchair at her [name] nursing home...she essentially does not ambulate, she sits in a wheelchair and sleeps in a recliner...weak muscles and painful to touch foot...Wound #5 Left dorsal fifth toe is a full thickness non-healing wound and has received a status of Not Healed. Initial wound encounter measurements are 0.6 cm length X 0.9 cm width X 0.1 cm depth, with an area of 0.424 sq cm and a volume of 0.042 cubic cm...there is a scant amount of sero-sanguineous drainage noted which has no odor...Wound bed is 76-100%

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slough...The periwound skin exhibited: Erythema. Wound #6 Right, Lateral Heel is an eschar covered Non-healing wound and has received a status of Not Healed. Initial wound encounter measurements are 1.9 cm length X 0.4 cm width X 0.2 cm depth, with an area of 0.597 sq cm and a volume of 0.119 cubic cm...undermining has been noted at 12:00 and ends at 12:00 with a maximum distance of 0.5 cm. There was no drainage noted...Wound bed is 76-100% eschar and 1-25% slough, 1-25% granulation...She has multiple wounds on both feet as she injures herself on something in her environment...PVD [peripheral vascular disease] in a chronically ill patient who is injuring her skin...She appears to have a chronic vasculitis based on the appearance of her extremities."

Notes from the wound clinic visit on 04/18/2017 contained the following: On the vascular study of 4/11/2017 her legs bilaterally have monophasic wave forms and there is distal bilateral critical ischemia. Both of her tibial arteries are occluded on the right and the posterior tibial artery on the left is occluded...Wound #5 Left dorsal Fifth Toe....no change in the wound progression...Wound #6 Right lateral heel...2 cm in length X 1 cm in width X .2 cm depth...the wound is deteriorating....Her wounds are the same or slowly getting worse. Is apparent that her inflow from the vascular study is very poor and wounds are unlikely to heal given the critical ischemia....severe PVD related to her vasculitis and other health issues....I think it is likely we will not be able to heal her wound of the feet and she is likely to come to amputation."

On 05/03/2017 at approximately 1:25 p.m., a family member for Resident #11 came to the

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conference room to speak with this surveyor. She identified herself as the POA (power of attorney) for Resident #11. She stated, "I wanted to speak with you about my sister's care...the quality and quantity of staffing has really gone down here...I want to show you some pictures." She showed this surveyor pictures she had taken of Resident #11's feet on 02/24/2017 and 03/27/2017. She stated, "Her wounds have gotten worse and worse, they haven't been taking care of them and treating them like they should...she has a history of problems that have sent her to the wound clinic in the past, they should have been more on top of this..."

On 05/03/2017 the medical director (who took the position on 04/01/2017) was interviewed regarding Resident #11. He was asked about the delay in obtaining the wound clinic appointment in regard to the outcome of Resident #11 and the lack of skin assessments and wound measurements at the facility. He stated, that due to Resident #11's medical problems and history the wounds would have not healed regardless of the time frame, but had she gone to the wound clinic when originally ordered it could have changed the quality of the end of her life. He stated that had Resident #11 gone to the wound clinic when ordered she would have had "Dry Gangrene" as opposed to "Wet Gangrene" which he stated, "That may sound strange but the dry is preferable to the wet...also had she gone to the wound clinic sooner we may have been able to get her on Hospice sooner which would have increased the quality of her end of life."

At approximately 5:00 p.m., on 05/03/2017, LPN #1 came to the conference room to tell this surveyor that she was ready to do the dressing

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change for Resident #11. This surveyor told her she would be there in just a minute. This surveyor arrived on the unit at 5:10 p.m., LPN # 1 and this surveyor started down the hall to Resident #11's room. LPN #4 was coming up the hall. LPN #1 stated, "Where are you going?" to LPN #4. She stated, "I've already done the dressing change." LPN #1 stated, "She (pointing to this surveyor) wanted to see it." LPN #4 stated, "Well it's already done." This surveyor asked LPN #4 if she was caring for Resident #11 for the evening. She stated, "No, I work on the other side (referring to the other units on the opposite side of the building)" This surveyor asked, "Why did you come over here to do the dressing change?" LPN #1 stated, "She is more familiar with the dressing change than I am." LPN #4 stated, "I can do it again if you want me to, it's only scheduled every other day...she's not doing very well and she is in pain." This surveyor stated, "No, I don't want to put the resident through that, but if the dressing needs to be changed again I want to see the wounds." LPN #1 verbalized her understanding.

During a meeting with the administrator, the DON (director of nursing) and the regional nurse consultant at 5:45 p.m., on 05/03/2017 the above information was discussed and concerns were voiced regarding the possibility of harm to resident #11 due to the delay in obtaining the wound clinic appointment, the lack of assessments for the non-pressure wounds and the lack of documentation regarding treatment to the areas. They were also informed that the wounds had not been seen by this surveyor due to the dressing being changed before the surveyor got to the unit. The DON was asked if due to Resident #11's history of PVD would she

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expect the nursing staff to be all the more diligent in assessing her feet and extremities. The DON stated, "Yes."

On 05/04/2017, LPN #1 was again asked to get this surveyor if the dressings were changed on Resident #11's feet. The dressings did not need to be changed.

On 05/08/2017 when the survey team returned to the facility the DON was asked if this surveyor could see the wounds on Resident #11's feet. The DON stated, "[Name of Resident #11] passed away over the weekend."

No further information was obtained prior to the exit conference on 05/09/2017.

This is a complaint deficiency.

6. The facility staff failed to follow physician's order's to catheterize one of 25 residents in the survey sample: Resident # 18, and also failed to assess and monitor for urinary retention, leading to the resident being admitted to the hospital which resulted in harm.

Resident # 18 was a closed record review and was admitted to the facility 3/20/17 with diagnoses to include, but were not limited to: degenerative joint disease, history of intracranial hemorrhage, benign prostate hyperplasia (enlarged prostate gland), and osteoarthritis.

The admission MDS (minimum data set) dated 3/27/17 had Resident # 18 assessed with long term and short term memory problems, and

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severe impairment in daily decision making skills.

The clinical record was reviewed 5/4/17 beginning at 10:00 a.m. The POS (physician order summary) at admission included an order documenting "May I/O (in and out) cath BID (twice a day) prn (as needed) for urinary retention/inability to urinate." A review of nurses' notes dated 3/21/17 through 3/28/17 revealed the following:

3/23/17 [no time documented] : "Rsd straight cath. No void 7a-7p. Clot noted to come out end of cath. Urine began flowing very slowly....rsd said he had no pain. Abd.(abdomen) not very distended....."

3/24/17 7:00 a.m.: "void mod amt. 9:30 p.m. and small amt. 1:30 a.m. straight cath with cath kit-difficult with prostate.....400 cc concentrated urine with small blood clot....."

3/24/17 7:00 a.m. "void through the night once moderate amt...."

3/26/17 7:00 a.m. "Pt. incontinent of bowel and bladder this shift....."

3/27/17 [no time given] "Rsd noted to be extremely lethargic but able to answer. Rsd noted to be weak and mouth dry. MD notified. Order for 1000 cc normal cc given by IV..... by end of shift Rsd was more alert stating 'I feel a lot better.'"

3/28/17 3:00 a.m. "alert....took meds with 1/2 cup of water but back to sleep quickly..... f/c (Foley catheter) in place, dark brown urine with sediment noted. 2,000 emptied, 1500 light straw

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urine.....telephone order to send to hospital....." (It should be noted that there was a physician order to "Place Foley catheter now" written by the physician).

A review of the TAR (treatment administration record) revealed the resident was straight cathed two times during the eight days he was in the facility.

On 5/4/17 hospital records were obtained and reviewed. The documentation from the emergency room visit documented ".....The patient was discharged [3/20/17] to [name of facility] and his Foley catheter was discontinued with plans for intermittent urinary catheterization. It is unclear whether the patient received any catheterizations while he was at the facility. A Foley catheter was placed with immediate return of 3500 cc of urine and the patient is continued to have a significant diuresis consistent with postobstructive nephropathy. The case was discussed with the on-call hospitalist and arrangements were made for direct admission..... " Under "Assessment and Plan" was documented "[name of resident] is a very pleasant but unfortunate gentleman now presenting with acute renal failure secondary to obstructive nephropathy with a known history of urinary retention with BPH."

On 5/8/17 at 11:45 a.m. the facility medical director was interviewed. The medical director stated "I was not his attending doctor at that time." The medical director was asked to read the emergency room report. He did so and stated "Yep; that's true, each and every word. The patient had shy of 4000 milliliters of urine in the bladder; I do know that [name of assistant

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medical director] was pretty fired up about it." The medical director then informed this surveyor he would send a page to that physician and ask him to call me.

On 5/8/17 at 12:05 p.m. LPN (licensed practical nurse) # 2 was interviewed. LPN # 2 was also asked if there were any other staff who may have any knowledge about Resident # 18. LPN # 2 stated "I didn't really know much about him; other staff at that time are either not here anymore, or were agency staff. I did do the transfer paperwork to the hospital, but I had only been here a couple of days before that happened. I never worked with the resident and did not know much about him, and unfortunately, there's no one here now that can speak to that."

On 5/8/17 at 1:15 p.m. the assistant medical director called this surveyor. The assistant medical director was asked about the care and services provided for the resident while he was in the facility, including the reason he had been sent to the hospital. The assistant medical director stated "The first time I saw the patient was 3/28/17 and I sent him out after the catheter was placed; his bladder was palpable and tender at the level of the umbilicus and had a huge volume of urine retained. It's hard to speak to the care and services provided while he was in the facility; I think the volume of urine obtained tells the story. Hard for me to defend in light of the amount of urine and no staff reporting it... [name of resident] is now on Hospice."

On 5/9/17 during a meeting with facility staff beginning at 1:30 p.m., the administrator, DON (director of nursing), and regional nurse consultant were informed of the above findings.

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The administrative team were informed of the finding at a harm level deficiency at that time.

No further information was presented prior to the exit conference.

THIS IS A COMPLAINT DEFICIENCY.

7. The facility staff failed to administer Vitamin D per physician's order for one of 25 residents in the survey sample: Resident # 6.

Resident # 6 was admitted to the facility 3/28/17. The admission MDS (minimum data set) dated 4/4/17 had Resident # 6 assessed with moderate impairment in cognition.

The clinical record was reviewed on 5/2/17 at 3:00 p.m. The current POS (physician order summary) included an order carried forward from 3/30/17 for "Vitamin D2 capsule 50,000 unit capsule Take one cap by mouth weekly on Monday."

A review of the MAR (medication administration record) was then conducted and revealed the boxed off area for staff initials when administered were blank for Monday April 10th and Monday April 17th 2017. The reverse side of the MAR did not contain any documentation regarding the blank areas.

On 5/2/17 at 3:30 p.m. LPN (licensed practical nurse) # 2 was asked for assistance explaining the blank areas on the MAR for the Vitamin D2 administration. LPN # 2 stated "Well, maybe there's a note- or could have been an agency nurse. Let me see what I can find." LPN # 2

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then took the clinical record for review. LPN # 2, after review stated "I don't see anything about the Vitamin D; there's no documentation on the MAR either. I don't know what happened."

The administrator, DON (director of nursing), and regional nurse consultant were informed of the above findings 5/9/17 during a meeting with facility staff beginning at 1:30 p.m.

No further information was provided prior to the exit conference.

8. For Resident # 4, the facility staff failed to attempt the use of non-pharmacological interventions to address pain control.

Resident # 4 in the survey sample, a 66 year-old female, was admitted to the facility on 4/7/15, and most recently readmitted on 4/14/17 with diagnoses that included obstructive sleep apnea, encephalopathy, acidosis, hypertension, restless leg syndrome, diabetes mellitus, asthma, congestive heart failure, bi-polar disorder, anxiety, chronic pain, morbid obesity, acute respiratory failure, chronic renal failure, seizure disorder, anemia, seizure disorder, depression, gastroesophageal reflux disease, chronic obstructive pulmonary disease, and respirator failure. According to the most recent Minimum Data Set (MDS), a Significant Change, with an Assessment Reference Date (ARD) of 4/21/17, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.

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Resident # 4 had the following medication orders to address pain:

Oxycodone 10 mg (milligrams) Tablet. 10 mg oral twice daily.
Oxycodone 5 mg Tablet. Take 1 tablet by mouth every 8 hours as needed for pain.

Review of the Medication Administration Record (MAR) for the month of March 2016 revealed the as needed Oxycodone was administered 30 times between 3/1/17 and 3/23/17. For the month of April 2017, the as needed Oxycodone was administered 13 times between 4/1/17 and 4/8/17.

A thorough review of Resident # 4's clinical record, including the Nurse's Notes and the comments section of the Medication Administration Record (MAR), failed to reveal any documentation that non-pharmacological interventions to address the resident's pain were attempted.

During an interview at 2:30 p.m. on 5/3/17, the resident was asked about the use of non-pharmacological interventions to address her pain. The resident said staff have use hot and cold packs occasionally. "Sometimes a hot or a cold compress will work. Compresses at night can sometimes get me all relaxed and I can sleep through the night without medication," the resident said. Further review of the resident's clinical record failed to reveal any documentation regarding the occasional use of hot and cold packs.

The findings were discussed at a meeting at 3:00 p.m. on 5/8/17 with the Interim Administrator,

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Director of Nursing, Corporate Nurse Consultant, and the survey team.

9a. For Resident # 5, the facility staff failed to assess the level of pain, and the location of the pain prior to the use of pain medication.

Resident # 5 in the survey sample, a 76 year-old male, was admitted to the facility on 10/29/16, and most recently readmitted on 12/31/16 with diagnoses that included gout, hyperlipidemia, right below the knee amputation stump wound, left great toe wound, diabetes mellitus, hypertension, coronary artery disease, gastroesophageal reflux disease, benign prostatic hyperplasia, depression, and arteriosclerotic heart disease. According to the most recent MDS, a Quarterly with an ARD of 2/5/17, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 12 out of 15.

Resident # 5 had the following medication order to address pain:

Oxycodone 5 mg Tablet. Take 1 tablet by mouth every 4 hours as needed for pain.

Review of the MAR for March 2017 revealed as needed Oxycodone was administered 40 times between 3/1/17 and 3/31/17. Review of the MAR for April 2017 revealed as needed Oxycodone was administered 43 times between 4/1/17 and 4/30/17.

A thorough review of Resident # 5's clinical record, including the Nurse's Notes and the

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comments section of the MAR, failed to reveal any documentation the resident was assessed for the level of his pain or the location of his pain.

9b. For Resident # 5, the facility staff failed to attempt the use of non-pharmacological interventions to address pain control.

A thorough review of Resident # 5's clinical record, including the Nurse's Notes and the comments section of the Medication Administration Record (MAR), failed to reveal any documentation that non-pharmacological interventions to address the resident's pain were attempted.

9c. For Resident # 5, the facility staff failed to follow physician orders for the application of a Fentanyl pain patch.

Resident # 5 had the following physician's medication order:

Fentanyl 12 mcg/hr (micrograms per hour). Apply 1 patch topically every 3 days.

NOTE: Fentanyl is an opiod analgesic used to control moderate to severe pain. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 496.

Review of the MAR for the month of March 2017 in Resident # 5's clinical record revealed the patch scheduled for application on 3/20/17 was not signed as having been applied. At approximately 1:30 p.m. on 5/3/17, LPN # 2 (Licensed Practical Nurse), the Unit Manager on

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Unit 2, was asked to determine whether or not the Fentanyl patch was applied as ordered on 3/20/17. At 2:10 p.m., LPN # 2 advised the surveyor that the Fentanyl patch not been signed out on the narcotic sheet. "It was not applied," LPN # 2 said.

The findings were discussed at a meeting at 3:00 p.m. on 5/8/17 with the Interim Administrator, Director of Nursing, Corporate Nurse Consultant, and the survey team.

10. For Resident # 15, the facility staff failed follow physician orders for the administration of Cyanocobalamin.

Resident # 15 in the survey sample, a 63 year-old female, was admitted to the facility on 11/26/14 with diagnoses that included generalized muscle weakness, bi-polar disorder, major depressive disorder, gout, hypertension, chronic pain syndrome, anemia, fibromyalgia, hyperlipidemia, gastroesophageal reflux disease, asthma, and anxiety disorder. According to the most recent MDS, a Quarterly with an ARD of 4/19/17, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 14 out of 15.

Resident # 15 had the following physician's order:

Cyanocobalamin 1000 mcg/1 ml (micrograms per milliliter) vial. Give 1 ml (1000 mcg) intramuscularly every month on the 27th for anemia.

NOTE: Cyanocobalamin (Vitamin B 12) is water soluble vitamin used to treat vitamin B 12

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| F 309 | Continued From page 91<br>deficiency and pernicious anemia. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 298.<br><br>During the orientation tour at 1:00 p.m. on 5/2/17, Resident # 15 told the surveyor, "I didn't get my shot (Cyanocobalamin) last month (March)."<br><br>A review of Resident # 15's MAR for the month of March 2017 revealed the Cyanocobalamin was not signed off as being given. As of 5/8/17, the date of clinical record review, the March injection of Cyanocobalamin had not been administered.<br><br>The findings were discussed at a meeting at 3:00 p.m. on 5/8/17 with the Interim Administrator, Director of Nursing, Corporate Nurse Consultant, and the survey team. | F 309 | | |
| F 312 SS=E | 483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, resident interview, and clinical record review, the facility staff failed ensure ADL (activities of daily living) was provided to four (4) of 25 dependent residents. Resident's #2, 11, 20 and 21.<br><br>1. Resident #2 was not provided ADL care for bathing.<br><br>2. Resident #21 was not provided ADL care for bathing and grooming. | F 312 | F 312: ADL Care Provided For Dependent Residents<br><br>1. Residents 2, 11, 20 and 21 no longer reside in the facility.<br>2. Quality review of residents bathing preferences were reviewed and updated as indicated.<br>3. Nursing staff re-educated by the Director of Clinical Services (DCS) / Designee to ensure bathing services are consistently provided and documented. | 06/23/17 |

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| F 312 | Continued From page 92 | F 312 | 4. ED/DCS/Designee through Morning Clinical meeting process to ensure consistent bathing services are provided and documented. Executive Director (ED) to randomly interview resident for bathing choices being honored. . Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. | |

3. Resident #11 was not provided ADL care for bathing.

4. Resident #20 was not provided ADL care for bathing.

The findings include:

1. Resident #2 was not provided ADL care for bathing.

Resident #2 was admitted to the facility on 12/2/16 with, but not limited to, the following diagnoses: dementia with behaviors, anxiety, major depressive disorder and chronic obstructive pulmonary disease (COPD). The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/11/17 was a significant change assessment. The resident was assessed as having short and long-term memory impairments and moderately impaired in decision-making skills. Section G (ADL) for bathing the resident was assessed as being a 4/2 (total dependence of one person).

On 5/3/17 at approximately 10:30 a.m., Resident #2's shower sheets were reviewed; the documentation on the shower sheets were as follows:

4/8/17 21:34 (9:34 p.m.) Partial
4/19/17 22:34 (10:34 p.m.) Partial
4/22/17 17:42 (5:42 p.m.) Tub

On 5/3/17 at approximately 11:30 a.m., the unit manager, who was a licensed practical nurse and will be identified as LPN #5 was interviewed regarding the above documentation and the

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residents ADL care. LPN #5 stated, "This is all I have." When interviewed and asked if the resident received three baths from admission on 12/2/16 to 4/30/17, LPN #5 stated, "This is all that I can provide."

2. Resident #21 was not provided ADL care for bathing and grooming.

Resident #21 was originally admitted to the facility on 1/8/16 and readmitted on 1/9/17 with, but not limited to, the following diagnoses: urine retention, vaginal fistula, unspecified ileus and quadriplegia related to a C5-C6 injury. The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/14/17 was a quarterly assessment. The resident was assessed as being a fifteen (15) for cognitive skills; able to make needs known and independent in decision-making skills. Section G (ADL) for bathing the resident was assessed as being a 4/4 (Total assist of 2 persons).

On 5/8/17 at approximately 11:30 a.m., An APS report was reviewed regarding Resident #21 not being provided ADL care during her menstrual cycle, bathing was not provided for several days and "bloody wipes" were found between the resident's legs.

On 5/8/17 at approximately 5:49 p.m., the administrative staff was made aware of the above findings. The facility staff involved in the above findings were not available for interview. Two of the employees were called multiple times on 5/8/17 at 3:20 p.m. and again at 5:24 p.m., but to no avail. The remainder of the staff involved were no longer employed at the facility.

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On 5/8/17 at approximately 12:45 p.m. during an interview with Resident #21, the resident stated that she was not provided ADL care from the facility staff during her menstrual cycle for approximately three days and that her bed was soaked with urine. Resident #21 stated that when she was finally cleaned a CNA (certified nursing assistant) "found wipes stuffed inside my vagina and between my legs saturated with blood." During the interview Resident #21 stated to this Surveyor, "Can I call you back I have an appointment I have to attend and I can finish telling you what happened when we talk again." This Surveyor agreed to continue the interview at a later time.

On 5/9/17 at approximately 9:07 a.m. Resident #21 was interviewed regarding the above findings of not being provided ADL care during her menstrual cycle and having to lie in bed soaked with urine for three days. Resident #21 stated, "I felt awful, humiliated and embarrassed when the CNA pulled the covers back and discovered blood on the sheets and between my legs" Resident #21 further stated, "When the CNA pulled the covers back to see the look on her face was humiliating." Resident #21 stated, "It is enough to have someone change you because you can't do it yourself but to have someone leave you laying in blood is disgusting. Resident #21 then stated, "The worst part of it all was I had to go to my care plan (CP) meeting and repeat this in front of my parents and my husband, it was degrading. When you are at the mercy of someone else it is just humiliating. I am so happy to be out of there I can't imagine having to go back there (sic)."

On 5/9/17 at approximately 9:20 a.m., the CNA

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involved in the above incident was called three times but no answer.

On 5/9/17 the investigation and witness statement was reviewed to include the following:

Witness Statement:
1/17 LPN-Called by aides doing shower to shower room. Bloody wipes noted, advised by aides they were between Residents legs at vagina area. Resident advised they have been there since 3-11 (second shift). I wasn't changed all night. Resident also states. "My gowns not been changed for 3 days." [ADON-assistant director of nursing named] made aware..."

1/17/17 CNA-On Tuesday January 17th around 1300 (1:00 p.m.) [Resident named] was scheduled for a shower. As I went to her room and got her things I brought her to the shower room. As I was preparing myself, getting all my things together, I noticed something between her legs like a napkin or her brief, I asked her what was between her legs she told me "oh probably the pad I was laying on," So I put gloves on and pulled her in the shower stall and spread her legs apart and pulled a wipe from just sitting between her legs, that had menstrual blood on it. She was telling me she was on her period, and was a little shocked by what she had seen. As I start the water to do perineal care I pulled two or three wipes folded together from between her legs also, about that time I just walked back from the trash the other shower aide walked in. I asked [Aide named] to get the unit manager so I can shoe her. [Resident named] was concerned so I try to calm her down and informed her I got the unit manager...(sic)."

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"1/26/17 CNA-...The incident where they said the wipes were left in between her legs. The other aide asked if I would her (sp) her and she placed the wipes there to clean her. I'm not sure if they were left there or not. Because I did see the girl pull them out (sic)."

On 5/9/17 at approximately 1:34 p.m., the administrative staff were made aware of the above findings.

3. Resident #11 did not receive showers as scheduled.

Resident #11 was originally admitted to the facility on 11/13/2015. Her diagnoses included but were not limited to: End stage renal disease, encephalopathy, atrial fibrillation, hypertension, Wegener's Granulomatosis with renal involvement, peripheral vascular disease and gangrene.

The most recent MDS (minimum data sheet) was a significant change assessment with an ARD (assessment reference date) of 05/05/2017. Resident #11 was assessed as having a problem with both long and short term memory and being severely impaired with daily decision making skills.

The clinical record was reviewed beginning on 05/03/2017. Bath records from January 1, 2017 to 05/03/2017 were requested and received. According to the documentation obtained Resident #11 received one shower in January, one shower and one tub bath in February, no baths or showers in March or April. All

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documented baths were partials or bed baths.

The Administrator was interviewed regarding the baths. She stated she took over as administrator on 02/08/2017. She stated that prior to her arrival, the facility used a shower team to provide all baths and showers to the residents. She stated that she felt that was not a good use of agency personnel and she dissolved the shower team making each CNA (certified nursing assistant) responsible for their assigned residents baths and showers. She stated that at first there had been some confusion and some of the baths/showers had been missed. She stated that she did not know if the problems with the showers observed on the bath records was a documentation issue or if the residents had not been getting baths. She also stated that the facility had identified problems with residents having showers/baths completed per a report from Adult Protective Services. She stated that area had been a focus of the QA (quality assurance committee). However, based on current survey findings they were not corrected per the AOC date of 03/30/2017.

During the course of the survey CNAs were interviewed. One CNA who asked not to be identified, stated, "My residents get their showers...I don't know about everyone else's...sometimes when we have 20 patients to care for it is hard to get everything done and the showers don't always happen.

The above information was discussed in a meeting with the DON and the administrator on 05/03/2017 at 5:45 p.m. The administrator nor the DON could confirm that dependent residents were receiving showers as scheduled.

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On 05/09/2017 at approximately 1:00 p.m., LPN (licensed practical nurse) # 5 was in the conference room. She stated, "I don't know if Residents have gotten their baths or not...I don't smell them or see their hair looking greasy...If I do I ask the CNA to take them to the shower." She was asked if that happened very often. She stated, "No more than at any other facility...I can tell you every resident here got a bath or shower over the weekend so we could be certain everyone was bathed."

No further information was obtained prior to the exit conference on 05/09/2017.

This is a complaint deficiency.

4. Resident #20 did not receive showers as scheduled.

Resident #20 was most recently readmitted to the facility on 12/21/2016. His diagnoses included but were not limited to: Dementia, Hypertension, acute kidney injury and dysphagia.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 03/30/2017. Resident #20 was assessed as having a cognitive summary score of "09", indicating moderate impairment with his cognitive status.

Resident # 20 was added to the survey sample due to being named in an APS (adult protective services report) that was converted to a complaint

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by the office of licensure and certification. The complainant alleged that residents in the facility were not groomed adequately and provided with showers 2 times per week.

The clinical record was reviewed beginning on 05/04/2017. Bath records for March, April and May were reviewed. According to the documentation, Resident # 20 received one shower in March, two showers in April, and none in May. All documented baths were partials or bed baths.

The Administrator was interviewed regarding the baths. She stated she took over as administrator on 02/08/2017. She stated that prior to her arrival, the facility used a shower team to provide all baths and showers to the residents. She stated that she felt that was not a good use of agency personnel and she dissolved the shower team making each CNA (certified nursing assistant) responsible for their assigned residents baths and showers. She stated that at first there had been some confusion and some of the baths/showers had been missed. She stated that she did not know if the problems with the showers observed on the bath records was a documentation issue or if the residents had not been getting baths. She also stated that the facility had identified problems with residents having showers/baths completed per a report from Adult Protective Services. She stated that area had been a focus of the QA (quality assurance committee). However, based on current survey findings they were not corrected per the AOC date of 03/30/2017.

During the course of the survey CNAs were interviewed. One CNA who asked not to be

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identified, stated, "My residents get their showers...I don't know about everyone else's...sometimes when we have 20 patients to care for it is hard to get everything done and the showers don't always happen.

Whether or not residents were receiving baths had been discussed in a meeting with the DON and the administrator on 05/03/2017 at 5:45 p.m. The administrator nor the DON could confirm that dependent residents were receiving showers as scheduled.

On 05/08/2017 at approximately 10:20 a.m., this surveyor spoke with Resident #20 about his baths and showers. He stated, "They wipe me off that's about it."

On 05/09/2017 at approximately 1:00 p.m., LPN (licensed practical nurse) # 5 was in the conference room. She stated, "I don't know if Residents have gotten their baths or not...I don't smell them or see their hair looking greasy...If I do I ask the CNA to take them to the shower." She was asked if that happened very often. She stated, "No more than at any other facility...I can tell you every resident here got a bath or shower over the weekend so we could be certain everyone was bathed."

No further information was obtained prior to the exit conference on 05/09/2017.

This is a complaint deficiency.

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| F 315 SS=G | 483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER | F 315 | F315: No Catheter, Prevent UTI, Restore Bladder | 06/23/17 |

(e) Incontinence.

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| F 315 | Continued From page 101<br>(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.<br><br>(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br><br>(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;<br><br>(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<br><br>(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.<br><br>(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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, resident interview, and staff interview, the facility staff failed for three of 25 residents in the survey | F 315 | 1. Resident #4 re-admitted 4/27/17 with no s/s of UTI. Resident # 21 was discharged on 01/27/17. Resident #7 performs self care of supra-pubic catheter per physician order. Resident able to demonstrate competency of supra-pubic care.<br>2. A quality review of resident lab results to ensure physician notification completed. Review of residents with indwelling and supra-pubic catheters to ensure care is provided per physician order completed. Peri-care skills competency checklist as indicated.<br>3. Licensed nurses re-educated by the Director of Clinical Services (DCS)/ designee regarding physician notification of lab results. Licensed nurses and C.N.As re-educated by the DCS/designee regarding providing catheter per physician order. | |

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| F 315 | Continued From page 102 | F 315 | 4. DCS/Designee to Quality monitoring residents who receive catheter care 5 x weekly x 2 weeks, 3 times weekly x 4 weeks, twice weekly x 4 weeks, weekly x 2 weeks, PRN and as indicated. DCS/Designee through Morning Clinical meeting process ensures physician is notified of laboratory results. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. | |

sample (Residents # 4, 7, and 21), to provide care and services to prevent and treat urinary tract infections, and to provide routine urinary catheter care.

1. For Resident # 4, the facility staff failed to notify the resident's attending physician of a lab result that identified the resident as having a urinary tract infection (UTI), leading to a one month delay in treatment, which lead to the resident being hospitalized and intubated, which constituted harm.

2. For Resident # 21, the facility staff failed to provide routine catheter care resulting in the resident being hospitalized, which constituted harm.

3. Facility staff did not follow physician orders regarding the care of Resident #7's supra-pubic catheter. Facility staff were to provide catheter care every shift and clean around the catheter with dermal wound cleanser, paint betadine around catheter every day. During an interview with Resident #7 he stated that he was providing his own catheter care and had all the supplies in his bedside table.

The findings include:

1. For Resident # 4, the facility staff failed to notify the resident's attending physician of a lab result that identified the resident as having a urinary tract infection (UTI), leading to a one month delay in treatment, which lead to the resident being hospitalized and intubated, which constituted harm.

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Resident # 4 in the survey sample, a 66 year-old female, was admitted to the facility on 4/7/15, and most recently readmitted on 4/14/17 with diagnoses that included obstructive sleep apnea, encephalopathy, acidosis, hypertension, restless leg syndrome, diabetes mellitus, asthma, congestive heart failure, bi-polar disorder, anxiety, chronic pain, morbid obesity, acute respiratory failure, chronic renal failure, seizure disorder, anemia, seizure disorder, depression, gastroesophageal reflux disease, chronic obstructive pulmonary disease, and respiratory failure. According to the most recent Minimum Data Set (MDS), a Significant Change, with an Assessment Reference Date (ARD) of 4/21/17, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.

Under Section H (Bladder and Bowel), the resident was assessed as occasionally incontinent of bowel and bladder.

Review of the Interdisciplinary Progress (Nurses) Notes revealed the following entry:

3/13/17 - 3:00 p.m. "...Told this nurse she thought she had a UTI (Urinary Tract Infection) d/t (due to) burning with urination...MD notified."

On 3/13/17, a telephone order from the Physician's Assistant was received for the following:

"UA (Urinalysis), EOS, Pyridium 200 mg (milligrams) PO (by mouth) tid (three times a day) x (times) 2 days."

NOTE: Pyridium is an over the counter

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medication used to "...relieve symptoms caused by irritation of the urinary tract such as pain, burning, and the feeling of needing to urinate urgently or frequently." Ref. www.WebMD.com.

Further review of the Interdisciplinary Progress (Nurses) Notes revealed the following entries:

4/9/17 - 5:00 a.m. "This nurse went in to resident room to give meds, resident asleep hard to waken. Once awake resident non-verbal, made eye contact, no facial grimacing. Resident breathing deep, skin sweaty. O2 (Oxygen) sat (saturation) 89, BS (Blood Sugar) 269, VS (vital signs) 103 - 136 (pulse), 32 (respirations), 134/58 (blood pressure). On call (MD) called was advised to send to ED (Emergency Department). 911 called, resident was taken to ED at 5:30 and RP (Responsible Party) notified."

4/9/17 - 11:10 a.m. "Called AH ER (hospital Emergency Room) for condition update. Resident to be admitted to ICU (Intensive Care Unit) on a breathing machine."

Review of the hospital Discharge Summary revealed the following:

"This is a 66-year-old female with a history of morbid obesity, obesity hypoventilation syndrome, seizure disorder, diabetes, diastolic heart failure, who was brought to the emergency room with lethargy and unresponsiveness. In the emergency room had difficulty breathing. To maintain her sats, she was ventilated. She was found to have a urinary tract infection and was admitted to ICU. She dropped her blood pressure requiring pressors (a medication used to raise blood pressure). The patient was found to

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have 2 out of 4 blood cultures positive for strep mitis (streptococcus mitis)...She also grew E-coli and Proteus in the urine, penicillin sensitive...."

Resident # 4 was discharged back to the facility on 4/14/17 with diagnoses that included septic shock secondary to urinary tract infection.

A thorough review of Resident # 4's clinical record failed to reveal the results of the UA ordered on 3/13/17. At approximately 1:00 p.m. on 5/8/17, at the request of the surveyor, LPN # 2 (Licensed Practical Nurse) was able to obtain a copy of the UA results via Fax from the laboratory that processed the urine sample. According to the UA report, dated 3/14/17, the results indicated Resident # 4 had a UTI. Asked if the resident's attending physician was notified of the UA results, LPN # 2 said, "He was not notified."

LPN # 2 was also asked about EOS. LPN # 2 explained that EOS is a protocol and stands for Enhanced Observation Order Set for suspected UTI. According to a blank copy of the EOS furnished by LPN # 2, the protocol included the following:

"1) Obtain vital signs (BP, pulse, resp rate, temp, pulse ox) every 6 hours for 3 days.
2) Record fluid intake each shift for 3 days.
3) Notify medical director or provider on call if fluid intake is less than 1600 ml per day.
4) Notify the medical director or on-call provider if condition worsens or if no improvement by the next morning.
5) Contact the medical director or on-call provider with an update on the resident's condition daily."

Asked if the EOS protocol was initiated for

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Resident # 4, LPN # 2 replied "No."

At approximately 2:30 p.m. on 5/3/17, an interview was conducted with Resident # 4. The resident immediately began speaking about her recent hospitalization. "I was a RN (Registered Nurse) for 27 years," Resident # 4 said, "if I tell you I'm having trouble with something, follow up." The resident went on to say she complained she had a UTI for four or five days, that she had pain and pressure when she voided. "(Name of the PA) ordered Pyridium. It got rid of the pain and pressure, but it did not get rid of the UTI."

The resident said she continued to complain. "I went to the ADON (Assistant Director of Nursing) and the Unit Manager. They didn't act." Resident # 4 went on to say that, "I was in the bathroom and I felt faint. I called out 'Help me, help me, I can't breathe.' That's all I remember. The next thing I know I was in the hospital. I was intubated and put on IV (intravenous) meds." The resident went on to say, "When I got back, (name of PA) said, 'We thought we were going to lose you.' "

Continuing, Resident # 4 said, "This is not the first time this (a UTI) has happened, but it's the first time I ended up in the hospital. They (staff) should know by now when I complain something is wrong, they need to follow up. A lot of the staff just don't listen, not just now, but always."

The findings were discussed at a meeting at 3:00 p.m. on 5/8/17 with the Interim Administrator, Director of Nursing, Corporate Nurse Consultant, and the survey team.

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2. Resident #21's catheter was not changed monthly as ordered; the resident developed a catheter induced urinary tract infection resulting in harm.

Resident #21 was originally admitted to the facility on 1/8/16 and readmitted on 1/9/17 with, but not limited to, the following diagnoses: urine retention, vaginal fistula, unspecified ileus and quadriplegia related to a C5-C6 injury. The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/14/17 was a quarterly assessment. The resident was assessed as being a fifteen (15) for cognitive skills; able to make needs known and independent in decision-making skills.

On 5/8/17 at approximately 11:30 a.m., Resident #21's clinical record was reviewed to include the following:

A Physician's Order Sheet (POS) dated 12/31/16 an order was written on the POS on 10/10/16 as follows: Treatments: 10/10/16 Change 14F (french) (Size) foley every month on the 1st of each month and as needed..."

The Treatment Administration Records were reviewed to include the following: "Change catheter (Foley) monthly..." Upon review of the November and December TARs, the Foley was documented as being last changed on 11/30/16.

A care plan initiated on 4/13/16 and updated on 10/20/16 was reviewed to include the following: "Focus: The resident has altered bladder elimination r/t indwelling catheter...Interventions:

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Cath care as ordered and prn (as needed)."

A hospital Discharge Summary dated 1/9/17 was reviewed to include the following:

"Discharge Diagnoses: 1. Catheter -associated urinary tract infection...9. Chronic Foley...History: ...resident of a local nursing care facility who presented with nausea, vomiting, and urinary tract infection. She reported that her catheter has not been changed for some time. Urinalysis was consistent with UTI and she was admitted. Hospital Course: On admission, Foley was removed and replaced. She was empirically started on Rocephin. Her leukocytosis resolved and she rapidly improved...The plan is to empirically treat with ongoing antibiotics to finish out a 7-day course."

"Assessment and Plan: Problems: (1) Complicated UTI (urinary tract infection) A&P: Has chronic Foley which had not been changed since 11/16, changed in ED (emergency department)..."

On 5/8/17 at approximately 1:34 p.m., the administrative staff was made aware of the above findings. The facility staff involved in the above findings were not available for interview. Two of the employees were called multiple times on 5/8/17 at 3:20 p.m. and again at 5:24 p.m., but to no avail. The remainder of the staff involved were no longer employed at the facility.

During the course of the survey from 5/2/17 through 5/9/17, no other information was provided regarding the Foley catheter being changed as ordered.

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3. Facility staff did not follow physician orders regarding the care of Resident #7's supra-pubic catheter. Facility staff were to provide catheter care every shift and clean around the catheter with dermal wound cleanser, paint betadine around catheter every day. During an interview with Resident #7 he stated that he was providing his own catheter care and had all the supplies in his bedside table.

Resident #7 was admitted to the facility on 04/28/2017. His diagnoses included, but were not limited to: paraplegia (incomplete), MRSA (methicillin-resistant staphylococcus aureus), anxiety, neurogenic bladder, chronic pain, urinary tract infection, and a history of DVT (deep vein thrombosis) with a filter.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 03/20/2017. Resident #7 was assessed as being cognitively intact with a cognitive summary score of "15".

On 05/02/2017 at approximately 3:00 p.m., Resident #7 was interviewed regarding his care at the facility. In the course of the discussion, Resident #7 was asked about his suprapubic catheter care. He stated, "I do that myself...I have all the supplies here in my drawer."

The clinical record was reviewed. The following orders were observed on the POS (physician order sheet) dated 05/01/2017 through 06/30/2017: "Catheter care every shift" and "...Cleanse area around catheter with dermal

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| F 315 | Continued From page 110<br>wound cleanser, paint betadine around catheter every day."<br><br>At approximately, 3:30 p.m., LPN (licensed practical nurse) #2 was interviewed. She was asked if Resident #7 was providing his own catheter care. She stated, "No, we do that." LPN #2 was told that Resident #7 had his supplies in his bedside table for catheter care and had stated that he was doing it himself. The TAR (Treatment administration record) was reviewed for April. All of the entries for the catheter care and cleaning were wither circled as not done or left blank. LPN #2 was asked what the entries meant. She stated, "It looks like it wasn't done." There were no entries on the back of the TAR explaining why the care had not been done. She was asked if an order was needed for Residents to provide their own care and to have items needed at their bedside table. She stated, "Yes, and he should be assessed to determine if he can do it properly."<br><br>The above information was discussed during a meeting with the administrator and the DON (director of nursing) on 05/03/2017.<br><br>No further information was obtained prior to the exit conference on 05/09/2017. | F 315 | | |
| F 323 SS=D | 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>(d) Accidents.<br>The facility must ensure that -<br><br>(1) The resident environment remains as free from accident hazards as is possible; and<br><br>(2) Each resident receives adequate supervision | F 323 | F323: Free of Accidents and Hazards<br><br>1. Resident #20 has been placed on restorative dining for cuing during meals. No straw order remains in place. Physician order remains in place for checking oral cavity for residual after meals/medications. | 06/23/17 |

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| F 323 | Continued From page 111 | F 323 | 2. Quality Reviews of residents requiring cueing during meal service and restricted use of straws. Follow up based on findings. | |

and assistance devices to prevent accidents.

(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.

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

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

(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review and in the course of a complaint investigation, the facility staff failed to ensure physician ordered one to one assistance for by mouth intake and restrictions regarding the use of straws were in place for one of 25 residents, Resident #20.

Resident #20 was not assisted with food and drink as ordered by the physician. Orders on the physician order sheet were: "...continues to require 1:1 assistance for by mouth intake- do not feed patient unless patient is alert-check oral cavity for residue at end of meals/meds." An additional order, "No straws" was also on the physician order sheet. Resident #20 was observed on 05/04/2017 and 05/08/2017 in his room with cups of fluid on his bedside table and a straw in his large water cup. On 05/08/2017,

3. Licensed nurses and C.N.A's re-educated by the Director of Clinical Services (DCS)/designee regarding following resident's dietary restrictions during meal service per physician order. Licensed nurses and C.N.A's re-educated by the Director of Clinical Services (DCS)/designee regarding providing residents' assistance with meals per plan of care.
4. DCS/designee to conduct quality reviews during meal services for following resident's dietary restrictions per physician orders 2 times weekly x 4 weeks, weekly x 4 weeks, 2 x monthly, PRN and as indicated. DCS/designee to conduct quality review 5 times per week X 2 weeks then weekly X 2 weeks then weekly X 4 weeks then monthly and PRN during meal services to ensure residents are provided assistance per plan of care.. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.

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Resident #20 was also observed eating a peanut butter and jelly sandwich, a banana, and a carton of milk with a straw in his room without staff present. On 05/08/2017, Resident #20 was observed in the dining room with his tray. There were no staff providing assistance to him.

Findings were:

Resident #20 was most recently readmitted to the facility on 12/21/2016. His diagnoses included but were not limited to: Dementia, Hypertension, acute kidney injury and dysphagia.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 03/30/2017. Resident #20 was assessed as having a cognitive summary score of "09", indicating moderate impairment with his cognitive status.

On 05/04/2017 the clinical record was reviewed. Observed on the POS (physician order sheet) dated 04/01/2017 through 05/31/2017 was the following orders: "Pt [patient] continues to require 1:1 assistance for by mouth intake- do not feed patient unless patient is alert-check oral cavity for residue at end of meals/meds" and "No straws".

On 05/04/2017 at 2:15 p.m., Resident #20 was observed sitting alone in his room. Beside him on his bedside table was a coffee cup with napkins stuffed inside, an empty cup used for med pass, and a large covered water cup with a straw. Resident #20 was asked if the items on the table belonged to him. He stated, "Yes, I just finished my coffee, that one (pointing to the med pass cup) is the stuff the nurse gave me to drink and that's my water."

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This surveyor went to the nurse giving medications, LPN (Licensed practical nurse) #7 and inquired about the med pass cup in his room. She stated, "I gave that to him when it was scheduled, he always drinks it all." She was asked why the cup was still in his room. She stated, "I watched him drink it."

On 05/08/2017, at 10:15 a.m., Resident #20 was observed sitting in his room. Beside him on the bedside table was a cup of coffee containing liquid, an opened bottle of Coca-Cola, and a large covered water cup with a straw. Resident #20 was asked if the items on the table were his. He stated, "Yes." Resident #20 also stated that he was hungry and would like a snack.

The unit manager, LPN #1 was at the nurse's station. This surveyor told her that Resident #20 was hungry and had requested a snack.

At 10:25 a.m., LPN #1 took a half of a peanut butter and jelly sandwich, a banana, and a carton of milk to Resident #20. She opened the milk for him and placed a straw in the carton. She asked him if he needed any further assistance and left the room.

At 10:30 a.m., Resident #20 was observed eating the sandwich, and drinking his milk with the straw. There was no one in the room with him or in the vicinity outside of his room. This surveyor went back to the nurse's station and re-reviewed the chart. The orders for 1:1 assistance with meals and the direction for the resident to not have a straw had not been discontinued. LPN #1 was at the nurse's station. She was asked if the orders were still in effect. She looked at the

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record and stated, "I will go back down there." LPN #1 was asked if she had been aware of the orders. She stated, "No."

On 05/08/2017 at noon, Resident #20 was observed in the restorative dining room. He was seated alone at a table with his back to the door. One CNA (certified nursing assistant) was in the room with him. She was at the opposite end of the room with her back to Resident #20, and was braiding another resident's hair. Resident #20 was feeding himself lunch and he had a straw.

LPN # 5 was seated at the nurse's station where Resident #20 resided. She was asked if Resident #20 was on restorative dining. She stated she would look. She reported back to this surveyor that he was not and just liked to eat in there.

At 12:40 p.m., on 05/08/2017 the speech therapist who had worked with Resident #20 was interviewed. She stated, "I made the recommendation about him receiving assistance with meals and not to have straws....we think he is having TIAs (transient ischemic attacks-mini strokes)..we can't do the testing for that to be sure because he has a pacemaker...his mentation because of that fluctuates from day to day...if he is having a bad day then he needs the 1:1, on good days, like today he is okay to eat and drink alone." She was asked about the straws. She stated, "There is a risk of aspiration for him when he uses a straw...the fluids have a tendency to go down the wrong way." She was asked if that was dependant on his alertness. She stated, "No, he should never have a straw."

A meeting was held with the DON (director of nursing), the administrator, and the regional

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| F 323 | Continued From page 115<br>nurse consultant on 05/08/2017 at approximately 12:45 p.m., and the following information was discussed.<br><br>On 05/08/2017 at approximately 3:30 p.m., LPN #5 brought a clarification order to this surveyor. The new order was: "...Pt to receive skilled ST eval/tx [evaluation/treatment] 5 times/treatments over 2 wks [weeks] for oropharyngeal dysphagia. SLP (speech language pathologist) recommends pt receives mech [mechanical] soft solids, thin liquids, NO STRAWS, as safest, least-restrictive diet." LPN #5 was asked if that meant Resident #20 could eat without 1:1 assistance. She stated, "No."<br><br>No further information was received prior to the exit conference on 05/09/2017.<br><br>This is a complaint deficiency. | F 323 | | |
| F 332 SS=D | 483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE<br><br>(f) Medication Errors. The facility must ensure that its-<br><br>(1) Medication error rates are not 5 percent or greater;<br>This REQUIREMENT is not met as evidenced by:<br>Based on medication administration observation, staff interview, facility document review and clinical record review, facility staff failed to ensure a medication error rate less than 5%.<br><br>Out of 40 opportunities, four errors were identified resulting in a 10% medication administration error rate. | F 332 | F332: Free of Medication Error Rates of 5% Or More<br><br>1. LPN #3 no longer works at the facility. Resident #12 has physician clarification order for multivitamin and minerals on 05/03/17. Resident receives multivitamin with minerals per manufacturer's recommendations. Do not crush medications are administered without crushing. Resident #12 receives medications within acceptable window. | 06/23/17 |

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| F 332 | Continued From page 116<br><br>Resident #12 was to receive Omeprazole DR (delayed release) and Oxybutin ER (extended release) with her medications. Both of these medications were crushed against manufacturer recommendation.<br><br>Resident #12 received the wrong Multivitamin per physician order and Resident #12 received her 8:00 a.m. medications at 10:25 a.m., one hour and 25 minutes past the acceptable window of receiving these medications.<br><br>Findings included:<br><br>On 05/03/17 at 8:00 a.m. this surveyor observed medication administration with LPN #3 (licensed practical nurse). LPN #3 prepared all medications for Resident #12 outside of Resident #12's room. During this preparation LPN #3 used hand sanitizer, coughed and stated, "I'm a little sickly today." LPN #3 proceeded to drop an aspirin out of the house stock bottle onto the cart, picked up the aspirin with her bare hands and placed into the medication cup. LPN #3 then removed all capsules from the pills with her bare hands, opened the capsules bare handed and poured into the crushed meds. Resident #12 was to receive Omeprazole DR (delayed release) and Oxybutin ER (extended release) with her medications. both of these medications were crushed against manufacturer recommendation. Resident #12 was eating breakfast. LPN #3 stated, "She is still eating her breakfast. I'm not going to interrupt her meal." LPN #3 wasted all of the prepared meds for Resident #12.<br><br>At 10:25 a.m. LPN #3 prepared the medications for Resident #12 again, crushed all meds and | F 332 | 2. Licensed nurses monitored by Consultant Nurse/desginee for following infection control practices during preparation of medication completed. Consultant Pharmacy Nurse / Designee to conduct medication skills competencies/ observation as indicated. Follow up based on findings. Medication administration times adjusted per physician order to ensure medications are administered per order within the acceptable time frame per regulation completed.<br>3. Licensed Nurses re-educated by the Director of Clinical Services (DCS) / Designee regarding following infection control practices during preparation of medications. Licensed nurses re-educated regarding administering medication per physician order and within acceptable time frame per regulation and in accordance with the the 5 R's of medication administration.. List of Do not crush medications placed in the front of each MAR. | |

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| F 332 | Continued From page 117 | F 332 | 4. DCS/Designee to conduct random quality monitoring of Licensed Nurses regarding following infection control practices during preparation of medication(s) twice weekly x 4 weeks, weekly times 4 weeks then monthly, PRN and as indicated. DCS/Designee to conduct random quality monitoring of Licensed Nurses regarding administration of medications within acceptable time frame per regulation twice weekly x 4 weeks, weekly times 4 weeks then monthly, PRN and as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. | |

opened capsules with her bare hands and administered to this resident. Resident #12 had a physician order for Thera-M 9mg-400mcg one orally everyday. LPN #3 stated, "I do not see this in the house stock. I will have to ask and see what they have been using." At 10:25 a.m., LPN #3 administered a "Multi Vitamin with Minerals-Dietary Supplement" to Resident #12. LPN #3 stated, "Per the unit director this is what they use for her Thera-M."

The label on the bottle of Multiple Vitamin with Minerals - Dietary Supplement included the following: "Vit. A 5000 IU, Vit. C 50 mg, Vit D3 400 IU, Thiamine 2 mg, Riboflavin 2.5 mg, Niacin 20 mg, Vit. B6 1 mg, Vit. B12 1 mcg, Pantothenic Acid 1 mg, Calcium 15.8 mg, Iron 4.5 mg, Phosphorus 11.6 mg, Iodine 150 mcg, Magnesium 10 mg, Zinc 3.75 mg, Selenium 5 mcg, Manganese 1 mg and Chromium 5 mcg." There is no dosage equivalent to 9mg-400mcg of anything on the label.

LPN #3 prepared medications for Resident #13. LPN #3 popped a Cogentin, Metoprolol, Geodon and Gabapentin from the bubble cards into her bare hands and placed into the medication cup. LPN #3 dropped a Buspar onto the med cart, picked up with her bare hand and placed into the med cup. While getting Tylenol tablets from the house stock bottle, LPN #3 poured several tablets into the lid, placed two into the med cup and placed the extra back into the house stock bottle all with her bare hands.

The Administrator and DON (director of nursing) were informed of the above observation during a meeting with the survey team on 05/03/17 at 5:45 p.m. Facility policy for "Medications-Oral

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| F 332 | Continued From page 118<br>Administration Of Effective Date: 11/30/2014.<br>Policy: It is the policy that the resident can expect safe and accurate administration of oral medication. Procedure: ...Refrain from touching powders, capsules or pills with hands...Most medications should not be crushed if they are not scored or if they are enteric coated, or if they are sustained release or long-acting...Wash hands..."<br><br>No further information was received by the survey team prior to the exit conference on 05/09/17. | F 332 | F333: Resident Free of Significant Medication Errors<br>1. Agency Licensed Nurses completed the Agency Orientation Checklist.<br>Medication error report completed for resident #10 per policy. LPN #2 (facility nurse) no longer works in the facility. LPN #3 (agency nurse) no longer works in the facility. Resident #10 currently resides in the facility and has no s/s of adverse effects.<br>At the time of immediacy, current agency nurses present in the facility received immediate orientation by Nursing Administration using the Agency Orientation Checklist, which included administration of medications, pain management and diabetic management.<br>Current schedule was reviewed by the Director of Clinical Services to identify future confirmed pre-scheduled agency personnel requiring orientation, with such orientation being provided using the Agency Orientation Checklist, prior to assumption of Nurse duties. | 06/23/17 |
| F 333 SS=G | 483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS<br><br>483.45(f) Medication Errors.<br><br>The facility must ensure that its-<br><br>(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical record review and in the course of a complaint investigation, facility staff failed to ensure one of 25 residents was free of a significant medication error resulting in harm, Resident #10.<br><br>Facility staff medicated Resident #10 with the wrong dose of Morphine which resulted in altered mental status, decreased oxygen saturations, and aspiration pneumonitis which resulted in an overnight stay at the hospital for opiod overdose.<br><br>Findings included:<br><br>Resident #10 was originally admitted to the facility on 11/19/2011 and readmitted on 04/03/2017 with | F 333 | | |

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| F 333 | Continued From page 119<br>diagnoses including, but not limited to: Paraplegia, Aspiration Pneumonitis, COPD (Chronic Obstructive Pulmonary Disease), Depression, Anxiety, Diabetes, Hypertension, Neurogenic Bladder, and Chronic UTI (Urinary Tract Infection).<br><br>The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 04/10/2017. Resident #10 was assessed as moderately impaired in her cognitive status with a total cognitive score of 10 out of 15.<br><br>Resident #10's clinical record was reviewed on 05/02/2017 at 2:15 p.m. and again on 05/03/2017 at 11:00 a.m. Included in Resident #10's most recent POS (physician order sheet) dated 05/01/17 through 06/30/17 was an order dated 04/03/17 that stated: "...Morphine Sulfate ER 60 MG (milligrams) Tablet ER (extended release) For MS Contin Take 1 (one) Tab by Mouth Every 12 Hours for Pain..." and an order dated 04/04/17 that stated: "...Morphine Sulfate 15 MG Tablet For Morphine Sulfate Take 1 (one) Tab by Mouth every 4 (four) Hours As Needed for Pain..."<br><br>An "Interdisciplinary Progress Note" dated "4-6-17 Late Entry" included the following: "On Sunday 4/2, I took report from (Name) RN, (registered nurse) after I was moved from Unit 4, at aprox 1130 and I noticed around 1pm, (Name) Resident #10 falling asleep reading newspaper. I checked her oxygen level was 88% her O2 was placed on and her oxygen came up to normal levels, after being toileted she requested to go to bed. A little after that around 3 pm her daughter called because she had tried to call her on her cell phone and she did not answer. I reported the change of condition to her daughter, she stated | F 333 | Potential agency placements were scheduled for orientation upon receipt of their credentials by the facility Human Resources Coordinator (HRC). No agency personnel assumed nursing duties until the Agency Orientation Checklist had been completed and received by the HRC. Notification occurred to all contracted agencies of this process on 05/04/17. The Executive Director/designee will review agency files weekly times 4 weeks, then monthly and report to the QAPI committee to ensure compliance with the plan.<br>2. Review of residents receiving pain management completed by DCS/designee to ensure mediations available and administered per physician order.<br>3. Licensed nurses re-educated by the Director of Clinical Services (DCS)/ designee regarding administration of controlled pain medications per physician order. Licensed nurses re-educated by the DCS/designee regarding process for ordering and re-ordering controlled pain .medications from pharmacy. Licensed nurses re-educated by the DCS/ designee regarding eKit and contents | |

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| F 333 | Continued From page 120 | F 333 | 4. DCS/Unit Managers/designee to conduct random quality review of residents receiving controlled pain medication(s) to ensure mediations available and administered per physician order 3 times weekly x 2 weeks, 2 times weekly x 2 weeks, weekly x 4 weeks, then monthly and PRN and as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. | |

'well she doesn't sound right so I will see you in a little bit.' About an hour later she arrived and she spoke with me. I read her the vital signs which I obtained. I reported her temp was elevated and respirations low, and we both agreed that she appeared the same way she had the last time she had a UTI (urinary tract infection), including facial grimacing and she should be sent out to be checked. I read her the last lab result for U/A (urinalysis) C&S (culture and sensitivity) and it was negative for nitrates. I spoke with (Name) transport and they informed me they had no availability until 9:30 p-10 pm. At that time I called (Name) and obtained claim # for transport at aprox 6:50 pm. (Name) Resident #10's daughter had told me that her 'mother had not felt right since she had taken that extra pain pill.' I went to check the MAR (medication administration sheet) and saw the medication error. I also asked (Name) another RN to do a respiratory assessment. At aprox 1915 (7:15 p.m.) the crew was still not here so I called the (unintelligible word) my ride # for (Name) ambulance service. At aprox 1930-1945 (7:30-7:45 p.m.) the crew arrived to transport (Name) Resident #10. (Name) Physician, nursing supervisor, (Name) Hospital ER (emergency room) aware of all health issues of said pt. (patient)."

A second "Interdisciplinary Progress Note" dated "4/2/17 1945" (7:45 p.m.) included the following documentation: "Nurse on front hall asked this nurse to assess lung fields of resident d/t (due to) medication error causing respiratory depression. This nurse auscultated all lung fields noting clear lung sounds w/respirations slow and shallow. Low respiratory count of 10-12 breaths per minute w/ periods of apnea...This nurse advised

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the nurse working front hall to admit resident to ER at (Name) hospital for further evaluation d/t decreased respiratory and the medication given causing the respiratory issues."

History and Physical from the emergency room dated 4/2/17, seen by MD (physician) 21:14 (9:14 p.m.). "...Chief Complaint: Altered Mental State; History of Present Illness: ...She was sent from (Name) nursing home with concern for accidental overdose. Patient reportedly received 60mg (milligrams) long-acting morphine at 9AM and 11AM today. She became less responsive throughout the day and was eventually sent to the ED for evaluation. Patient is unable to provide and history and at best grimaces to pain...Differential Diagnosis: After history and physical exam a differential diagnosis was considered, but was not limited to narcotic overdose...ED Course/Procedures: Patient is a 76-year old female who presents from nursing facility with concern for accidental narcotic overdose. She is somnolent on arrival and, at best, grimaces to sternal rub... Primary Diagnosis: Sepsis; Secondary Diagnosis: Pneumonia, urinary tract infection, acute encephalopathy; Condition: Guarded; Disposition: Admitted to (Initials) hospital from ED..."

Hospitalist H&P dated 04/03/17 0312 (3:12 a.m.) "HPI: ....presented to the ED from her nursing facility after she was found to be progressively somnolent.

Briefly, the patient appears to have been in her usual state of health until earlier in the day when she inadvertently received twice the dose of her long-acting morphine which she takes for her

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chronic pain. It appears that she received 60 mg at 9 AM and a second dose of 60 in lieu of a as needed dose of her immediate release morphine at 11 AM. She was then noted to become increasingly somnolent and less responsive and so was sent to the emergency room...Assessment and Plan: (1) Sepsis: The patient presented with fever and leukocytosis of 17,000 in the setting of some mild hypoxia and what appears to be right lower lobe infiltrate meeting criteria for sepsis. At this time I still suspect that her source is pulmonary and further have clinical suspicion that the patient may have aspirated following and inadvertent morphine overdose resulting in an aspiration pneumonitis... (2) Aspiration pneumonitis: The patient has apparent right lower lobe airspace disease which in the setting of her presentation I believe represents a chemical aspiration pneumonitis... (4) Acute encephalopathy: The patient was reportedly increasingly somnolent at the nursing facility however upon evaluation she is awake, alert and oriented x3 and so I believe that her acute encephalopathy was due to an inadvertent morphine overdose which is now resolved..."

Nursing Facility H&P dated 4/4/17 1611 (4:11 p.m.), signed by the physician.
"Assessment/Plan: (1) Toxic encephalopathy (2) Aspiration pneumonitis...Discussion: I saw the patient today to readmitted to our facility after a hospitalization for urinary tract infection, aspiration pneumonitis, and unintentional opiod overdose. The day prior to admission, the patient received 120 mg of extended release morphine, which was an extra dose, instead of her 15 mg breakthrough dose. This resulted in lethargy and some respiratory depression, and she was sent to the emergency department. There, she was

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| F 333 | Continued From page 123 | F 333 | | |

found have aspiration pneumonitis..."

A "Medication Error Report" dated 4/2/17 1105 AM included, "Medication as ordered: prn Morphine 15mg po (orally) Description of error...PRN Order for Morphine 15mg; took 60mg tablet instead...Outcome to resident and care provided: Resident had a change to respiratory/alertness status. Sent to hospital and admitted for sepsis...Type of Error: Wrong dose; Reason for Error: Misread error..." Signed by RN that administered wrong medication and dose of morphine.

The Administrator was asked for a copy of any investigation regarding the above incident. The investigation was received by this surveyor. The Administrator stated, "She was given the wrong dose of her morphine and when the error was realized we sent her to the emergency room." Included in the investigation was the policy, "Adverse Drug Reactions & Medication Discrepancy; Effective Date: 11/30/2014; Policy: Medication discrepancies and adverse drug reactions are documented and reported. Medication discrepancy refers to: a) Failure to administer, b) Administered at the wrong time, c) Administered wrong amount of medication, d) Administered to wrong resident, e) Administered through wrong route, f) Administered the wrong Medication. Adverse reaction refers to an unintended/undesirable effect that occurs as a result of giving a medication..."

Fundamentals of Nursing 6th Edition on page 841 states concerning medication administration, "Standards are those actions that ensure safe nursing practice. To ensure safe medication administration the nurse should be aware of a

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| F 333 | Continued From page 124<br>nursing standard called the six rights of medication administration. All medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication 2. The right dose 3. The right client 4. The right route 5. The right time 6. The right documentation." (1)<br><br>No further information was received by the survey team prior to the exit conference on 05/09/17.<br><br>This is a complaint deficiency.<br><br>(1) Potter, Patricia A. and Perry, Anne G. Fundamentals of Nursing. St. Louis: Mosby, 2005. | F 333 | | |
| F 360 SS=D | 483.60 PROVIDED DIET MEETS NEEDS OF EACH RESIDENT<br><br>The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident interview, staff interview, clinical record review and in the course of a complaint investigation, the facility staff failed to honor dietary preferences and follow dietary orders for one of 25 residents in the survey sample: Resident # 9.<br><br>Findings include:<br><br>Resident # 9 was admitted to the facility 1/25/16 | F 360 | F360: Provided Diet Meets Needs of Each Resident<br><br>1. Resident #9 receives milk on tray. Resident discharged on 05/31/17. Prior to discharge resident received milk per dietary preferences from 05/03/17 until the discharge.<br>2. Residents to be interviewed ensuring preferences are being honored completed. Quality review of dietary the tray card system and dietary communication form to ensure resident preferences are being honored completed. | 06/23/17 |

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| F 360 | Continued From page 125 | F 360 | 3. Licensed Nurses re-educated by the Director of Clinical Services (DCS) / designee regarding ensuring diets are provided per physician order. Licensed Nurses re-educated by the DCS/designee regarding ensuring dietary communication form matches current physician orders. Dietary staff re-educated by the DCS regarding obtaining and ensuring resident's preferences are honored. Dietary staff re-educated by the DCS regarding ensuring diet preferences are honored and reflected on the diet slip. Facility staff are re-educated by the DCS regarding honoring resident requests/preferences. | |

with a readmission date of 2/15/17. The admission MDS (minimum data set) dated 2/22/17 assessed Resident # 9 as cognitively intact.

During an interview with Resident # 9 5/2/17 at 1:45 p.m. he commented during the portion of the interview pertaining to food that he doesn't get milk on his meal trays. Resident # 9 went on to say "I asked the CNA (certified nursing assistant) why I wasn't getting a milk carton on my tray, and she told me I wasn't supposed to have it. I always ask for two fudge rounds and two milks for snack at night, and I get it, so I don't see why I can't have it at lunch." This surveyor told the resident I would see if I could find out what was going on.

The clinical record was reviewed 5/2/17 at 4:15 p.m. In the front section of the record there two dietary communication forms. One was dated 2/15/17 and included an order for "Mechanical soft diet, thin liquids, water only." The other form was dated 2/28/17 and directed "Diet modification. Pt to receive mechanical soft solids, thin liquids. Pt may have liquids other than water." LPN (licensed practical nurse) # 5 was sitting at the nurses' station, and this surveyor relayed what Resident # 9 had stated about milk. LPN # 9 stated she wasn't sure what was going on, but before she could speak further, the Registered Dietitian (RD) for the facility spoke up and stated "I think I can help you clear that up." The RD then reviewed the two forms and stated "He clearly can have milk if he wants it; let me go see what I can find out from the kitchen." A few minutes later, the RD returned to the nurses' station and told this surveyor "This dietary communication form got overlooked; it was still in

4. Registered Dietitian/Certified dietary manager/DCS/designee to review resident's diet ensuring preferences are being honored 3 times weekly x 2 weeks, 2 times weekly x 2 weeks, weekly x 2 weeks, PRN and as indicated. Registered Dietitian/Certified dietary manager/DCS/ designee review current diets to ensure meals are being provided per physician order 3 times weekly x 2 weeks, 2 times weekly x 2 weeks, weekly x 2 weeks, PRN and as indicated. Registered Dietitian/ Certified dietary manager/DCS/designee review resident's diet to ensure dietary communication form and tray ticket match per physician order 3 times weekly x 2 weeks, 2 times weekly x 2 weeks, weekly x 2 weeks, PRN and as indicated.

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| F 360 | Continued From page 126<br>the box, but the new order never got instituted..... we have fixed that now and he will start getting milk on his meal trays."<br><br>The administrator, DON (director of nursing), and regional nurse consultant were informed of the above findings 5/9/17 during a meeting with facility staff beginning at 1:30 p.m.<br><br>No further information was provided prior to the exit conference. | F 360 | Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. | |
| F 406 SS=D | THIS IS A COMPLAINT DEFICIENCY.<br>483.65(a)(1)(2) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES<br><br>(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must-<br><br>(1) Provide the required services; or<br><br>(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, resident interview, and | F 406 | F406: Provide / Obtain Specialized Rehab Services<br><br>1. Resident #21 no longer resides in the facility.<br>2. Review of residents discharged from Speech Therapy previous 30 days to ensure resident(s) received proper notification of discontinuation of services. Review of residents discharged from Speech Therapy previous 30 days to ensure services were appropriately and safely discontinued per resident's plan of care completed. | 06/23/17 |

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| F 406 | Continued From page 127<br>clinical record review, the facility staff failed to ensure specialized services were provided for one of 25 residents, Resident #21.<br><br>Resident #21's Speech therapy was discontinued without the resident's knowledge and before therapy services were exhausted by the facility's administrator.<br><br>The findings include:<br><br>Resident #21 was originally admitted to the facility on 1/8/16 and readmitted on 1/9/17 with, but not limited to, the following diagnoses: urine retention, vaginal fistula, unspecified ileus and quadriplegia related to a C5-C6 injury. The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/14/17 was a quarterly assessment. The resident was assessed as being a fifteen (15) for cognitive skills; able to make needs known and independent in decision-making skills.<br><br>On 5/8/17 at approximately 12:35 p.m. during an interview with Resident #21, the resident stated that her "therapy services were discontinued without prior notice and before her therapy services were exhausted." Resident #21 stated that upon return to the facility from the hospital she was told that her Speech therapy would no longer be available to her. When interviewed and asked the reason she was receiving Speech therapy, Resident #21 stated, "I was getting it for swallowing, and voice retraining because of the C5- C6 spinal cord injury."<br><br>On 5/8/17 at approximately 12: 40 p.m., the Speech therapist who will be identified as Other Staff (OS) #4 was interviewed regarding the | F 406 | 3. Therapy staff and Executive Director re-educated regarding proper notification of discontinuation of Speech Therapy services and ensuring services were appropriately and safely discontinued per resident's plan of care.<br>4. Therapy Director/Designee to review and discuss with IDT team through weekly Utilization Review Meeting residents receiving Speech Therapy services to ensure specialized services are delivered per resident's plan of care and/or resident(s) received proper notification of discontinuation of services. Therapy Director/Designee to conduct quality monitoring weekly, PRN and as indicated to ensure residents receive specialized services are delivered per resident's plan of care along with proper notification of discontinuation of services. Executive Director (ED) to conduct random quality monitoring monthly to ensure compliance specialized services are delivered per resident's plan of care and/or resident(s) received proper notification of discontinuation of services. Findings to be reported to QAPI committee monthly and updated as indicated. | |

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resident being discharged from Speech therapy. OS #4 stated, "I was told to discharge her from therapy from the administrator due to the allegation of abuse of drugs. When interviewed and asked the correlation of the resident receiving Speech and drug abuse, OS #4 stated, "I don't know I was just doing what I was told.

On 5/8/17 at approximately 4:30 p.m., Resident #21's Speech Therapy (ST) Discharge Summary was reviewed to include the following:

"Date of Service: 11/9/16-1/14/17 Supervision/ Justification / Communication: Justification for Skilled Services: Skilled ST intervention was necessary to provide skilled evaluation and treatment of pt's voice skills secondary to pt with new onset decline in vocal function following spinal abscess on C5-C6. Due to pt's complex medical status, skilled ST services necessary to update pt's personalized POC (plan of care) to address pt's disordered vocal function in order to improve pt's vocal function, pulmonary toilet efficiency, and expressive communication and reduce pt's risk of physical injury and vocal pathologies. Without skilled ST intervention and tx, pt was at increased risk of pneumonia, increased weakness, weight loss, skin breakdown, reduced benefit from therapeutic medication, reduced ability to communicate needs wants and medical symptoms, vocal pathology, reduced participation in social and occupational settings, reduced quality of life, rehospitalization and physical injury..."

On 5/8/17 at approximately 5:12 p.m., OS #4 was interviewed regarding the Discharge Summary from ST and asked, after reading the Supervision, Justification, and Communication

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| F 406 | Continued From page 129<br>note, if the resident was ready for discharge from ST. OS #4 stated, "I did not feel she was ready for discharge but I was doing what I was told by the administrator (sic)."<br><br>On 5/9/17 at approximately 1:34 p.m., the administrative staff were made aware of the above findings. | F 406 | | |
| F 425 SS=G | 483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH<br><br>(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.<br><br>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--<br><br>(1) Provides consultation on all aspects of the provision of pharmacy services in the facility;<br>This REQUIREMENT is not met as evidenced by:<br>Based on family interview, staff interview, clinical record review and in the course of a complaint investigation, facility staff failed to ensure medications were available for administration for one of 25 residents in the survey sample, Resident #10 resulting in harm.<br><br>1a) Facility staff failed to administer long acting morphine per physician order resulting in withdrawal symptoms and subsequent harm due to unavailability of the medication.<br><br>1b) Resident #10 had a physician order for | F 425 | F425: Pharmaceutical SVC-Accurate Procedures<br><br>1. Resident #10 Hard script obtained for Morphine, received from pharmacy and currently available. Resident #10 received Morphine per physician order. Resident #10 Nystatin Swish and Swallow administered 5/5-5/9 2017per physician order.<br>2 Review of residents receiving controlled pain medication(s) completed by DCS/designee to ensure medication available and administered per physician order completed. Review of residents receiving Nystatin Swish and Swallow to ensure medications available and administered per physician order completed. | 06/23/17 |

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| F 425 | Continued From page 130<br>Nystatin Swish and Swallow ordered on 05/01/17. As of 05/04/17, Resident #10 had not received any doses of the ordered Nystatin.<br><br>The findings include:<br><br>1a) Facility staff failed to administer long acting morphine per physician order resulting in withdrawal symptoms and subsequent harm due to unavailability of the medication.<br><br>Resident #10 was originally admitted to the facility on 11/19/2011 and readmitted on 04/03/2017 with diagnoses including, but not limited to: Paraplegia, Aspiration Pneumonitis, COPD (Chronic Obstructive Pulmonary Disease), Depression, Anxiety, Diabetes, Hypertension, Neurogenic Bladder, and Chronic UTI (Urinary Tract Infection).<br><br>The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 04/10/2017. Resident #10 was assessed as moderately impaired in her cognitive status with a total cognitive score of 10 out of 15.<br><br>Resident #10's clinical record was reviewed on 05/02/2017 at 2:15 p.m. The most recent POS (physician order sheet) dated 05/01/17 through 06/30/17 included the following order dated 04/03/17 that stated: "...Morphine Sulfate ER 60 MG (milligrams) Tablet ER (extended release) For MS Contin Take 1 (one) Tab by Mouth Every 12 Hours for Pain..." and an order dated 04/04/17 that stated: "...Morphine Sulfate 15 MG Tablet For Morphine Sulfate Take 1 (one) Tab by Mouth every 4 (four) Hours As Needed for Pain..." | F 425 | 3. Licensed nurses re-educated by the Director of Clinical Services (DCS)/ designee regarding administration of controlled pain medications per physician order. Licensed nurses re-educated by the DCS/designee regarding process for ordering and re-ordering controlled pain medications from pharmacy. Licensed nurses re-educated by the Director of Clinical Services (DCS)/designee regarding administration of Nystatin Swish and Swallow per physician order. Licensed nurses re-educated by the DCS/ designee regarding eKit and contents.<br>4. DCS/Unit Managers/designee to conduct random quality review of residents receiving controlled pain management to ensure mediations available and administered per physician order 3 times weekly x 2 weeks, 2 times weekly x 2 weeks, weekly x 4 weeks, then monthly and PRN and as indicated. DCS/ Unit Managers/designee to conduct random quality review of residents receiving Nystatin Swish and Swallow to ensure mediations available and administered per physician order 3 times weekly x 2 weeks, 2 times weekly x 2 weeks, weekly x 4 weeks, PRN and as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings | |

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Review of the MARS (medication administration sheets) for Resident #10 included documentation that Resident #10 did not receive a dose of Morphine Sulfate 60mg ER on 04/30/17 at 8:00 a.m. or 8:00 p.m. and also did not receive a dose on 05/01/17 at 8:00 a.m. The first dose the resident received since 04/29/17 at 8:00 p.m. was on 05/01/17 at approximately 10:00 p.m.

Resident #10 was administered Morphine 15 MG by mouth on 04/29/17 at 7:40 p.m., 04/30/17 at 2:10 a.m. and 9:00 p.m. She received no other prn (as needed) doses according to documentation on the MAR. Resident #10 also received Vistaril 25 MG on 04/30/17 at 1:00 p.m. for anxiety.

Resident #10's daughter was interviewed on 05/03/17 at 1:35 p.m. per her request. During this conversation Resident #10's daughter stated, "...On Friday 4/28 a hard script was needed for Mom's Morphine 60 MG every 12 hours. She missed a dose on Saturday, 4/29 at 8:00 p.m., Sunday, 4/30 at 8:00 a.m., 8:00 p.m., and a dose on Monday, 05/01 at 8:00 a.m. (Name) the PA (physician assistant) gave the nurse a prescription at 10:30 a.m. on Monday, 05/01. The medicine came from the pharmacy at 10:30 p.m. Monday night. Her Monday bedtime dose was late. I spoke with the Sunday nurse working 7A-7P and she would not call the doctor. Nurse stated, 'Another doctor will not write a prescription for Morphine.' I, myself called the on-call doctor Sunday evening around 10:00 p.m. The on-call doctor was going to call the nurse at the facility to make sure Mom's Morphine would be delivered on Monday. The nurse working didn't know who the Administrator on-call was for the weekend. They gave Mom her prn Morphine over the

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weekend every four hours when she would take it. Mom called me Sunday evening, crying and stated: "I can't take this pain much longer.'"

LPN #1 (licensed practical nurse) was interviewed on 05/03/17 at approximately 2:00 p.m. regarding the missed Morphine Sulfate ER doses. LPN #1 stated, "A hard script was needed on Friday and not obtained. She (Resident #10) ran out of Morphine over the weekend."

The Medical Director confirmed Resident #10 went into withdrawal from not having her long acting Morphine over the weekend during a conversation with this surveyor on 05/03/17 at approximately 3:00 p.m.

Resident #10 was interviewed on 05/08/17 at 10:30 a.m. Resident #10 stated, "I ran out of my long acting Morphine that weekend. My legs hurt so bad, they had constant pain, then turned to constant tingling up into my thighs. It was miserable. I didn't a take a lot of the other Morphine because it didn't help."

The Administrator and DON (director of nursing) were informed of the above during a meeting with the survey team on 05/03/17 at 5:45 p.m. The DON stated, "The hard script should have been obtained on Friday and the medicine ordered from the pharmacy and received at the facility before (Name) Resident #10 ran out of medicine. I don't know how that happened."

This is a complaint deficiency.

1b) Resident #10 had a physician order for Nystatin Swish and Swallow ordered on 05/01/17.

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As of 05/04/17, Resident #10 had not received any doses of the ordered Nystatin.

During review of Resident #10's clinical record on 05/03/17 at approximately 11:00 a.m., a physician telephone order was noted that stated, "5-1-17 1213 (12:13 p.m.) Nystatin Oral Suspension 100,000 units po (orally) tid (three times daily) x (times) 7 days. May swish and swallow. Indication: Thrush."

During an interview with Resident #10's daughter on 05/03/17 at 1:35 p.m., the daughter mentioned her Mother had been ordered medicine for thrush a couple of days ago, but she hadn't received any. Review of the May 2017 MAR (medication administration record) revealed Resident #10 had not received any doses of the Nystatin Oral Suspension.

On 05/04/17 at 8:35 a.m., LPN #1 (licensed practical nurse) was interviewed regarding Resident #10's Nystatin. LPN #1 stated, "I spoke with the pharmacy and they said they called here on Tuesday asking for an order clarification, needing the amount of cc's (cubic centimeters) to dispense. They sent Nystatin last night, but sent cream not the swish and swallow. I have called the pharmacy this morning and they are sending out Nystatin swish and swallow out of the stat pharmacy."

The Administrator and DON (director of nursing) were informed of the above information during a meeting with the survey team on 05/09/17 at approximately 1:35 p.m. No further information was received prior to the exit conference on 05/09/17.

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| F 441 | Continued From page 134 | F 441 | | |
| F 441 SS=D | 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);<br><br>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br><br>(iv) When and how isolation should be used for a resident; including but not limited to: | F 441 | F441: Infection Control Prevent Spread, Linens<br><br>1. LPN #3 was re-educated regarding following infection control practices during medication pass. Resident #12 received her medication per physician order and did not suffer and s/s of infection and/or adverse effects from administration of medication by LPN #3. House stock Tylenol was removed from the medication cart, discarded and replaced. Medication pass observations have been conducted with LPN #3.<br>2. Licensed nurses monitored for following infection control practices during medication pass observations by DCS/designee completed. Consultant Pharmacy Nurse / Designee to conduct medication skills competencies as indicated. Follow up based on findings.<br>3. Licensed Nurses re-educated by the Director of Clinical Services (DCS) / Designee regarding following infection control practices during medication pass. | 06/23/17 |

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| F 441 | Continued From page 135<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(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<br><br>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medication administration observation, staff interview, and facility document review, facility staff failed to follow infection control practices during a med pass observation on Unit #3.<br><br>LPN #3 (licensed practical nurse) failed to use proper hand hygiene while preparing and administering medications on Unit #3. | F 441 | 4. DCS/Designee to conduct random quality monitoring of Licensed Nurses regarding following infection control practices during preparation of medication(s) and medication administration twice weekly x 4 weeks, then weekly times 4 weeks then monthly and PRN. Quality monitoring schedule modified based on findings. Findings to be reported to QAPI committee monthly and updated as indicated. | |

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| F 441 | Continued From page 136 | F 441 | | |

Findings included:

On 05/03/17 at 8:00 a.m. this surveyor observed medication administration with LPN #3 (licensed practical nurse). LPN #3 prepared all medications for Resident #12 outside of Resident #12's room. During this preparation LPN #3 used hand sanitizer, coughed and stated, "I'm a little sickly today." LPN #3 proceeded to drop an aspirin out of the house stock bottle onto the cart, picked up the aspirin with her bare hands and placed into the medication cup. LPN #3 then removed all capsules from the pills with her bare hands, opened the capsules bare handed and poured into the crushed meds.

Resident #12 was eating breakfast. LPN #3 stated, "She is still eating her breakfast. I'm not going to interrupt her meal." LPN #3 wasted all of the prepared meds for Resident #12. At 10:25 a.m. LPN #3 prepared the medications for Resident #12 again and opened capsules with her bare hands and administered to this resident.

LPN #3 prepared medications for Resident #13. LPN #3 popped a Cogentin, Metoprolol, Geodon and Gabapentin from the bubble cards into her bare hands and placed into the medication cup. LPN #3 dropped a Buspar onto the med cart, picked up with her bare hand and placed into the med cup. While getting Tylenol tablets from the house stock bottle, LPN #3 poured several tablets into the lid, placed two into the med cup and placed the extra back into the house stock bottle all with her bare hands.

The Administrator and DON (director of nursing) were informed of the above observation during a meeting with the survey team on 05/03/17 at 5:45

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| F 441 | Continued From page 137<br>p.m. Facility policy for "Medications-Oral Administration Of Effective Date: 11/30/2014. Policy: It is the policy that the resident can expect safe and accurate administration of oral medication. Procedure: ...Refrain from touching powders, capsules or pills with hands...Most medications should not be crushed if they are not scored or if they are enteric coated, or if they are sustained release or long-acting...Wash hands..."<br><br>No further information was received by the survey team prior to the exit conference on 05/09/17. | F 441 | | |
| F 497 SS=F | 483.35(d)(7) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE<br><br>(d)(7) Regular In-Service Education<br><br>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g).<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review, and as part of the survey process with the identification of substandard quality of care, the facility failed to ensure the certified nursing assistant's (CNA) received required training/in-servicing and performance reviews.<br><br>Findings include:<br><br>As part of the survey process with the identification of substandard quality of care, additional information was requested from the facility administrator at 10:00 a.m. 5/9/17 to | F 497 | F497: Nurse Aide Perform Review-12 hour in-service<br>1. Residents #4 and #10 did not suffer and s/s of physical or psychosocial adverse effects. Resident #21 no longer resides in the facility. Nurse aide who cared for residents #4, 10 and 21 is no longer employed at the facility. | 06/23/17 |

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| F 497 | Continued From page 138<br>include, but was not limited to: CNA registry verification; CNA annual performance reviews and education (to include staff yearly training/in-servicing of 12 hours). On 5/9/17 at approximately 2:30 p.m., the facility administrator, DON (director of nursing), and Regional Nurse Consultant told the survey team there had not been any performance evaluations completed for the CNA staff. The survey team was told some performance reviews had been completed over the weekend when the problem was identified. The DON further informed the survey team there were no in-servicing records available for any of the CNA's. A list of all currently employed CNA's was requested. The list was received and compared to the performance evaluations completed over the weekend. Not all staff had been evaluated; some staff currently working in the facility had been employed since 2013, with no evidence of performance evaluations or required in-servicing.<br><br>On 5/8/17 at approximately 3:00 p.m., six CNA's were interviewed; two of the six CNA's had been working at the facility for more than one year and both stated they had not received any yearly training, nor had a performance evaluation been done to let them know how they were doing. Four of the CNA's were recent hires of the facility, with less than 1 year employment. The four CNA's recently hired stated upon hire, they "followed" another CNA for 3-5 days as orientation, and then were "put out on the floor to care for residents." One CNA stated "I will tell you this since you're asking; I don't feel as though I've had enough training to be put out here and working with residents I don't know very much about."<br><br>The CNA statements reflected lack of training in | F 497 | 2. Quality Review completed of current CNA files on May 8, 2017 to determine completion of appropriate education. CNA's educated on topics per the 2017 Consulate Education Calendar by ADCS/Designee completed. Human Resource Coordinator responsible for placing education information in the staff member's personnel file. New hires to complete orientation and competencies prior to working independently. CNA's to complete Consulate Health Care competency requirements per guideline. Human Resource Coordinator is responsible for maintaining the appropriate documentation in the employee file. Human Resource Coordinator to provide a copy of the Quality Monitor monthly to the DCS and ED. CNAs to receive their annual performance evaluation presented to them by the DCS/designee during the month of their annual date of hire. Human Resource Coordinator to develop a file alerting the DCS of annual performance reviews due monthly. C.N.A's to complete annual competencies per the Consulate Education Calendar. | |

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| F 497 | Continued From page 139<br>the area of Resident Care as evidenced by Resident # 4 who was left sitting in urine and feces for approximately two hours, and also left unclothed by an open window by CNA staff(see F241). Resident # 10 was put to bed on two separate occasions without proper bedclothes by CNA staff (see F241). A CNA (certified nursing assistant) provided improper menstrual cycle care for Resident # 21's (see F224 and F241). While the CNA's who provided the deficient care were no longer employed by the facility, current CNA staff were not trained, in serviced, and/or provided adequate education to care for dependent residents in their care. | F 497 | 3. ED/DCS/UM's/ADCS re-educated by the Division Education Specialist regarding completion of C.N.A education per the Consulate Education Calendar, completing Orientation and competencies prior to working independently and timely completion of annual performance evaluations. Human Resources re-educated by the DCS regarding responsibility for maintaining the appropriate documentation in the employee file, providing a copy of the Quality Monitor monthly to the DCS and | |
| F 498 SS=F | 483.35(c); 483.95(g)(1)(2)(4) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS<br><br>483.35<br>(c) Proficiency of Nurse Aides<br><br>The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br><br>483.95<br>(g) Required in-service training for nurse aides.<br><br>In-service training must-<br>(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.<br><br>(g)(2) Include dementia management training and resident abuse prevention training.<br><br>(g)(4) For nurse aides providing services to | F 498 | ED along with maintaining a file system to alert the DCS of annual performance reviews due each month for C.N.As.<br>4. DCS/Designee to conduct random quality monitoring monthly and PRN of new employee files to ensure education and competencies are completed prior to working independently per the education calendar. DCS/Designee to conduct random quality monitoring monthly regarding Annual Education and competencies are completed by C.N.A's per the education calendar. Human Resources/ED/Designee to conduct random quality monitoring monthly regarding completion of C.N.A annual performance evaluations. Quality monitoring schedule modified based on findings. Findings to be reported to QAPI committee monthly and updated as indicated. | |

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| F 498 | Continued From page 140<br>individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review, and as part of the survey process with the identification of substandard quality of care, the facility failed to ensure the certified nursing assistant's (CNA) demonstrated competency and training on resident care needs.<br><br>Findings include:<br><br>As part of the survey process with the identification of substandard quality of care, additional information was requested from the facility administrator at 10:00 a.m. 5/9/17 to include, but was not limited to: CNA registry verification; CNA annual performance reviews and education (to include staff training/in-servicing of 12 hours) and return demonstration of competencies upon orientation to the facility. On 5/9/17 at approximately 2:30 p.m., the facility administrator, DON (director of nursing), and Regional Nurse Consultant told the survey team there had not been any performance evaluations completed for the CNA staff, and there were no orientation/competency checklists available for new hires.<br><br>On 5/8/17 at approximately 3:00 pm, six CNA's were interviewed. Four of the CNA's were recent hires of the facility, with less than 1 year employment. The four CNA's recently hired stated upon hire, they "followed" another CNA for 3-5 days as orientation, and then were "put out on the floor to care for residents." One CNA stated "I will tell you this since you're asking; I don't feel as though I've had enough training to be put out here | F 498 | F498: Nurse Aide Demonstrate Competency/Care Needs<br><br>1. Resident #21 no longer resides in the facility. C.N.A no longer works at the facility. Resident #10 provided bedclothes per resident choice. Resident #4 was provided ADL care.<br>Audit completed of all current CNA files on May 8, 2017 to determine if appropriate education was completed.<br>All CNA's educated on the topics per the 2017 Consulate Education Calendar as delineated below.<br>The education provided by the ADCS or designee.<br>Education began on 05/09/2017 at 9:00 AM and will be completed by June 23, 2017.<br>When the education is completed, the Human Resource Coordinator/designee will be responsible to place the information in the staff member's personnel file.<br>Going forward, all new hires will complete orientation and competencies prior to working on the unit.<br>Annually, all CNA's will complete Consulate Health Care competency requirements. The Human Resource Coordinator will be responsible to maintain the appropriate documentation.<br>The Human Resource Coordinator/designee will provide a copy of the Quality Monitor monthly to the DCS and ED. | 06/23/17 |

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| F 498 | Continued From page 141<br>and working with residents I don't know very much about." The CNA further stated another CNA had told her how to use a Hoyer lift and Sit to Stand lift, but a return demonstration was not part of that information. "All the information was verbal; there was no return demonstration and no nurse was involved in any training; all four CNA's voiced their orientation was done by another CNA.<br><br>The CNA statements reflected lack of training in the area of Resident Care as evidenced by Resident # 4 who was left sitting in urine and feces for approximately two hours, and also left unclothed by an open window by CNA staff(see F241). Resident # 10 was put to bed on two separate occasions without proper bedclothes by CNA staff (see F241). A CNA (certified nursing assistant) provided improper menstrual cycle care for Resident # 21's (see F224 and F241). While the CNA's who provided the deficient care were no longer employed by the facility, current CNA staff were not trained, in serviced, and/or provided adequate education to care for dependent residents in their care. | F 498 | This information will be presented monthly at the QAPI meeting to attain and maintain compliance.<br>CNAs will receive an annual performance evaluation presented to them by the DCS/ designee on their anniversary date. The Human Resource Coordinator/designee will develop a file to alert the DCS when their annual review is due.<br>This information will be presented monthly at the QAPI meeting to attain and maintain compliance.<br><br>2. Quality Review of current residents was completed to determine appropriate ADL care was provided completed. Peri-care skills competency conducted as indicated. Quality review completed of current CNA files on May 8, 2017 to determine completion of appropriate education. CNA's educated on topics per the 2017 Consulate Education Calendar completed. C.N.As to complete annual competencies per the Consulate 2017 Education Calendar. Human Resource Coordinator responsible for placing education information in the staff member's personnel file. New hires to complete orientation and competencies prior to working independently. CNAs to complete Consulate Health Care competency requirements per guideline. Human Resource Coordinator is responsible for maintaining the appropriate documentation in the employee file. Human Resource Coordinator to provide a copy of the Quality Monitor monthly to the Director of Clinical Services (DCS) and Executive Director (ED). | |
| F 505 SS=G | 483.50(a)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS<br><br>(a) Laboratory Services<br><br>(2) The facility must-<br><br>(ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering | F 505 | | |

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| F 505 | Continued From page 142 | F 505 | 3. ED/DCS/UM's/ADCS re-educated by the Division Education Specialist/designee regarding completion of C.N.A education per the 2017 Consulate Education Calendar, completing Orientation and competencies prior to working independently. Human Resources re-educated by the ED/DCS/designee regarding responsibility for maintaining the appropriate documentation in the employee file and providing a copy of the Quality Monitor monthly to the DCS and ED. | |

physician's orders.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility staff failed, for two of 25 residents in the survey sample (Residents # 4 and 10), to promptly notify the residents' attending physician of abnormal lab results, resulting in harm.

1. For Resident # 4, the facility staff failed to notify the resident's attending physician of a lab result that identified the resident as having a urinary tract infection (UTI), leading to a one month delay in treatment, which lead to the resident being hospitalized and intubated, which constituted harm.

2. For Resident # 10, the facility staff failed to notify the resident's attending physician of low blood sugar and the initiation of hypoglycemic measures.

The findings include:

1. For Resident # 4, the facility staff failed to notify the resident's attending physician of a lab result that identified the resident as having a urinary tract infection (UTI), leading to a one month delay in treatment, which lead to the resident being hospitalized and intubated, which constituted harm.

Resident # 4 in the survey sample, a 66 year-old female, was admitted to the facility on 4/7/15, and most recently readmitted on 4/14/17 with diagnoses that included obstructive sleep apnea, encephalopathy, acidosis, hypertension, restless leg syndrome, diabetes mellitus, asthma,

4. DCS/Designee to conduct random quality monitoring monthly and PRN as indicated of new employee files to ensure orientation and competencies are completed prior to working independently per the 2017 education calendar. ED/ DCS/Designee to conduct random quality monitoring monthly and PRN and as indicated of current C.N.As to ensure education completed per the 2017 Consulate Education Calendar and competencies are completed by C.N.As per the 2017 education calendar. Human Resources to conduct random quality monitoring monthly and PRN as indicated of employee files to ensure annual education, competencies and orientation is completed per guideline. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.

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| F 505 | Continued From page 143<br>congestive heart failure, bi-polar disorder, anxiety, chronic pain, morbid obesity, acute respiratory failure, chronic renal failure, seizure disorder, anemia, seizure disorder, depression, gastroesophageal reflux disease, chronic obstructive pulmonary disease, and respirator failure. According to the most recent Minimum Data Set (MDS), a Significant Change, with an Assessment Reference Date (ARD) of 4/21/17, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.<br><br>Review of the Interdisciplinary Progress (Nurses) Notes revealed the following entry:<br><br>3/13/17 - 3:00 p.m. "...Told this nurse she thought she had a UTI (Urinary Tract Infection) d/t (due to) burning with urination...MD notified."<br><br>On 3/13/17, a telephone order from the Physician's Assistant was received for the following:<br><br>"UA (Urinalysis), EOS, Pyridium 200 mg (milligrams) PO (by mouth) tid (three times a day) x (times) 2 days."<br><br>NOTE: Pyridium is an over the counter medication used to "...relieve symptoms caused by irritation of the urinary tract such as pain, burning, and the feeling of needing to urinate urgently or frequently." Ref. www.WebMD.com.<br><br>Further review of the Interdisciplinary Progress (Nurses) Notes revealed the following entries:<br><br>4/9/17 - 5:00 a.m. "This nurse went in to resident room to give meds, resident asleep hard to | F 505 | F505: Lab Results<br><br>1. Resident #10 suffered no adverse affects and did not require transfer to a higher level of care. Resident #10 has parameters in place and hypo/ hyperglycemic protocol. Resident #4 re-admitted 4/27/17 with no s/s of UTI.<br>2. A Quality Review of current residents with physician orders for sliding scale insulin and/or Insulin dependent was completed to verify finger stick blood sugar (FSBS) checks are in place with high/low parameters, hypo/hyperglycemic protocols and when to contact physician. Quality Review of physician notification r/ t residents with low FSBS per order and/or administration of oral glucose or IM glucagon is present in the medical record completed. A quality review completed of resident lab results ordered within the last 30 days to ensure physician notification present and documented in the medical record. | 06/23/17 |

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| F 505 | Continued From page 144 | F 505 | 3. Licensed nurses re-educated by the DCS/Designee regarding obtaining orders for FSBS containing high/low parameters, hypo/hyperglycemic protocol PRN per physician orders and when to contact physician with documentation in the medical record. Licensed nurses re-educated by the DCS/Designee r/t to timely physician notification of residents with low FSBS per order and/or administration of oral glucose and/or IM glucagon is present in the medical record. Licensed nurses re-educated by the DCS/ Designee regarding location of physician contact information along with hypoglycemic management process. Licensed nurses re-educated by the Director of Clinical Services (DCS)/ designee regarding physician notification of lab results with documentation in the medical record. | |

waken. Once awake resident non-verbal, made eye contact, no facial grimacing. Resident breathing deep, skin sweaty. O2 (Oxygen) sat (saturation) 89, BS (Blood Sugar) 269, VS (vital signs) 103 - 136 (pulse), 32 (respirations), 134/58 (blood pressure). On call (MD) called was advised to send to ED (Emergency Department). 911 called, resident was taken to ED at 5:30 and RP (Responsible Party) notified."

4/9/17 - 11:10 a.m. "Called AH ER (hospital Emergency Room) for condition update. Resident to be admitted to ICU (Intensive Care Unit) on a breathing machine."

Resident # 4's hospitalization came approximately one month after the UA lab the identified her as having a UTI.

Review of the hospital Discharge Summary revealed the following:

"This is a 66-year-old female with a history of morbid obesity, obesity hypoventilation syndrome, seizure disorder, diabetes, diastolic heart failure, who was brought to the emergency room with lethargy and unresponsiveness. In the emergency room had difficulty breathing. To maintain her sats, she was ventilated. She was found to have a urinary tract infection and was admitted to ICU. She dropped her blood pressure requiring pressors (a medication used to raise blood pressure). The patient was found to have 2 out of 4 blood cultures positive for strep mitis...She also grew E-coli and Proteus in the urine, penicillin sensitive...."

Resident # 4 was discharged back to the facility on 4/14/17 with diagnoses that included septic

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| F 505 | Continued From page 145<br>shock secondary to urinary tract infection.<br><br>A thorough review of Resident # 4's clinical record failed to reveal the results of the UA ordered on 3/13/17. At approximately 1:00 p.m. on 5/8/17, at the request of the surveyor, LPN # 2 (Licensed Practical Nurse) was able to obtain a copy of the UA results via Fax from the laboratory that processed the urine sample. According to the UA report, Resident # 4 had a UTI. Asked if the resident's attending physician was notified of the UA results, LPN # 2 said, "He was not notified."<br><br>LPN # 2 was also asked about EOS. LPN # 2 explained that EOS is a protocol and stands for Enhanced Observation Order Set for suspected UTI. According to a blank copy of the EOS furnished by LPN # 2, the protocol included the following:<br><br>"1) Obtain vital signs (BP, pulse, resp rate, temp, pulse ox) every 6 hours for 3 days.<br>2) Record fluid intake each shift for 3 days.<br>3) Notify medical director or provider on call if fluid intake is less than 1600 ml (milliliters) per day.<br>4) Notify the medical director or on-call provider if condition worsens or if no improvement by the next morning.<br>5) Contact the medical director or on-call provider with an update on the resident's condition daily."<br><br>Asked if the EOS protocol was initiated for Resident # 4, LPN # 2 replied "No."<br><br>The findings were discussed at a meeting at 3:00 p.m. on 5/8/17 with the Interim Administrator, Director of Nursing, Corporate Nurse Consultant, and the survey team. | F 505 | 4. DCS/Designee during morning clinical meeting to conduct quality monitoring of physician orders for new admissions related to FSBS, high/low parameters, when to contact physician, and hypo/ hyperglycemic protocols daily x 4, weekly x 4 then monthly, PRN and as indicated. DCS/Designee to conduct quality monitoring related to timely physician notification of residents who require administration of hypoglycemic protocols per physician order with documentation in the medical record daily x 4, weekly x 4 then monthly, PRN and as indicated. DCS/Designee through Morning Clinical meeting process ensures physician is promptly notified of laboratory results daily x 4, weekly x 4 then monthly, PRN and as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. | |

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| F 505 | Continued From page 146 | F 505 | | |

2. Facility staff failed to notify the physician of a blood sugar result of 25 for Resident #10.

Resident #10 was originally admitted to the facility on 11/19/2011 and readmitted on 04/03/2017 with diagnoses including, but not limited to: Paraplegia, Aspiration Pneumonitis, COPD (Chronic Obstructive Pulmonary Disease), Depression, Anxiety, Diabetes, Hypertension, Neurogenic Bladder, and Chronic UTI (Urinary Tract Infection).

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 04/10/2017. Resident #10 was assessed as moderately impaired in her cognitive status with a total cognitive score of 10 out of 15.

During review of Resident #10's medical record on 05/03/17 at approximately 10:00 a.m. the following documentation was located in the clinical record. "Interdisciplinary Progress Note" dated "5/3/17 0500 (5:00 a.m.) I checked the resident's BS (blood sugar) and it was 25. I gave the resident a glucose tab (tablet) and pudding but she couldn't chew the tab. I then gave her the glucagon shot to raise her BS. The final number was 85. I called her RP (responsible party) and will notify the MD (physician)."

LPN #2 (licensed practical nurse) was interviewed on 05/03/2017 at 10:55 a.m. LPN #2 stated, "There are no standing orders for diabetes. I asked that when I got here."

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| F 505 | Continued From page 147<br>LPN #3 was interviewed on 05/03/2017 at 11:10 a.m. LPN #3 stated, "Received in report of low blood sugar this morning. (Name) PA (physician assistant) knows. I rechecked; it was 127. I don't know if the on-call doctor was notified."<br><br>PA was interviewed on 05/03/2017 at 11:15 a.m. PA stated, "I was notified this morning at 9:08 when I came in. I don't know if the on-call doctor was notified or not. I am going to find out who was on-call last night and ask them myself. I will let you know. She also didn't get her bedtime snack last night."<br><br>On 05/03/2017 at approximately 1:00 p.m. the PA entered the conference room and handed this surveyor the following note: "5-3-17 Noon To Whom It May Concern: In regard to (Name) Resident #10, I was notified at 0908 (9:08 a.m.) that her accuchek (blood sugar) was 25. Nursing gave her a glucose tab and pudding. She then was administered a Glucagon injection. I inquired about any input from the on call doctor but no one knew. I called over office (sic) and there was no call made to the on call physician to direct these orders. This incident occurred about 5:30 a.m. today. An accuchek at time of exam was 136..."<br><br>The Administrator and DON (director of nursing) were notified of the above findings during a meeting with the survey team on 05/03/2017 at approximately 5:45 p.m. No further information was received by the survey team prior to the exit conference on 05/09/2017. | F 505 | | |
| F 520 SS=F | 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS | F 520 | | |

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| F 520 | Continued From page 148<br>(g) Quality assessment and assurance.<br><br>(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:<br><br>(i) The director of nursing services;<br><br>(ii) The Medical Director or his/her designee;<br><br>(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and<br><br>(g)(2) The quality assessment and assurance committee must :<br><br>(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br><br>(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. | F 520 | F520: QAA Committee-Members/Meet Quarterly/Plans<br><br>1. Facility Quality Assurance Performance Improvement (QAPI) committee reviewed findings on 5/25/17 identified during annual survey on 5/2-5/9 2017 to include the identification of substandard Quality of Care r/t pain, non-pressure related wounds and not following physician orders. Findings identified have a plan of correction (POC) to include immediate correction, quality review, re-education and ongoing quality monitoring with review by the QAPI committee.<br>2. Facility Quality Assurance Performance Improvement (QAPI) committee reviews findings identified during annual survey 5/2-5/9 2017, maintains and updates PIP/quality monitoring as indicated. Follow up and revision based on findings.<br>3. QAPI committee/Executive Director/ IDT re-educated by RVPO regarding conducting an effective QAPI committee that identifies using Root Cause Analysis, develops and implements appropriate performance improvement plans to address, analyze and facilitate process changes as indicated. | 06/23/17 |

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| F 520 | Continued From page 149 | F 520 | 4. QAPI committee to meet weekly times 4 weeks, then as indicated by QAPI findings, but a minimum of monthly thereafter to review performance improvement related to areas identified during Annual Survey May 2-9 20-17 identify, develop and implement quality improvement measures. ED/DCS/ Designee to continue ongoing QI monitoring of Plan of Correction quality monitoring through QAPI meeting process. The Regional Vice President of Operations and/or Regional Director of Clinical Services/designee to conduct monitoring of the Facility's QAPI process weekly times 4 weeks, monthly times 2 months, then randomly thereafter with recommendations for improvement as indicated. QAPI meeting held 5/25/17 to review 2567 and POC with medical director in attendance. PIP's reviewed and modified as needed. | |

This REQUIREMENT is not met as evidenced by:
Based on survey findings the facility failed to ensure an effective system wide quality assurance program to prevent substandard quality of care in the area of Quality of Care and the identification of immediate jeopardy in the areas of comprehensive person-centered care planning and nursing services.

Findings were:

An onsite survey was conducted 05/02/2017 through 05/04/2017. An extended survey was conducted 05/08/2017 through 05/09/2017. During the survey process multiple areas of deficient practice were cited including the identification of substandard quality care due a pattern of harm in the area of Quality of Care. Residents were not assessed for pain, not assessed for non-pressure related wounds, and physician orders were not followed, resulting in harm to residents.

Immediate jeopardy was identified in the areas of Comprehensive Person-Centered Care Planning and Nursing Services. Agency licensed nurses were permitted to enter the facility and implement nursing care to residents, including the administration of medications, without receiving orientation to the facility or being deemed competent in facility tasks, policies or procedures. CNA (certified nursing assistant) staff were not evaluated annually on their performance nor were they provided with ongoing in-service training by the facility.

During the survey it was ascertained that the turnover of facility staff including administrative

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staff had been ongoing. The administrator in place at the time of the survey team's entry had been taken over the facility on 02/08/2017 and was leaving the facility on 05/06/2017. The administrator taking her place arrived at the facility on 05/01/2017 and assumed duties accordingly. The DON (director of nursing) was hired on 03/17/2017 and the Medical Director took over his position on 04/01/2017.

During a conversation with the administrator (Admin #1) she stated that the facility had identified problems with residents having showers completed, medication administration, and skin assessments. She stated those areas had been focused on. However, based on survey findings they were not corrected per the AOC date of 03/30/2017.

Admin #1 also stated that the facility used a number of agency nurses to staff the facility, each of which were only there for a brief time. During the survey process, the survey team were unable to interview staff involved with resident care when questions arose due to the fact that those staff were no longer at the facility.

With such a large turnover of staff, including administrative staff at the facility, the one constant for improving and monitoring resident care, staff development and competency should have been the quality assurance committee. The QA committee should have been aware of the failure to implement facility policies regarding staff competency and education.

The above information was discussed with the administrative team of the facility on 05/09/2017 during an end of survey meeting.

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| F 520 | Continued From page 151<br><br>No further information was obtained prior to the exit conference on 05/09/2017. | F 520 | | |