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CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 09/05/17 through 09/11/17. Significant Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two complaints were investigated during the survey. The census in this 180 certified bed facility was 152 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents 1 through 21) and three closed record reviews (Residents 22 through 24).	F 000	Preparation and submission of this plan of correction by **Charlottesville Pointe Rehabilitation and Healthcare, LLC.,** does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The Plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.	
F 155 SS=D	483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES 483.10 (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. (g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F 155	F155: 1. Resident #2 's physician orders and care plan were corrected on 9 /6/2017 by licensed nurse. Resident #2 was also assessed by a Registered Nurse on 9/27/17 and physician notified regarding order and resident right to refuse medication by a licensed nurse. 2. A 100% audit of current residents was completed on 9/13/2017 by the regional nurse consultant related to any other physician orders related to administration of intra-muscular medication as a result of medication refusal. No negative findings noted. 3. Licensed Staff will be reeducated by Staff Development Coordinator or designee by 10/3/2017 related to ensuring residents rights regarding medication refusals are upheld.	

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

Cheryl L Martin 9/27/17

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(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.

(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.

(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.

(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

483.24
(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, clinical record review and complaint investigation, the facility staff denied one of 24 residents in the survey sample the right to refuse medications (Resident #2).

4. The Social Services Director or designee will conduct audits of 5 residents weekly for 4 weeks and monthly for 2 months to ensure resident rights related to medication refusals are upheld.
The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for recommendations of any follow up that may be needed.
5. Completed by 10/3/2017

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1. When Resident #2 refused an oral dose of the anti-anxiety medication Lorazepam, a physician's order was obtained to administer the medication by injection if refused orally. Resident #2 was administered eight doses of Lorazepam by injection after one prior refusal to take the medication orally.

The findings include:

1. When Resident #2 refused an oral dose of the anti-anxiety medication Lorazepam, a physician's order was obtained to administer the medication by injection if refused orally. Resident #2 was administered eight doses of Lorazepam by injection after one prior refusal to take the medication orally. The clinical record documented no rationale for the injected Lorazepam.

Resident #2 was admitted to the facility on 7/13/17 with diagnoses that included bipolar disorder, history of catatonia, hypernatremia (excess sodium in the blood), hyperkalemia (high potassium concentration in the blood), depression, diabetes, high blood pressure, anxiety, osteoporosis and dementia. The minimum data set (MDS) dated 7/26/17 assessed Resident #2 with severely impaired cognitive skills.

Resident #2's clinical record documented a physician's order dated 7/13/17 for Lorazepam 2 mg (milligrams) to be administered three times per day for management of anxiety. The resident's medication administration record (MAR) for July 2017 documented the medication was administered as ordered until 7/28/17. The

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MAR documented the resident refused to take the Lorazepam at 9:00 a.m. on 7/28/17 and at again at 2:00 p.m. on 7/29/17.

A nursing note dated 7/28/17 at 2:16 p.m. documented, "Resident refuse meds [medications] not talking daughter in spoke with... [community day program] md [physician] new order obtain for im [intramuscular] Ativan [Lorazepam] if resident refuse po [oral]..." (sic) The record documented a physician's order dated 7/28/17 stating, "Lorazepam Solution 2 mg/ml [milligrams per milliliter] Inject intramuscularly three times a day...if resident refuses po."

Resident #2's MAR documented the resident was administered eight doses of Lorazepam by injection. Lorazepam injections were administered to Resident #2 on 7/28/17, 7/29/17, 7/30/17 (3 doses), 7/31/17 and 8/1/17 (2 doses). The July 2017 MAR documented only one dose of oral Lorazepam refused by the resident prior to the order and administration of injectable Lorazepam. Nursing notes documented no behaviors demonstrated by the resident during July 2017 or August 2017 and documented no rationale for obtaining the order for injectable Lorazepam other than the resident's refusal to take the medication by mouth. The record documented no progress notes from the resident's physician indicating why the resident's right to refuse medication was not honored or any rationale for the injected Lorazepam.

Resident #2's plan of care (revised 8/9/17) documented the resident at times refused to go to community day programming and refused to eat meals but made no mention of any refused of medications.

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On 9/5/17 at 2:30 p.m. the registered nurse (RN #3) caring for Resident #2 was interviewed about the order for Lorazepam injections. RN #3 stated he had no issues with Resident #2 taking medications by mouth. RN #3 stated the resident occasionally refused but usually took medications after encouragement. RN #3 stated the resident occasionally turned her head and held her mouth shut when offered oral medications. RN #3 stated when the resident refused to take oral medications he returned at a later time, talked with the resident and encouraged her to take the medicines. RN #3 stated most times the resident was cooperative and took the medications. RN #3 stated Resident #2 was "always pleasant" and demonstrated no aggressive behaviors. RN #3 stated he did not know why the order was obtained to give the Lorazepam by injection.

The facility's policy regarding resident rights (revised 7/03) stated a resident, "Is assured of adequate and appropriate medical care, is fully informed, by a physician, of his medical condition unless medically contraindicated (as documented, by a physician, in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to refuse to participate in experimental research, and to refuse medication and treatment after being fully informed of and understanding the consequences of such actions..."

These findings were reviewed with the administrator and director of nursing during a meeting on 9/5/17 at 5:00 p.m.

F 155

F 157 483.10(g)(14) NOTIFY OF CHANGES
SS=G (INJURY/DECLINE/ROOM, ETC)

F 157

F157:

1. The physician for Resident# 14 was notified of the wound on 9/ 6 /2017. Resident #14 was also assessed by a

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F 157	Continued From page 5 (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 157	Registered Nurse on 9/6/17 regarding status of current wounds; care plan for resident#14 was also reviewed on 9/6/17 regarding wounds. 2. An 100% audit of all current residents skin was completed on 9/10/2017 by Licensed Nurse. The physician has been notified of new skin related issues found during audit process. 3. The nursing staff will be reeducated by the Staff Development Coordinator or designee related to notification related to skin related issues by 10/3/2017. 4. The Director of Nursing or designee will conduct audits of 5 residents weekly for 4 weeks and monthly for 2 months to ensure physician is notified of wounds. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed. 5. Completed by 10/3/2017	

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as specified in §483.10(e)(6); or

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.

(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to notify the physician of a change in condition for one of 24 residents, Resident #14. This resulted in harm.

An unknown staff member identified a wound on Resident #14's left leg stump, and placed a dressing over the wound without a physician's order. The physician was not notified of the wound's presence until it was identified by the survey team. The dressing remained in place for an unknown length of time and when removed on 09/06/2017 the wound was an unstageable pressure ulcer.

Findings were:

Resident #14 was admitted to the facility on 05/05/2016. His diagnoses included but were not limited to: Bilateral BKA (below the knee amputations), atrial fibrillation, hypertension, diabetes mellitus with diabetic polyneuropathy, and acute respiratory failure.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 07/27/2017. Resident #14 was

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assessed as having a cognitive summary score of "04", indicating severe impairment with his cognitive status. However, Resident #14 answered the survey team's questions appropriately during a resident interview and during verbal interaction with the survey team members. Resident #14 was very hard of hearing and while this hindered his ability to understand, if spoken to directly and into his ear he answered and carried on a conversation with no difficulty.

Resident #14 was interviewed by a member of the survey team on 09/05/2017 at approximately 2:30 p.m. During the interview he pulled up his left pants leg to show the surveyor a dressing on his left leg stump. He stated that he had been asking for three weeks to go to the "leg doctor'...that his prosthetic leg had rubbed a spot on his stump.

On 09/06/2017 at approximately 8:00 a.m., Resident #14's clinical record was reviewed. There were no entries in the clinical record regarding a wound for Resident #14.

At approximately, 9:00 a.m., RN (registered nurse) #4 who was one of the wound nurses at the facility was in the conference room to speak with a member of the survey team. She was asked if she was doing dressing changes for (Name of Resident #14). She stated that she was not doing any dressing changes with him and was not aware that he had a wound.

This surveyor went to the unit where Resident #14 resided. Resident #14 was asked if he had a dressing on one of his legs. Resident #14 stated, "Yeah", and pulled up his pants leg on his left leg

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stump. Observed was a square border gauze dressing. An area of drainage was observed on the bandage. The was no date, time or initials to indicate when the dressing had been applied or who had applied it. Resident #14 was asked who put the dressing on his leg and how long it had been there. He stated, "It's been on there for three days... one of the girls here put it on there, I don't remember which one... it's came from trying to wear my legs... you want to see it? I'll take it [the dressing] off of there." Resident #14 was asked to leave the dressing in place until this surveyor could get a staff person in the room to assist him.

This surveyor went out into the hallway and asked RN # 7 if she knew anything about a dressing on Resident #14's leg. She stated, "I've worked here since last Thursday... this is the first time I have been on this hall, I don't know anything about these residents, I am just giving medications." This surveyor then went to the other side of the unit. RN # 3 was observed in an office with his cell phone in hand. He came out to speak with this surveyor. He was asked if he knew anything about Resident #14. He stated that he did not work that end of the hall. He was asked who the unit manager was. He stated "We don't have a unit manager so [Name of the Director of Nursing] is who we go to."

This surveyor went to the DON's office. The DON was asked who could discuss the dressing on Resident #14's leg. She directed this surveyor to RN #2, who was the other wound nurse at the facility. RN #2 was busy with another resident.

At approximately 10:00 a.m., this surveyor met RN #2 in the hallway. RN #2 was asked if she

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knew anything about a dressing over a wound on Resident #14's leg. She stated, "I just heard about that." This surveyor, RN #2 and the medical director went to Resident #14's room. The dressing had been removed from his left leg stump. The wound was covered with a scab. The medical director, lifted the scab up stating, "This is a mobile scab." The wound nurse was asked to measure the wound. She measured the area underneath the scab and stated, "It is 1.2 X 1 X .2" She was asked what the yellow area covering the bottom of the wound was. She stated, "That's slough". The edges of the wound were rolled and bright pink in color. The wound nurse was asked what she would stage the wound as. She stated, "A three." The medical director stated, "I would call it a stage 2 or a Stage 3...it's about the depth." The physician was asked if he had been made notified of the wound prior to that morning (09/06/2017). He stated, "No." He was asked if he would expect to be notified when an open wound was discovered on a resident. He stated, "Yes.

The above information was discussed with the administrator, the administrator in training (AIT), the DON, and other facility staff during an end of the day meeting on 09/07/2017. The DON was asked what her expectation would be if a pressure ulcer was identified by staff. She stated, "The doctor should be notified and orders obtained for treatment." A copy of any facility policy/protocol for physician notification was requested.

On 09/11/2017, at approximately 9:00 a.m., the Administrator and the AIT came to the conference room to present additional information to the survey team. Included in the information was a

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F 157	Continued From page 10 facility policy for "Change in Condition". The policy contained the following instruction: "In order to maintain the resident's safety, a resident's change in condition will be collected and reported in a timely manner...The nursing staff will contact the Physician about significant changes in condition..." The administrator asked if the policy presented is what should have been followed when the wound on Resident #14's left leg stump was originally identified by facility staff and covered without an order. She stated, "Yes." No further information was presented prior to the exit conference on 09/11/2017.	F 157		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or	F 225	F225 1. The facility investigated and reported the alleged unusual occurrence for Resident #3 on 9/11/2017. The facility investigated and reported the alleged unusual occurrence with Resident #2 on 9/27/2017. 2. An audit was conducted by the Regional Nurse Consultant on 9/14/2017 of all incidents over last 30 days to determine if any incidents meet the requirement of Federal/State reporting guidelines and are investigated thoroughly. No negative findings noted.	

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licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate

3. The Administrator was re-educated by the Regional Nurse Consultant on 9/27/17 related to guidelines for reportable events according to Federal/State guidelines. Licensed staff will be inserviced by 10/03/17 related to conducting a thorough investigation related to incidents.
4. Audits related to any incidents will be conducted by the Administrator weekly

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CHARLOTTESVILLE POINTE REHABILITATION AND HEALTHCA	1150 NORTHWEST DRIVE CHARLOTTESVILLE, VA 22901

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corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, facility document review and during a complaint investigation, the facility staff failed to investigate and report an incident with potential neglect for two of 24 residents in the survey sample (Resident #3 and Resident # 2).

1. Resident #3 voluntarily signed himself out of the facility for a temporary leave of absence from the facility, the resident did not return; the resident was found under a bridge with loss of consciousness; the resident was taken to the emergency department and subsequently admitted for treatment. The facility staff did not report this to the state agency and did not conduct an investigation into the matter.

2. Resident #2 became entrapped by a side rail on the bed; the facility staff failed to report and investigate this incident.

Findings include:

1. Resident #3 voluntarily signed himself out of the facility for a temporary leave of absence from the facility, the resident did not return; the resident was found under a bridge with loss of consciousness; the resident was taken to the emergency department and subsequently admitted for treatment. The facility staff did not report this to the state agency and did not conduct an investigation into the matter.

Resident #3 was originally admitted to the facility on 10/11/16, with a current readmission on

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08/07/17. Diagnoses for Resident #3 included, but were not limited to: diabetes mellitus, anxiety disorder, depression, complete traumatic amputation of the left great toe, muscle weakness, difficulty walking, unsteadiness, cellulitis of the left lower limb, cough, lymphedema and osteomyelitis.

The most current full MDS (minimum data set) assessment with CAAS (care area assessment summary) was a significant change assessment dated 07/18/17. This MDS assessed the resident as having a cognitive score of '12', indicating resident had moderate impairment in daily decision making skills. The resident was also assessed as requiring limited assistance from one staff person for transfers, ambulation and bathing. The resident was assessed on this MDS to have cellulitis with infection and a surgical wound present. Additionally it was documented on this MDS, the resident received insulin injections in the 7 day look back period and also received IV ABX (intravenous antibiotics) during the 7 day look back. The resident triggered for cognition, ADL's (activities of daily living) and falls in the CAAS section of this MDS.

A 14 day admission MDS assessment was reviewed for comparison, dated 08/21/17. This MDS assessed the resident to have a cognitive score of '13', indicating the resident was cognitively intact for decision making skills. The resident was assessed as requiring supervision with setup for transfers and ambulation. The resident was also assessed as receiving IV ABX and insulin during the 7 day look back.

During a complaint investigation on 09/5/17 through 09/07/17, Resident #3's clinical record

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was reviewed.

ED [emergency department] provider notes for Resident #3 were reviewed for 8/4/17, timed for 6:15 a.m. documented, '...found altered by ems [emergency medical services] under a bridge, unknown down time or last seen normal, elevated blood sugar by fingerstick...history of alcohol abuse, cardiac arrest...seizure...he was non-responsive but able to talk upon EMS arrival...per [name of long term care facility] patient signed himself out at 4:30 p.m...[history] was admitted to gerontology for osteomyelitis due to diabetic foot ulcer from 7/3/17-7/7/17...6 weeks of IV vancomycin, ceftriaxone and oral flagyl...PICC was placed in left basillic vein for IV antibiotics...[current] glucose 641...ethanol 222...' It was documented that the resident received 10 units of IV insulin, IV fluids, insulin infusion protocol initiated and MICU [medical intensive care unit] was consulted. The resident was admitted to the MICU, the PICC line was removed on admission due to the PICC line ports inability to flush or infuse. The PICC was cultured with no growth at time of discharge on 8/7/17. A new PICC line was placed on 8/7/17.

Nursing notes were reviewed from August 1, 2017 through August 10, 2017.

On 08/02/16 at 3:28 a.m., it was documented that the resident 'continues on abx via picc [peripherally inserted central catheter]...purple port flushes well, but red port is occluded...'

08/02/17 at 2:02 p.m., it was documented, '...antibiotic iv for wound L [left] foot cellulitis resident ambulates on off unit using walker...'

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08/02/17 at 6:31 p.m., it was documented, '...continues on IV...for wound infection...'

08/03/17 at 2:31 a.m., it was documented, '...continues on IV...for infection and surgical removal of left great toe...'

A 'late entry' nursing note dated 8/3/17 and timed 10:19 a.m. [created on 8/14/17 at 10:26 p.m.] documented, '...located under a bridge, and later went to the hospital. SS [social services] created an APS referral as the facility staff feels he is a danger to himself as a reflection of his choices while signed out of the facility.'

A nursing note dated 8/4/17 and timed 7:08 a.m., documented, 'Reesident [sic] sign self out on 8/3/17 at 4:30 p.m. and did not return. at this time [name of hospital] called to ask if resident stay here [sic] and was told yes Nurse stated he was found under bridge and brough [sic] to ER [emergency room] Social worker states walker is with him and they will try to clear clog picc line ER [sic]...'

A 'late entry' nursing note dated 8/8/17 and timed 10:26 a.m. [created on 8/14/17 and timed 10:27 a.m.] documented, '...returned to the facility yesterday, and the APS referral was submitted to APS on today as the staff feels his recent choices while signed out could make him a danger to himself.'

On 9/5/17 at 5:00 p.m., the AA (acting administrator) was asked for a policy on residents signing themselves out of the facility.

On 9/6/17 at approximately 10:40 a.m., the AA and DON (director of nursing) were made aware

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of concerns regarding the above information and that this was not reported to the state agency. The facility's investigation on Resident #3 regarding the above information was requested at this time, along with a policy on resident's signing out of the facility, in addition to a policy on reportable incidents.

At approximately 3:45 p.m., the AA stated, '...we would not have reported to state, he is alert and oriented and goes out on LOA [leave of absence], goes out quite often, he was homeless..." The AA stated that the facility did not conduct an investigation for Resident # 22 regarding the above information and the facility does not have a policy on leave of absence and stated that the facility reported it to APS. The AA then stated, there may be something in the admission packet about resident's signing themselves out of the facility.

A policy was presented and reviewed on 'conducting a thorough investigation', which documented, 'When an actual and/or potential care and service failure occurs involving a resident, it is necessary for facility administration to initiate an investigation to determine the facts and then act upon or respond accordingly to the findings. Examples of issues that would require investigation...falls with injury or non-injury, allegations of abuse, injuries of unknown origin...elopement....The administrator is always the individual in the facility who has overall responsibility for ensuring that the investigation is conducted and that a conclusion is reached. The administrator, however may not always be the individual who will conduct the investigation. It is very important to determine who the responsible individual will be so that the investigation is

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completed in a timely and efficient manner..."

This policy did not document time frames as to when an investigation should be initiated and/or completed.

A policy was presented and reviewed on 'reporting abuse to state agencies and other entities' documented, 'All suspected violations and all substantiated incidents of abuse will be immediately reported...the facility administrator or his/her designee will promptly notify the following persons or agencies...a. The state licensing/certification agency responsible for surveying/licensing the facility..."

On 9/7/17 at approximately 3:20 p.m., the administrator, the AA, and DON were made aware of the above information and concerns surrounding the incident with Resident #3 and that the incident was not reported to the state agency and was not investigated.

On 9/11/17 at 11:50 a.m., the administrator stated that, 'as far as time frames' for reporting and investigating the regulations state 'immediately' and went on to say that is what the facility should be following.

No further information and/or documentation was presented prior to the exit conference on 9/7/17 at 4:30 p.m., to evidence that the facility conducted an investigation and/or reported this incident to the state agency.

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2. Facility staff failed to report to the state agency and conduct a thorough investigation after Resident #2 was found on the floor with her head wedged between the bed rail and the air mattress. There was no effort made by the facility to determine if Resident #2's entrapment incident involved neglect.

Resident #2 was admitted to the facility on 7/13/17 with diagnoses that included bipolar disorder, hypernatremia (excess sodium in the blood), hyperkalemia (high potassium concentration in the blood), depression, diabetes, high blood pressure, anxiety, osteoporosis and dementia. The minimum data set (MDS) dated 7/26/17 assessed Resident #2 with severely impaired cognitive skills.

Resident #2's clinical record documented a nursing note dated 7/17/17 at 3:05 a.m. stating, "Resident was observed with her bottom sitting on the floor and her head in between the bed rail and the air mattress. Resident stated she was trying to get up out of the bed. No c/o [complaints of] pain..."

The physician was notified of the resident's entrapment on 7/17/17 and ordered the resident to go the emergency room for evaluation and treatment. The emergency room discharge summary dated 7/17/17 documented, "Patient coming from nursing home, found half way out of bed with legs on the ground by neck and head caught within the railings. Complaining of anterior neck pain. Denies LOC [loss of consciousness]... Pt's [patient's] pain is moderate throbbing, without radiation and unchanged from onset. Worse with palpatiojn [palpation], not worse with movement. No associated swelling or

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shortness of breath, no dysphagia...No evidence of acute cervical spine fracture...minor trauma to anterior right neck, no expanding mass, minimally tender...Imaging reveals no acute injury...A diagnosis of Neck pain was also pertinent to this visit..."

The resident returned to the facility from the emergency room on 7/17/17. A nursing note dated 7/17/17 at 5:24 p.m. documented, "...returned from ED [emergency department]... with no new orders...Resident observed with bruise to back. Resident reports that she hit her back when she attempted to walk and fell to floor from bed. Resident was in pain...order obtained for Tylenol 325 mg [milligrams] two tablets by mouth q. [every] 6 hours. Resident reports pain management is effective..."

The clinical record documented no prior assessment to ensure safe use of bed rails or a physician's order for the specialty air mattress prior to the entrapment incident on 7/17/17. There was no evidence of informed consent from Resident #2's responsible party (RP) or review with the RP of benefits and/or risks of side rail use prior to the entrapment. The resident's admission assessment dated 7/13/17 documented the resident was alert and oriented to person but not place, time or situation and was at risk for falls. This assessment documented the resident was independent with walking using an ambulation device and required total assistance of one person for safe transfers. This admission assessment documented side rails were not in use by the resident at the time of admission.

The resident's plan of care prior to the fall (dated 7/17/17) listed the resident was at risk for falls.

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Interventions to prevent falls included low bed position, alternate periods of activity with rest, participate in activities, call light within reach and a clutter free environment. There was no mention of side rail use or a specialty air mattress prior to the entrapment incident on 7/17/17.

There was no facility investigation of Resident #2's entrapment on 7/17/17. The facility's incident form documented the resident had an unwitnessed fall on 7/17/17 at 3:00 a.m. and was found with the side rails in the up position but made no mention the resident was found with her head wedged between the bed rail and the air mattress. The incident form did not include the length of the rails in use at the time or the area of the bed where the resident was wedged. Staff members caring for the resident around the time of the incident were not identified. There were no witness statements and/or interviews from staff members caring for the resident. This incident was not reported to the state agency. There was no evidence the facility made any attempts to determine if the entrapment incident involved neglect of Resident #2.

On 9/6/17 at 3:45 p.m. the administrator was interviewed about reporting Resident #2's entrapment to the state agency and any investigation of the incident. The administrator stated she found no facility investigation of the incident. The administrator stated she was new and was not aware of the entrapment incident until it was brought up during the current survey. The administrator stated, "As an administrator I would have reported and investigated this incident." The administrator stated the previous administration listed the incident as a fall and not an entrapment. The administrator stated the

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former administrator told the staff development coordinator not to report the incident and reporting was not needed because it was a fall. The administrator stated the incident should have been reported and investigated.

The facility's policy titled, "Reporting Abuse to Stage Agencies and Other Entities (dated March 2013) documented, "All suspected violations and all substantiated incidents of abuse will be immediately reported to appropriate state agencies and other entities or individuals as may be required by law... Should a suspected violation or substantiated incident of neglect, injuries of an unknown source, or abuse (including resident to resident abuse) be reported, the facility Administrator, or his/her designee, will promptly notify the following persons or agencies (verbally and written) of such incident...The State licensing/certification agency responsible for surveying/licensing the facility... Verbal/written notices to agencies will be made within twenty-four (24) hours of the occurrence or such incident...The Administrator...will provide the appropriate agencies...with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident..." This policy defines neglect as, "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."

These findings were reviewed with the administrator and director of nursing during meetings on 9/5/17 at 4:25 p.m. and on 9/6/17 at 4:45 p.m.

This was a complaint deficiency.

F 226 483.12(b)(1)-(3), 483.95(c)(1)-(3) F 226

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483.12
(b) The facility must develop and implement written policies and procedures that:

(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,

(2) Establish policies and procedures to investigate any such allegations, and

(3) Include training as required at paragraph §483.95,

483.95
(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-

(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.

(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property

(c)(3) Dementia management and resident abuse prevention.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, facility document review and during a complaint investigation, the facility staff failed to follow

F226:

1. The facility developed a policy on Leave of Absences on 9/18/2017.
2. All residents have the potential to be effected.
3. The LOA policy was presented to the QA committee for review , acceptance, and was adopted by Medical Director and Committee. The staff will be educated about Leave of Absence Policy by Staff Development Coordinator / designee by 10/3/2017.
4. Audits related to LOA incidents will be conducted by the Administrator or designee weekly for 4 weeks and monthly for 2 months to ensure awareness of residents rights. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed.
5. Completed by 10/3/2017

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and/or implement policies and procedures for reporting and investigating allegations of abuse and neglect for two of 24 residents in the survey sample, Resident #3 and Resident # 2.

1. Resident #3 voluntarily signed himself out of the facility for a temporary leave of absence from the facility, the resident did not return; the resident was found under a bridge with loss of consciousness; the resident was taken to the emergency department and subsequently admitted for treatment. The facility staff did not report this incident to the state agency and did not conduct an investigation into the matter.

2. Facility staff failed to follow policies requiring a report to the state agency and a thorough investigation after Resident #2 was found on the floor with her head wedged between the bed rail and the air mattress. There was no effort by the facility to follow policies to determine if Resident #2's entrapment incident involved neglect.

Findings include:

1. Resident #3 voluntarily signed himself out of the facility for a temporary leave of absence from the facility, the resident did not return; the resident was found under a bridge with loss of consciousness; the resident was taken to the emergency department and subsequently admitted for treatment. The facility staff did not report this incident to the state agency and did not conduct an investigation into the matter.

Resident #3 was originally admitted to the facility on 10/11/16, with a current readmission on

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08/07/17. Diagnoses for Resident #3 included, but were not limited to: diabetes mellitus, anxiety disorder, depression, complete traumatic amputation of the left great toe, muscle weakness, difficulty walking, unsteadiness, cellulitis of the left lower limb, cough, lymphedema and osteomyelitis.

The most current full MDS (minimum data set) assessment with CAAS (care area assessment summary) was a significant change assessment dated 07/18/17. This MDS assessed the resident as having a cognitive score of '12', indicating resident had moderate impairment in daily decision making skills. The resident was also assessed as requiring limited assistance from one staff person for transfers, ambulation and bathing. The resident was assessed on this MDS to have cellulitis with infection and a surgical wound present. Additionally it was documented on this MDS, the resident received insulin injections in the 7 day look back period and also received IV ABX (intravenous antibiotics) during the 7 day look back. The resident triggered for cognition, ADL's (activities of daily living) and falls in the CAAS section of this MDS.

A 14 day admission MDS assessment was reviewed for comparison, dated 08/21/17. This MDS assessed the resident to have a cognitive score of '13', indicating the resident was cognitively intact for decision making skills. The resident was assessed as supervision with setup for transfers and ambulation. The resident was also assessed as receiving IV ABX during the look back.

During a complaint investigation on 09/5/17 through 09/07/17, Resident #3's clinical record

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was reviewed.

ED [emergency department] provider notes for Resident #3 were reviewed for 8/4/17, timed for 6:15 a.m. documented, '...found altered by ems [emergency medical services] under a bridge, unknown down time or last seen normal, elevated blood sugar by fingerstick...history of alcohol abuse, cardiac arrest...seizure...he was non-responsive but able to talk upon EMS arrival...per [name of long term care facility] patient signed himself out at 4:30 p.m...was admitted to gerontology for osteomyelitis due to diabetic foot ulcer from 7/3/17-7/7/17...6 weeks of IV vancomycin, ceftriaxone and oral flagyl...PICC was placed in left basillic vein for IV antibiotics...glucose 641...ethanol 222...' It was documented that the resident received 10 units of IV insulin, IV fluids, insulin infusion protocol initiated and was MICU [medical intensive care unit] was consulted. The resident was admitted to MICU, PICC line was removed on admission and cultured with no growth at time of discharge. A new PICC line was placed on 8/7/17.

Nursing notes were reviewed from August 1, 2017 through August 10, 2017.

On 08/02/16 at 3:28 a.m., it was documented that the resident 'continues on abx via picc [peripherally inserted central catheter]...purple port flushes well, but red port is occluded...'

08/02/17 at 2:02 p.m., it was documented, '...antibiotic iv for wound l [left] foot cellulitis resident ambulate on off unit using walker...'

08/02/17 at 6:31 p.m., it was documented, '...continues on IV...for wound infection...'

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08/03/17 at 2:31 a.m., it was documented, '...continues on IV...for infection and surgical removal of left great toe...'

A 'late entry' nursing note dated 8/3/17 10:19 a.m. [created on 8/14/17 at 10:26 p.m.] documented, '...located under a bridge, and later went to the hospital. SS [social services] created an APS referral as the facility staff feels he is a danger to himself as a reflection of his choices while signed out of the facility.'

A nursing note dated 8/4/17 and timed 7:08 a.m., documented, 'Reesident [sic] sign self out on 8/3/17 at 4:30 p.m. and did not return. at this time [name of hospital] called to ask if resident stay here [sic] and was told yes Nurse stated he was found under bridge and brough [sic] to ER [emergency room] Social worker states walker is with him and they will try to clear clog picc line ER [sic]...'

A 'late entry' nursing note dated 8/8/17 and timed 10:26 a.m. [created on 8/14/17 and timed 10:27 a.m.] documented, '...returned to the facility yesterday, and the APS referral was submitted to APS on today as the staff feels his recent choices while signed out could make him a danger to himself.'

On 9/5/17 at 5:00 p.m., the acting administrator was asked for a policy on residents signing themselves out of the facility.

On 9/6/17 at approximately 10:40 a.m., the AA (acting administrator) and DON (director of nursing) were made aware of concerns regarding the above information and that this was not

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reported to the state agency, the investigation on Resident #3 regarding the above was then requested, along with a policies on reporting and investigating incidents.

At approximately 3:45 p.m., the acting administrator stated, '...we would not have reported to state, he is alert and oriented and goes out on LOA [leave of absence], goes out quite often, he was homeless..." The AA stated that the facility does not have a policy on leave of absence and stated that the facility reported it to APS. The AA was made aware that the incident occurred on 8/3/17 and was not reported to APS until 8/8/17, five days after the incident.

A policy was presented on 'conducting a thorough investigation', which documented, 'When an actual and/or potential care and service failure occurs involving a resident, it is necessary for facility administration to initiate an investigation to determine the facts and then act upon or respond accordingly to the findings. Examples of issues that would require investigation...falls with injury or non-injury, allegations of abuse...elopement...The administrator is always the individual in the facility who has overall responsibility for ensuring that the investigation is conducted and that a conclusion is reached. The administrator, however may not always be the individual who will conduct the investigation. It is very important to determine who the responsible individual will be so that the investigation is completed in a timely and efficient manner..."

A policy was presented on 'reporting abuse to state agencies and other entities' documented, 'All suspected violations and all substantiated incidents of abuse will be immediately

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reported...the facility administrator or his/her designee will promptly notify the following persons or agencies...a. The state licensing/certification agency responsible for surveying/licensing the facility..."

On 9/7/17 at approximately 3:20 p.m., the administrator, the AA, and DON were made aware of the above information and concerns surrounding the incident with Resident #3 and that the incident was not reported to the state agency and was not investigated, per the facility's policies presented.

On 9/11/17 at 11:50 a.m., the administrator stated that, 'as far as time frames' for reporting and investigating the regulations state 'immediately' and went on to say that is what the facility should be following.

No further information and/or documentation was presented prior to the exit conference on 9/7/17 at 4:30 p.m., to evidence that the facility staff followed their policy and procedure of reporting and conducting an investigation for Resident #3.

2. Facility staff failed to follow policies requiring a report to the state agency and a thorough investigation after Resident #2 was found on the floor with her head wedged between the bed rail and the air mattress. There was no effort by the facility to follow policies to determine if Resident #2's entrapment incident involved neglect.

Resident #2 was admitted to the facility on 7/13/17 with diagnoses that included bipolar

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disorder, hypernatremia (excess sodium in the blood), hyperkalemia (high potassium concentration in the blood), depression, diabetes, high blood pressure, anxiety, osteoporosis and dementia. The minimum data set (MDS) dated 7/26/17 assessed Resident #2 with severely impaired cognitive skills.

Resident #2's clinical record documented a nursing note dated 7/17/17 at 3:05 a.m. stating, "Resident was observed with her bottom sitting on the floor and her head in between the bed rail and the air mattress. Resident stated she was trying to get up out of the bed. No c/o [complaints of] pain..."

The physician was notified of the resident's entrapment on 7/17/17 and ordered the resident to go the emergency room for evaluation and treatment. The emergency room discharge summary dated 7/17/17 documented, "Patient coming from nursing home, found half way out of bed with legs on the ground by neck and head caught within the railings. Complaining of anterior neck pain. Denies LOC [loss of consciousness]... Pt's [patient's] pain is moderate throbbing, without radiation and unchanged from onset. Worse with palpatiojn [palpation], not worse with movement. No associated swelling or shortness of breath, no dysphagia...No evidence of acute cervical spine fracture...minor trauma to anterior right neck, no expanding mass, minimally tender...Imaging reveals no acute injury...A diagnosis of Neck pain was also pertinent to this visit..."

The resident returned to the facility from the emergency room on 7/17/17. A nursing note dated 7/17/17 at 5:24 p.m. documented,

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"...returned from ED [emergency department]... with no new orders...Resident observed with bruise to back. Resident reports that she hit her back when she attempted to walk and fell to floor from bed. Resident was in pain...order obtained for Tylenol 325 mg [milligrams] two tablets by mouth q. [every] 6 hours. Resident reports pain management is effective..."

The clinical record documented no prior assessment to ensure safe use of bed rails or a physician's order for the specialty air mattress prior to the entrapment incident on 7/17/17. There was no evidence of informed consent from Resident #2's responsible party (RP) or review with the RP of benefits and/or risks of side rail use prior to the entrapment. The resident's admission assessment dated 7/13/17 documented the resident was alert and oriented to person but not place, time or situation and was at risk for falls. This assessment documented the resident was independent with walking using an ambulation device and required total assistance of one person for safe transfers. This admission assessment documented side rails were not in use by the resident at the time of admission.

The resident's plan of care prior to the fall (dated 7/17/17) listed the resident was at risk for falls. Interventions to prevent falls included low bed position, alternate periods of activity with rest, participate in activities, call light within reach and a clutter free environment. There was no mention of side rail use or a specialty air mattress prior to the entrapment incident on 7/17/17.

There was no facility investigation of Resident #2's entrapment on 7/17/17. The facility's incident form documented the resident had an

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unwitnessed fall on 7/17/17 at 3:00 a.m. and was found with the side rails in the up position but made no mention the resident was found with her head wedged between the bed rail and the air mattress. The incident form did not include the length of the rails in use at the time or the area of the bed where the resident was wedged. Staff members caring for the resident around the time of the incident were not identified. There were no witness statements and/or interviews from staff members caring for the resident. This incident was not reported to the state agency. There was no evidence the facility made any attempts to determine if the entrapment incident involved neglect of Resident #2.

On 9/6/17 at 3:45 p.m. the administrator was interviewed about reporting Resident #2's entrapment to the state agency and any investigation of the incident. The administrator stated she found no facility investigation of the incident. The administrator stated she was new and was not aware of the entrapment incident until it was brought up during the current survey. The administrator stated, "As an administrator I would have reported and investigated this incident." The administrator stated the previous administration listed the incident as a fall and not an entrapment. The administrator stated the former administrator told the staff development coordinator not to report the incident and reporting was not needed because it was a fall. The administrator stated the incident should have been reported and investigated.

The facility's policy titled, "Reporting Abuse to Stage Agencies and Other Entities (dated March 2013) documented, "All suspected violations and all substantiated incidents of abuse will be

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immediately reported to appropriate state agencies and other entities or individuals as may be required by law... Should a suspected violation or substantiated incident of neglect, injuries of an unknown source, or abuse (including resident to resident abuse) be reported, the facility Administrator, or his/her designee, will promptly notify the following persons or agencies (verbally and written) of such incident...The State licensing/certification agency responsible for surveying/licensing the facility... Verbal/written notices to agencies will be made within twenty-four (24) hours of the occurrence or such incident...The Administrator...will provide the appropriate agencies...with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident..." This policy defines neglect as, "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."

These findings were reviewed with the administrator and director of nursing during meetings on 9/5/17 at 4:25 p.m. and on 9/6/17 at 4:45 p.m.

This was a complaint deficiency.

F 252 SS=D — 483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT — F 252

(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

§483.10(i) Safe environment. The resident has a

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right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-

(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.

(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.

(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.
This REQUIREMENT is not met as evidenced by:
Based on observation, and staff interview, the facility failed to ensure a clean homelike environment.

Multiple vents in common areas were observed with dust and debris.

The Findings Include:

On 9/7/17 during general observation rounds, exhaust vents were observed as part of a complaint allegation. The following ventilation units were observed with large amount of dust and debris:

1st floor vent near to room 100.
Exhaust vent in library.
Exhaust vent near to nurses station on 2nd floor.
Exhaust vent in shower room on second floor.
Damper vent on 3rd floor next to room 300.

1. 1st floor vent near room 100, exhaust vent in library, exhaust vent near nurses' station on 2nd floor, exhaust vent in shower room on 2nd floor and damper vent on 3rd floor next to room 300 were cleaned.
2. An audit was completed by Facility Maintenance and Environmental Services Manager on 9/10/2017 of facility vents. Any vents found to be dirty were cleaned.
3. Maintenance and Housekeeping staff were reeducated on cleaning schedules of facility vents by Administrator on 9/10/2017.
4. The Maintenance Director or designee will conduct audits of 5 facility area vents weekly for 4 weeks and monthly for 2 months to ensure cleanliness of vents. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed.
5. Completion date 10/3/17

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On 9/7/17 at 2:50 p.m. the maintenance director (other staff, OS #10) was interviewed concerning the vents. OS #10 verbalized that he has only been at the facility for a few days, but has been taking notes and is aware that the facilities entire ventilation system needs to be cleaned.

On 9/7/17 at 4:00 p.m. the above finding was brought to the attention of the administrator and director of nursing in a meeting in the library. This surveyor pointed out the exhaust vent in the library at this time.

No other information was presented prior to exit conference on 9/11/17.

This is a complaint deficiency.

F 278 SS=D 483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED

F 278

(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.

(h) Coordination
A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

(i) Certification
(1) A registered nurse must sign and certify that the assessment is completed.

(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

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F 278	Continued From page 35 (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed for one of 24 residents in the survey sample (Resident # 9) to ensure a complete and accurate Quarterly Minimum Data Set. Resident # 9's bowel and bladder status was incorrectly assessed on the most recent Quarterly Minimum Data Set. The findings were: Resident # 9 in the survey sample, a 55 year-old female, was admitted to the facility on 4/6/12 with diagnoses that included dementia with behavioral disturbances, hyperlipidemia, Vitamin D deficiency, candidiasis, dysphagia, pain, depressive disorder, diabetes mellitus, rheumatoid arthritis, and Non-Alzheimer's Dementia. According to the most recent Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/30/17, and the most recent Quarterly MDS, with an ARD of 7/30/17,	F 278	F278 1. Resident #9's Bowel and Bladder status on the minimum data set (MDS) was corrected by MDS Coordinator on 9/06/17. 2. An audit of current resident's bowel and bladder section of MDS was conducted and any finding corrected by on 9/14/2017. 3. The Minimum Data Set coordinators were reeducated regarding proper coding of MDS's related to bowel and bladder by regional clinical reimbursement specialist on 9/15/2017 and 9/19/2017. 4. The Minimum Data Set Coordinator or designee will conduct audits of 5 residents MDS for correct bowel and bladder entries weekly for 4 weeks and monthly for 2 months to ensure compliance. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed. 5. Completion date 10/3/2017	

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the resident was assessed under Section C (Cognitive Patterns) as having short and long term memory problems with severely impaired daily decision making skills.

According to the Annual MDS, Resident # 9 was assessed under Section H (Bladder and Bowel) as being always incontinent of bladder and bowel.

According to the most recent Quarterly MDS, the resident was assessed under Section H as being always continent of bladder and bowel.

At 11:35 a.m. on 9/6/17, RN # 6 (Registered Nurse), one of three MDS Coordinators, was interviewed regarding the discrepancy in bladder and bowel assessments between the Annual and Quarterly MDS's. After checking her records, and after checking with one of the other MDS Coordinators, RN # 6 said the Quarterly assessment of always continent of bladder and bowel was incorrect. RN # 6 went on the say that the Quarterly MDS at Section H should have been the same as the Annual MDS at Section H, i.e., always incontinent of bladder and bowel.

During a meeting at 4:30 p.m. on 9/6/17, that included the Administrator in Training, the Administrator in Training Mentor, the Director of Nursing, and the survey team, the incorrect assessment of Resident # 9's bladder and bowel status was discussed.

F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

483.10
(c)(2) The right to participate in the development and implementation of his or her person-centered

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plan of care, including but not limited to:

(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

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

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

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

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

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

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

483.21
(b) Comprehensive Care Plans

1. Resident #9's plan of care was revised to address continuing weight loss by the Minimum Data Set Coordinator on 9/14/17.
   Resident #3's care plan was updated by Minimum Data Set Coordinator on 9/20/2017 to include physician order for leave of absence.
2. A facility wide audit of the plan of care for current residents who are at risk for weight loss was conducted by Minimum Data Set Coordinator on 9/09/2017. Any negative findings were corrected at that time. A facility wide audit for current residents having physician orders related to permission for leave of absence was completed on 9/22/2017 by a registered nurse. Any negative findings were corrected at that time.
3. Licensed nurses to include Minimum Data Set department will be reeducated related to weight loss care planning and leave of absence by on 9/19/2017.
4. The Minimum Data Set Coordinator or designee will conduct audits of 5 residents with weight loss's plan of care and for leave of absence for 4 weeks and monthly for 2 months to ensure compliance. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed.
5. Completion date 10/3/2017

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(2) A comprehensive care plan must be-

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

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

(A) The attending physician.

(B) A registered nurse with responsibility for the resident.

(C) A nurse aide with responsibility for the resident.

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

This REQUIREMENT is not met as evidenced by:

Based on clinical record review and staff interview, the facility staff failed for two of 24 residents in the survey sample (Residents # 3

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and 9) to review and revise the residents' plan of care. For Resident # 3, the facility failed to revise the plan of care to address expectations and personal responsibilities regarding Leaves of Absences taken by the resident. For Resident # 9, the facility failed to revise the plan of care to address a continuing loss of weight.

1. The facility failed to revise the plan of care of Resident # 9 to address a continuing loss of weight.

2. The facility staff failed to review and revise the CCP (comprehensive care plan) with interventions concerning Resident #3 Leave of Absences without supervision.

The findings include:

1. The facility failed to revise the plan of care of Resident # 9 to address a continuing loss of weight.

Resident # 9 in the survey sample, a 55 year-old female, was admitted to the facility on 4/6/12 with diagnoses that included dementia with behavioral disturbances, hyperlipidemia, Vitamin D deficiency, candidiasis, dysphagia, pain, depressive disorder, diabetes mellitus, rheumatoid arthritis, and Non-Alzheimer's Dementia. According to the most recent Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/30/17, and the most recent Quarterly MDS, with an ARD of 7/30/17, the resident was assessed under Section C (Cognitive Patterns) as having short and long

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term memory problems with severely impaired daily decision making skills.

Under Section G (Functional Status) on the Annual and Quarterly MDS's, the resident was assessed as totally dependent with one person physical assist for eating, indicating Resident # 9 was unable to feed herself and needed to be fed by staff.

Resident # 9's care plan, with an initiation date of 4/14/17, included the following problem in the area of Nutrition, "Potential for alteration in nutrition at risk for metabolic imbalance r/t (related to) diabetes type 2 with hypo/hyperglycemia, resident with weight loss." The goal for the problem was, "Resident will consume diet at a tolerated consistency during this review period."

The interventions for the stated problem were, "Large portions with supplements; Observe daily po (oral) and fluid intake; Obtain weights as ordered, notify MD/ARNP if significant weight loss occurs; Provide diet as ordered, document intake; RD (Registered Dietician) to evaluate prn (as needed); Receives supplements per order; Resident is a feeder; ST (Speech Therapy) to screen prn."

Resident # 9 had a CCD (Controlled Carbohydrate Diet) with pureed texture and large portions at all meals. The resident also had an order for Magic Cup, a dietary supplement, four times a day. The Magic Cup order was dated 10/24/16.

Review of the weight record in Resident # 9's Electronic Health Record revealed the resident's

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weight on 4/3/17 was 154 pounds, and on 10/3/16 her weight was 191.6 pounds, for a loss of 37.6 pounds (19.6%) in 180 days.

The resident's care plan for nutrition, initiated on 4/14/17, failed to offer pro-active interventions to address the weight loss of 37.6 pounds in 180 days. The intervention "Receives supplements per order" was for the Magic Cup, which had been in place since 10/24/16.

During a meeting at 4:30 p.m. on 9/6/17, that included the Administrator in Training, the Administrator in Training Mentor, the Director of Nursing, and the survey team, the lack of pro-active interventions to address Resident # 9's weight loss was discussed.

2. The facility staff failed to review and revise the CCP (comprehensive care plan) with interventions concerning Resident #3 Leave of Absences without supervision.

Resident #3 signed himself out of the facility on 8/3/17 at approximately 4:30 p.m. and did not return. The resident was found the next morning (approximately 13.5 hours later) under a bridge by EMS (emergency medical services) with loss of consciousness. The resident was taken to the emergency department and subsequently admitted for 4 days.

During a complaint investigation on 95/17 through 9/7/17, Resident #3's clinical record was reviewed.

Resident #3's current POS (physician's order sheet) was reviewed. The POS included an order

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for, but not limited to: "...May go out on pass: Yes ( ) No ( ) With meds ( ) without meds ( ) May have annual flu vaccine: Yes (X) No ( ) May have pneumococcal vaccine: Yes (X) No ( ) PPD: Yes (X) No ( )..." The date for this order was dated 7/11/17 and was listed as an 'Active' order.

The area to be marked [by an X] to indicate if the resident was able to go out on pass was blank, therefore the resident did not have a current physician's order for the resident to be able to leave the facility with or without medications.

The resident did not have a current active physician's order to go out on pass with or without medications.

Resident #3's CCP (comprehensive care plan) prior to 8/3/17 (the day the resident signed himself out of the facility) was reviewed and documented, '...4/4/17...activity...he is a smoker and socializes in the gazebo...5/11/17...instruct resident about smoking risks and hazards and about smoking cessation, instruct resident about the facility smoking policy, locations, times, safety concerns, notify charge nurse immediately if it is suspected resident has violated facility smoking policy, the resident requires SUPERVISION while smoking...encourage resident to maintain communication with his family, SW [social worker] and his relationships with his peers in the facility...7/11/17...IV medications...administer antibiotic via PICC...'

The resident's current CCP after 8/3/17 was reviewed and documented, '...4/5/17 he is a smoker and socializes in the gazebo...05/11/17...instruct resident about

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smoking risks and hazards and about smoking cessation, instruct resident about the facility smoking policy, locations, times, safety concerns, notify charge nurse immediately if it is suspected resident has violated facility smoking policy, the resident requires SUPERVISION while smoking...8/9/17 resident refused to go to appointment out of facility...8/9/17...behavioral symptoms, non-compliance with signing self out of building with PICC line...allow me to verbalize my feelings about the situation, educate me on risk of my non-compliance..explain risk of signing self out while having IV access device (PICC)...notify my representative, physician/nurse practitioner of any hazardous items/unsafe practices as needed...observe me for any unsafe practices/behaviors and provide education/supervision as needed related to risk versus benefits...'

Resident #3's CCP was not reviewed and revised to reflect any information and/or documentation regarding the resident leaving the facility with or without supervision and no interventions regarding the resident signing himself out of the facility for any type of LOA, for a pass, or for leaving the grounds of the facility without supervision.

On 9/6/17 at approximately 4:50 p.m., the AA and DON were made aware of concerns regarding the resident's CCP. The DON stated that the CCP had been updated for Resident #3.

No further information and/or documentation was presented prior to the exit conference on 9/11/17 at 2:45 p.m.

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

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F 281 SS=D	Continued From page 44 PROFESSIONAL STANDARDS	F 281		

(b)(3) Comprehensive Care Plans

The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-

(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:
Based on medication pass and pour observation, staff interview, and facility document review, the facility staff failed to follow professional standards of practice while giving medications for one of 24 residents, Resident #18.

During medication pass and pour observation on 09/06/2017, a medication card for "ATENOLOL 50 MG TABLET" (a blood pressure medication), was labeled with inaccurate medication administration information as compared to the physician orders on the electronic medical record.

Findings were:

A medication pass and pour observation was conducted on 09/06/2017 beginning at approximately 8:05 a.m. LPN (licensed practical nurse) # 1 was observed preparing medications for Resident #18.

Resident #18 was admitted to the facility on 03/10/2017. His diagnoses included but were not limited to: Cerebrovascular disease with hemiplegia, hypertension, osteoporosis and osteopathic.

The initial MDS with an ARD (assessment

F281

1. Resident #18 medication was labeled correctly by nurse on 9/06/2017 and suffered no negative outcome. Resident #18 discharged from facility on 9/12/2017.
2. An audit of all current residents for proper labeling was conducted by Pharmacy on 9/19/2017.
3. Licensed Nurses were re-educated on medication administration as it pertains to labeling on 9/19/2017 by Pharmacy. LPN #1 was re-educated by a registered nurse on 9/14/2017 related to medication administration with emphasis on proper labeling.
4. The Director of Nurses or designee will conduct audits of 5 residents medications for correct labeling weekly for 4 weeks and monthly for 2 months to ensure compliance. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed.
5. Completion date 10/3/2017

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reference date) of 03/17/2017. Resident #18 was assessed as having a cognitive summary score of "13", indicating he was cognitively intact.

During the preparation of medications for Resident #18, the medication card for Atenolol was pulled by LPN # 1. Directions on the card were listed as "ATENOLOL 50 MG TABLET give 1 tab by mouth every day". LPN # 1 donned a pair of nonsterile gloves, popped a pill out of the medication card, broke it in half, threw half away and put the other half in the medication cup. This surveyor asked her what she just did. LPN # 1 stated, "The order on the computer is for 25 mg, I have 50 mg tablets. I just broke it in half to give him the 25 mg he needs and I threw the other half away." LPN # 1 was asked how she knew which source was correct, the medication card or the computer. She stated, "I always go by the computer... it is the most updated order." She was asked when the order changed from 50 mg to 25 mg. She looked at the computer and stated, "It looks like it changed around August 24th...we normally use the card up if we can before they send us a new one." LPN # 1 looked in the medication cart drawers and stated, "We have stickers to put on there when it changes, but I don't see any in here [medication cart drawers]."

The DON (Director of Nursing) was in the conference room at approximately 10:00 a.m., and the above information was discussed. She stated, "There should be a sticker on the card that the order changed, otherwise the nurse should verify with the physician which order is correct."

A policy/procedure regarding the use of the medication label stickers was requested and

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F 281	Continued From page 46 received. The policy "Reordering, Changing, and Discontinuing Orders", contained the following information: "Change Orders: ...If pharmacy receives a new order that changes the strength or dose of a medication previously ordered, and there is adequate supply on hand: ...Facility should notify Pharmacy not to send the medication and attach a "Change in Directions" sticker to the existing quantity of medications." The above information was discussed during meeting with the DON and the administrator on 09/06/2017 at approximately 5:15 p.m. The administrator stated, "We found the stickers, they are in the cart now." No further information was obtained prior to the exit conference on 09/11/2017.	F 281		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F 314		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, facility document review, clinical record review and in the course of a complaint investigation, the facility staff failed to provide treatment and services for the prevention of pressure ulcers for two of 24 residents, Resident #14 and Resident # 4.

1. The facility failed to prevent a facility acquired medical device related pressure ulcer for one of 24 residents, Resident #14. An unknown staff member placed a dressing over a wound on Resident #14's left leg stump. The dressing remained in place for an unknown length of time and when removed on 09/06/2017 the wound was an unstageable pressure ulcer . The most recent weekly skin observation sheet was dated 08/27/2017 and indicated no new skin issues. This resulted in harm.

2. The facility staff failed to provide weekly skin assessments for Resident # 4 for four weeks.

Findings were:

1. The facility failed to prevent a facility acquired medical device related pressure ulcer for one of 24 residents, Resident #14. An unknown staff member placed a dressing over a wound on Resident #14's left leg stump. The dressing remained in place for an unknown length of time and when removed on 09/06/2017 the wound was an unstageable pressure ulcer . The most recent weekly skin observation sheet was dated 08/27/2017 and indicated no new skin issues.

1. New wound assessments were done for Resident #14 and Resident #4 on 9/22/17 by a registered nurse also Resident#4 on 9/18/17. NA new RN Wound Care Nurse has been designated as of 9/22/17.
2. On 9/22/2017, the Director of Nurses / designee conducted an audit of all current residents for completed wound assessments. A 100% skin audit was completed by licensed nurses with the physician being notified of any new skin related issues found during audit process.
3. The Nursing Staff will reeducated on conducting timely and accurate wound assessments by Staff Development Coordinator or designee by 10/3/17. A protocol was initiated on 9/29/17 related to residents with prosthetic devices. A licensed nurse will evaluate the skin prior to and at removal of prosthetic device. Any changes in skin will be communicated to the physician. Licensed nurses will be inserviced beginning 9/29/17 regarding the protocol related to residents with prosthetic devices.
4. The Director of Nurses or designee will conduct audits of 5 residents wound assessments weekly for 4 weeks and monthly for 2 months to ensure compliance. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed.
5. Completion date 10/3/2017

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This resulted in harm.

Resident #14 was admitted to the facility on 05/05/2016. His diagnoses included but were not limited to: Bilateral BKA (below the knee amputations), atrial fibrillation, hypertension, diabetes mellitus with diabetic polyneuropathy, and acute respiratory failure.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 07/27/2017. Resident #14 was assessed as having a cognitive summary score of "04", indicating severe impairment with his cognitive status. However, Resident #14 answered the survey team's questions appropriately during a resident interview and during verbal interaction with the survey team members. Resident #14 was very hard of hearing and while this hindered his ability to understand, if spoken to directly and into his ear he answered and carried on a conversation with no difficulty.

Resident #14 was interviewed by a member of the survey team on 09/05/2017 at approximately 2:30 p.m. During the interview he pulled up his left pants leg to show the surveyor a dressing on his left leg stump. He stated that he had been asking for three weeks to go to the "leg doctor'...that his prosthetic leg had rubbed a spot on his stump.

On 09/06/2017 at approximately 8:00 a.m., Resident #14's clinical record was reviewed. Observed on the electronic physician orders was an order for weekly body audits. The TAR (treatment administration record) was reviewed. Two entries were checked off on 09/01/2017 and

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09/02/2017 that body audits were completed. Review of the progress note section did not provide a corresponding note for either of those dates regarding any skin issues. Weekly Skin Observation assessments were observed in the electronic record with the last recorded assessment being 08/27/2017. Under the section "OBSERVATIONS", the following information was documented: "Does the resident have any skin issues?". The question was answered "No." There were no Weekly Skin Observation assessments completed for the body audits conducted in September.

At approximately, 9:00 a.m., RN (registered nurse) #4 who was one of the wound nurses at the facility was in the conference room to speak with a member of the survey team. She was asked if she was doing dressing changes for (Name of Resident #14). She stated that she was not doing any dressing changes with him and was not aware that he had a wound.

This surveyor went to the unit where Resident #14 resided on 09/06/2017 at approximately 9:15 a.m. Resident #14 was asked if he had a dressing on one of his legs. Resident #14 stated, "Yeah", and pulled up his pants leg on his left leg stump. Observed was a square border gauze dressing. An area of drainage was observed on the bandage. There was no date, time or initials to indicate when the dressing had been applied or who had applied it. Resident #14 was asked who put the dressing on his leg and how long it had been there. He stated, "It's been on there for three days...one of the girls here put it on there, I don't remember which one...it's came from trying to wear my legs....you want to see it? I'll take it [the dressing] off of there." Resident #14 was

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asked to leave the dressing in place until this surveyor could get a staff person in the room to assist him.

This surveyor went out into the hallway and asked RN # 7 if she knew anything about a dressing on Resident #14's leg. She stated, "I've worked here since last Thursday...this is the first time I have been on this hall, I don't know anything about these residents, I am just giving medications." This surveyor then went to the other side of the unit. RN # 3 was observed in an office with his cell phone in hand. He came out to speak with this surveyor. He was asked if he knew anything about Resident #14. He stated that he did not work that end of the hall. He was asked who the unit manager was. He stated "We don't have a unit manager so [Name of the Director of Nursing] is who we go to."

This surveyor went to the DON's office. The DON was asked who could discuss the dressing on Resident #14's leg. She directed this surveyor to RN #2, who was the other wound nurse at the facility. RN #2 was busy with another resident.

At approximately 10:00 a.m., this surveyor met RN #2 in the hallway. RN #2 was asked if she knew anything about a dressing over a wound on Resident #14's leg. She stated, "I just heard about that." This surveyor, RN #2 and the medical director went to Resident #14's room. The dressing had been removed from his left leg stump. The wound was covered with a scab. The medical director, lifted the scab up stating, "This is a mobile scab." The wound nurse was asked to measure the wound. She measured the area underneath the scab and stated, "It is 1.2 X 1 X .2" She was asked what the yellow area

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covering the bottom of the wound was. She stated, "That's slough". The edges of the wound were rolled and bright pink in color. The wound nurse was asked what she would stage the wound as. She stated, "A three." The medical director stated, "I would call it a stage 2 or a Stage 3...it's about the depth." The medical director asked Resident #14 how long the dressing had been in place. He stated, "Three days..." The medical director asked Resident #14 if he knew what day it was or the date. Resident #14 stated, "It's Wednesday isn't it...either September 6th or 7th".

The clinical record was reviewed and a note written on 09/06/2017 at 13:24 (1:24 p.m.) written by RN #2 was observed which read: "Resident found with open area to front of LLE [Left lower extremity]. Resident was assessed by MD and nurse. Resident has stag [sic] II pressure ulcer to that area. MD gave treatment order for daily dressing change (cleanse area with wound cleanser, apply hydrogel and cover with border gauze q [every] day shift and PRN [as needed]). MD gave consult referral to resident to follow up with amputation clinic at [name of office] for evaluation and treatment of prosthetic legs/fit. MD educated resident to not wear shrinker at this time..."

A copy of the facility reference and guidelines for the staging of pressure ulcers was requested and received. According to the document provided, "Wound Classification Guide-2016 NPUAP [National Pressure Ulcer Advisory Panel]" a stage II Pressure ulcer is described as: "The wound bed is viable, pink or red, moist...Granulation tissue, slough and eschar are not present." A stage III pressure ulcer is

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described as: "...granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible." An unstageable pressure ulcer is described as: "Extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If the slough or eschar is removed, a Stage III or Stage IV pressure injury will be revealed."

During an end of the day meeting on 09/06/2017, the staging of Resident #14's pressure ulcer was discussed with RN #2, the administrator and the DON. RN #2 stated, "The doctor called it a 2 so that's what I wrote." RN #2 was asked based on the facility guidelines what would she stage the pressure ulcer as. She stated, "A three or unstageable." RN #2 was asked if she would discuss the wound with the medical director and let this surveyor know the following morning what had been decided regarding the staging of the wound. RN #2 agreed.

On 09/07/2017 at approximately 8:00 a.m., the administrator was in the conference room speaking with the survey team. She was asked if RN #2 was ready to speak with this surveyor regarding the staging of Resident #14's pressure ulcer. The administrator stated, "Oh, yesterday was her last day...she doesn't work here anymore...we can call her if you want to talk to her." This surveyor voiced concern that RN #2 was suppose to discuss Resident #14's pressure wound that morning. The administrator stated, "Oh she talked to [name of physician] about it last night...we are sending him [Resident #14] to the wound clinic today."

The medical director came to the conference room to speak with the surveyors at

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approximately 10:00 a.m. Resident #14's pressure ulcer was discussed. He stated that a wound specialist was coming in to look at the wound and would determine how it should be staged but he (medical director) felt it should be classified as unstageable.

At approximately 12:15 p.m., the wound specialist arrived at the facility. This surveyor accompanied him to Resident #14's room. He removed the bandage and stated, "It's unstageable...you cant stage that." He lifted up the scab that was present and pulled it off. He stated, "I'm just debriding this a little." He then looked at the underlying wound. He stated, "It's all about the base...the base of this wound is covered with slough...there is some granulation tissue but it is mainly slough...we don't know what is under there...it's unstageable and if we had to give it a stage it would minimally be a three....this is a medical device related pressure ulcer that has come from his prosthetic legs."

The above information was discussed with the administrator,the administrator in training (AIT), the DON, and other facility staff during an end of the day meeting on 09/07/2017. Concerns of were voiced that the wound had been covered without treatment orders by someone in the facility, not reported to the physician, and when discovered by the survey team was determined to be unstageable by the wound specialist. The DON was asked what her expectation would be if a pressure ulcer was identified by staff. She stated, "The doctor should be notified and orders obtained for treatment." The facility staff were informed that due to the severity of the pressure ulcer at the time of discovery, the lack of weekly skin observation assessments and the initiation of

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treatment by an unknown staff member without orders, the survey team had identified harm.

On 09/11/2017, at approximately 9:00 a.m., the Administrator and the AIT came to the conference room to present additional information to the survey team. Included in the information were facility policies for wound care, "Dressing, Dry/Clean" and "Skin and Wound Care Program". The "Dressing, Dry/Clean" policy contained the following instruction: "Verify that there is a physician's order for this procedure." The "Skin and Wound Care Program" policy contained the following statement: "The licensed nurse will assess skin weekly and report concerns to the Director of Nursing and the Physician." The administrator and the AIT were asked if any documentation associated with the skin audits checked off as completed on 09/01/2017 and 09/02/2017 had been located. The administrator stated, "Not at this time." A copy of all progress notes and orders from 09/07/2017 through 09/11/2017 were requested.

Review of the presented documentation from 09/07/2017 through 09/11/2017 contained a note from the wound specialist. The note contained the following information: "KEY FINDINGS: L [left] stump with 1.5 X .5 full thickness wound which debrided easily to a yellow/pink granulated bed 20/80% slough. No evidence of infection. ASSESSMENT AND PLAN: 1) Medical device related pressure injury unstageable. Start Silvasorb gel to area daily with border gauze. Resident should not wear prosthesis until wound closure. 2) Debility - -Continue LTC [long term care]. Have prosthetics and orthotics come in here to evaluated fitment of shrinker/device."

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No further information was presented prior to the exit conference on 09/11/2017.

This is a complaint deficiency.

2. Resident #4 (R 4) did not have completed wound assessments for four weeks.

Findings include:

R 4 was admitted to the facility on 2/11/17 with a readmission on 9/1/17 with diagnoses including pressure ulcers.

The most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 5/26/17. R 4 was assessed as being severely cognitively impaired.

R 4's electronic record was reviewed on 9/5/17 and evidenced, via weekly wound care notes (dated 7/14/17 and 7/20/17) that R 4 had stage two pressure ulcers on the sacrum and left heel that were being treated. There were no documentation or evidence that weekly wound assessments were being done after 7/20/17 through 8/21/17 (yielding 4 missed assessments) when R 4 had been discharged to the hospital. R 4 was readmitted with the same pressure ulcers on 9/1/17.

On 9/6/17 at 9:00 a.m. an interview with the acting facility wound nurse took place (registered nurse RN #4). RN #4 verbalized that she works

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part time and the days RN #4 works are Saturday, Sunday, Tuesday, and Wednesday. RN #4 verbalized that she wasn't familiar with the electronic record and was unable to document any assessments, but another wound nurse documents the wound assessments in the electronic record. RN #4 was asked if she had any paper documentation that the assessments were done. RN 4 verbalized that she did not because the other wound nurse was supposed to document the assessments.

On 9/6/17 at 9:20 RN #2 (wound nurse) was interviewed regarding the missing wound assessments. RN #2 verbalized that she had went on leave for two weeks beginning 7/22/17 and when she came back she (RN #2) was placed in a different roll as a unit manager and not the wound nurse, leaving only the part time wound nurse to complete assessments.

On 9/6/17 at 4:30 p.m. the above finding was presented to the administrator and director of nursing. On 9/7/17 at 8:30 a.m. the administrator verbalized that she was unable to provide weekly wound assessments.

No other information was provided prior to exit conference on 9/11/17.

This is a complaint deficiency.

F 322 SS=D — 483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE EATING SKILLS — F 322

(g) Assisted nutrition and hydration.
(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and

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enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-

(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and

(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility policy review and clinical record review, the facility staff failed to provide care to prevent gastrostomy complications for one of 24 residents in the survey sample. For Resident #19, a nurse failed to check placement of the gastrostomy tube prior to administration of medications; failed to determine the residual volume prior to administration of medications; failed to administer water flushes as ordered; and pushed medications through the gastrostomy with a syringe instead of allowing them to infuse by gravity.

The findings include:

Resident #19 was admitted to the facility on 3/1/17 with a re-admission on 5/25/17. Diagnoses for Resident #19 included paraplegia, anemia, neurogenic bladder, dysphagia with

F322

1. Resident #19 was assessed by a registered nurse with no negative outcome on 9/15/2017. Resident #19 is currently receiving appropriate gastrostomy care.
2. All residents requiring enteral feeding have the ability to be affected.
3. Licensed nurses will be re-educated by Staff Development Coordinator or designee regarding appropriate gastrostomy care by 10/03/2017 with return competency. Licensed Nurse #2 received 1:1 in service regarding medication administration by Registered Nurse on 9/21/17.
4. The Director of Nurses or designee will conduct competency testing of 5 licensed nurses regarding gastrostomy care weekly for 4 weeks and monthly for 2 months to ensure compliance. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed.
5. Completion date 10/3/2017

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gastrostomy, pressure sores and cellulitis. The minimum data set (MDS) dated 8/2/17 assessed Resident #19 as cognitively intact.

A medication pass observation was conducted on 9/6/17 at 8:20 a.m. with licensed practical nurse (LPN) #2 administering medications to Resident #19. LPN #2 administered medication to Resident #19 through a gastrostomy tube. LPN #2 failed to check placement of the gastrostomy tube prior to administering medications, failed to determine residual volume amount prior to giving medications and failed to follow physician orders for water flushes through the tube prior to and between medications. In addition the medicines were pushed with a syringe into the gastrostomy instead of allowing the medications and water to gravity feed.

On 9/6/17 at 8:20 a.m. LPN #2 prepared the following medications for Resident #19: Ferrous Sulfate 325 mg (milligrams), Oxybutynin chloride 5 mg, Magnesium oxide 400 mg, multivitamin and natural vegetable laxative with Colace 50 mg (2 tabs).

Each medicine was crushed and placed in a separate medicine cup. LPN #2 disconnected the resident's tube feeding (Two Cal HN) that was running at 60 cc's (cubic centimeters) per hour and clamped the tubing. LPN #2 then mixed the first cup of crushed medicine with a small amount of water and stirred it to mix. LPN #2 pulled the medicine mix from the cup into a large syringe. The gastrostomy tube placement was not checked prior to administering the medicines. LPN #2 did not determine any residual volume of gastric contents prior to giving medicines. Without a prior water flush, LPN #3 pushed the

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first medicine mixture into the gastrostomy tube with the syringe. Without administering any water into the tube, the next crushed medicine mix was pushed into the gastrostomy tube with the syringe. LPN #2 followed the second medication mix with a small amount of water. LPN #2 proceeded to administer the other medicines pushing them with the syringe into the gastrostomy with each followed by a small amount of water.

Resident #19's clinical record documented a physician's order dated 4/28/17 for Two Cal HN tube feeding formula to infuse at 60 cc's per hour for 12 hours each day (on at 8:00 p.m. and off at 8:00 a.m.). The clinical record also documented a physician's order dated 4/28/17 stating, "Flush tube [gastrostomy] with 60 cc free water before and 30 cc between meds [medicines]." The resident's plan of care (revised 8/24/17) stated the resident had a PEG (percutaneous endoscopic gastrostomy) due to severe protein calorie malnutrition. Interventions for care of the gastrostomy included, "Check for tube placement and gastric contents/residual volume per facility protocol and record."

On 9/6/17 at 8:55 a.m. LPN #2 was interviewed about not checking placement or determining the residual, the lack of water flushes and pushing the medicines with a syringe with Resident #19's gastrostomy. LPN #2 stated she was supposed to check placement of the gastrostomy before giving the medications. LPN #2 stated she usually flushed the gastrostomy tube prior to starting medications and she was supposed to flush the tube between each medicine as ordered. LPN #2 stated she forgot and realized she missed the flushes part way through the

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medication pass and then started with the water flushes. Concerning pushing the medicines with a syringe instead of allowing them to flow by gravity, LPN #2 stated the medicine mix was difficult to flow by gravity into Resident #19's gastrostomy. LPN #2 stated the gravity flow was very slow so she had to push the medicine mixture to get them through the tube.

The facility's policy titled Gastrostomy Feeding (revised November 2016) stated, "...Check gastric residual volume (GRV) before each feeding (for bolus and intermittent feedings), prior to administration of medications and every 6 to 8 hours (for continuous feedings) to monitor tolerance...Draw up to 10 to 30 ml [milliliters] air into syringe and connect to end of feeding tube...Verify for placement by inject air into the tube. If air is heard, pull back slowly and aspirate total amount of gastric contents...Do not administer feeding when a single GRV measurement exceeds 100 ml [milliliters]...Notify physician for further orders/recommendations...Use 5 cc of water to dilute each medication...Administer medication via gravity...Flush feeding tube after administration according to physician order..." (sic)

These findings were reviewed with the administrator and director of nursing during a meeting on 9/6/17 at 2:10 p.m.

F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

(d) Accidents.
The facility must ensure that -

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(1) The resident environment remains as free from accident hazards as is possible; and

(2) Each resident receives adequate supervision 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 resident interview, staff interview, clinical record review and facility document review, the facility staff failed to supervise a leave of absence for one of 24 residents in the survey sample, which resulted in harm (Resident #3) and failed to ensure one of 24 residents was safe for the use side rails (Resident #2) and failed to answer call bells in a timely manner per the group meeting.

1. The facility staff failed to ensure that Resident #3 had a current physician's order to leave the facility on a leave of absence and failed to locate the resident, when the resident was away from the facility for an extended amount of time, as a

1. Resident #3's medical record was updated on 9/22/2017 to include a physician's order for leave of absence. Resident #2 physician's orders were updated to include use of concave mattress. Resident #2 had new side rail assessment conducted on 9/13/2017 by licensed nurse.
A wandering assessment was completed for resident # 3 on 9/8/2017 by social services.
All residents have the potential to be effected by timely call bell response.
2. An audit of current resident's medical records for leave of absence orders on 9/22/2017 by registered nurse. An audit of side rail assessments were conducted to assure compliance by licensed nurses on 9/07/2017 . An initial audit for call

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result the resident left the facility and did not return. The resident was found the next day (approximately 13.5 hours later) under a bridge by EMS (emergency medical services) with loss of consciousness. The resident was taken to the emergency department and subsequently admitted for 4 days.

2. Resident #2 was found on the floor with her head wedged between the bed rail and the air mattress. The resident had no prior assessment for safe use of the bed rails and no physician's order for the use of a specialty air mattress. The resident suffered pain and bruising to her neck and back from the entrapment and was sent to the hospital for evaluation.

3. During the Group Meeting, residents complained of a lack of call bell response.

Findings include:

1. The facility staff failed to ensure that Resident #3 had a current physician's order to leave the facility on a leave of absence and failed to locate the resident, when the resident was away from the facility for an extended amount of time, as a result the resident left the facility and did not return. The resident was found the next day (approximately 13.5 hours later) under a bridge by EMS (emergency medical services) with loss of consciousness. The resident was taken to the emergency department and subsequently admitted for 4 days.

Resident #3 was originally admitted to the facility on 10/11/16, with a current readmission on

bell response times will be conducted by 10/3/2017 by Activity Director.

3. Nursing staff were reeducated on leave of absence orders and side rail assessments by licensed nurse by 10/3/2017. Staff will be reeducated on call bell responsiveness by Administrator or designee by 10/3/2017.
4. The Director of Nurses or designee will conduct audits of 5 residents medical records for LOA orders and side rail assessments weekly for 4 weeks and monthly for 2 months to ensure compliance. The Activity Director or designee will conduct 5 residents call bell responses weekly for 4 weeks and monthly for 2 months to ensure compliance. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed.
5. Completion date 10/3/2017

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08/07/17. Diagnoses for Resident #3 included, but were not limited to: diabetes mellitus, anxiety disorder, major depression, complete traumatic amputation of the left great toe, muscle weakness, difficulty walking, unsteadiness, cellulitis of the left lower limb, cough, lymphedema and osteomyelitis.

The most current full MDS (minimum data set) assessment with CAAS (care area assessment summary) was a significant change assessment dated 07/18/17. This MDS assessed the resident as having a cognitive score of '12', indicating resident had moderate impairment in daily decision making skills. The resident was also assessed as requiring limited assistance from one staff person for transfers, ambulation and bathing. The resident's was assessed as using a walker and w/c (wheelchair) for mobility. The resident was assessed on this MDS to have cellulitis with infection and a surgical wound present. Additionally it was documented on this MDS, that the resident received insulin injections in the previous 7 day look back period and also received IV ABX (intravenous antibiotics) during the 7 day look back period. The resident also triggered for cognition, ADL's (activities of daily living) and falls in the CAAS section of this MDS.

A 14 day admission MDS assessment was reviewed for comparison, dated 08/21/17. This MDS assessed the resident to have a cognitive score of '13', indicating the resident was cognitively intact for decision making skills. The resident was assessed as requiring supervision with setup for transfers and ambulation. The resident was assessed as using a walker for mobility. The resident was also assessed as receiving IV ABX and insulin during the previous 7

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day look back.

Resident #3 was named in a complaint. The complaint alleged in the intake information that APS (adult protective services) reported that they (APS) received a call from the hospital ED (emergency department) that Resident #3 was found under a bridge with loss of consciousness and highly intoxicated on 8/4/17. It was reported that the resident signed himself out of the facility on 08/03/17 at approximately 4:30 p.m. The hospital ED called the facility to inform the facility that the resident had been admitted to the hospital. APS documented concerns regarding the resident's complex medical history and that the fact that the resident had a PICC (peripherally inserted central catheter) in place and had left the building for an extended amount of time and no steps were taken by facility to attempt to locate the resident when he did not return in a reasonable amount of time.

During a complaint investigation on 09/5/17 through 09/07/17, Resident #3's clinical record was reviewed.

The ED [emergency department] provider notes for Resident #3 were reviewed for 8/4/17, timed for 6:15 a.m. documented, '...found altered by ems [emergency medical services] under a bridge, unknown down time or last seen normal, elevated blood sugar by fingerstick...history of alcohol abuse, cardiac arrest...seizure...he was non-responsive but able to talk upon EMS arrival [to hospital]...per [name of long term care facility] patient signed himself out at 4:30 p.m. [08/03/17]...[history] was admitted to gerontology for osteomyelitis due to diabetic foot ulcer from 7/3/17-7/7/17...6 weeks of IV vancomycin,

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ceftriaxone and oral flagyl...PICC was placed in left basillic vein for IV antibiotics...[current] glucose 641...ethanol 222...'

It was documented that the resident received 10 units of IV insulin, IV fluids, insulin infusion protocol initiated and the MICU [medical intensive care unit] was consulted. The resident was admitted to the MICU, the current PICC line was removed on admission due to being completely not functioning and was cultured with no growth at time of discharge on 8/7/17. A new PICC line was placed on 8/7/17 prior to discharge.

Resident #3's current POS (physician's order sheet) was reviewed. The POS included an order for, but not limited to: "...May go out on pass: Yes ( ) No ( ) With meds ( ) without meds ( ) May have annual flu vaccine: Yes (X) No ( ) May have pneumococcal vaccine: Yes (X) No ( ) PPD: Yes (X) No ( )..." The date for this order was dated 7/11/17 and was listed as an 'Active' order.

The area to be marked [by an X] to indicate if the resident was able to go out on pass was blank, therefore the resident did not have a current physician's order for the resident to be able to leave the facility with or without medications.

The resident did not have a current active physician's order to go out on pass with or without medications.

Resident #3's CCP (comprehensive care plan) prior to 8/3/17 (the day the resident signed himself out of the facility) was reviewed and documented, '...4/4/17...activity...he is a smoker and socializes in the gazebo...5/11/17...instruct

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resident about smoking risks and hazards and about smoking cessation, instruct resident about the facility smoking policy, locations, times, safety concerns, notify charge nurse immediately if it is suspected resident has violated facility smoking policy, the resident requires SUPERVISION while smoking...encourage resident to maintain communication with his family, SW [social worker] and his relationships with his peers in the facility...7/11/17...IV medications...administer antibiotic via PICC...'

There was no information and/or documentation in the resident's CCP regarding the resident having permission and/or a physician's order to leave the facility with or without supervision, there was no information about the resident signing himself out of the facility for any type of LOA, for a pass, or for leaving the grounds of the facility without supervision.

The resident's current CCP after 8/3/17 was reviewed and documented, '...4/5/17 he is a smoker and socializes in the gazebo...05/11/17...instruct resident about smoking risks and hazards and about smoking cessation, instruct resident about the facility smoking policy, locations, times, safety concerns, notify charge nurse immediately if it is suspected resident has violated facility smoking policy, the resident requires SUPERVISION while smoking...8/9/17 resident refused to go to appointment out of facility...8/9/17...behavioral symptoms, non-compliance with signing self out of building with PICC line...allow me to verbalize my feelings about the situation, educate me on risk of my non-compliance..explain risk of signing self out while having IV access device (PICC)...notify my representative, physician/nurse

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practitioner of any hazardous items/unsafe practices as needed...observe me for any unsafe practices/behaviors and provide education/supervision as needed related to risk versus benefits...'

There was no information and/or documentation in the resident's CCP regarding the resident having permission and/or a physician's order for leaving the facility with or without supervision, there were not interventions regarding the resident signing himself out of the facility for any type of LOA, for a pass, or for leaving the grounds of the facility without supervision.

A 'Wander Evaluation' was then reviewed dated 5/4/17, which documented that the resident was cognitively impaired with poor decision-making skills (intermittent confusion, inattention, poor decisions, etc.), and that the resident had a diagnosis of dementia, Alzheimer's, depression, anxiety, delusions/hallucinations or schizophrenia, and that the resident had deficits in communications, vision or auditory. It was also documented that the 'interventions' to be utilized would consist of exit/stairwell alarms. In the summary section of this evaluation it was documented that the resident 'is not an elopement or wander risk... ambulated independently with his walker... wears glasses...has occasional inattention... has anxiety and major depression disorders...'

No other wander evaluation had been completed on Resident #3 since 5/4/17.

No other assessments and/or evaluations could be located within the clinical record to evidence that Resident #3 was assessed by facility staff, as

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being a safe candidate to sign himself out of the facility at anytime with or without supervision.

Progress [nursing] notes were reviewed from August 1, 2017 through August 10, 2017.

On 08/02/16 at 3:28 a.m., it was documented that the resident 'continues on abx via picc [peripherally inserted central catheter]...purple port flushes well, but red port is occluded...'

08/02/17 at 2:02 p.m., it was documented, '...antibiotic iv for wound L [left] foot cellulitis resident ambulates on off unit using walker...'

08/02/17 at 6:31 p.m., it was documented, '...continues on IV...for wound infection...'

08/03/17 at 2:31 a.m., it was documented, '...continues on IV...for infection and surgical removal of left great toe...'

A 'late entry' nursing note dated 8/3/17 10:19 a.m. [created on 8/14/17 at 10:26 p.m.] documented, '...located under a bridge, and later went to the hospital. SS [social services] created an APS referral as the facility staff feels he is a danger to himself as a reflection of his choices while signed out of the facility.' This note was created 11 days after the resident left the facility and 7 days after the resident was readmitted.

A nursing note dated 8/4/17 and timed 7:08 a.m., documented, 'Reesident [sic] sign self out on 8/3/17 at 4:30 p.m. and did not return. at this time [name of hospital] called to ask if resident stay here [sic] and was told yes, Nurse stated he was found under bridge and brough [sic] to ER [emergency room] Social worker states walker is

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with him and they will try to clear clog picc line ER [sic]...'

A 'late entry' nursing note dated 8/7/17 6:03 p.m. [created on 8/16/17 1:37 a.m.] documented, '...was admitted on 8/7/17 via stretcher...continue IV antibiotics wound care management of diabetes education of health state...see admission/readmission evaluation for additional information...'

A 'late entry' nursing note dated 8/8/17 and timed 10:26 a.m. [created on 8/14/17 and timed 10:27 a.m.] documented, '...returned to the facility yesterday, and the APS referral was submitted to APS on today as the staff feels his recent choices while signed out could make him a danger to himself.'

The resident's admission evaluation dated 8/7/17 and timed 6:03 p.m. (signed as completed on 8/16/17) documented, '...alcohol use: yes, tobacco use: yes...IV...PICC...'

On 9/5/17 at 5:00 p.m., the AA (acting administrator) was asked for a policy on residents signing themselves out of the facility.

On 9/6/17 at approximately 8:20 a.m., Resident #3 was interviewed in his room regarding the incident on 8/3/17, when he signed himself out of the facility. Resident #3 stated that he thought he signed himself, but couldn't remember for sure on 8/3/17. The resident stated that he had 'to get away for a little while' and stated that he was extremely depressed during that time. The resident stated that his mother had passed away, as well as an uncle that he was very close to and he was really depressed. The resident did not

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provide dates of the loss of his mother and/or uncle. The resident asked if he had told anyone he was depressed. The resident stated, "Yes" and stated that he had been speaking with the SW (social worker) # 13 and that he did not like it here and wanted to try to get his own place or move to assisted living and that the SW # 13 'won't try to help me find a place.' The resident stated that he is a diabetic and isn't in the best health and that when he left he was so depressed and drank 4 pints of Vodka and went to a bridge he used to visit when he was a child, again stating he just needed to get away from it all.

On 9/6/17 at approximately 10:40 a.m., the AA and DON (director of nursing) were made aware of concerns regarding Resident #3 and that this information was not reported to the state agency, an investigation on Resident #3 regarding the above was then requested, again a policy on resident's signing out of the facility was requested.

At approximately 3:45 p.m., the AA (acting administrator) stated, '...we would not have reported to state, he is alert and oriented and goes out on LOA [leave of absence], goes out quite often, he was homeless..." The AA stated at that time, the facility does not have a policy on leave of absence or a policy on residents signing themselves out of the facility and stated that the facility reported it to APS. The AA then stated that there may something in the admission packet about residents signing themselves out of the facility.

The admission packet was reviewed by the survey team and did not provide any information regarding residents signing themselves out of the

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facility for a LOA and/or a pass.

A policy was presented on 'conducting a thorough investigation', which documented, 'When an actual and/or potential care and service failure occurs involving a resident, it is necessary for facility administration to initiate an investigation to determine the facts and then act upon or respond accordingly to the findings. Examples of issues that would require investigation...falls with injury or non-injury, allegations of abuse...elopement...."

A policy was presented on 'reporting abuse to state agencies and other entities' documented, 'All suspected violations and all substantiated incidents of abuse will be immediately reported...the facility administrator or his/her designee will promptly notify the following persons or agencies...a. The state licensing/certification agency responsible for surveying/licensing the facility..."

On 9/6/17 at 4:50 p.m., again concerns were raised by the survey team to the administrator, AA (assistant administrator), and DON regarding Resident #3 leaving the facility without being assessed as safe to sign out and that the resident was away from the facility and there was no evidence at all that staff attempted to locate the resident who had been away form the facility for approximately 13.5 hours. The facility staff were additionally made aware that there was no information in the admission packet regarding residents signing themselves out of the facility. The facility staff were also made aware that the sign out sheet that Resident #3 signed actually had another resident's name on top [a name similar to Resident #3] and that the sign out sheet clearly documented an area for 'signing [back] in'

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to the facility with a date, time and a signature of facility representative, that was completely blank.

No evidence was found that the facility attempted to locate the resident during the extended amount of leave from the facility. The facility had no policy and/or procedures to identify when a resident was gone from the facility for an extended amount of time or a policy and/or procedure to direct actions of staff in an event of this type. The facility staff did not assess the resident to determine if the resident was safe to leave the facility on a LOA and/or pass and the resident did not have a physician's order for the resident to leave the facility with or without supervision.

No further information and/or documentation was presented prior to the exit conference on 9/11/17 at 2:45 p.m.

The is a complaint deficiency.

2. Resident #2 was found on the floor with her head wedged between the bed rail and the air mattress. The resident had no prior assessment for safe use of the bed rails and no physician's order for the use of a specialty air mattress. The resident suffered pain and bruising to her neck and back from the entrapment.

Resident #2 was admitted to the facility on

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7/13/17 with diagnoses that included bipolar disorder, hypernatremia (excess sodium in the blood), hyperkalemia (high potassium concentration in the blood), depression, diabetes, high blood pressure, anxiety, osteoporosis and dementia. The minimum data set (MDS) dated 7/26/17 assessed Resident #2 with severely impaired cognitive skills.

Resident #2's clinical record documented a nursing note dated 7/17/17 at 3:05 a.m. stating, "Resident was observed with her bottom sitting on the floor and her head in between the bed rail and the air mattress. Resident stated she was trying to get up out of the bed. No c/o [complaints of] pain..."

The physician was notified of the resident's entrapment on 7/17/17 and ordered the resident to go the emergency room for evaluation and treatment. The emergency room discharge summary dated 7/17/17 documented, "Patient coming from nursing home, found half way out of bed with legs on the ground by neck and head caught within the railings. Complaining of anterior neck pain. Denies LOC [loss of consciousness]... Pt's [patient's] pain is moderate throbbing, without radiation and unchanged from onset. Worse with palpatiojn [palpation], not worse with movement. No associated swelling or shortness of breath, no dysphagia...No evidence of acute cervical spine fracture...minor trauma to anterior right neck, no expanding mass, minimally tender...Imaging reveals no acute injury...A diagnosis of Neck pain was also pertinent to this visit..."

The resident returned to the facility from the emergency room on 7/17/17. A nursing note

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dated 7/17/17 at 5:24 p.m. documented, "...returned from ED [emergency department]... with no new orders...Resident observed with bruise to back. Resident reports that she hit her back when she attempted to walk and fell to floor from bed. Resident was in pain...order obtained for Tylenol 325 mg [milligrams] two tablets by mouth q. [every] 6 hours. Resident reports pain management is effective..."

The clinical record documented no prior assessment for safe use of bed rails or a physician's order for the specialty air mattress prior to the entrapment incident on 7/17/17. There was no evidence of informed consent from Resident #2's responsible party (RP) or review with the RP of benefits and/or risks of side rail use prior to the entrapment. The resident's admission assessment dated 7/13/17 documented the resident was alert and oriented to person but not place, time or situation and was at risk for falls. This assessment documented the resident was independent with walking using an ambulation device and required total assistance of one person for safe transfers. This admission assessment documented side rails were not in use by the resident at the time of admission.

The resident's plan of care prior to the fall (dated 7/17/17) listed the resident was at risk for falls. Interventions to prevent falls included low bed position, alternate periods of activity with rest, participate in activities, call light within reach and a clutter free environment. There was no mention of side rail use or a specialty air mattress prior to the entrapment incident on 7/17/17.

There was no facility investigation of Resident #2's entrapment on 7/17/17. The facility's

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incident form documented the resident had an unwitnessed fall on 7/17/17 at 3:00 a.m. and was found with the side rails in the up position but made no mention the resident was found with her head wedged between the bed rail and the air mattress. The incident form did not include the length of the rails in use at the time or the area of the bed where the resident was wedged.

On 9/5/17 at 2:30 p.m. the registered nurse (RN #3) caring for Resident #2 was interviewed about the entrapment incident of 7/17/17 and the resident's assessment for bed rail use and the air mattress. RN #3 stated he was not aware the resident had been wedged in between the side rails and the mattress. RN #3 reviewed the clinical record and stated he did not see an assessment for side rail use or an order for the air mattress. RN #3 stated he thought side rail assessments were done upon admission for all residents.

On 9/5/17 at 4:20 p.m. the staff development coordinator (RN #2) at the time of the Resident #2's entrapment was interviewed about any prior assessment and/or order for the side rails or the air mattress. RN #2 stated Resident #2 had no prior assessment for safe use of side rails. RN #2 stated she was not sure why the resident had a specialty air mattress in use.

On 9/5/17 at 4:25 p.m. the director of nursing (DON) was interviewed about Resident #2's entrapment. The DON stated the use of a specialty air mattress required a physician's order prior to use. The DON stated assessment for safe use of bed rails was supposed to be done on admission or re-admission to the facility. The DON stated she was not aware of how or why the

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resident had side rails in use with the air mattress.

On 9/6/17 at 9:10 a.m. the administrator was interviewed about Resident #2's entrapment and lack of a prior assessment for side rail use or order for the specialty mattress. The administrator stated the use of side rails was supposed to be triggered based upon the admission assessment. The administrator stated, "We [facility] don't have a policy about assessment for side rails." The administrator stated there was no side rail assessment for Resident #2 prior to the entrapment incident on 7/17/17. The administrator stated she was new and did not have access to all the policies but would continue looking for a side rail policy.

On 9/6/17 at 2:10 p.m. the administrator stated she found a facility policy about side rails. The policy was titled "Side Rails" and had no effective or review dates listed. This policy stated, "Residents will be evaluated for indication of use of side rails by licensed nurse to determine if side rail is necessary to promote resident independence or safety on implementation and at least quarterly basis thereafter. Resident should be assessed to determine if side rails pose risk of restraint. Resident/responsible party should be provided education regarding risk versus benefit of use of side rails."

On 9/7/17 at 9:10 a.m. the corporate admissions director was interviewed about any information concerning the source of Resident #2's specialty air mattress. On 9/7/17 at 11:00 a.m. the corporate admission director stated the resident was admitted with poor intake and potential for skin breakdown. The corporate admissions

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director stated the resident had a specialty mattress at the hospital so admissions "thought it would be best" for her to have one in the facility. The corporate admissions director stated the facility admissions director had initiated the paperwork to order for the mattress from their supplier based on her hospital history. The corporate admissions director stated there was no physician's order found for Resident #2's air mattress.

On 9/11/17 at 9:10 a.m. the administrator stated, "An assumption had been made that she [Resident #2] had a MD [physician] order for the air mattress." The administrator stated she did not find an order for the mattress.

The facility presented the air mattress manufacturer's product information guide related to the specialty air mattress in use with Resident #2 at the time of entrapment on 7/17/17. The air mattress product information guide documented warnings and danger of entrapment risks with use of the air mattress. Page 17 of the air mattress product information guide documented, "Danger: Evaluate Gaps...The mattress is designed to fit on a standard bed frame. The risk of entrapment can arise when the equipment is placed on bed frames that leave gaps of even a few inches between the mattress and the head panel, and bed or side rails. The equipment is NOT to be used when such gaps are present."

There was no evidence of a side rail assessment, no physician's order for the specialty air mattress and no evidence of gap measurements or any interventions to ensure Resident #2's bed environment was safe prior to the entrapment incident on 7/17/17.

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These findings were reviewed with the administrator and director of nursing during meetings on 9/5/17 at 4:25 p.m. and on 9/6/17 at 4:45 p.m.

This was a complaint deficiency.

3. During the Group Meeting, residents complained of a lack of call bell response.

At 9:30 a.m. on 9/6/17, a Group Meeting was conducted with six alert and oriented facility residents. Prior to the meeting, the Resident Council Minutes for the most recent three council meetings were reviewed. Under Old Business, the August 30, 2017 minutes included the following, "Call bells at times still problem. Call bells not being answered timely."

During the meeting, the residents all agreed that call bell response was a problem. "I ring the call bell and they come in, ask me what I want, and then they never come back," one resident said. Another resident stated, "They don't follow-up on requests." "Call bell response is very slow. If you need help when they (CNA's) (Certified Nursing Assistants) are passing trays, you will wait a long time, or they will never come back."

F 325 SS=G	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325		

(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's

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F 325	Continued From page 79 comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to ensure acceptable nutritional parameters for two of 24 residents in the survey sample (Residents # 9 and # 22), resulting in harm and failed to ensure a therapeutic diet was provided as ordered by the physician for one of 24 residents, Resident # 2. 1. The facility failed to address the Resident # 9's continued weight loss of greater than 10% over six consecutive 180 day periods between 9/4/17 and 10/3/16. The facility failed to address the resident's continued weight loss ranging from 10.7% over 180 days to 19.6% over 180 days, resulting in harm. 2. The facility staff failed to ensure interventions recommended by the Dietitian were implemented for Resident # 22, as written and failed to implement additional interventions to prevent a weight loss of 31.7 pounds (20.7%) in 6 months resulting in harm	F 325	F325 1. Resident #9 were reassessed by Registered Dietitian on 9/22/2017 and Resident #22 reassessed by Registered Dietitian on 9/25/2017 with resulting recommendations communicated with resident's responsible party, physician, new orders received, medical record updated, care plans, and mds were modified with any changes. Resident #2 is receiving diet according to physicians order. 2. Registered Dietician reviewed nutritional therapy recommendations for time frame 7/28/17 thru 9/13/2017 to validate any recommendations were carried thru as indicated on 9/15/2017. 3. Nursing staff were reeducated on protocols for preventing weight loss by licensed nurse by 10/3/2017. Education was also provided to licensed nursing staff regarding the protocol for communicating diet changes to the dietary department by licensed nurse by 10/3/2017.	

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3. Resident #2, with history of poor intake and high sodium and potassium levels, was not provided a low potassium diet as ordered by the physician.

The findings include:

1. The facility failed to address the Resident # 9's continued weight loss of greater than 10% over six consecutive 180 day periods between 9/4/17 and 10/3/16. The facility failed to address the resident's continued weight loss ranging from 10.7% over 180 days to 19.6% over 180 days, resulting in harm.

Resident # 9 in the survey sample, a 55 year-old female, was admitted to the facility on 4/6/12 with diagnoses that included dementia with behavioral disturbances, hyperlipidemia, Vitamin D deficiency, candidiasis, dysphagia, pain, depressive disorder, diabetes mellitus, rheumatoid arthritis, and Non-Alzheimer's Dementia. According to the most recent Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/30/17, and the most recent Quarterly MDS, with an ARD of 7/30/17, the resident was assessed under Section C (Cognitive Patterns) as having short and long term memory problems with severely impaired daily decision making skills.

Under Section G (Functional Status) on the Annual and Quarterly MDS's, the resident was assessed as totally dependent with one person physical assist for eating, indicating Resident # 9 was unable to feed herself and needed to be fed

4. The Director of Nurses or designee will conduct audits of 5 residents at risk for weight loss weekly for 4 weeks and monthly for 2 months to ensure compliance.
The Director of Nurses or designees will conduct audits of 5 physicians orders related to diet changes to validate dietary received communication for 4 weeks and monthly for 2 months to ensure compliance. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed.
5. Completion date 10/3/2017

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by staff.

Review of the weight record in Resident # 9's Electronic Health Record revealed the following weight history:

The resident's weight on 4/3/17 was 154 pounds, and on 10/3/16 her weight was 191.6 pounds, for a loss of 37.6 pounds, or 19.6% in 180 days.

The resident's weight on 5/1/17 was 148.8 pounds, and on 11/1/16 her weight was 184.2 pounds, for a loss of 35.4 pounds, or 19.2% in 180 days.

The resident's weight on 6/1/17 was 146.8 pounds, and on 12/6/16 her weight was 176.8 pounds, for a loss of 30 pounds, or 16.9% in 180 days.

The resident's weight on 7/3/17 was 145 pounds, and on 1/2/17 her weight was 165 pounds, for a loss of 20 pounds, or 12.1 % in 180 days.

The resident's weight on 8/1/17 was 144.6 pounds, and on 2/1/17 her weight was 162 pounds, for a loss of 17.4 pounds, or 10.7 % in 180 days.

The resident's weight on 9/4/17 was 142.2 pounds, and on 3/1/17 her weight was 163 pounds, for a loss of 20.8 pounds, or 12.7 % in 180 days.

The Physician Progress Notes in the resident's paper clinical record, reviewed on 9/6/17, revealed the following entry dated 8/28/17:

"No recent behaviors, now bed bound, poor eye

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contact...Looks thinner to me...requires to be fed."

At 8:50 a.m. on 9/7/17, the facility's RD (Registered Dietician) was interviewed by telephone. The RD stated he started as the RD for the facility in mid-July (2017). Regarding Resident # 9, the RD said, "Her monthly weights are stabilizing. I saw no need to put in any interventions."

The resident's continued weight loss of greater than 10% over six consecutive 180 day periods between 9/4/17 and 10/3/16, and her use of a Magic Cup four times a day since 10/24/16 was discussed. When asked, based on that information, if new interventions should have been initiated, the RD said, "We should have, based on that information."

During a meeting at 4:30 p.m. on 9/7/17, that included the Administrator in Training, the Administrator in Training Mentor, the Director of Nursing, and the survey team, Resident # 9's continued weight loss and the lack of new interventions was discussed.

2. The facility staff failed to ensure interventions recommended by the Dietitian were implemented for Resident # 22, as written and failed to implement additional interventions to prevent a weight loss of 31.7 pounds (20.7%) in 6 months resulting in harm

Resident # 22 had a documented weight loss of 31.7 lbs (pounds) in 6 months, without appropriate interventions to maintain an

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acceptable weight for the resident.

Findings include:

Resident # 22 was admitted to the facility originally on 4/12/16, with the most current readmission on 3/21/17. The resident was again discharged on 9/2/17 and returned late on 9/6/17. Diagnoses for Resident # 22 included, but were not limited to: depression, anxiety, asthma, history of urinary tract infections, history of blood clots in lower extremities, atrial fibrillation, history of stroke with left side weakness and difficulty swallowing.

The most current full MDS (minimum data set) was a significant change assessment dated 03/28/17, this MDS assessed the resident with a cognitive score of '13', indicating the resident was cognitively intact for daily decision making skills. The resident was also assessed as extensive assistance from staff for most all ADL's (activities of daily living) except for eating, which was supervision with one person assist. The resident also triggered for the CAAS (care area assessment summary) section of this MDS for nutrition. The resident's height and weight was recorded on this MDS as 64' inches tall and weighing 150 lbs.

A comparison MDS was reviewed. A quarterly assessment dated 6/23/17 documented the resident as having a cognitive score of '10', indicating moderate impairment in daily decision making skills and as requiring extensive to total assistance from staff for most ADL's, including eating which was now extensive assistance with one person assist. The resident's height and weight were recorded on this MDS as 64' inches

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tall and weighing 126 lbs. A difference of 24 lbs between the two MDS assessments, in a 3 month period.

Resident # 22's weight records were then reviewed and revealed the following weights.

2/1/17-152.6
4/3/17-141.2
5/3/17-134.3
6/1/17-126.3
7/8/17-123.0
8/1/17-120.9

A total weight loss of 31.7 lbs (20.7%) in 6 months.

Resident # 22's CCP (comprehensive care plan) was then reviewed.

The CCP documented, "...ADL...eating: The resident requires assistance by staff to eat [3/30/17]...Nutritional...monitor/document/report as needed signs and symptoms of dysphasia [difficulty swallowing] pocketing, choking coughing, drooling, holding food in mouth, refusing to eat...weight loss...> [greater than] 10% in 6 months...provide and serve diet supplements as ordered...med pass per order [revision on 6/30/17]...RD to evaluation and make diet change recommendations...weigh as indicated..."

Resident # 22's progress notes were documented were reviewed.

A nutritional/dietary note dated 5/12/17 documented: "...134.3...11.99% X 90 day weight loss...Recommend: House supplement/med pass 120 cc TID [three times daily]. continue to

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monitor..."

A nutrition/dietary note dated 7/7/17 documented: "...123.3...19.49% loss x 6 months...Med pass 120 cc BID [twice daily] started 5/14/17...appetite good weight loss has slowed over the last month. Recommend increasing Med Pass to TID and will continue to monitor..."

A nutritional/dietary note dated 8/11/17 documented: "...120.9...Med Pass 120 cc started on 5/14/17, recommendation to increase to TID made on 7/7/17, increased to TID on 8/9/17...will continue to monitor weights as received...no new interventions at this time..."

Resident # 22's POS (physician's orders sheet) was reviewed and documented an order for 'Ready Care 2.0 Give 120 cc by mouth three times a day for supplement', the order date for the supplement was 7/8/17, but had listed on the POS to start date of 8/9/17.

Resident # 22's did not have any nutritional evaluations and/or assessments that could be located in the clinical record.

On 9/7/17 at approximately 2:00 p.m., the administrator, DON (director of nursing) and AA were made aware of concerns regarding Resident # 22's weight loss and the fact that the Dietitian recommended in 5/12/17 for the resident to receive 120 cc of supplement three times a day, which was started on 5/14/17 and only given twice a day-not three times a day as recommended, and then on 7/7/17 the supplement was again recommended to be increased to at 120 cc three time a day and that was not initiated until 8/9/17. The staff were

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asked for assistance in determining why the resident did not get the supplements as recommended.

On 09/11/17 at approximately 9:00 a.m., the resident's clinical record was again reviewed and documented a 'significant nutritional therapy evaluation' dated 9/11/17 and documented, which was "in progress." The evaluation did not have any pertinent data entered related to the resident's nutritional status or state, the evaluation was basically blank.

No further information and/or documentation was presented prior to the exit conference on 9/11/17 at 2:45 p.m., to clarify or explain why the resident did not get the recommended supplement to prevent weight loss in May and then again in July, and why no other interventions were implemented to prevent a significant weight loss for Resident # 22.

3. Resident #2, with history of poor intake and high sodium and potassium levels, was not provided a low potassium diet as ordered by the physician.

Resident #2 was admitted to the facility on 7/13/17 with diagnoses that included bipolar disorder, history of catatonia, hypernatremia (excess sodium in the blood), hyperkalemia (high potassium concentration in the blood), depression, diabetes, high blood pressure, anxiety, osteoporosis and dementia. The

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minimum data set (MDS) dated 7/26/17 assessed Resident #2 with severely impaired cognitive skills and body weight of 107 pounds.

Resident #2's admission history and physical dated 7/14/17 documented the resident had poor intake and had diagnoses of hypernatremia and hyperkalemia. This physician's note stated the resident was prescribed a low potassium diet and ordered to be given at least 1500 cc's of fluid daily for management of hyperkalemia and hypernatremia.

Resident #2's clinical record documented a physician's order 7/13/17 for a regular pureed texture diet. A telephone physician's order dated 7/14/17 documented, "low K+ diet (low-potassium)."

Resident #2's diet requisition form dated 7/14/17 documented a regular pureed diet. The diet slip made no mention of the order for a low potassium diet.

The resident's plan of care (revised 8/8/17) documented the resident had potential for impaired nutrition due to dementia and underweight body mass index and refusals to eat meals. Interventions to maintain weight and prevent weight loss included, "Nutritional supplement as ordered d/t [due to] underweight...Observe daily po [oral] and fluid intake...Provide diet as ordered...Resident has been refusing meals at times, Encourage assist with meals..."

On 9/5/17 at 2:30 p.m. the registered nurse (RN #3) caring for Resident #2 was interviewed about the ordered low potassium diet. RN #3 stated he

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was not aware of a low potassium diet. RN #3 stated the resident may have been discharged and readmitted with a new diet order.

The clinical record documented no re-admissions to the facility and no further diet orders since 7/14/17.

On 9/5/17 at 3:50 p.m. the dietary manager was interviewed about Resident #2's physician ordered low potassium diet. The dietary manager stated the resident had not received a low potassium diet since admission. The dietary manager stated the last diet communication form sent to the kitchen was dated 7/14/17 and listed a regular pureed diet with no mention of low potassium. The dietary manager stated the low potassium order was not sent or communicated to the kitchen. The dietary manager stated high potassium foods were avoided for residents with orders for a low potassium diet. The dietary manager stated the registered dietitian was on vacation but he would attempt to contact him regarding Resident #2.

On 9/5/17 at 4:40 p.m. the dietary manager stated he contacted the facility's registered dietitian by telephone about Resident #2's diet. The dietary manager stated the RD had no knowledge of any recommendation or orders for a low potassium diet for Resident #2.

These findings were reviewed with the administrator and director of nursing during a meeting on 9/5/17 at 5:00 p.m.

F 327 SS=E 483.25(g)(2) SUFFICIENT FLUID TO MAINTAIN HYDRATION — F 327

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(g) Assisted nutrition and hydration.
(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-

(2) Is offered sufficient fluid intake to maintain proper hydration and health.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure fluid intake as ordered by the physician and/or recommended by the registered dietitian (RD) for two of 24 residents in the survey sample. Facility staff failed to track and implement interventions to ensure Resident #2 received 1500 cc's (cubic centimeters) of daily fluid intake as ordered by the physician. Resident #9, totally dependent on staff for oral intake, was not provided fluid intake amounts as recommended by the registered dietitian.

The findings include:

1. Facility staff failed to track and implement interventions to ensure Resident #2 received 1500 cc's (cubic centimeters) of daily fluid intake as ordered by the physician.

Resident #2 was admitted to the facility on 7/13/17 with diagnoses that included bipolar disorder, history of catatonia, hypernatremia (excess sodium in the blood), hyperkalemia (high potassium concentration in the blood), depression, diabetes, high blood pressure, anxiety, osteoporosis and dementia. The

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1. Resident #9 was reassessed by Registered Dietitian on 9/22/2017 with resulting recommendations communicated with Resident's responsible party, physician, medical record updated, care plans, and mds were modified with any changes. Resident #2 is receiving diet according to physcians orders.
2. An audit of current residents' ADL records to assure compliance with accuracy of fluid consumption will be conducted by 10/3/2017 by licensed nurse or designee .
3. Nursing staff were reeducated on protocols for recording of fluid consumption on ADL's by Staff Development or designee by 10/3/2017.
4. The Director of Nurses or designee will conduct audits of 5 residents fluid consumption weekly for 4 weeks and monthly for 2 months to ensure compliance. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed.
5. Completion date 10/3/2017

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minimum data set (MDS) dated 7/26/17 assessed Resident #2 with severely impaired cognitive skills.

Resident #2's admission history and physical dated 7/14/17 documented the resident had poor intake and had diagnoses of hypernatremia and hyperkalemia. This physician's note stated the resident was prescribed a low potassium diet and ordered to be given at least 1500 cc's of fluid daily for management of hyperkalemia and hypernatremia.

Resident #2's clinical record documented a physician's order dated 7/14/17 stating, "Please assure at least 1500 cc fluid intake daily."

Resident #2's most recent lab results dated 8/10/17 documented a high sodium level at 149 mmol/L (millimoles per liter) with normal range listed as 136 to 145 mmol/L and high potassium level of 5.2 mmol/L with normal range listed as 3.5 to 5.1 mmol/L.

Resident #2's clinical record documented no daily summary of the resident's fluid intake. The resident's activity of daily living (ADL) records documented fluid intake amounts for each meal and the evening snack but no other fluid intake amounts. In July 2017 Resident #2 was documented with fluid intake amounts ranging from 0 to 960 cc's per day. The August 2017 ADL record documented fluid intake amounts for Resident #2 ranging from 120 to 720 cc's per day. The September 2017 (from 9/1/17 through 9/8/17) documented fluid intake amounts from 300 to 620 cc's per day. The resident had no days from 8/1/17 through 9/8/17 with fluid intake amounts of 1500 cc's as ordered by the

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physician. Nursing notes made no mention of tracking the resident's fluid intake. The order for tracking the resident's fluid intake was not listed on the resident's medication or treatment records.

Resident #2's plan of care (revised 8/8/17) listed the resident was "at risk of alteration in fluid imbalance..." Interventions to prevent fluid imbalance included, "Provide me [Resident #2] with increased fluid intake as indicated." The resident's plan of care also documented the resident had potential for impaired nutrition due to dementia and underweight body mass index and refusal to eat meals. Interventions to maintain weight and prevent weight loss included, "Nutritional supplement as ordered d/t [due to] underweight...Observe daily po [oral] and fluid intake...Provide diet as ordered...Resident has been refusing meals at times, Encourage assist with meals..."

On 9/5/17 at 2:30 p.m. the registered nurse (RN #3) caring for Resident #2 was interviewed about the physician's order for 1500 cc's of daily fluid intake. RN #3 stated the order regarding the fluid intake amount was not listed on the resident's medication or treatment records. RN #3 stated, "We try to encourage fluids." When asked if the resident's daily fluid intake was summarized or tracked in some manner, RN #3 stated he thought the intake amounts were tracked in the clinical record.

On 9/6/17 at 7:35 a.m. the certified nurses' aide (CNA #1) routinely caring for Resident #2 was interviewed about any tracking of the resident's fluid intake. CNA #1 stated fluid intake amounts were entered on the ADL records. CNA #1 stated the ADL records only documented fluid intake at

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meals and the evening snack. CNA #1 stated Resident #2 had juice and water available to her during the day and these amounts were not tracked. CNA #1 stated Resident #2 went out frequently to a community day program and she did not know if fluid amounts were tracked while the resident was out of the facility.

On 9/6/17 at 9:15 a.m. RN #3 was interviewed again about how the facility ensured the resident received the ordered 1500 cc's of fluid daily. RN #3 stated staff members encouraged the resident to take as much fluid as possible. RN #3 stated he thought the fluid provided on the resident's meal trays was enough to meet the ordered requirement. RN #3 presented no daily summaries or total daily intake amounts for Resident #2.

These findings were reviewed with the administrator and director of nursing during a meeting on 9/6/17 at 4:15 p.m. The administrator stated at this time the resident's community day program did not track the resident's fluid intake.

2. The facility failed to maintain acceptable parameters of hydration as recommended by the Registered Dietician.

Resident # 9 in the survey sample, a 55 year-old female, was admitted to the facility on 4/6/12 with diagnoses that included dementia with behavioral disturbances, hyperlipidemia, Vitamin D deficiency, candidiasis, dysphagia, pain, depressive disorder, diabetes mellitus, rheumatoid arthritis, and Non-Alzheimer's Dementia. According to the most recent Annual Minimum Data Set (MDS), with an Assessment

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Reference Date (ARD) of 4/30/17, and the most recent Quarterly MDS, with an ARD of 7/30/17, the resident was assessed under Section C (Cognitive Patterns) as having short and long term memory problems with severely impaired daily decision making skills.

Under Section G (Functional Status) on the Annual and Quarterly MDS's, the resident was assessed as totally dependent with one person physical assist for eating, indicating Resident # 9 was unable to feed herself and needed to be fed by staff.

Review of the fluid intake portion of the Resident ADL (Activities of Daily Living) Record for Resident # 9 included the following:

For the month of May 2017, Resident # 9's daily fluid intake ranged from a low of 50 cc (cubic centimeters) on 5/20/17, to a high of 580 cc on 5/29/17.

For the month of June 2017, Resident # 9's daily fluid intake ranged from a low of 100 cc on 6/12 and 6/19/17, to a high of 720 cc on 6/3, 6/17 and 6/18/17.

For the month of July 2017, Resident # 9's daily fluid intake ranged from a low of 200 cc on 7/3, 7/8 and 7/9/17, to a high of 840 cc on 7/21/17.

For the month of August 2017, Resident # 9's daily fluid intake ranged from a low of 240 cc on 8/14 and 8/15/17, to a high of 840 cc on 8/27/17.

As on 9/11/17, the date of record review, for the month of September May 2017, Resident # 9's daily fluid intake ranged from a low of 340 cc on

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9/4/17, to a high of 720 cc on 9/1/17.

At 8:30 a.m. on 9/7/17, LPN # 3 (Licensed Practical Nurse) was interviewed regarding Resident # 9's fluid intake. "She does not drink on her own, she has to be offered (fluids). She takes tiny sips," LPN # 3 said.

During a telephone interview with the facility's RD (Registered Dietician) at 8:50 a.m. on 9/7/17, the issue of Resident # 9's fluid intake was discussed. "I would expect 1600 to 1900 cc (of fluid) per day given her current weight," the RD said. Continuing, the RD said, "Fluids would need to be offered by staff since she is a feeder, and with dementia she probably won't take fluids by herself."

During a meeting at 4:30 p.m. on 9/7/17, that included the Administrator in Training, the Administrator in Training Mentor, the Director of Nursing, and the survey team, Resident # 9's fluid intake was discussed.

F 332 SS=D 483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE — F 332

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

(1) Medication error rates are not 5 percent or greater;
This REQUIREMENT is not met as evidenced by:
Based on a medication pass observation, staff interview and clinical record review, the facility staff failed to ensure a medication error rate of less than 5%. There were two errors out of 30 opportunities resulting in a medication error rate

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F 332	Continued From page 95 of 6.6%. The findings include: A medication pass observation was conducted on 9/6/17 at 8:20 a.m. with licensed practical nurse (LPN) #2 administering medications to Resident #19. LPN #2 administered medications to Resident #19 through a gastrostomy tube. LPN #2 failed to follow physician orders for water flushes through the gastrostomy tube prior to administering medications and failed to follow physician orders for water flushes through the gastrostomy between medications administered. On 9/6/17 at 8:20 a.m. LPN #2 prepared the following medications for Resident #19: Ferrous Sulfate 325 mg (milligrams), Oxybutynin chloride 5 mg, Magnesium oxide 400 mg, multivitamin and natural vegetable laxative with Colace 50 mg (2 tabs). Each medicine was crushed and placed in a separate medicine cup. LPN #2 disconnected the resident's tube feeding (Two Cal HN) that was running at 60 cc's (cubic centimeters) per hour and clamped the tubing. LPN #2 then mixed the first cup of crushed medicine with a small amount of water and stirred it to mix. LPN #2 pulled the medicine mix from the cup into a large syringe. Without a prior check of the gastrostomy tube placement and without a prior water flush, LPN #3 pushed the first medicine mixture into the gastrostomy tube with the syringe. Without administering any water into the tube, the next crushed medicine mix was pushed into the gastrostomy tube. LPN #2 followed the second medication mix with a small amount of water. LPN #2 proceeded to administer the other medicines pushing them with the syringe into the gastrostomy with each followed by a small	F 332	F332 1. Resident #19 was assessed by a registered nurse with no negative outcome on 9/15/2017.Resident #19 is currently receiving appropriate gastrostomy care. 2. All residents requiring enteral feeding have the ability to be affected. 3. Licensed nurses will be re-educated by Staff Development Coordinator or designee regarding appropriate gastrostomy care by 10/03/2017 with return competency. Licensed Nurses #2 received 1:1 in service regarding medication administration by Registered Nurse on 9/21/17. 4. The Director of Nurses or designee will conduct competency testing of 5 licensed nurses regarding gastrostomy care weekly for 4 weeks and monthly for 2 months to ensure compliance. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed. 5. Completion date 10/3/2017.	

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F 332	Continued From page 96 amount of water. Resident #19's clinical record documented a physician's order dated 4/28/17 stating, "Flush tube [gastrostomy] with 60 cc free water before and 30 cc between meds [medicines]." On 9/6/17 at 8:55 a.m. LPN #2 was interviewed about the lack of water flushes prior to and between the first two medicines administered to Resident #19. LPN #2 stated she usually flushes the gastrostomy tube prior to starting medications and she was supposed to flush the tube between each medicine as ordered. LPN #2 stated she forgot and realized she missed the flushes part way through the medication pass and then started with adding water flushes. The facility's policy for medication administration through a gastrostomy (revised November 2016) stated, "...Use 5 cc of water to dilute each medication...Administer medication via gravity...Flush feeding tube after administration according to physician order..." These findings were reviewed with the administrator and director of nursing during a meeting on 9/6/17 at 2:10 p.m.	F 332		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative	F 334		

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receives education regarding the benefits and potential side effects of the immunization;

(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and

(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and

(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-

(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;

(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has

1. Resident #2 received immunization on 9/28/2017.
2. An audit of current residents medical records were conducted to assure compliance with pneumococcal vaccinations by Medical records department on 9/22/2017.
3. Licensed nurses will be re-educated on protocols for pneumococcal vaccinations by Staff Development Coordinator by 10/3/2017.
4. The Director of Nurses or designee will conduct audits of 5 residents medical record weekly for 4 weeks and monthly for 2 months to ensure compliance. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed.
5. Completion date 10/3/2017

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already been immunized;

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and

(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and

(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.

This REQUIREMENT is not met as evidenced by:

Based on staff interview, facility document review and clinical record review, the facility staff failed to determine the pneumococcal immunization status and/or offer the pneumococcal vaccine to one of 24 residents in the survey sample. Resident #2's clinical record failed to document if the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to a medical contraindication or refusal.

The findings include:

Resident #2 was admitted to the facility on 7/13/17 with diagnoses that included bipolar disorder, history of catatonia, hypernatremia (excess sodium in the blood), hyperkalemia (high potassium concentration in the blood), depression, diabetes, high blood pressure,

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anxiety, osteoporosis and dementia. The minimum data set (MDS) dated 7/26/17 assessed Resident #2 with severely impaired cognitive skills.

Resident #2's clinical record documented no information regarding the resident's pneumococcal immunization status. The clinical record tab for immunization status listed "no information." There was no documented pneumococcal immunization status, no documented education information provided to the resident's responsible party or any information regarding consent, risks and benefits of the immunization or of any reason the pneumococcal vaccine was not offered or administered. The resident's admission assessment dated 7/13/17 listed the resident's pneumococcal immunization status as "unknown."

On 9/5/17 at 2:30 p.m. the registered nurse (RN #3) caring of Resident #2 was interviewed about the resident's pneumococcal immunization status. RN #3 reviewed the clinical record and stated he did not see any information about immunizations. On 9/6/17 at 10:40 a.m. RN #3 stated he contacted the director of nursing (DON) and there was no record indicating if Resident #2 had been immunized for pneumonia.

The facility's policy titled Pneumococcal Immunization (revised 10/7/13) stated, "All residents will be offered the Pneumovax (pneumococcal vaccine) to aid in preventing pneumococcal infections (e.g., pneumonia)...Prior to or upon admission, residents will be assessed for eligibility to receive the Pneumovax (pneumococcal vaccine), and when indicated, will be offered the vaccination within thirty (30) days

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F 334	Continued From page 100 of admission to the facility unless medically contraindicated or the resident has already been vaccinated...Assessments of pneumococcal vaccination status will be conducted within in five (5) working days of the resident's admission if not conducted prior to admission..." These findings were reviewed with the administrator and director of nursing during a meeting on 9/5/17 at 5:00 p.m.	F 334		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced	F 371	F371 1. The wall in the adjoining the dishwasher was cleaned on by Dietary personnel and will be repaired by Maintenance / designee by 10/3/2017. 2. An audit of the kitchen was conducted to assure absence of pests on 9/22/2017 by Health Services Group. 3. Staff were reeducated on protocols for prevention of insect infestations by Health Services Group on 9/18/2017. 4. The Dietary Manager or designee will conduct audits of the kitchen area weekly for 4 weeks and monthly for 2 months to ensure compliance. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed. 5. Completion date 10/3/2017	

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by:
Based on observation, staff interviews, and facility document review, the facility failed to ensure a sanitary kitchen environment.

The wall adjoining the dishwasher was observed to have a black substance, food debris and harboring fruit flies.

The findings include:

The facilities pest control invoices were reviewed on 9/7/17 for a time period of 6/12/17 through 8/7/17 (total of 5 invoices). Each service report indicated that fruit flies were observed and being treated in the kitchen and each report recommenced that food debris and grease be cleaned from the wall behind the dish washer as this is considered a breeding site.

On 9/11/17 at 9:45 a.m. pest control service was in the building and an interview was conducted concerning fruit flies. Service technician (OS #11) verbalized that fruit flies continue to be a problem. OS #11 verbalized that fruit flies are especially bad in the kitchen area around the dishwasher due to moisture and food debris. OS #11 verbalized that he has reported this to the facility 14 times and this hasn't been resolved. OS #11 along with this surveyor observed the wall adjoining the dishwasher. The wall was totally black with what OS #11 thought might be mold.

On 9/11/17 at 10:00 a.m. the dishwasher room was observed along with the dietary manager. The entire wall underneath the counter at the dishwasher was black with what appeared to be mold. Also noted was food debris and fruit flies.

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F 371	Continued From page 102 At this time this surveyor requested that the maintenance director (other staff, OS #10) also observe the wall. OS #10 observed the wall and verbalized that he did not know if the black substance on the wall was grease or mold, but either way the wall needed to be completely cleaned or replaced. On 9/11/17 at 10:20 a.m. the dietary manager (other staff #1) verbalized to this surveyor that the kitchen staff had tried to pressure wash the wall in the past, but the wall just crumbled so they did not continue. OS #1 also verbalized that it had been reported to the previous administrator and owners of the facility. On 9/11/17 at 1:00 p.m. the above finding was brought to the attention of the administrator and director of nursing. No other information was presented prior to exit on 9/11/17. This is a complaint deficiency.	F 371		
F 386 SS=E	483.30(b)(1)-(3) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS (b) Physician Visits The physician must-- (1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; (2) Write, sign, and date progress notes at each visit; and (3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility	F 386		

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policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility failed to review and sign physician orders for two of 24 residents in the survey sample. The physician had not reviewed and/or signed physician orders and/or progress notes for Resident #2 and Resident #18.

1. The physician failed to review the plan of care and sign verbal and telephone orders for Resident #2. No monthly physician order summary sheets or telephone orders for Resident #2 had been signed by a physician since 7/14/17.

2. Resident #18 who attended PACE (Program for All-inclusive Care of the Elderly) did not have signed physician orders in his clinical record, nor were there physician progress notes indicating the resident had been visited by his physician.

The findings include:

1. The physician failed to review the plan of care and sign verbal and telephone orders for Resident #2. No monthly physician order summary sheets or telephone orders for Resident #2 had been signed by a physician since 7/14/17.

Resident #2 was admitted to the facility on 7/13/17 with diagnoses that included bipolar disorder, hypernatremia (excess sodium in the blood), hyperkalemia (high potassium concentration in the blood), depression, diabetes, high blood pressure, anxiety, osteoporosis and dementia. The minimum data set (MDS) dated 7/26/17 assessed Resident #2 with severely impaired cognitive skills.

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1. Resident #2 and #18's physician orders statement and progress notes were completed and signed by the Medical Director.
2. An audit of residents' medical records who attend PACE for signed physician orders and progress notes was conducted by Nursing Administration.
3. Physicians and medical records were educated on timely physician visits and orders 9/8/2017.
4. Medical records or designee will conduct audits of 5 PACE residents' medical charts weekly for 4 weeks and monthly for 2 months to ensure compliance. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed.
5. Completion date 10/3/2017

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Resident #2's clinical record documented admission orders for medications, care and treatment signed by the physician on 7/14/17. In addition there were three telephone orders for Resident #2 dated 7/14/17 signed by the physician on 7/14/17.

As of 9/5/17 there were no other orders in Resident #2's clinical record signed by the physician or any health care provider. Resident #2's physician order summary reports dated 7/31/17 and 8/29/17 were not signed by a physician. There were 28 telephone and/or verbal orders documented from 7/17/17 through 8/10/17. None of these orders had been signed by a physician. A faxed list of physician orders for medications from PACE (program for all inclusive care of the elderly) was documented on 8/2/17 stating "Corrected Orders for [Resident #2]." This list of medications had no physician signature (actual or electronic).

On 9/7/17 at 12:00 p.m. the director of nursing (DON) was interviewed about physician review of care and signing of orders. The DON stated routinely physicians reviewed and signed any verbal and/or telephone orders during their required visits. The DON stated the PACE physicians did not come to see residents at the nursing facility as the residents were seen during their visits to the day facility. The DON stated the paperwork for review and signatures was supposed to be sent to the PACE physicians for review and then returned to the facility to be filed in the resident's clinical record. The DON was not sure who was responsible for sending the orders to the PACE physicians for signatures.

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These findings were reviewed with the administrator and director of nursing during a meeting on 9/7/17 at 3:20 p.m.

2. Resident #18 who attended PACE (Program for All-inclusive Care of the Elderly) did not have signed physician orders in his clinical record, nor were there physician progress notes indicating the resident had been visited by his physician.

Resident #18 was admitted to the facility on 03/10/2017. His diagnoses included but were not limited to: Cerebrovascular disease with hemiplegia, hypertension, osteoporosis and osteoarthritis.

The initial MDS with an ARD (assessment reference date) of 03/17/2017. Resident #18 was assessed as having a cognitive summary score of "13", indicating he was cognitively intact.

The clinical record was reviewed on 09/07/2017. Documentation from the time of his admission on 03/10/2017 included the following history and physician electronically written and signed by his physician: "This is a PACE patient seen at PACE facility." There was also a handwritten note from his PACE physician dated 03/10/2017. The next progress note was completed by a nurse practitioner on 04/26/2017. There were no additional progress notes in the clinical record.

Review of the physician order section revealed that none of the orders on the clinical record had been signed by a physician except for one order

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on 08/31/2017 to discontinue the use of his left knee immobilizer.

During a meeting with the medical director on 09/07/2017. He stated that the physician of record for the PACE program was no longer working at the PACE facility. He stated that he had assumed the role of provider for one of the residents at the facility the evening before and would be reviewing the records of the other PACE residents.

A meeting was held on 09/07/2017 at approximately 3:30 p.m., concerns were voiced that there was no physician oversight evident on the clinical record for Resident #18. There were no physician visits or signed orders. The acting administrator and the DON (director of nursing) wee asked how the orders were suppose to be signed and when did the physician see the resident. Both the DON and the acting administrator stated that they were not familiar with PACE and did not know how the orders were suppose to be signed. An administrator from a sister facility who was there to help the acting administrator stated, "The assumption is that the physician sees them there at PACE." The DON and the acting administrator stated they would look at the contract and report back to the survey team.

On 09/11/2017 at approximately 9:00 a.m., the administrator and the AIT (administrator in training) came to the conference room to speak with the survey team. The administrator stated that multiple calls had been put through to the PACE program and the facility had eventually gone there to get orders progress notes, etc and she would present them to the survey team.

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At approximately 10:30 a.m., information from the PACE program was presented by the AIT Progress notes were presented for March, April, July and August. There was no evidence that Resident #14 was seen during the month of June by the PACE physician. There were no signed orders presented. Multiple notes from other areas of PACE (occupational therapy, physical therapy, social worker, etc) were presented. The AIT was asked if any signed orders had been obtained from PACE to be placed on Resident #18's clinical record since none of his orders had been signed. She stated, "This is what we have."

No further information was obtained prior to the exit conference on 09/11/2017.

F 387 SS=E 483.30(c)(1)(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT — F 387

(c) Frequency of Physician Visits

(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter.

(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure a physician visit once every 30 days for the first 90 days after admission for two of 24 residents in the survey sample. Resident #2 missed a physician visit due in August 2017 and Resident #18 missed a physician visit due in May 2017.

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The findings include:

1. Resident #2 missed a physician visit due in August 2017.

Resident #2 was admitted to the facility on 7/13/17 with diagnoses that included bipolar disorder, hypernatremia (excess sodium in the blood), hyperkalemia (high potassium concentration in the blood), depression, diabetes, high blood pressure, anxiety, osteoporosis and dementia. The minimum data set (MDS) dated 7/26/17 assessed Resident #2 with severely impaired cognitive skills.

Resident #2's clinical record documented the resident was admitted to the facility on 7/13/17. The physician documented a history and physical and admission orders on 7/14/17. As of 9/5/17 there was no evidence of a physician visit for Resident #2. The clinical record documented no physician progress notes since the admission physical.

On 9/7/17 at 7:50 a.m. the administrator was interviewed about any evidence of physician visits for Resident #2. The administrator stated there were no progress notes in the resident's clinical record but she would contact PACE (program for all inclusive care for the elderly) for the records. The administrator stated Resident #2 went to day programming at the PACE facility and was seen by a physician there.

On 9/7/17 at 12:00 p.m. the director of nursing (DON) was interviewed about physician visits for Resident #2. The DON stated Resident #2 was seen by the physician at PACE and was not a

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1. Resident #18 had planned discharge on 9/12/2017. Resident # 2 was seen by the Medical Director on 9/7/2017 and #18 on 9/8/17.
2. An audit of residents' medical records who attend PACE for timely physician visits was conducted by Nursing Administration.
3. Physicians and medical records will be educated on timely physician visits and orders by 10/3/2017.
4. Medical records or designee will conduct audits of 5 PACE residents medical charts weekly for 4 weeks and monthly for 2 months to ensure compliance. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed.
5. Completion date 10/3/2017.

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patient of the in house physicians. The DON stated the PACE physicians did not come to see residents at the nursing facility as the residents were seen by during their visits to the day facility. The DON stated the paperwork for review and signatures was supposed to be sent to the PACE physicians for review and then returned to be filed in the resident's clinical record. The DON stated she would look for any physician visit notes for Resident #2.

On 9/11/17 at 9:10 a.m. the administrator was interviewed again about any physician progress notes or evidence of a physician visit for Resident #2. The administrator stated the progress notes were at the PACE facility and not in the clinical record. The administrator stated the assumption was that PACE would share their records with the facility.

On 9/11/17 at 10:45 a.m. the administrator presented copies of all the notes from the PACE facility for Resident #2. There was no physician progress note documented indicating the resident had been seen by a physician since 7/14/17.

These findings were reviewed with the administrator and director of nursing during meetings on 9/6/17 at 4:45 p.m. and 9/7/17 at 3:20 p.m.

2. Resident #18 who attended PACE (Program for All-inclusive Care of the Elderly) did not have physician progress notes indicating the resident had been visited by his physician every thirty days for the first ninety days after admission.

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Findings were:

Resident #18 was admitted to the facility on 03/10/2017. His diagnoses included but were not limited to: Cerebrovascular disease with hemiplegia, hypertension, osteoporosis and osteoarthritis.

The initial MDS with an ARD (assessment reference date) of 03/17/2017. Resident #18 was assessed as having a cognitive summary score of "13", indicating he was cognitively intact.

The clinical record was reviewed on 09/07/2017. Documentation from the time of his admission on 03/10/2017 included the following history and physician electronically written and signed by his physician: "This is a PACE patient seen at PACE facility." There was also a handwritten note from his PACE physician dated 03/10/2017. The next progress note was completed by a nurse practitioner on 04/26/2017. There were no additional progress notes in the clinical record.

During a meeting with the medical director on 09/07/2017. He stated that the physician of record for the PACE program was no longer working at the PACE facility. He stated that he had assumed the role of provider for one of the residents at the facility the evening before and would be reviewing the records of the other PACE residents.

A meeting was held on 09/07/2017 at approximately 3:30 p.m., concerns were voiced that there was no physician oversight evident on the clinical record for Resident #18. There were no physician visits or signed orders. The acting administrator and the DON (director of nursing)

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were asked how the orders were suppose to be signed and when did the physician see the resident. Both the DON and the acting administrator stated that they were not familiar with PACE and did not know how the orders were suppose to be signed. An administrator from a sister facility who was there to help the acting administrator stated, "The assumption is that the physician sees them there at PACE." The DON and the acting administrator stated they would look at the contract and report back to the survey team.

On 09/11/2017 at approximately 9:00 a.m., the administrator and the AIT (administrator in training) came to the conference room to speak with the survey team. The administrator stated that multiple calls had been put through to the PACE program and the facility had eventually gone there to get orders progress notes, etc and she would present them to the survey team.

At approximately 10:30 a.m., information from the PACE program was presented by the AIT Progress notes were presented for March, April, July and August. There was no evidence that Resident #14 was seen during the month of May by the PACE physician.

No further information was obtained prior to the exit conference on 09/11/2017.

F 431 SS=D 483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS — F 431

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit

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unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked,

1. The liquid lorazepam was placed in the correct locked area at the time of discovery by the nurse on 9/7/2017.
2. An audit of the facilities medication storage areas was conducted by Registered nurse on 9/14/2017 to validate narcotics medications are stored according to protocol.
3. Initiated Licensed nurses re-educated on medication storage by Pharmacy representative on 9/19/2017.
4. The Director of Nurses or designee will conduct 5 audits of medication storage areas weekly for 4 weeks and monthly for 2 months to ensure compliance. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed.
5. Completion date 10/3/2017

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permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, facility document review and staff interview, the facility staff failed to ensure a drug subject to abuse was stored in a separate, permanently affixed locked compartment on one of three nursing units. An opened bottle of liquid Lorazepam was stored in the medication refrigerator on unit two with other medications and not in the available permanently affixed locked box.

The findings include:

On 9/7/17 at 7:45 a.m. accompanied by licensed practical nurse (LPN) #2, the medication storage room was inspected on unit two. Stored in the refrigerator in the medication room with other medications was an opened 30 ml (milliliter) bottle of liquid Lorazepam. The bottle was marked as opened on 9/4/17. The medication was stored on the refrigerator shelf and was not in the mounted permanently affixed locked box available for use. LPN #2 was interviewed at this time about the liquid Lorazepam storage. LPN #2 the Lorazepam was supposed to be stored in the affixed lock box inside the refrigerator. LPN #3 stated she always put the Lorazepam in the separate locked box and did not know why the Lorazepam was stored on the refrigerator shelf with other medicines.

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On 9/7/17 at 8:55 a.m. the director of nursing (DON) was interviewed about the storage and security of liquid Lorazepam. The DON stated the liquid Lorazepam should be stored in the separate locked box inside the refrigerator according to policy.

The facility's policy titled Storage and Expiration of Medications, Biologicals, Syringes and Needles (revised 1/1/13) stated, "Facility should store Schedule II controlled substances and other medications deemed by Facility to be at risk for abuse or diversion in a separate compartment within the locked medications carts and should have a different key... Facility should ensure that Schedule II - V controlled substances are only accessible to licensed nursing, Pharmacy, and medical personnel designated by Facility...After receiving controlled substances and adding to inventory, Facility should ensure that Schedule II - V controlled substances are immediately placed into a secured storage area (i.e., a safe, self-locked cabinet, or locked room, in all cases in accordance with Applicable Law)."

These findings were reviewed with the administrator and director of nursing during a meeting on 9/7/17 at 3:20 p.m.

F 463 SS=D — 483.90(g)(2) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH — F 463

(g) Resident Call System

The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff

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work area -

(2) Toilet and bathing facilities.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, and staff interview, facility staff failed to ensure a working call light for one of 24 residents in the survey sample, Resident #6.

Facility staff failed to ensure a working call system in room 118-B affecting Resident #6.

Findings included:

Resident #6 was admitted to the facility on 07/29/2016 with diagnoses including, but not limited to: Hypertension, Neurogenic Bladder, Diabetes, Multiple Sclerosis, Depression, Chronic Obstructive Pulmonary Disease and a Stage 4 Pressure Ulcer.

The most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 07/28/17. Resident #6 was assessed as cognitively intact with a total cognitive score of 14 out of 15.

On 09/07/17 at approximately 10:15 a.m., Resident #6 was interviewed regarding timeliness of call lights being answered by facility staff. Resident #6 stated, "Well, my light doesn't work outside the room. I don't know if it works at the nurse's station. It hasn't worked for about two weeks. I told one of the aides and someone at the nurse's station."

At 10:20 a.m., this surveyor entered Resident #6's room and tried his call light. The light

F463

1. Resident #6 had call light repaired by Maintenance on 9/7/2017.
2. An audit of residents' call bells was completed by Maintenance on 9/10/17 .
3. Staff were educated on reporting of inoperable call bells by Staff Development / designee by 10/3/2017.
4. Maintenance or designee will conduct audits of 5 residents call bells weekly for 4 weeks and monthly for 2 months to ensure compliance. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed.
5. Completion date 10/3/2017

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outside of room 118 did not light up and it did not alarm at the nurse's station. The call light for 118-A bed did light up outside of the room and alarmed at the nurse's station.

At 10:25 a.m., LPN #1 (licensed practical nurse) was interviewed regarding the call light for Resident #6. LPN #1 stated, "I do not know anything about his call light not working."

At 10:35 a.m., the Maintenance Director (Other #4-O#4) was interviewed regarding the call light system in room 118-B. O#4 stated, "They are just now putting me in the TEL system [computer system] to receive work requests. The staff are pretty good about telling me about stuff. I will check my office and see if I have written anything down."

At 10:40 a.m., O#4 and this surveyor entered room 118-B and tested the call light. The light on the wall lit up when the red call light button was pushed down, but went off when released. The light outside of the room did not light up. O#4 replaced the call light cord. The new call light cord was tested and worked the light outside of room 118 and at the nurse's station.

At 10:55 a.m., this surveyor reviewed a TELS report that listed recent maintenance issues. August 15, 2017 and August 21, 2017 were listed with issues to "Call Cords." No specific rooms were listed on the report. O#4 was interviewed regarding said report. O#4 stated, "I cannot get into TELS system yet, but someone from corporate can."

RN #5 (registered nurse)-Corporate Nurse Consultant was interviewed at 11:05 a.m.

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F 463	Continued From page 117 regarding the above TELS report. RN #5 stated, "I cannot get into TELS, but I will find someone that can." At approximately 11:30 a.m., this surveyor was informed that the call cord issues listed for August 15, 2017 and August 21, 2017 were for rooms 313 and 220, not 118. The Administrator and DON (director of nursing) were informed of the above information during a meeting with the survey team on 09/07/17. No further information was received prior to the exit conference on 09/11/17.	F 463		
F 469 SS=F	483.90(i)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM (i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and facility document review, the facility failed to ensure an effective pest control program throughout the facility. The facility did not have pest control service from 2/16/17 through 6/12/17 due to non payment and fruit flies were observed throughout the facility. The findings include: Throughout the survey process conducted from 9/5/17 through 9/11/17 fruit flies were observed by the survey team on all units including resident rooms and common areas. The facilities pest control invoices were reviewed	F 469	F469 1. Facility wide preventative pest control service was conducted on 9/22/2017 by Service Pro. 2. A facility wide audit was conducted by Service Pro on 9/22/2017. 3. Staff will be reeducated on preventative pest control and reporting by Administrator/designee by 10/3/2017. 4. Maintenance or designee will conduct audits of 5 residents call bells weekly for 4 weeks and monthly for 2 months to ensure compliance. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed. 5. Completion date 10/3/2017	

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on 9/7/17 and evidenced that pest control was in the facility on 2/16/17. On 2/21/17 a letter to the facilities administrator documented "The facilities pest control technician called this a.m. He informed me that his office instructed him to suspend service at the facility until outstanding invoices are paid."

Further review of pest control invoices indicated that the pest control resumed on 6/12/17. The pest control service reports indicated that pest control had been performed at the facility 5 times from 6/12/17 through 8/7/17.

Each service report indicated that fruit flies were observed and being treated in the kitchen and resident rooms and each report recommenced that food debris and grease be cleaned from the wall behind the dish washer and plants be removed from resident rooms as this is considered a breeding site.

On 9/11/17 at 9:45 a.m. pest control service was in the building and an interview was conducted concerning fruit flies. Service technician (OS #11) verbalized that fruit flies continue to be a problem throughout the facility because staff are not doing a good enough job of cleaning around bathroom areas (as areas close to moisture breeds fruit flies) and plants (not deposed of), and urinals are not always cleaned. OS #11 verbalized that fruit flies are especially bad in the kitchen area around the dishwasher due to moisture and food debris. OS #11 verbalized that he has reported this to the facility 14 times and this hasn't been resolved.

On 9/11/17 at 1:00 p.m. the above finding was brought to the attention of the administrator and

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F 469	Continued From page 119 director of nursing. No other information was presented prior to exit on 9/11/17. This is a complaint deficiency.	F 469		
F 490 SS=D	483.70 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING 483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to ensure its resources were administered effectively and efficiently by not following its policy that cardiopulmonary resuscitation (CPR) certification be maintained for one employee. 1. The facility staff failed to ensure CPR (cardiopulmonary resuscitation) certification was obtained and valid for one nurse, who was a current employee of the facility. Findings include: On 9/6/17 at approximately 10:40 a.m., the DON (director of nursing) and AS (administrative staff) # 4 were asked for a current list of employees with evidence of CPR certification for nurses and CNA's. AS #4 stated that the nurses are the only ones in this facility who are required to have CPR certification and they are the only ones who can initiate CPR, this facility does not require CNA's	F 490	F490 1. Employee #1 has a valid Cardio-pulmonary resuscitation (CPR) card at this time. 2. An audit was conducted by Assistant Administrator on 9/20/2017 ensuring current active Licensed Nurses have a valid CPR license. 3. Human Resources and Staff Development Coordinator were educated on ensuring compliance for maintaining valid CPR certifications for licensed nurses by Regional Nurse Consultant on 09/27/2017. 4. Staff Development Coordinator or designee will conduct audits of 5 employee records weekly for 4 weeks and monthly for 2 months to ensure compliance. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed. 5. Completion date 10/3/2017	

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to have CPR certification and CNA's are not allowed to do CPR. AS #4 was also asked to present job descriptions for nurses and CNA's.

The facility policy on CPR titled, "CPR Awareness" documented, "...CPR is initiated on all residents without DNR (Do Not Resuscitate) or advance directives identified...Nursing is to perform CPR on residents who do not have a directive to do otherwise...The only time a nurse can initiate CPR or can cease performing CPR once initiated is when you have been directed to do so by a physician or when EMS [emergency medical services] arrives and takes over...There is never a situation in which a nurse can make a decision not to initiate CPR on a full code resident. NEVER!...There is never a situation in which a nurse can order CPR to be stopped once initiated. NEVER!...By signing this form I am aware that as a nurse I am mandated to have CPR on file to perform my duties: CPR cannot be an online course, this must be by return demonstration with an instructor...my responsibility and until I can prove via CPR certification card I will not be able to work until this card is on file..."

A list of current employees were presented with a book of CPR cards and/or evidence of CPR certifications on 9/6/17 at approximately 1:00 p.m., in addition to job descriptions for nurses and CNA's. The nurses job description documented that nurses are to maintain current CPR certification. The job description for CNA's documented that CNA's are to maintain CPR certification as mandated by state requirements.

The AA (assistant administrator) was asked on 9/6/17 at approximately 2:00 p.m., if all the

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nurses in the facility were CPR certified. The AA stated that, 'most of nurses are CPR certified' and went on to say that they (the facility) use agency staff also. The AA was asked for a list of agency staff used and to present their CPR certifications, as well.

During the review of the CPR certification it was found that a current employee of the facility (not agency staff) an LPN (licensed practical nurse), also known as Employee # 1 did not have a copy of a CPR card and/or evidence of certification in the book presented by the facility.

On 9/6/17 at 4:50 p.m., the survey team met with the AA, AS #4, and the DON. The staff were asked for assistance in locating evidence of Employee # 1's on CPR certification. The staff were also asked to provide the last day the employee worked.

On 09/11/17 at approximately 10:15 a.m., the AA was again asked for evidence of Employee # 1's CPR certification. The AA stated, 'she does not have an active CPR...' The AA was asked where evidence was that the employee had a card. The AA stated that someone must have taken the card on file out of the book and there was no evidence as to when it expired.

At approximately 10:45 a.m., LPN # 4 stated that Employee # 1 last worked on 8/25/17.

On 9/1/17 at approximately 1:00 p.m., the administrator, AA and DON were made aware in a meeting with the survey team that this was part of a complaint investigation and it will be substantiated with deficient practice. No further information and/or documentation was presented

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F 490	Continued From page 122 prior to the exit conference on 9/11/17 at 2:45 p.m. This is a complaint deficiency.	F 490		
F 514 SS=E	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and	F 514	F514 1. Resident #4's physician orders were corrected on 09/ 7/2017. Resident # 2 and 18's medical records from PACE were placed on chart on 9/9/2017. Resident #3 medication record was corrected on 9/10/2017 by licensed nurse. 2. An initial audit of residents' medical records who attend PACE and corrected. An initial audit of Medication Records for errors for September was conducted by Director of Nurses / designee by 10/03/17. All residents that have enteral feeding have potential to be affected. 3. Medical records were educated on maintaining records of the PACE residents. Nursing staff were reeducated on documentation to include accurateness of Medication administration records and nothing by mouth (NPO) orders.	

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(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, the facility failed to ensure a complete and accurate clinical record for four of 24 Residents, Resident's #4, #2, #18, #3.

1. Resident #4 (R 4's) physician orders indicated to give medications by mouth, however R 4 receives all medications via feeding tube.

2. Resident #2 clinical record did not include clinical documentation for care and services provided by "PACE." (Program for All inclusive Care for the Elderly).

3. Resident #18 did not have PACE notes in the clinical record.

4. Resident #3 had an inaccurate medication administration record.

The Findings Include:

1. R 4 was admitted to the facility on 2/11/17 with a readmission on 9/1/17 with diagnoses including tube feeding.

The most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 5/26/17. R 4 was assessed as being severely cognitively impaired.

R 4's electronic record was reviewed on 9/5/17 and evidenced, via physician order set (POS) that R 4 received tube feedings 22 of 24 hours per day. The POS also gave instruction to give some

4. Medical records or designee will conduct audits of 5 PACE residents' medical charts weekly for 4 weeks and monthly for 2 months to ensure compliance. The Director of Nurses or designee will audit 5 resident charts weekly for 4 weeks and monthly for 2 months to ensure compliance with NPO orders and documentation on MARS. The findings of these reports will be forwarded to the Quality Assurance Committee for 3 months for any follow up that may be needed.

5. Completion date 10/3/2017

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medication (such as Januvia, Levetiracetam and Magnesium-oxide) via feeding tube and some medications (such as Tylenol, Aspirin, and Amlodipine) orally.

On 9/6/17 at 4:30 p.m. during a meeting with the facility staff, this surveyor asked if R 4 received medications orally and through a feeding tube. Registered nurse (RN #2) verbalized that she thought that R 4 did not receive anything orally and everything was given via feeding tube, but would check to make sure.

On 9/7/17 at 3:30 p.m. during a facility surveyor meeting, the administrator verbalized that R 4 takes all medications via feeding tube. This surveyor explained that the orders in the POS has R 4 taking medications by mouth. The administrator nodded her head with understanding.

No other information was presented prior to exit conference on 9/11/17.

2. Resident #2's clinical record had no signed physician orders since 7/14/17 and did not include clinical documentation for care and services provided by PACE.

Resident #2 was admitted to the facility on 7/13/17 with diagnoses that included bipolar disorder, hypernatremia (excess sodium in the blood), hyperkalemia (high potassium concentration in the blood), depression, diabetes, high blood pressure, anxiety, osteoporosis and dementia. The minimum data set (MDS) dated

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7/26/17 assessed Resident #2 with severely impaired cognitive skills.

Resident #2's clinical record documented admission orders for medications, care and treatment signed by the physician on 7/14/17. In addition there were three telephone orders for Resident #2 dated 7/14/17 signed by the physician on 7/14/17. As of 9/5/17 there were no other orders in Resident #2's clinical record signed by the physician or any health care provider. Resident #2's physician order summary reports dated 7/31/17 and 8/29/17 were not signed by a physician. There were 28 telephone and/or verbal orders documented from 7/17/17 through 8/10/17. None of these orders had been reviewed or signed by a physician. The clinical record documented the resident was prescribed therapy services that included speech, physical and occupational therapy. There were no records of the resident's participation or progress with therapy.

On 9/7/17 at 12:00 p.m. the director of nursing (DON) was interviewed about clinical documentation for Resident #2. The DON stated Resident #2 was treated by a PACE physician and received therapy services at the PACE facility. The DON stated routinely physicians reviewed and signed any verbal and/or telephone orders during their required visits. The DON stated the PACE physicians did not come to see residents at the nursing facility as the residents were seen during their visits to the day facility. The DON stated the paperwork for review and signatures was supposed to be sent to the PACE physicians for review and then returned to be filed in the resident's clinical record. The DON was not sure who was responsible for sending the

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orders to the PACE physicians for signature or for getting clinical documents from PACE.

On 9/11/17 at 9:10 a.m. the administrator was interviewed about any physician progress notes or clinical documentation from PACE for Resident #2. The administrator stated the progress notes and other documentation were at the PACE facility and not in the clinical record. The administrator stated the assumption was that PACE would share their records with the facility.

On 9/11/17 at 10:45 a.m. the administrator presented copies of all the notes and documentation retrieved from the PACE facility for Resident #2. The notes presented included therapy progress notes, nursing notes about medications administered at the facility, social worker notes and notes from the PACE registered dietitian. These notes had not been sent to the facility and had not been part of the resident's clinical record.

These findings were reviewed with the administrator and director of nursing during meetings on 9/6/17 at 4:45 p.m. and 9/7/17 at 3:20 p.m.

3. Resident #18 who attended PACE (Program for All-inclusive Care of the Elderly) did not have progress notes or signed orders in his clinical record to reflect and coordinate the care received at PACE with the facility.

Findings were:

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Resident #18 was admitted to the facility on 03/10/2017. His diagnoses included but were not limited to: Cerebrovascular disease with hemiplegia, hypertension, osteoporosis and osteoarthritis.

The initial MDS with an ARD (assessment reference date) of 03/17/2017. Resident #18 was assessed as having a cognitive summary score of "13", indicating he was cognitively intact.

The clinical record was reviewed on 09/07/2017. Documentation from the time of his admission on 03/10/2017 included the following history and physician electronically written and signed by his physician: "This is a PACE patient seen at PACE facility." There was also a handwritten note from his PACE physician dated 03/10/2017. The next progress note was completed by a nurse practitioner on 04/26/2017. There were no additional progress notes in the clinical record.

Review of the physician order section revealed that none of the orders on the clinical record had been signed by a physician except for one order on 08/31/2017 to discontinue the use of his left knee immobilizer.

During a meeting with the medical director on 09/07/2017. He stated that the physician of record for the PACE program was no longer working at the PACE facility. He stated that he had assumed the role of provider for one of the residents at the facility the evening before and would be reviewing the records of the other PACE residents.

A meeting was held on 09/07/2017 at approximately 3:30 p.m., concerns were voiced

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that there was no physician oversight evident on the clinical record for Resident #18. There were no physician visits or signed orders present in the clinical record. The acting administrator and the DON (director of nursing) were asked how the orders were suppose to be signed and when did the physician see the resident. Both the DON and the acting administrator stated that they were not familiar with PACE and did not know how the orders were suppose to be signed. An administrator from a sister facility who was there to help the acting administrator stated, "The assumption is that the physician sees them there at PACE." The DON and the acting administrator stated they would look at the contract and report back to the survey team.

On 09/11/2017 at approximately 9:00 a.m., the administrator and the AIT (administrator in training) came to the conference room to speak with the survey team. The administrator stated that multiple calls had been put through to the PACE program and the facility had eventually gone there to get orders progress notes, etc and she would present them to the survey team.

At approximately 10:30 a.m., information from the PACE program was presented by the AIT. Progress notes were presented for March, April, July and August. There was no evidence that Resident #14 was seen during the month of June by the PACE physician. There were no signed orders presented. Multiple notes from other areas of PACE (occupational therapy, physical therapy, social worker, etc) were presented. The AIT was asked if any signed orders had been obtained from PACE to be placed on Resident #18's clinical record since none of his orders had been signed. She stated, "This is what we have."

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The AIT was asked if the information presented should have been part of the clinical record at the facility. She stated, "Yes."

No further information was obtained prior to the exit conference on 09/11/2017.

4. Resident #3 had an inaccurate medication administration record.

Resident #3 signed himself out of the facility on 8/3/17 at approximately 4:30 p.m. and did not return. The facility staff documented that the resident received medications after the resident signed himself out of the facility.

Resident #3 was originally admitted to the facility on 10/11/16, with a current readmission on 08/07/17. Diagnoses for Resident #3 included, but were not limited to: diabetes mellitus, anxiety disorder, depression, complete traumatic amputation of the left great toe, muscle weakness, difficulty walking, unsteadiness, cellulitis of the left lower limb, cough, lymphedema and osteomyelitis.

The most current full MDS (minimum data set) assessment with CAAS (care area assessment summary) was a significant change assessment dated 07/18/17. This MDS assessed the resident as having a cognitive score of '12', indicating resident had moderate impairment in daily decision making skills. The resident was also assessed as requiring limited assistance from one staff person for transfers, ambulation and bathing. The resident was assessed on this MDS to have cellulitis with infection and a surgical wound present. Additionally it was documented

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on this MDS, the resident received insulin injections in the 7 day look back period and also received IV ABX (intravenous antibiotics) during the 7 day look back. The resident triggered for cognition, ADL's (activities of daily living) and falls in the CAAS section of this MDS.

A 14 day admission MDS assessment was reviewed for comparison, dated 08/21/17. This MDS assessed the resident to have a cognitive score of '13', indicating the resident was cognitively intact for decision making skills. The resident was assessed as requiring supervision with setup for transfers and ambulation. The resident was also assessed as receiving IV ABX and insulin during the 7 day look back.

During a complaint investigation on 9/5/17 through 9/7/17, Resident #3's clinical record was reviewed.

Resident #3 signed himself out of the facility on 8/3/17 at 4:30 p.m. and did not return. The resident was found the next morning 8/4/17 (approximately 13.5 hours later) under a bridge by EMS (emergency medical services) with loss of consciousness. The resident was taken to the emergency department and subsequently admitted for 4 days.

Resident #3's clinical records were reviewed, specifically the resident's MARs (medication administration records were reviewed for August 3, 2017.

It was documented that Resident # 3 was administered medications at 5:00 p.m., when it was documented that the resident signed himself out of the facility at 4:30 p.m.

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It was documented that Resident # 3 was administered medications at 6:00 p.m., when it was documented that the resident signed himself out of the facility at 4:30 p.m.

It was documented that Resident #3 was administered medications on 8/4/17 at 9:00 p.m. and the resident had left the facility on 8/3/17 at 4:30 p.m. and was admitted to the hospital at approximately 6:00 a.m. on 8/4/17.

On 9/6/17 at approximately 4:50 p.m., the AA (assistant administrator) and DON (director of nursing) were made aware of concerns that staff were documenting that the resident received medications when there was evidence that the resident signed himself out of the facility on 8/3/17 at 4:30 p.m. and did not sign himself back in at anytime after that; the resident was admitted to the hospital the next morning on 8/4/17.

No further information and/or documentation was presented prior to the exit conference on 9/11/17 at 2:45 p.m.

F 520 SS=D — 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS — F 520

(g) Quality assessment and assurance.

(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:

(i) The director of nursing services;

(ii) The Medical Director or his/her designee;

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(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

(g)(2) The quality assessment and assurance committee must :

(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

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;

(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.

(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document review, the facility staff failed to meet the quarterly QA (Quality Assurance) committee meeting requirements.

The facility staff failed to ensure that the QA committee met quarterly and that the facility medical director was present; the last

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documented QA meeting was in April of 2017 with an attendance sheet, that showed the medical director was not in attendance.

Findings include:

During the facility's QA program review on 9/11/7 at 12:00 p.m., the administrator and AA (acting administrator) were made aware of a complaint allegation that the facility did not have regular QA meetings and that there are no processes in place to identify issues related to falls, weights, wounds, etc.

The administrator was interviewed regarding the members of the facility's QA committee. The administrator stated that she could not speak to previous QA meetings, but did present documentation of the last meeting held by the previous QA staff, which was April 20, 2017. The documentation included an attendance sheet, that did not include the medical directors name as being present at this meeting. The documentation also had an area called "agenda", which was blank. The administrator stated that the QA meeting in April was the most recent records regarding QA that could be found.

The administrator stated that going forward, the QA committee would include, herself, the DON, various department heads, pharmacy and the facility's Medical Director and presented the facility's process for identifying, tracking, developing action plans, monitoring and reevaluating concerns that would be picked up by the QA committee.

No further information or documentation was provided to evidence that the facility staff were

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F 520	Continued From page 134 having regular QA meetings or that the Medical Director was in attendance for last recorded quarterly QA meetings prior to the exit conference on 79/11/17 at 2:45 p.m. This is a complaint deficiency.	F 520	F520 1. A Quality assurance Meeting was completed on 9/11/17 by the Administrator with Department Managers, Medical Director, and Director of Nurses present and calendar established. 2. An audit was conducted by Administrator of QA records on 9/8/2017. 3. Administrator was educated on the Quality Assessment and Assurance committee required meetings and attendees by Regional Nurse Consultant on 9/14/2017. 4. Audits will be conducted through Regional Nurse Consultant to assure compliance with findings forwarded to QA committee for further review. 5. Completion date 10/3/2017	