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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 01/23/18 through 01/26/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for	E 015		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Killie Baker	Skilled Nursing Administrator	2/15/2018

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

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hospice-operated inpatient care facilities only. The policies and procedures must address the following:
(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:
(A) Food, water, medical, and pharmaceutical supplies.
(B) Alternate sources of energy to maintain the following:
(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(2) Emergency lighting.
(3) Fire detection, extinguishing, and alarm systems.
(C) Sewage and waste disposal.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan.

The facility staff failed to develop policies and procedures to provide for sewage and waste disposal.

The findings include:

On 01/26/18 at 8:30 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, the administrator ASM # 2, director of nursing, OSM (other staff member) # 10, director of security and OSM # 11, director of engineering. Review of the facility's emergency preparedness plan failed to evidence

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E 015	Continued From page 2 documentation of policies and procedures to provide for sewage and waste disposal. ASM # 2 stated, "We don't have documentation for waste disposal nor have we trained the staff regarding waste disposal." On 01/26/18 at approximately 10:30 a.m. ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit.	E 015		
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to demonstrate the method the facility had developed for sharing the emergency plan with residents or client and their families or representatives.	E 035		

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E 035	Continued From page 3 The findings include: On 01/26/18 at 8:30 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, the administrator ASM # 2, director of nursing, OSM (other staff member) # 10, director of security and OSM # 11, director of engineering. Review of the facility's emergency preparedness plan failed to demonstrate the method the facility had developed for sharing the emergency plan with residents or client and their families or representatives. ASM # 1 stated, "We have the website address in the emergency plan but we haven't made it available for residents or families." On 01/26/18 at approximately 10:30 a.m. ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit.	E 035		
F 000	INITIAL COMMENTS An unannouced Medicare/Medicaid survey was conducted from 1/23/18 through 1/26/18. Corrections are required for compliance with the following 42 CFR Part 483 of the Federal Long Term Care requirements. The life safety code survey/report will follow. The census at this 56 certified bed facility was 50 at the time of the survey. The survey sample consisted of 16 current residents Residents # 5, 17, 198, 28, 6, 32, 203, 43, 13, 102, 42, 7, 45, 15, 22, and 103 and three closed records, Residents #48, 49 and 50.	F 000		

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F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		

§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or

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(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.

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If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, it was determined that facility staff failed to provide written documentation evidencing the ombudsman was provided notice of a transfer to the hospital for one of 19 residents in the survey sample, Resident #203.

The facility staff failed to provide written documentation that the ombudsman was notified when Resident #203 was transferred to the hospital twice on 1/9/18.

The findings include:

Resident #203 was admitted to the facility on 12/26/17 with diagnoses that included but were not limited to high blood pressure, fracture of the right and left femur, difficulty in walking, and age-related cognitive decline. Resident #203's most recent MDS (minimum data set) assessment was an admission assessment with

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an ARD (assessment reference date) of 1/10/2018. Resident #203 was coded as being severely impaired in cognitive function scoring 05 out of a possible 15 on the BIMS (brief interview for mental status) exam. Resident #203 was coded as requiring extensive assistance from two or more persons with transfers; extensive assistance with one person physical assist with bed mobility, toileting, and personal hygiene; and total dependence on staff with bathing.

Review of Resident #203's clinical record revealed that she had went out to the hospital on 1/9/18 at 8:11 a.m. The following was documented: "nursese (sic) were called in residents room @ (at) aprox (approximately) 7:50 a.m. by private aid, resident was not responding to verbal commands, resident unable to arouse per many attempts by nurses, Vital Signs Bp (blood pressure) 143/73, P (pulse) 92 R (respirations) 17, T (temperature) 97.4, Spo2 (oxygen saturation) 96, ...911 was called at 8;00 (sic), am left @8:11 a.m. .... son (name of son) made aware at 8;20 (sic) am of residents transport to Er (emergency room), Md (sic) (Medical Doctor) also notified of this."

There was no further evidence in the clinical record that the ombudsman was made aware of this transfer.

Further review of the clinical record revealed that Resident #203 went to the hospital a second time on 1/9/18 at 7:00 p.m. The following was documented, "Resident observed sitting on the floor leaning on the night stand at 6 Pm (sic). PT (Patient) was asked what happened unable to explain what happened. PT sustained hematoma with laceration on the back of her head. Neuro

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(neurological) check initiate. ROM (Range of Motion) within normal limit. PT denies pain or discomfort...Dr. (Name of DR)/SON/ADON (assistant director of nursing) notified...Order obtain to transfer for further evaluation."

There was no further evidence in the clinical record that the ombudsman was made aware of the second transfer to the hospital.

On 1/25/18 at 8:39 a.m., an interview was conducted with ASM (administrative staff member) #2, DON (Director of Nursing). When asked who is notified when a resident is transferred to the hospital, ASM #1 stated that it depended on the resident. If the resident is their own RP (responsible party) and alert, then they are made aware of the transfer. If the resident is not his/her own representative or if the resident is not alert, the POA (power of attorney) or a family member is notified. When asked if the ombudsman is notified of a resident transfer to the hospital, ASM #2 stated the ombudsman is made aware after the resident arrives back to the facility from the hospital or while the resident is in the hospital. When asked if the ombudsman notification is in writing, ASM #2 stated, "No we verbally tell her if it is egregious." ASM #2 stated she did not have evidence in writing that the ombudsman was notified for Resident #203's transfers on 1/9/18. ASM #2 stated the ombudsman was notified verbally of Resident #203's hospital transfers.

On 1/25/18 at 1:55 p.m., an interview was conducted with OSM (other staff member) #12, the local long term care ombudsman. OSM #12 stated she was not familiar with Resident #203's hospital transfers. OSM #12 stated she is not

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notified of a resident hospital transfer until she arrives to the facility and sees that a resident is not in their room or at the facility. OSM #12 stated the facility may have called her office to notify her, but her office has other local ombudsmen working there. OSM #12 stated she was the ombudsman that visited the facility on a weekly basis.

On 1/25/18 at 1:31 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

The facility policy titled, "Transfer, Discharge, and Bed Hold Notices" did not address the above concerns.

No further information was provided prior to exit.

F 656 SS=D — Develop/Implement Comprehensive Care Plan
CFR(s): 483.21(b)(1)

§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required

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under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to implement the comprehensive care plan for one of 19 residents in the survey sample, Resident #203.

The facility staff failed to implement fall mats for Resident #203 on 1/24/18 and 1/25/18, per the resident's plan of care.

The findings include:

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Resident #203 was admitted to the facility on 12/26/17 with diagnoses that included but were not limited to high blood pressure, fracture of the right and left femur, difficulty in walking, and age-related cognitive decline. Resident #203's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 1/10/2018. Resident #203 was coded as being severely impaired in cognitive function scoring 05 out of a possible 15 on the BIMS (brief interview for mental status) exam. Resident #203 was coded as requiring extensive assistance from two or more persons with transfers; extensive assistance with one person physical assist with bed mobility, toileting, and personal hygiene; and total dependence on staff with bathing.

On 1/23/18 at 1:15 p.m., an observation was made of Resident #203. She was lying in bed awake with bilateral fall mats in place and a private sitter at her bedside.

On 1/24/18, several observations were made of Resident #203 up in a wheelchair participating in activities.

On 1/24/18 at 5:07 p.m., observation revealed Resident #203 had changed rooms. Resident #203 was lying in bed with her sitter at her bedside. Fall mats were not in place on the floor.

On 1/24/18 at 5:08 p.m., an observation was made of Resident #203's old room. Fall mats were up against the wall of her old room.

Review of Resident #203's fall care plan initiated on 1/6/18, documented the following intervention: "Provide resident with safe environment...floor

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mats."

Review of Resident #203's clinical record revealed Resident #203 had sustained two falls since admission on 12/27/17 and 1/9/18, both requiring hospitalization.

On 1/25/18 at 10:51 a.m., further observation was made of Resident #203. Resident #203 was sleeping in bed. Bilateral fall mats were not in place. Resident #203's private sitter was not at her bedside. A nurse, (LPN (licensed practical nurse) #2, was also observed at this time preparing medications for Resident #203 in the doorway of Resident #203's room. On 1/25/18 at 10:52 p.m., observation revealed LPN #2 was administering Resident #203's medications. LPN #2 then walked out of the room and then returned to her room with the vital sign machine. LPN #2 took Resident #203's vital signs and then walked out of her room.

On 1/25/18 at 10:54 a.m., LPN #2 stated to this writer she was finished with Resident #203. When asked if Resident #203 was a fall risk, LPN #2 stated Resident #203 was a fall risk. When asked what Resident #203 needed to have in place to prevent falls, LPN #2 stated the resident needed to have fall mats in place. When asked if fall mats were in place, LPN #2 stated, "I'll take a look." This writer accompanied LPN #2 into Resident #203's room. Observation revealed Resident #203 did not have fall mats in place. Resident #203's private sitter was in the room at this time. LPN #2 stated, "No. she doesn't." When asked how nurses are made aware of interventions that need to be put into place for a particular resident, LPN #2 stated the nurses would look at the chart and the orders to see

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what each resident needed. When asked if nurses could look anywhere else to see what each resident required, LPN #2 stated she was not sure. When asked the purpose of the care plan, LPN #2 stated the care plan had general information about each resident. LPN #2 also stated the care plan instructed the nurses on what interventions need to be in place for each resident. On 1/25/18 at 10:58 a.m., LPN #2 stated the fall mats must not have made it to Resident #203's new room. This writer accompanied LPN #2 to Resident #203's old room. Observation of Resident #203's old room revealed the fall mats resting up against the wall.

On 1/25/18 at approximately 12:00 p.m., further interview was conducted with LPN #2. When asked how CNAs (certified nursing assistants) are made aware of interventions that need to be in place to prevent falls, LPN #2 stated after a fall nursing staff would have a meeting with the aides. LPN #2 stated fall mats should also be in their documentation under PCC (point click care). When asked who was responsible for updating the interventions in PCC for the nursing aides to follow, LPN #2 stated she was not sure who updated the guide for the nursing aides. LPN #2 stated she has never updated interventions under PCC.

On 1/25/18 at 3:04 p.m., an interview was conducted with CNA (certified nursing assistant) #1. When asked how CNAs are made aware of resident needs to prevent falls, CNA #1 stated that she would get that information in a verbal report from the nurses. CNA #1 stated interventions also should be documented on the Kardex for that particular resident. CNA #1 stated she could access the Kardex through PCC. When

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asked if she works with Resident #203, CNA #1 stated she does not normally work with her. CNA #1 pulled up Resident #203's Kardex. Fall mats were not on Resident #203's Kardex.

On 1/25/18 at 1:31 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

Review of the facility's "Fall Management Program" documents in part, the following: "The fall management program describes the interdisciplinary approach to managing resident falls. The program focuses on two areas: - Mitigate the risk of falls through increased awareness. - Managing falls that occur, including a root-cause analysis to determine how to minimize future risk. The program's components are -The assessment of residents and identification of risk for falls. -Ensure a focus on a safe environment and reduce the likelihood of injury from a fall. -Implement interventions to help prevent falls. - Manage falls; despite best efforts -can occur in the community.

Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the

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F 656	Continued From page 15 nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care. No further information was presented prior to exit.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		

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Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to review and revise the comprehensive care plan for one of 19 residents in the survey sample, Resident #203.

The facility staff failed to revise Resident #203's comprehensive care plan when she was diagnosed with a UTI (urinary tract infection).

The findings include:

Resident #203 was admitted to the facility on 12/26/17 with diagnoses that included but were not limited to high blood pressure, fracture of the right and left femur, difficulty in walking, and age-related cognitive decline. Resident #203's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 1/10/2018. Resident #203 was coded as being severely impaired in cognitive function scoring 05 out of a possible 15 on the BIMS (brief interview for mental status) exam. Resident #203 was coded as requiring extensive assistance from two or more persons with transfers; extensive assistance with one person physical assist with bed mobility, toileting, and personal hygiene; and total dependence on staff with bathing.

Review of the nursing notes dated 1/9/18, revealed that Resident #203 was sent to the hospital at 8:11 a.m. The following was documented, "nursese (sic) were called in residents room @ (at) aprox (approximately) 7:50 a.m. by private aid, resident was not responding to verbal commands, resident unable to arouse per many attempts by nurses, Vital Signs Bp (blood pressure) 143/73, P (pulse) 92 R

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(respirations) 17, T (temperature) 97.4, Spo2 (oxygen saturation) 96, ...911 was called at 8;00 (sic), am left @8:11 a.m. .... son (name of son) made aware at 8;20 (sic) am of residents transport to Er (emergency room), Md (sic) (Medical Doctor) also notified of this."

Further review of the nursing notes revealed that Resident #203 arrived back to the facility at 3 p.m. The return note documented the following: "Resident returned back to facility at 3 Pm (sic) from (Name of Hospital). New order for ABT (antibiotic therapy) Macrobid [1] 100 mg (milligrams) cap (capsule) for UTI (Urinary Tract Infection) x (times) 10 days. First initial dose administer, noted no adverse reaction."

Review of Resident #203's January 2018 MAR (Medication Administration Record) revealed that Resident #203 received Macrobid x ten days. The last dose was given on 1/19/18.

Review of Resident #203's comprehensive care plan dated 1/6/18, with revisions, failed to document Resident #203's recent UTI. The following was documented under focus area bladder incontinence, "Observe for and report to nurse and MD (medical doctor) any of the following signs/or symptoms or a urinary tract infection: pain, burning, blood tinged urine, urinary frequency, foul smelling urine, altered mental status, change in behavior, such as confusion."

On 1/25/18 at 9:30 a.m., an interview was conducted with LPN (licensed practical nurse) #1, a nurse who works with Resident #203 on occasion. When asked who was responsible for updating the care plan, LPN #1 stated that the

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nurses were responsible for updating the care plans. When asked when the care plan would be updated, LPN #1 stated that the care plan would be updated for things like falls, a change in condition, and change in treatments such as new orders etc. When asked if a resident developed a UTI, if that would be on the care plan, LPN #1 stated, "Sure." When asked what the care plan was used for, LPN #1 stated the care plan served as a guideline for patient care. LPN #1 stated she would expect to see each instance where a resident developed a UTI on the care plan. LPN #1 reviewed Resident #203's comprehensive care plan with revisions and stated the only thing she saw was the intervention to monitor for a UTI. LPN #1 stated the nurses used the care plan, but they also checked 24 hour reports and nursing notes to get an idea of what is going on with their patient. LPN #1 was aware Resident #203 just had a UTI and that she was admitted back to the facility on an antibiotic. LPN #1 stated she was the nurse who transferred Resident #203 to the hospital for unresponsiveness. LPN #1 stated she had just received report from night shift when the resident's sitter alerted her that the resident was unresponsive.

On 1/25/18 at 1:31 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. ASM #2 stated that the UTI might have been a resolved item on the care plan. ASM #2 stated that she would look into that.

Facility policy titled, "Individualized care plan" did not address the above concerns. ASM #2 stated that the facility used Potter and Perry as a professional reference.

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No further information was presented prior to exit.

[1] Macrobid is an antibiotic used to treat urinary tract infections. This information was obtained from The National Institutes of Health https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011426/?report=details.

F 658 SS=D — Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) — F 658

§483.21(b)(3) Comprehensive Care Plans
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:

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Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to follow professional standards of practice for two of 19 residents in the survey sample, Residents #45 and #15.

1. The facility staff failed to clarify a physician's order for the amount of eye drops to be administered to Resident #45.

2. The facility staff failed to transcribe a physician's order for Resident #15's wound care onto the MAR (medication administration record) or TAR (treatment administration record) on 12/21/17.

The findings include:

1. The facility staff failed to clarify a physician's order for the amount of eye drops to be administered to Resident #45.

Resident #45 was admitted to the facility on 10/22/11 and readmitted on 3/24/16. Resident #45's diagnoses included but were not limited to: diabetes, heart failure and glaucoma (1). Resident #45's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/29/17, coded the resident as cognitively intact.

On 1/24/18 at 8:39 a.m., during the medication administration observation, LPN (licensed practical nurse), #2 was observed administering one drop of dorzolamide (2) 2% eye drop solution into both of Resident #45's eyes. The pharmacy instructions labeled on the bottle containing the eye drops documented to instill one drop into both

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eyes. However, review of Resident #45's January 2018 MAR (medication administration record) revealed the following instructions: "Dorzolamide HCL Solution 2%- Instill 2 drops in both eyes two times a day."

On 1/24/18 at 2:45 p.m. ASM (administrative staff member) #2 (the director of nursing) presented Resident #45's electronic physician's order for the resident's dorzolamide. The order documented conflicting directions. One direction documented, "Instill 2 drop in both eyes two times a day" and another direction documented, "INSTILL 1 DROP INTO BOTH EYES TWICE DAILY."

Resident #45's comprehensive care plan initiated on 1/10/14 failed to document specific information regarding eye drops.

On 1/25/18 at 8:14 a.m., an interview was conducted with LPN #2. LPN #2 stated that although Resident #45's MAR documented to instill two drops of dorzolamide into the resident's eyes, she elected to instill one drop because of the labeled instructions on the bottle containing the eye drops. LPN #2 stated the instructions to instill two drops should had been removed from the computer system. LPN #2 was asked how she knew the physician ordered one drop when there was two different instructions on the physician's order. LPN #2 stated at the moment she could not tell whether the physician ordered one drop or two drops. LPN #2 stated the pharmacy makes recommendations to the physician then the physician "Okays" the recommendations. LPN #2 stated the pharmacy had to reconcile the order. LPN #2 stated staff had to call the pharmacy because they could fax the order they had and she would have to change

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the order in the computer system. When asked if she was going to consult with the physician, LPN #2 stated, "I sure will." When asked if she was going to contact the pharmacy and the physician to clarify the order, LPN #2 stated, "Yes."

On 1/25/18 at 9:20 a.m., a telephone interview was conducted with OSM (other staff member) #9 (the consulting pharmacist). OSM #9 stated the directions for the dorzolamide in the computer system documented to administer two drops but the original order from 2016 documented to administer one drop and the current pharmacy label documented one drop. OSM #9 stated either the physician's order changed and the pharmacy staff never saw the change or the order was clarified for one drop and this was not documented in the computer system. OSM #9 stated something may have been wrong with the computer system and he was having a hard time figuring out what happened. OSM #9 stated his advice was for the facility staff to talk to the physician, find out what the order should be and go from there.

On 1/25/18 at 1:31 p.m. ASM #1 (the administrator) and ASM #2 were made aware of the above findings. ASM #2 was asked what standard of practice the facility staff uses when providing care. ASM #1 and ASM #2 stated they follow Perry and Potter. ASM #2 was asked to provide the standard of practice and facility policy for the clarification of physician's orders.

The facility pharmacy policy titled, "4.5 Reordering, Changing, and Discontinuing Orders" documented, "3. Change Orders: Any request to change an existing order should be treated by Facility as a new order, with a corresponding

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cancellation of the previous order..." The policy did not document specific information regarding clarification. No standard of practice from Perry and Potter regarding clarification was provided.

No further information was presented prior to exit.

(1) Glaucoma is a group of eye diseases. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=glaucoma

(2) Dorzolamide is used to treat glaucoma. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697049.html

2. The facility staff failed to transcribe a physician's order for Resident #15's wound care onto the MAR (medication administration record) or TAR (treatment administration record) on 12/21/17.

Resident #15 was admitted to the facility on 8/18/17. Resident #15's diagnoses included but were not limited to a stage four pressure injury (1) to the sacral region (2), Huntington's disease (3) and muscle weakness. Resident #15's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/24/17, coded the resident's cognition as moderately impaired.

Review of Resident #15's clinical record revealed a paper physician's order dated 12/21/17 that documented, "Cleanse sacral wound with wound cleanser, pat dry, apply pack wound with silver alginate (4) and cover with dry dressing daily."

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Review of Resident #15's December 2017 MAR/TAR revealed the order was not transcribed onto the MAR until 12/24/17. Review of facility documentation and interviews with nurses revealed the wound treatment ordered on 12/21/17 was provided to Resident #15 from 12/21/17 through 12/24/17 but was not documented.

On 1/25/18 at 11:06 a.m. an interview was conducted with RN (registered nurse) #2 (the wound care nurse). RN #2 stated the paper physician's order was not properly transcribed into the computer. When asked who was responsible, RN #2 stated, "I think me." RN #2 stated she thought she entered the order into the computer on 12/21/17 but entered a start date of 12/24/17. RN #2 stated any order entered into the computer would not show up on the MAR/TAR until the entered start date.

On 1/25/18 at 1:31 p.m. ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. ASM #2 was asked what standard of practice the facility staff uses when providing care. ASM #1 and ASM #2 stated they follow Perry and Potter. ASM #2 was asked to provide the standard of practice and facility policy for the transcription of physician's orders.

A facility "Quick Reference Guide" documented, "TRANSCRIPTION OF THE TELEPHONE ORDER- Telephone orders for medications and treatments are transcribed/entered into the electronic Medication Administration Record (MAR)/Treatment Administration Record (TAR) by the licensed nurse..." No standard of practice

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from Perry and Potter regarding transcription was provided.

No further information was presented prior to exit.

(1) "A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue...Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer..." This information was obtained from the website: http://www.npuap.org/national-pressure-ulcer-advisory-panel-npuap-announces-a-change-in-terminology-from-pressure-ulcer-to-pressure-injury-and-updates-the-stages-of-pressure-injury/

(2) "The sacrum is a shield-shaped bony structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis." This information was obtained from the website: https://medlineplus.gov/ency/imagepages/19464.htm

(3) "Huntington's disease (HD) is an inherited disease that causes certain nerve cells in the brain to waste away..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=

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medlineplus-bundle&query=huntington%27s&_ga=2.258684494.51318264.1517228909-139120270.1477942321

(4) Silver Alginate is used to treat wounds. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4486446/

F 689 SS=D — Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) — F 689

§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to maintain a safe environment for one of 19 residents in the survey sample, Resident #203.

The facility staff failed to ensure bilateral fall mats were in place while Resident #203 was in bed, to ensure a safe environment.

The findings include:

Resident #203 was admitted to the facility on 12/26/17 with diagnoses that included but were not limited to high blood pressure, fracture of the right and left femur, difficulty in walking, and age-related cognitive decline. Resident #203's

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most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 1/10/2018. Resident #203 was coded as being severely impaired in cognitive function scoring 05 out of a possible 15 on the BIMS (brief interview for mental status) exam. Resident #203 was coded as requiring extensive assistance from two or more persons with transfers; extensive assistance with one person physical assist with bed mobility, toileting, and personal hygiene; and total dependence on staff with bathing.

On 1/23/18 at 1:15 p.m., an observation was made of Resident #203. She was lying in bed awake with bilateral fall mats in place and a private sitter at her bedside.

On 1/24/18, several observations were made of Resident #203 up in a wheelchair participating in activities.

On 1/24/18 at 5:07 p.m., observation revealed Resident #203 had changed rooms. Resident #203 was lying in bed with her sitter at her bedside. Fall mats were not in place on the floor.

On 1/24/18 at 5:08 p.m., an observation was made of Resident #203's old room. Fall mats were up against the wall of her old room.

Review of Resident #203's fall care plan initiated on 1/6/18, documented the following intervention: "Provide resident with safe environment...floor mats."

Review of Resident #203's clinical record revealed Resident #203 had sustained two falls since admission on 12/27/17 and 1/9/18, both

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requiring hospitalization.

On 1/25/18 at 10:51 a.m., further observation was made of Resident #203. Resident #203 was sleeping in bed. Bilateral fall mats were not in place. Resident #203's private sitter was not at her bedside. A nurse, (LPN (licensed practical nurse) #2, was also observed at this time preparing medications for Resident #203 in the doorway of Resident #203's room. On 1/25/18 at 10:52 p.m., observation revealed LPN #2 was administering Resident #203's medications. LPN #2 then walked out of the room and then returned to her room with the vital sign machine. LPN #2 took Resident #203's vital signs and then walked out of her room.

On 1/25/18 at 10:54 a.m., LPN #2 stated to this writer she was finished with Resident #203. When asked if Resident #203 was a fall risk, LPN #2 stated Resident #203 was a fall risk. When asked what Resident #203 needed to have in place to prevent falls, LPN #2 stated the resident needed to have fall mats in place. When asked if fall mats were in place, LPN #2 stated, "I'll take a look." This writer accompanied LPN #2 into Resident #203's room. Observation revealed Resident #203 did not have fall mats in place. Resident #203's private sitter was in the room at this time. LPN #2 stated, "No. she doesn't." When asked how nurses are made aware of interventions that need to be put into place for a particular resident, LPN #2 stated the nurses would look at the chart and the orders to see what each resident needed. When asked if nurses could look anywhere else to see what each resident required, LPN #2 stated she was not sure. When asked the purpose of the care plan, LPN #2 stated the care plan had general

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information about each resident. LPN #2 also stated the care plan instructed the nurses on what interventions need to be in place for each resident. On 1/25/18 at 10:58 a.m., LPN #2 stated the fall mats must not have made it to Resident #203's new room. This writer accompanied LPN #2 to Resident #203's old room. Observation of Resident #203's old room revealed the fall mats resting up against the wall.

On 1/25/18 at approximately 12:00 p.m., further interview was conducted with LPN #2. When asked how CNAs (certified nursing assistants) are made aware of interventions that need to be in place to prevent falls, LPN #2 stated after a fall nursing staff would have a meeting with the aides. LPN #2 stated fall mats should also be in their documentation under PCC (point click care). When asked who was responsible for updating the interventions in PCC for the nursing aides to follow, LPN #2 stated she was not sure who updated the guide for the nursing aides. LPN #2 stated she has never updated interventions under PCC.

On 1/25/18 at 3:04 p.m., an interview was conducted with CNA (certified nursing assistant) #1. When asked how CNAs are made aware of resident needs to prevent falls, CNA #1 stated that she would get that information in a verbal report from the nurses. CNA #1 stated interventions also should be documented on the Kardex for that particular resident. CNA #1 stated she could access the Kardex through PCC. When asked if she works with Resident #203, CNA #1 stated she does not normally work with her. CNA #1 pulled up Resident #203's Kardex. Fall mats were not on Resident #203's Kardex.

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F 689	Continued From page 30 On 1/25/18 at 1:31 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. Review of the facility's "Fall Management Program" documents in part, the following: "The fall management program describes the interdisciplinary approach to managing resident falls. The program focuses on two areas: - Mitigate the risk of falls through increased awareness. - Managing falls that occur, including a root-cause analysis to determine how to minimize future risk. The program's components are -The assessment of residents and identification of risk for falls. -Ensure a focus on a safe environment and reduce the likelihood of injury from a fall. -Implement interventions to help prevent falls. - Manage falls; despite best efforts -can occur in the community. Goal: The goal is to provide residents with an environment that promotes safety while minimizing the risk of injury. This can be accomplished by using prevention and management strategies." No further information was presented prior to exit.	F 689		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record	F 697		

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review, it was determined the facility staff failed to ensure a comprehensive pain management program for one of 19 residents in the survey sample, Resident # 6.

The facility staff failed to implement non-pharmacological interventions prior to the administration of PRN (as needed) pain medication for Resident # 6.

The findings include:

Resident # 6 was admitted to the facility on 06/18/2015 with a readmission date of 06/16/2017 with diagnoses that included but were not limited to; hypertension (1), glaucoma (2), mononeuropathy (3), anemia (4), depression and mitral valve prolapse (5).

Resident # 6's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/12/17, coded Resident # 6 as scoring a 13 on the brief interview for mental status (BIMS), of a score of 0 - 15, 13 being cognitively intact for making daily decisions. Resident # 6 was coded as requiring extensive assistance of one staff member for activities of daily living.

The POS (Physician's Order Sheet) for Resident # 6 dated "Nov (November) 6, 2017 and signed by the physician on 11/8/17 documented, "Tylenol (6) - tablet; 325 MG (milligrams) (Acetaminophen). Give 2 (two) tablet by mouth every 6 (six) hours as needed for pain." Start Date: 11/17/2016.

The POS (Physician's Order Sheet) for Resident # 6 dated "Dec (December) 4, 2017 and signed

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by the physician on 12/6/17 documented, "Tylenol - tablet; 325 MG (milligrams) (Acetaminophen). Give 2 (two) tablet by mouth every 6 (six) hours as needed for pain." Start Date: 11/17/2016.

The POS (Physician's Order Sheet) for Resident # 6 dated "Jan (January) 3, 2017 and signed by the physician on 1/3/18 documented, "Tylenol - tablet; 325 MG (milligrams) (Acetaminophen). Give 2 (two) tablet by mouth every 6 (six) hours as needed for pain." Start Date: 11/17/2016.

The eMAR dated November 1, 2017 through November 30, 2017 documented Acetaminophen tablet 325 MG was administered on the following dates and times: 11/07/17 at 2:04 a.m. and 6:35 p.m., 11/09/17 at 12:38 a.m., and 11/25/17 at 1:45 a.m. The eMAR code for each date the Acetaminophen tablet; 325 MG tablet was administered documented, "E (effective)."

The eMAR dated December 1, 2017 through December 31, 2017 documented Acetaminophen tablet 325 MG was administered on the following dates and times: 12/04/17 at 2:20 a.m. and 12/13/17 at1:44 a.m. The eMAR code for each date the Acetaminophen tablet; 325 MG tablet was administered documented, "E (effective)."

The eMAR dated January 1, 2018 through January 24, 2018 documented Acetaminophen tablet 325 MG was administered on the following dates and times: 01/01/18 at 3:58 a.m., 01/05/18 at 12:25 p.m., 01/09/18 at 4:15 a.m., 01/11/18 at 2:15 a.m., 01/18/18 at 2:29 a.m., 01/19/18 at 5:50 p.m., and 01/23/18 at1:11 a.m. The eMAR code for each date the Acetaminophen tablet; 325 MG tablet was administered documented, "E (effective)."

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The eMARs dated November 2017, December 2017 and January 2018 failed to evidence documentation of non-pharmacological approaches.

The care plan to address pain for Resident # 6 dated 10/23/2017 failed to evidence documentation regarding non-pharmacological approaches.

On 01/24/18 at 03:15 p.m., an interview was conducted with Resident # 6. Resident # 6 was in her bed awake, neat and clean. When asked if the nurse tries other interventions before administering her as needed pain medication Resident # 6 stated, "No, not necessarily."

On 01/24/18 at 3:58 p.m., an interview was conducted with LPN (licensed practical nurse) # 1. LPN #1 was asked to describe the procedure staff follows when administering PRN (as needed) pain medication. LPN # 1 stated, "If the patient is verbal I find out their pain level on a scale of 1 (one) to 10, with 10 being the worst. If the patient is nonverbal I use there facial expressions to see how much pain they are in. I check the last time pain medication was given, ask the patient to describe the pain and where it is. I check the MAR (medication administration record) and the physician's order for the pain medication and based on that I give the pain medication." When asked where and what is documented, LPN # 1 stated, "I check the MAR that the pain med (medication) was given. I check the patient after about 30 minutes to see if the pain has improved and continue to monitor the patient." When asked about using non-pharmacological interventions, LPN # 1

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stated, "Those are tried first before giving the pain medication." When asked about documenting the non-pharmacological interventions LPN # 1 stated, "I would document in the progress notes what interventions where tried and what the pain level was before and after the interventions or medication."

On 01/25/18 at 9:16 a.m., an interview was conducted with LPN # 1. LPN # 1 was asked to review the progress notes and MARs dated 11/01/17 through 01/23/18 for Resident # 6. When asked if there was documentation that non-pharmacological intervention were attempted prior to the administration of PRN pain medications, LPN # 1 stated, "No." LPN # 1 further stated, "If it wasn't documented I can't say it was done."

On 01/25/18 at 4:53 p.m. an interview with ASM (administrative staff member) # 2, director of nursing. When asked to describe the procedure for administering PRN pain medications, ASM # 2 stated, "Reassess resident using pain scale, ask where the pain is, what their pain goal is (what is comfortable for the resident). First, try a non-pharmacological approach, if it doesn't work offer the pain meds (medications) according to the physician's orders. Reassess after 30 to 45 minutes. If the resident is, still having pain try another non-pharmacological approach. Reassess again in 30 minutes. Nurses should document on the MAR what pain medication was administered. The non-pharmacological interventions should be documented on the point of care or progress notes." When asked what the point of care was, ASM # 2 stated, "The point of care is part of the HER (electronic health record). It is used to document ADLs (activities of daily

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living), vitals, pain level, weights and interventions including non-pharmacological." ASM # 2 was then asked to provide copies of the point of care sheet from 11/01/17 through 01/24/18 for Resident # 6.

On 01/26/18 at 8:15 a.m., ASM # 2 provided this surveyor copies of the point of care for Resident # 6 dated January 1, 2018 through January 25, 2018. ASM # 2 stated she was unable to print off the point of care reports for November and December 2017 because the system would only print the current month. Resident #6's point of care report was reviewed with ASM # 2. When asked if there was documentation that non-pharmacological were attempted before the administration of the PRN acetaminophen, ASM # 2 stated, "No." ASM # 2 further stated there was no additional information that non-pharmacological interventions were attempted for the PRN acetaminophen administered to Resident # 6 in November and December 2017.

On 01/25/18 at approximately 1:30 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:
(1) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(2) A group of diseases that can damage the eye's optic nerve. This information was obtained

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from the website: https://www.nlm.nih.gov/medlineplus/glaucoma.html.

(3) Damage to a single nerve, which results in loss of movement, sensation, or other function of that nerve. This information was obtained from the website: https://medlineplus.gov/ency/article/000780.htm.

(4) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .

(5) A heart problem involving the mitral valve, which separates the upper and lower chambers of the left side of the heart. In this condition, the valve does not close normally. This information was obtained from the website: https://medlineplus.gov/ency/article/000180.htm.

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

F 759 Free of Medication Error Rts 5 Prcnt or More — F 759

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§483.45(f) Medication Errors.
The facility must ensure that its-

§483.45(f)(1) Medication error rates are not 5 percent or greater;
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure two of five residents in the medication administration observation (Residents #7 and #103) were free of a medication error rate of five percent or greater. There were three errors out of 34 opportunities and the error rate was 8.82%.

1. The facility staff failed to administer buspirone 15 mg (milligrams) to Resident #7 per physician's order.

2.a. The facility staff failed to administer apixaban 5 mg to Resident #103 per physician's order.

2.b. The facility staff failed to hold Resident #103's metoprolol per physician's order.

The findings include:

1. The facility staff failed to administer buspirone (1) 15 mg (milligrams) to Resident #7 per physician's order.

Resident #7 was admitted to the facility on 4/22/15 and readmitted on 1/4/17. Resident #7's diagnoses included but were not limited to: diabetes, major depressive disorder and anxiety disorder. Resident #7's most recent MDS

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(minimum data set), an annual assessment with an ARD (assessment reference date) of 1/11/18, coded the resident's cognition as severely impaired.

Review of Resident #7's clinical record revealed a physician's order dated 1/4/17 for buspirone 15 mg- one tablet by mouth one time a day. Resident #7's January 2018 MAR (medication administration record) documented the above physician's order and scheduled the medication administration at 8:00 a.m... Resident #7's comprehensive care plan initiated on 7/21/15 documented, "Administer anti-anxiety medication as ordered by the physician..."

On 1/24/18 at 7:48 a.m., during the medication administration observation, LPN (licensed practical nurse) #1 was observed preparing and administering medications to Resident #7. LPN #1 failed to prepare and administer the physician ordered buspirone. On 1/24/18 at 9:50 a.m., an interview was conducted with LPN #1. LPN #1 was made aware this surveyor did not observe her prepare or administer Resident #7's buspirone. LPN #1 pulled the bubble pack containing buspirone from the medication cart and stated the medication was in the cart along with the other medications she prepared and administered.

On 1/25/18 at 1:31 p.m. ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

The facility document titled, "Medication Administration- Key points to Remember Potter & Perry 9th Edition documented, "The six rights of

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medication administration contribute to accurate preparation and administration of medication doses. The six rights of medication administration are the right medication, right dose, right patient, right route, right time, and right documentation."

No further information was presented prior to exit.

(1) Buspirone is used to treat anxiety. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a688005.html

2.a. The facility staff failed to administer apixaban (1) 5 mg (milligrams) to Resident #103 per physician's order.

Resident #103 was admitted to the facility on 11/22/15 and readmitted on 1/18/18. Resident #103's diagnoses included but were not limited to: muscle weakness, anxiety disorder and atrial fibrillation (1). Resident #103's admission MDS (minimum data set) assessment was not complete. An admission service evaluation and health assessment dated 1/18/18 documented Resident #103 made independent decisions regarding tasks of daily life.

Review of Resident #103's clinical record revealed a physician's order dated 1/18/18 for apixaban 5 mg- one tablet by mouth every 12 hours. Resident #103's January 2018 MAR (medication administration record) documented the above physician's order and scheduled the medication at 8:00 a.m. Resident #103's comprehensive care plan initiated on 1/19/18 documented, "The resident (sic) receiving anticoagulant therapy...Administer medications as

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ordered by the physician..."

On 1/24/18 at 7:53 a.m., during the medication administration observation, LPN (licensed practical nurse) #1 was observed preparing and administering medications to Resident #103. LPN #1 failed to prepare and administer the physician ordered apixaban. On 1/24/18 at 9:50 a.m., an interview was conducted with LPN #1. LPN #1 was made aware this surveyor did not observe her prepare or administer Resident #103's apixaban. LPN #1 stated every medication she administered to Resident #103 was in an individual bubble pack but the packs were all together in the medication cart. LPN #1 pulled a group of Resident #103's medication packs that were grouped together with a rubber band from the medication cart and showed this surveyor the resident's apixaban that had not been administered.

On 1/25/18 at 1:31 p.m. ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

No further information was presented prior to exit.

(1) "Apixaban is used help prevent strokes or blood clots in people who have atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body and possibly causing strokes) that is not caused by heart valve disease." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a613032.html

2.b. The facility staff failed to hold Resident

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#103's metoprolol (1) per physician's order.

Review of Resident #103's clinical record revealed a physician's order dated 1/18/18 for metoprolol 12.5 mg (milligrams) by mouth two times a day and to hold the medication if the resident's blood pressure was less than 110 or if the resident's pulse (heart rate) was less than 60. Resident #103's January 2018 MAR (medication administration record) documented the above order. Resident #103's comprehensive care plan initiated on 1/19/18 failed to document specific information regarding blood pressure medication.

On 1/24/18 at 7:53 a.m., during the medication administration observation, LPN (licensed practical nurse) #1 was observed preparing and administering medications to Resident #103. Resident #103's blood pressure was 108/66; however, LPN #1 prepared and administered metoprolol 12.5 mg to the resident.

On 1/24/18 at 9:50 a.m., an interview was conducted with LPN #1. LPN #1 was asked why she administered metoprolol to Resident #103 when the resident's blood pressure was 108 and the physician's order documented to hold the medication for a blood pressure less than 110. LPN #1 stated she spoke to (name of physician) earlier in the week and asked why Resident #103 was receiving metoprolol (used to treat high blood pressure) and another medication used to treat low blood pressure. LPN #1 stated (name of physician) wanted the metoprolol to be given to Resident #103 based on the resident's pulse and the medication should be administered when the resident's pulse is over 60. LPN #1 was asked to provide evidence of this since there was a current physician's order to hold the metoprolol for a

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blood pressure less than 110.

On 1/25/18 at 7:48 a.m., a telephone interview was conducted with ASM (administrative staff member) #3 (the physician LPN #1 stated she spoke with earlier in the week). ASM #3 stated he did have a conversation with LPN #1. ASM #3 stated LPN #1 was going through Resident #103's chart and questioned why Resident #103 was receiving metoprolol and a medication that lowers blood pressure. ASM #3 stated he looked at Resident #103's chart and noted the dose of metoprolol was low. ASM #3 stated the medication orders were part of the resident's hospital discharge and he wanted to make sure Resident #103's blood pressure was stable until the cardiologist saw the resident because beta-blockers (a class of medications including metoprolol) are more so for heart rate control versus blood pressure control. ASM #3 stated he mentioned he usually orders parameters to hold the medication for a blood pressure less than 100 and a heart rate less than 55 but Resident #103 already had established parameters to hold the medication for a blood pressure less than 110 and a heart rate less than 60. ASM #3 stated he decided to continue to monitor Resident #103 without making any changes and did not write or verbalize any new orders. ASM #3 confirmed the parameters were to remain the same as ordered.

On 1/25/18 at 1:31 p.m. ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

No further information was presented prior to exit.

(1) Metoprolol is used to treat high blood pressure

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and heart failure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682864.html

F 812 SS=E — Food Procurement,Store/Prepare/Serve-Sanitary — CFR(s): 483.60(i)(1)(2) — F 812

§483.60(i) Food safety requirements.
The facility must -

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, it was determined the facility staff failed to prepare food in a clean and sanitary manner.

The facility staff failed to maintain the food processor in a sanitary condition.

The findings include:

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Observation and tour of the kitchen was conducted on 01/23/18 at approximately 11:40 a.m. with OSM (other staff member) # 8, the dietary manager. The following was observed:

A food processor was observed setting on the food preparation table. OSM # 8 was asked if the food processor was cleaned and ready for use, she stated, "Yes." Further observation of the food processor revealed the processing bowl on the food preparation table with the blade attached inside the bowl and a plastic lid on the bowl. Examination of the inside of the bowl revealed the blade was wet and small pool of water in the bottom of the bowl. OSM # 8 was asked to examine the inside of the food processor bowl. When asked if the food processor blade was wet, and if there was standing water in the bottom of the bowl, OSM # 8 stated, "Yes." When asked if the parts of the food processor were to be stored wet, OSM # 8 stated, "No" and immediately had them removed to be washed.

The facility's policy "Food Processor" documented, "1. Wash attachments in hot water in pot and pan sink. Use hot water and sanitizing solution. Allow attachments to air dry."

On 01/25/18 at approximately 1:30 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

F 842 Resident Records - Identifiable Information F 842
SS=D CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)

§483.20(f)(5) Resident-identifiable information.

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(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for one of 19 residents in the survey sample, Resident #15.

The facility staff failed to document wound care on 12/21/17 through 12/23/17.

The findings include:

Resident #15 was admitted to the facility on 8/18/17. Resident #15's diagnoses included but

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were not limited to a stage four pressure injury (1) to the sacral region (2), Huntington's disease (3) and muscle weakness. Resident #15's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/24/17, coded the resident's cognition as moderately impaired.

Review of Resident #15's clinical record revealed a paper physician's order dated 12/21/17 that documented, "Cleanse sacral wound with wound cleanser, pat dry, apply pack wound with silver alginate (4) and cover with dry dressing daily." Review of Resident #15's December 2017 MAR/TAR revealed the order was not transcribed onto the MAR until 12/24/17. Review of facility documentation and interviews with nurses revealed the wound treatment ordered on 12/21/17 was provided to Resident #15 from 12/21/17 through 12/24/17 but was not documented in the clinical record (including on the December 2017 MAR/TAR or nurses' notes).

Resident #15's comprehensive care plan initiated on 8/22/17 documented, "Adhere to the residents (sic) treatment plan for the prevention/treatment of skin breakdown..."

On 1/25/18 at 11:41 a.m., an interview was conducted with RN (registered nurse) #3. RN #3 stated he completed Resident #15's wound care treatments as ordered but did not realize the order was not on the MAR/TAR or realize he failed to document the completed treatments.

On 1/25/18 at 1:31 p.m. ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. A policy regarding documentation

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of wound care treatments was requested.

The facility "Skin Care & Pressure Ulcer (injury) Management Program" failed to document specific information regarding the documentation of daily treatments.

No further information was presented prior to exit.

(1) "A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue...Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer..." This information was obtained from the website: http://www.npuap.org/national-pressure-ulcer-advisory-panel-npuap-announces-a-change-in-terminology-from-pressure-ulcer-to-pressure-injury-and-updates-the-stages-of-pressure-injury/

(2) "The sacrum is a shield-shaped bony structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis." This information was obtained from the website: https://medlineplus.gov/ency/imagepages/19464.htm

(3) "Huntington's disease (HD) is an inherited disease that causes certain nerve cells in the

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brain to waste away..." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=huntington%27s&_ga=2.258684494.51318264.1517228909-139120270.1477942321

(4) Silver Alginate is used to treat wounds. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4486446/

F 880 SS=F — Infection Prevention & Control — F 880
CFR(s): 483.80(a)(1)(2)(4)(e)(f)

§483.80 Infection Control
The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, 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;

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§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.

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The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:

Based on observations and staff interview, it was determined that the facility staff failed to process and store linens in a sanitary manner.

The facility staff failed to keep clean linens off the floor when folding them and failed to keep air vent and fans free of dust when folding and storing clean linens.

The findings include:

On 01/24/18 at approximately 9:15 a.m., an observation of the facility's laundry room was conducted. In the clean laundry area, two bins of unfolded clean towels and tablecloths were uncovered, setting in front of the dryers and a bin of unfolded and uncovered clean tablecloths to the right and in front of the ironing/pressing machine. OSM (other staff member) # 1, housekeeping supervisor for Mondays, Tuesdays, Wednesdays, Saturdays and Sundays was observed folding table clothes in half and placing them into the ironing/pressing machine. As OSM # 1 was folding the tablecloths, the bottom ends were being dropped onto the floor as they were placed in the ironing/pressing machine. Further observation of the clean laundry area revealed a 12-inch fan mounted on the wall to the left of the ironing/pressing machine. The fan blades and fan guards were covered in gray dust. The fan was on and blowing toward the ironing machine and the bins of clean towels and tablecloths. Above and to the right of the ironing machine was a cold air return vent on the ceiling with several baffles covered with dark gray dust. Above and

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to the right of the ironing/pressing machine and to the left of the clothes dryers on the ceiling was an AC (air conditioning)/ heating vent measuring approximately 10 inches square with diffusers. The vent was mounted through a 24 by 24 inch ceiling tile. The ceiling tile was observed to have gray dust hanging from the ceiling tile and blowing. The four edges of the ceiling tile that were in contact with the AC/ heating vent were yellowed, gray and black in color. Directly below the AC/heating vent were the two uncovered clean bin of towels and tablecloths.

Further observation of the laundry area reveal an area in the hallway outside of the clean laundry area where OSM # 3, housekeeping supervisor Monday through Fridays was observed folding clean linens. The area in the hallway revealed two square 3 foot by 3-foot tables, a long eight-foot table, and an uncovered bin of clean tablecloths and cloth napkins. Observation of the eight-foot table revealed a stack of clean, folded tablecloths and cloth napkins. Observation of the ceiling above the uncovered bin of tablecloths and cloth napkins revealed an AC / heating vent measuring approximately 10 inches square with diffusers. The vent was mounted through a 24 by 24 inch ceiling tile. The AC / heating vent was observed with gray dust on the baffles and surrounding ceiling tiles. Observation of the ceiling tiles extending over the tables revealed gray dust collected on the ceiling tiles.

On 01/24/18 at approximately 9:30 a.m., an interview was conducted with OSM # 1, housekeeping supervisor. When asked if the linens, table clothes and cloth napkins were for the health care unit OSM # 1 stated, "Yes. They're for the health care unit and assisted living

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unit."

On 01/25/18 at approximately 9:55 a.m., an observation of the facility's laundry room was conducted. In the clean laundry area two bins of unfolded clean tablecloths were uncovered, one setting in front of the dryer and another bin of unfolded, uncovered clean tablecloths to the right and in front of the ironing/pressing machine. OSM (other staff member) # 6, housekeeping supervisor was observed placing clean cloth napkins into the ironing/pressing machine. Further observation of the clean laundry area revealed a 12-inch fan mounted on the wall to the left of the ironing/pressing machine. The fan blades and fan guards were covered in gray dust. The fan was on and blowing toward the ironing/pressing machine and the bins of unfolded, clean tablecloths and cloth napkins. Above and to the right of the ironing/pressing machine was a cold air return vent on the ceiling with several baffles covered with dark gray dust. Above and to the right of the ironing/pressing machine and to the left of the clothes dryers was an AC (air conditioning)/ heating vent on the ceiling measuring approximately 10 inches square with diffusers. The vent was mounted through a 24 by 24 inch ceiling tile. The ceiling tile was observed to have gray dust collecting and hanging from the ceiling tile and blowing. The four edges of the ceiling tile that were in contact with the AC/ heating vent were yellowed, gray and black in color. Directly below the AC / heating vent were the two uncovered, clean bins of cloth napkins and tablecloths.

Further observation of the laundry area reveal an area in the hallway outside of the clean laundry area where OSM # 5, laundry attendant and OSM

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7, housekeeper were observed folding clean linens, tablecloths and cloth napkins. The area in the hallway revealed two square 3 foot by 3-foot tables, a long eight-foot table, and an uncovered bin of clean tablecloths and cloth napkins. Observation of the eight-foot table revealed a stack of clean, folded tablecloths and cloth napkins. The two, three-foot square tables had clean and folded linens, clothing protectors and bed mats stacked on them. Observation of the ceiling above the uncovered bin of table clothes and cloth napkins revealed an AC / heating vent measuring approximately 10 inches square with diffusers. The vent was mounted through a 24 by 24 inch ceiling tile. The AC / heating vent was observed with gray dust on the baffles and surrounding ceiling tiles. Observation of the ceiling tiles extending over the tables revealed gray dust collected on the ceiling tiles.

On 01/25/18 at approximately 10:05 a.m. an interview and observation of the facility's laundry area was conducted with OSM # 2, director of housekeeping. After pointing out and observing the wall mounted fan, AC/heating vents in the clean laundry area and hallway, the cold air return vent in the clean laundry area and the ceiling tiles in the hallway above the tables and in the clean laundry area OSM # 2 stated, "They should be cleaned." OSM # 2 stated that he had just started working at the facility two months ago and was not aware of the dusty fan, vents and ceiling tiles. OSM # 2 further stated he would be creating a log for cleaning the fans, vents and ceiling tiles every other day. When asked about the clean linens touching the floor as they were placed in the ironing/pressing machine OSM # 2 stated, "Clean linens should never touch the floor."

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F 880	Continued From page 55 On 01/25/18 at approximately 1:30 p.m. ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit.	F 880		