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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/24/17 through 1/26/17. One complaint was investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 176 certified bed facility was 147 at the time of the survey. The survey sample consisted of 21 current resident reviews (Residents # 1 through # 21) and six closed record reviews (Residents # 22 through # 27).	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (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	F 157	F- 157 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #1. All licensed staff were educated on the importance of notifying the MD and POA on thoughts of self-harm and changes in physician's orders. 2. Current facility residents have the potential to be affected by the alleged deficient practice. The 24 hour report will be audited from 1/26/17 through 2/13/17 for any changes and new orders and ensure notification of the MD and POA. 3. Measures put into place to ensure the alleged deficient practice does not recur include: The Director of Nursing and/or nursing administration team will monitor 10 residents per week for 4 weeks then 15 residents per month for 3 months to ensure MD and POA are notified of any changes in condition and/or new orders.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ramona J. Ringstaff	Administrator	2/15/2017

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

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F 157	Continued From page 1 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to notify the RP (responsible party) and MD (Medical Doctor) of a change in condition for one of 27 residents in the survey sample, Resident #1. 1a. For Resident #1, facility staff failed to notify the MD and Responsible Party about thoughts of self-harm that were reported to the social worker on 11/10/16.	F 157	4. The Director of Nursing and/or designee will analyze reviews/observations for patterns/trends and report in the Quality Assurance Committee quarterly for six months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. 5. Completion Date: 3/3/17	

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b. For Resident #1, facility staff failed to notify the RP of a new physician's order for Risperdal [1] that was initiated on 12/15/16.

The findings include:

1a. Resident #1 was admitted to the facility on 5/4/14 and readmitted on 5/13/16 with diagnoses that included but were not limited to mood disorder, high blood pressure, chronic kidney disease (stage 3), atrial fibrillation, stroke, and COPD (chronic obstructive pulmonary disease). Resident #1's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/9/16. Resident #1 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #1 was coded as requiring extensive assistance from staff with most ADLS (activities of daily living) including transfers, locomotion, toileting, and personal hygiene; total dependence on staff with bathing, and independent with meals.

Section D (Mood) of the 11/9/16 MDS documented the following for Resident #1: "Say to the Resident: "Over the last 2 weeks, have you been bothered by any of the following problems?...I. Thoughts that you would be better off dead, or of hurting yourself in some way." A "1" was documented under "Symptom Presence" indicating "Yes." A "0" (zero) was documented under "Symptom Frequency" indicating the resident never had these thoughts or had these thoughts for one day.

Review of the clinical record revealed the following social services note dated 11/10/16,

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"This worker went in to talk to see how she is doing. Resident was sad. We talked about different things. This worker asked resident if she had a thought of hurting herself and resident said yes but she has no plan. Resident says she wants a medication for her depression during the day that would help her. Resident takes Wellbutrin [2] 150 mg (milligrams) per day. Resident is seen by (Name of Psychiatrist). Resident said she is interested in talking one on one with a counselor. Resident would feel better if her daughter would visit her. Resident says her daughter called the other day and said she will come to see her but did not say when. Resident talked about doing exercises in the restorative program. This worker told the nurse on duty all of the above information. This information will be given to the clinical Nurse who works with (Name of Psychiatrist)."

The next note dated 11/11/16 from the social worker documented the following: "Quarterly review. Resident is alert and oriented X3 (person, place, and time). Resident is compliant with her care. Resident has a diagnosis of Depression. Resident is seen by (Name of Psychiatrist). For this review, this worker talked with resident to see how she was doing. Resident had some sadness. Resident was sad because her daughter has not been in to see her. This worker asked resident if she had a thought of hurting herself and resident said yes but she has no plan. It would make her feel better if her daughter visited her. Resident says her daughter called the other day and said she will come to see her but did not say when. Resident said she is interested in meeting with a counselor one on one. The above information was told to the Nurse on duty after this conversation on

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11-10-16. The above information was given to the clinical nurse who works with (Name of Psychiatrist)."

No other notes or assessments could be found regarding the above situation. There was no evidence that the Responsible Party, Medical doctor or Psychiatrist were made aware of the above events.

On 1/25/17 at 9:22 a.m., an interview was conducted with OSM (Other Staff Member) #9, the social worker. When asked about the process staff follows when a resident reports thoughts of self harm, OSM #9 stated that she would speak with the resident to see if they had a plan of self-harm. OSM #9 stated she would also report this to the nurse manager or nurse on shift. OSM #9 stated that if the resident was not already seeing the psychiatrist, she would have the psychiatrist evaluate the resident. OSM #9 stated that if the resident was already under the care of the psychiatrist, she would have the psychiatrist come in for an as needed visit. OSM #9 stated that Resident #1 is often tearful, and has a diagnosis of depression. When OSM #9 was asked if she could recall when Resident #1 reported thoughts of self harm, OSM #9 stated, "It's been awhile back. I think I told the nurse on duty, [name of nurse (LPN -- licensed practical nurse-- #17) 7-3 (7:00 a.m. to 3:00 p.m.) shift, and (name of nurse (LPN #1)." OSM #9 stated that LPN #1 worked directly with the Psychiatrist, and made rounds with him. When asked how often the psychiatrist visited the facility, OSM #9 stated, "Once a week." When asked who was responsible for notifying the responsible party, medical doctor or psychiatrist when there are reports of verbalizations regarding self harm from

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a resident, OSM #9 stated that the nurses were responsible. OSM #9 stated, "I am not sure if the nurses notified the RP (responsible party) or doctor. I don't think I did. I personally didn't make the (name of psychiatrist) aware. I don't know if (Name of LPN #1) did. You would have to ask her."

On 1/25/17 at 9:35 a.m., an interview was conducted with LPN (licensed practical) #1, the clinical nurse. LPN #1 was asked about her role when following the psychiatrist. LPN #1 stated that she takes notes during rounding and writes orders when the psychiatrist recommends certain medications, and monitoring etc. When asked how often the psychiatrist visits the facility, LPN #1 stated that he comes in every week, unless he is on vacation. LPN #1 was asked about the process staff is to follow if a resident reports thoughts of self harm to the social worker. LPN #1 stated that if a resident was already under psychiatric services then (Name of Psychiatrist) would follow up that week with the resident on a prn (as needed) basis or a psychological evaluation would be requested if the resident was not receiving psychological services. LPN #1 stated that she would notify (Name of psychiatrist). When asked who was responsible for notifying the responsible party, LPN #1 stated that if the thoughts of self-harm were reported to the social worker, than the social worker should be notifying the RP. LPN #1 stated that facility staff usually could not get a hold of Resident #1's RP. When asked if she could recall when Resident #1 reported thoughts of self-harm to the social worker, LPN #1 stated, "I can't remember." LPN #1 stated that if Resident #1 reported thoughts of self harm and the psychiatrist was made aware, there should have been a progress

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summary from when the psychiatrist came to visit on a prn basis. LPN #1 stated, "Let me see if I can find that." When asked if she could recall if the responsible party was made aware, LPN #1 stated, "No, not if the social worker didn't document."

On 1/25/17 at 10:45 p.m., LPN #1 stated, "He (Psychiatrist) did not see her until December." When asked if he was made aware of Resident #1's reports of self harm, LPN #1 stated, "I don't know because I'm not sure if I was even made aware."

On 1/25/17 at 2:13 p.m., an interview was conducted with ASM (administrative staff member) #4, the Psychiatrist. ASM #4 stated that he would expect nursing staff to contact him when a resident reports any thoughts of self harm or suicide. ASM #4 stated that LPN #1 usually prompts him. ASM #4 stated that if it is reported to him that a resident has thoughts of self-harm, he would visit with that resident that week. ASM #4 stated that he did not recall Resident #1 reporting any thoughts of self-harm. ASM #4 did not recall being notified.

On 1/25/17 at 4:08 p.m., an interview was conducted with LPN #17, the nurse the social worker stated that she reported Resident #1's thoughts of self-harm to. LPN #17 was asked about the process followed when it is reported to her that a resident has thoughts of self-harm. LPN #17 stated that she would sit down and talk with the resident to figure out the cause of these thoughts, review current medications, request family come in, and continue to monitor. LPN #17 stated that she would also check the room for any objects that could inflict harm. LPN #17

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stated that she would call the doctor, supervisor, and notify the family or any close relatives. LPN #17 stated that she would also follow up with (Name of Psychiatrist). LPN #17 stated she remembered hearing about the above events, but she was not the nurse that this was reported to. LPN #17 stated she could not recall the nurse on duty that day who was assigned to Resident #1.

On 1/25/17 at 5:25 p.m., an interview was conducted with ASM #2, the DON (Director of Nursing). ASM #2 stated that he would expect nursing staff to assess and interview the resident for a plan of self-harm; and notify himself, the administrator, MD (medical doctor) or NP (nurse practitioner) on call. ASM #2 stated that if nursing staff felt that the resident was at risk for self-harm, they would need to be monitored or sent to the hospital for a psychological evaluation, depending on the severity of the situation. ASM #2 stated that he may recall an incident with Resident #1. ASM #2 stated, "I'll look into that and provide information tomorrow."

On 1/26/17 at 8:45 a.m., an interview was conducted with ASM #1, the administrator. ASM #1 stated that she would expect nursing to notify the responsible party, physician, psychiatrist and administration if a resident reports any thoughts of self-harm. She could not recall the above events. ASM 1 stated, "We are going to look into it."

On 1/26/17 at 9:04 a.m. and 9:26 a.m., an interview was attempted with ASM #3, the primary physician. He could not be reached for an interview.

On 1/26/17 at 10:11 a.m., an interview was

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conducted with LPN #16, a nurse who worked on 10/11/16 7-3 shift. She could not recall the above events.

On 1/26/17 at 10:25 a.m., an interview was attempted with LPN #19, a nurse who worked on 10/11/16 7-3 shift. She could not be reached.

On 1/25/17 at 5:25 p.m., ASM #1, the administrator, and ASM#2, the DON (Director of Nursing) were made aware of the above concerns.

The facility policy titled "Notification of Physician and Responsible" documents in part, the following: "To inform physician and responsible party of any changes in the care of the resident. PROCEDURE: 1. Notify MD/NP (Nurse Practitioner) of any changes in care, changes in condition of the resident ...2. Document name of MD/NP notified and their response to notification in progress notes. 3. Notify responsible party of any changes and/or new orders. 4. Document name of POA (power of attorney) notified and POA statement. 5. Check 24 hour report box to allow information to flow to 24 hour report." No further information was presented prior to exit.

b. For Resident #1, facility staff failed to notify the RP (responsible party) of a new physician's order for Risperdal [1] that was initiated on 12/15/16. Review of Resident #1's clinical record revealed the following note from the psychiatrist dated 12/14/16, "...This is an 81 year old Caucasian female who appears of her stated age. She was sitting in a chair I (Sic.) her room and a normal posture. She was cooperative, easily engage-able and made poor eye contact during the interview. She was dressed in casual attire

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and her grooming and hygiene were fair. No evidence of aggression or agitation. Her speech was spontaneous with normal rate, volume and tone. She described her mood was "Depressed and her affect was tearful and dysphoric. Thought process was linear and goal directed. She denied and demonstrated no evidence if suicidal, homicidal or psychotic ideation. She was alert and oriented to herself and place ...PLAN: I woul (sic) add Risperdal 0.25 mg at bedtime for mood disorder and discontinue Nuedexta [3] as it does not seem to be beneficial at this time..."

Further review of Resident #1's clinical record revealed the following order dated 12/14/16: "Risperdal Tablet 0.25 MG (milligrams) (Risperidone) Give 1 mg by mouth at bedtime for psychosis." This order was written by LPN (licensed practical nurse) #1.

Review of Resident #1's nurses notes revealed the following note dated 12/14/16: (Name of Psychiatrist) in for follow-up appointment. New order to decrease Nuedexta to 1 qd (every day) for 1 week then 1 QOD (every other day) for 1 week the (sic) discontinue. Start Risperdal 0.25 mg po (by mouth) at every bedtime. Resident aware of new orders."

Review of the clinical record revealed no evidence that the Responsible party was made aware of the new orders.

On 1/25/17 at 10:36 a.m., an interview was conducted with LPN (licensed practical nurse) #1, the nurse who wrote the order for Risperdal. When asked the process staff follows once a new order is placed into the system, LPN #1 stated

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the responsible party and resident would be made aware. When asked if the responsible party was made aware of the new order for Resident #1's Risperdal, LPN #1 stated that she would have to check.

On 1/26/17 at 8:15 a.m., an interview was conducted with LPN #16. When asked about the process followed when a physician writes a new order, LPN #16 stated that she would notify the family and resident of the new order, make a copy of the order and fax to pharmacy. LPN #16 stated that she would chart that she notified everyone.
On 1/26/17 at 9:00 a.m., information that Resident #1's RP was notified of the Risperdal order was requested from RN (registered nurse) #6, the staff development coordinator. RN #6 stated that she would look into it.
On 1/25/17 at 5:25 p.m., ASM #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.
No further information was provided prior to exit.

[1] Risperdal- antipsychotic used to treat symptoms of schizophrenia, bipolar disorder or irritability associated with autistic disorder. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012012/?report=details.
[2] Wellbutrin-antidepressant, used to treat depression. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009361/?report=details.
[3] Nuedexta- Used to treat uncontrollable laughing or crying. This information was obtained

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F 157	Continued From page 11 from The National Institutes of Health. <https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009896/?report=details>.	F 157		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain the privacy of a urinary catheter bag for one of 27 residents in the survey sample, Resident #18. Facility staff failed to store Resident #18's urinary catheter bag in a privacy bag. The findings include: Resident #18 was admitted to the facility on 7/25/16 and readmitted on 10/28/16 with diagnoses that included but were not limited to: stroke, difficulty walking, depression, retention of urine and difficulty sleeping. The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 11/4/16 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview of mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living. An observation of Resident #18 was made on	F 241	F- 241 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #18. On 1/25/17, the nurse placed the resident's catheter drainage bag in a privacy bag. The Director of Nursing and/or the nursing administrative team provided in service education for current licensed nursing staff regarding the importance of ensuring all catheter bags are in privacy bags to preserve resident privacy and dignity. 2. Current facility residents have the potential to be affected by the alleged deficient practice. 100% audit of all residents with foley catheters has been completed to ensure no other residents were affected. 3. Measures put in place to ensure the alleged deficient practice does not recur include: On 2/13/17 in-service education will begin for all licensed nursing staff regarding verifying that each catheter drainage bag is in a privacy bag or has a privacy cover attached. The Director of Nursing and/or nursing administration team will review 5 residents weekly for 6 weeks to verify privacy covers are in place.	

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EVERGREEN HEALTH AND REHAB	380 MILLWOOD AVENUE WINCHESTER, VA 22601

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F 241	Continued From page 12 1/25/17 at 1:05 p.m. The resident was sitting up in bed. There was a urinary catheter bag hanging from the bottom railing of the bed. Urine was observed in the bag. An observation of Resident #18 was made on 1/25/17 at 1:15 p.m. with another surveyor. The surveyor confirmed that the catheter bag was not in a privacy bag and urine was observed in the bag. Review of the 1/2016 physician's orders documented, "Foley Catheter in place, 14 F (French) with 10 cc (cubic centimeters) balloon, please continue maintenance Dx (diagnosis) Urinary retention every shift. Order date 11/17/2016." Review of the 12/2016 treatment administration record documented, "Foley Catheter in place, 14 F with 10 cc balloon, please continue maintenance..." Review of Resident #18's care plan initiated on 11/14/16 documented, "Focus The resident has an indwelling catheter r/t (related to) urinary retention. Interventions/Tasks CATHETER Position catheter bag and tubing below the level of the bladder and away from the entrance room door." An interview was conducted on 1/25/17 at 4:20 p.m. with LPN (licensed practical nurse) #5. When asked how staff cared for a resident who had urinary catheter, LPN #5 stated, "I make sure it's in the bladder, the balloon is inflated and the catheter is kept in a privacy bag." When asked why a privacy bag was used, LPN #5 stated, "It's a dignity issue." An interview was conducted on 1/26/17 at 8:02 a.m. with LPN #7, the nurse who cared for the resident on 1/25/17. When asked if there had been anything unusual about Resident #18's foley catheter on 1/25/17, LPN #7 stated, "I was	F 241	4. The Director of Nursing will analyze reviews/observations for patterns/trends and report in the Quality Assurance Committee quarterly for six months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. 5. Completion Date: 3/3/17	

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F 241	Continued From page 13 walking up the hall and saw it wasn't in a privacy bag so we put it in one. She had a privacy bag on her wheelchair but not on her bed." When asked why the catheter was kept in a privacy bag, LPN #7 stated, "Would you want someone to see a bag with lots of urine in it? That's why we put them into the privacy bag." An interview was conducted on 1/26/17 at 10:20 a.m. with Resident #18. When asked how she felt about having her catheter bag open to view, Resident #18 stated, "I never thought of it before but they have it in a bag now so I'm ok." On 1/26/17 at 10:25 a.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. Review of the facility's policy titled, "Indwelling Catheter Care" documented, "PROCEDURE 8. Maintain drainage bag below bladder and cover with dignity bag." No further information was provided prior to exit.	F 241		
F 250 SS=D	483.40(d) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services 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, and clinical record review, it was determined that facility staff failed to provide medically related social services for one of 27 residents in survey sample, Resident #1. The facility staff failed to follow up with Resident #1, after she reported having thoughts of self-harm to the social worker on 11/10/16.	F 250	F- 250 1. Corrective action has been accomplished for the alleged deficient practice in regards to Resident #1. On 1/26/17 the Social Worker was educated on the suicide prevention policy. 2. Current facility residents have the potential to be affected by the alleged deficient practice. The Director of Nursing and/or nursing administration team completed 100% audit of all resident orders to validate each resident has an order for a psychiatric consult as needed.	

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F 250	Continued From page 14 The findings include: Resident #1 was admitted to the facility on 5/4/14 and readmitted on 5/13/16 with diagnoses that included but were not limited to mood disorder, high blood pressure, chronic kidney disease (stage 3), atrial fibrillation, stroke, and COPD (chronic obstructive pulmonary disease). Resident #1's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/9/16. Resident #1 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #1 was coded as requiring extensive assistance from staff with most ADLS (activities of daily living) including transfers, locomotion, toileting, and personal hygiene; total dependence on staff with bathing, and independent with meals. Section D (Mood) of the 11/9/16 MDS documented the following for Resident #1: "Say to the Resident: "Over the last 2 weeks, have you been bothered by any of the following problems? ...I. Thoughts that you would be better off dead, or of hurting yourself in some way." A "1" was documented under "Symptom Presence" indicating "Yes." A "0" (zero) was documented under "Symptom Frequency" indicating the resident never had these thoughts or had these thoughts for one day. Review of the clinical record revealed the following social services note dated 11/10/16, "This worker went in to talk to see how she (Resident #1) is doing. Resident was sad. We talked about different things. This worker asked resident if she had a thought of hurting herself and resident said yes but she has no plan. Resident says she wants a medication for her depression during the day that would help her.	F 250	3. Measures put into place to ensure the alleged deficient practice does not recur include: The Director of Nursing and/or nursing administration team began re-in-service education for licensed nursing staff regarding suicide prevention policy. The Director of Nursing and/or nursing administration team will review all new admissions to ensure each resident has an order for a psychiatric consult as needed for three months and then ongoing as needed. A random sample of residents will be audited quarterly thereafter to ensure continued compliance. 4. The Director of Nursing and/or designee will analyze reviews/observations for patterns/trends and report in the Quality Assurance Committee quarterly for six months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. 5. Completion Date: 3/3/17	

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Resident takes Wellbutrin [1] 150 mg (milligrams) per day. Resident is seen by (Name of Psychiatrist). Resident said she is interested in talking one on one with a counselor. Resident would feel better if her daughter would visit her. Resident says her daughter called the other day and said she will come to see her but did not say when. Resident talked about doing exercises in the restorative program. This worker told the nurse on duty all of the above information. This information will be given to the clinical Nurse who works with (Name of Psychiatrist)."

The next note dated 11/11/16 from the social worker documented the following: "Quarterly review. Resident is alert and oriented X3. Resident is compliant with her care. Resident has a diagnosis of Depression. Resident is seen by (Name of Psychiatrist). For this review, this worker talked with resident to see how she was doing. Resident had some sadness. Resident was sad because her daughter has not been in to see her. This worker asked resident if she had a thought of hurting herself and resident said yes but she has no plan. It would make her feel better if her daughter visited her. Resident says her daughter called the other day and said she will come to see her but did not say when. Resident said she is interested in meeting with a Counselor one on one. The above information was told to the Nurse on duty after this conversation on 11-10-16. The above information was given to the clinical nurse who works with (Name of Psychiatrist)."

No other notes or assessments could be found regarding the above situation. There was no evidence that the social worker had followed up with the clinical nurse or Resident #1 to see if interventions were in place to meet Resident #1's psychosocial needs. No other social work notes

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could be found since 11/10/16.
On 1/25/17 at 9:22 a.m., an interview was conducted with OSM (Other Staff Member) #9, the social worker. OSM #9 was asked about the process staff follows if a resident reports having thoughts of self harm. OSM #9 stated that she would speak with the resident to see if they had a plan of self-harm. OSM #9 stated she would also report this to the nurse manager or nurse on shift. OSM #9 stated that if the resident was not already seeing the psychiatrist, she would have the psychiatrist evaluate the resident. OSM #9 stated that if the resident was already under the care of the psychiatrist, she would have the psychiatrist come in for an as needed visit. OSM #9 stated that Resident #1 is often tearful, and has a diagnosis of depression. When OSM #9 was asked if she could recall when Resident #1 reported thoughts of self harm, OSM #9 stated, "It's been awhile back. I think I told the nurse on duty, (name of nurse, LPN (licensed practical nurse) #17) 7-3 shift, and (name of nurse, LPN #1)." OSM #9 stated that LPN #1 worked directly with the Psychiatrist, and made rounds with him. When asked how often the psychiatrist visited the facility, OSM #9 stated, "Once a week."
On 1/25/17 at 10:36 a.m., an interview was conducted with LPN #1, the clinical nurse. LPN #1 stated that she didn't think that she was even made aware of the resident reporting having thoughts of self-harm to the social worker.
On 1/25/17 at 11:33 a.m., further interview was conducted with OSM #9. When asked if she provided any type of follow-up to ensure Resident #1 was receiving care and services to meet her needs, or any monitoring after the reports of self-harm, OSM #9 stated, "I just told her (resident) that I talked to (Name of clinical nurse) and I told (Name of clinical nurse) that she

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wanted a counselor." OSM #9 was not sure if Resident #1 ever talked to a counselor. OSM #9 stated, "To my knowledge, she had no other thoughts since then."
On 1/26/17 at 8:45 a.m., an interview was conducted with ASM (administrative staff member) #1, the administrator. ASM #1 stated that she would expect the social worker to follow up with the resident after reports of having thoughts of self-harm to ensure the resident was being monitored.
On 1/25/17 at 5:25 p.m., ASM #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.
Review of the Social Services Manager Job description documents in part, the following: "SUMMARY: Has administrative authority and accountability for the provision of psychosocial needs or the residents and patients. Acts as Resident Advocate. Essential Duties and Responsibilities include the following. Other duties may be assigned ...Collects and assesses data relevant to patients' psychosocial needs, risk factors for psychosocial deterioration, and responses to interventions. Implements social service interventions that achieve treatment goals, addresses resident's needs, link social supports, physical care and physical environment to enhance quality of life."
No further information was presented prior to exit.

[1] Wellbutrin-antidepressant, used to treat depression. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009361/?report=details.

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F 252 SS=D	Continued From page 18 483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (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. (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, staff interview and facility document review, it was determined that the facility staff failed to maintain a clean comfortable homelike environment for one of 86 resident rooms, room 124. In room 124, the enamel on the corner of the sink was chipped; exposing the black cast iron and the duct tape around the plastic portion of the toilet arm rest was eroded. The findings include: On 1/24/17 at approximately 11:55 a.m. and 1/25/17 at 8:00 a.m., observation of the bathroom	F 252 F 252	F-252 1. Corrective action has been accomplished for the alleged deficient practice in regards to Room 124. The sink and toilet arm rest were replaced by the maintenance staff on 1/26/17. 2. Current facility residents have the potential to be affected by the alleged deficient practice. 100% audit of all resident bathroom sinks and toilet arm rests was completed on 1/26/17 by the maintenance staff to validate that there were no additional chips in the enamel of the sinks or duct tape on the toilet arm rests. 3. Measures put into place to assure alleged deficient practice does not recur include: The maintenance staff will audit 10 bathrooms per week for 4 weeks, then 23 bathrooms per month times 2 months to validate that there are no chips in the sinks and no duct tape on the toilet arm rests. All staff will be educated on the use of maintenance logs to report any repairs needed in resident rooms. 4. The Director of Nursing and/or designee will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting quarterly for a minimum of six months to evaluate the effectiveness of the plan and will adjust the plan as the committee may recommend, based on outcomes/trends identified from trend data. 5. Completion Date: 3/3/17	

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in room 124 was conducted. Approximately two inches by two inches of the white enamel on the front left corner of the sink (facing the sink) was chipped, exposing the black cast iron underneath. Silver duct tape was wrapped around the plastic portion of the adaptive arm rest on the right side facing the toilet. The silver portion of the duct tape was eroded, exposing white threads. Some of the threads were stained with a brown color.

On 1/25/17 at 1:57 p.m., an interview was conducted with OSM (other staff member) #1 (the maintenance director). OSM #1 was asked how the maintenance department was made aware of repairs that were needed in residents' rooms. OSM #1 stated each unit contained a maintenance log book and staff was supposed to document needed repairs in that book. OSM #1 stated the maintenance staff checked the book multiple times a day and made repairs. OSM #1 stated during the day shift, staff paged the maintenance department for needed repairs. At this time, OSM #1 and this surveyor reviewed the Wing 100 log book. No repairs were requested for room 124. At approximately 2:05 p.m., OSM #1 was shown the sink in room 124. OSM #1 stated there was "nothing much" he could do about the sink. When asked if he had to obtain approval to replace the sink, OSM #1 stated the facility was in the process of renovations and he guessed he could replace the sink. At this time, OSM #1 was shown the duct tape around the adaptive arm rest on the toilet. OSM #1 confirmed the arm rest needed to be replaced and stated he would replace the arm rest.

On 1/25/17 at 2:15 p.m., an interview was conducted with CNA (certified nursing assistant) #1 (the CNA responsible for room 124). CNA #1

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F 252	Continued From page 20 was asked how she communicated needed repairs to the maintenance department. CNA #1 stated she documented needed repairs in the maintenance book and the maintenance staff checked the book daily. At this time, CNA #1 was shown the sink in room 124. CNA #1 stated, "I think that's normal wear and tear." CNA #1 stated she didn't think the sink was "totally broke." When asked if she thought the sink was homelike, CNA #1 stated, "No." CNA #1 was shown the duct tape around the toilet arm rest. CNA #1 stated she would report the arm rest to the maintenance department and confirmed the duct tape did not look homelike. On 1/25/17 at 5:25 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concerns. ASM #1 and ASM #2 stated the facility did not have policies regarding maintaining a clean comfortable homelike environment, maintenance or work orders. No further information was presented prior to exit.	F 252		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans	F 279	F-279 1. Corrective action has been accomplished for the alleged deficient practice in regards to Residents #5, #4 and #15. Resident #5 now has a care plan to address areas of urinary incontinence and psychosocial well-being. Resident #4 has a care plan to address dehydration. Resident #15 has a comprehensive care plan. The Care Plan Coordinator was in-serviced on 1/25/17 on developing care plans that trigger on the CAA. 2. Current facility residents have the potential to be affected by the alleged deficient practice. 100% audit of triggered CAAs from 1/1/17 has been completed to ensure all areas have been care planned.	

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F 279	Continued From page 21 (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 279	3. Measures put into place to assure alleged deficient practice does not recur include: In-service education on 1/25/17 for Care Plan Coordinator and MDS nurses regarding care planning of the triggered CAAs. MDS nurses will print triggered CAAs and give to the Care Plan Coordinator to ensure the Care Plan Coordinator knows what needs to be added to the resident's care plan. The Director of Nursing and/or nursing administration team will review 10 current residents weekly for 4 weeks, then 15 residents monthly for 3 months to validate that the appropriate care plans have been initiated for the resident. A random sample of residents will be audited quarterly thereafter to ensure continued compliance. 4. The Director of Nursing and/or designee will analyze audits/reviews for patterns/trends and report in the Quality Assurance committee meeting quarterly for six months to evaluate the effectiveness of the plan and will adjust the plan as the committee may recommend, based on outcomes/trends identified from trend data. 5. Completion Date: 3/3/17	

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community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to develop a comprehensive care plan for three of 27 residents in the survey sample, Residents #5, #4, and #15.

1. The facility staff failed to develop care plans for the CAA (care area assessments) areas of urinary incontinence and psychosocial well-being triggered on the 12/22/16 admission MDS (minimum data set) for Resident #5.

2. The facility staff failed to develop a care plan for the CAA triggered area of dehydration on Resident #4's significant change assessment, with an ARD of 1/4/17.

3. For Resident #15, the facility staff failed to develop a comprehensive care plan based on triggered areas from the CAA Summary (Section V) of the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/5/16.

The findings include:

1. Resident #5 was admitted to the facility on 12/15/16 with diagnoses including, but not limited

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to: history of a stroke, dementia with behaviors, difficulty swallowing, high blood pressure, and diabetes. On the most recent MDS (minimum data set), a 30-day Medicare assessment with an assessment reference date of 1/12/17, Resident #5 was coded as being severely cognitively impaired for making daily decisions.

A review of Resident #5's admission MDS with assessment reference date 12/22/16 revealed that the CAA (care area assessment) in section V triggered urinary incontinence and psychosocial well-being as areas to be addressed in the comprehensive care plan.

A review of the comprehensive care plan for Resident #5 dated 12/15/16 failed to reveal a care plan for urinary incontinence and psychosocial well-being

On 1/25/17 at 8:45 a.m., RN (registered nurse) #4 and RN #5, MDS coordinators, were interviewed. RN #5 and #4 stated that they "work the CAA worksheets" for triggered areas, then make a decision regarding whether or not a care plan should be developed. RN #5 and #4 stated that, at that point, the care plan nurse finishes the care plans triggered by the CAA areas. RN #5 stated: "We've told her to make sure she looks at what's triggering. As far as I know, she is looking directly at the computer system."

On 1/25/17 at 10:15 a.m., RN #2, the current care plan nurse, was interviewed. RN #2 stated: "I didn't know about the CAAs. [The former care plan nurse] never trained me on it." When asked what she bases the care plans on, RN #2 stated: "I do the care plans based on the admission paperwork from the hospital and what the floor

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nurses tell me."

On 1/25/17 at 4:00 p.m., RN #4 returned to the surveyor and stated: "I cannot find care plans for urinary incontinence or psychosocial well-being for [Resident #5]. I have looked. I just wanted to let you know.

On 1/25/17 at 5:15 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.

A review of the facility policy entitled "Care Plan" revealed, in part, the following: "The company's guideline is to ensure interdisciplinary care plans (CP) are accurate and reflective of the patient/residents current medical needs. Care plans are to be periodically reviewed for accuracy and updated as needed...Care Area Assessment Summary (CAAS) that trigger in Minimum Data Set (MDS) will be included in the CP in addition to other areas that the IDT feels is appropriate."

No further information was provided prior to exit.

According to the CMS RAI (Centers for Medicaid and Medicare Services Resident Assessment Instrument) Version 1.13 (October 2015): "Coding Instructions for V0200A, CAAs
·Facility staff are to use the RAI triggering mechanism to determine which care areas require review and additional assessment. The triggered care areas are checked in Column A "Care Area Triggered" in the CAAs section. For each triggered care area, use the CAA process and current standard of practice, evidence-based or expert-endorsed clinical guidelines and resources to conduct further assessment of the

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care area. Document relevant assessment information regarding the resident's status. Chapter 4 of this manual provides detailed instructions on the CAA process, care planning, and documentation.
·For each triggered care area, Column B "Care Planning Decision" is checked to indicate that a new care plan, care plan revision, or continuation of the current care plan is necessary to address the issue(s) identified in the assessment of that care area. The "Care Planning Decision" column must be completed within 7 days of completing the RAI, as indicated by the date in V0200C2, which is the date that the care planning decision(s) were completed and that the resident's care plan was completed."
2. The facility staff failed to develop a care plan for the CAA triggered area of dehydration on Resident #4's significant change assessment, with an ARD of 1/4/17.

Resident #4 was admitted to the facility on 7/6/16 with a readmission on 10/1/16 with diagnoses that included, but were not limited to, hip fracture, hyperlipidemia (elevated lipid levels in the blood stream), dysphagia (difficulty with swallowing), hypothyroidism (low functioning thyroid) and dementia.

Resident #4's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/15/16. Resident #4 was coded on the MDS as having a BIMS (Brief Interview for Mental Status) score of 6 out of 15. The MDS manual documents that a score of 6 indicates that the resident's cognition is severely impaired.

A significant change assessment, for Resident #

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4 with an ARD of 1/4/17, revealed in section Section V - Care Area Assessment (CAA), that "14. Dehydration" was checked as a triggered care area under the column "A". Dehydration was also checked under column "B. Care Planning Decision". The instruction provided in Section V documents, "2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. Check column B if the triggered care area is addressed in the care plan." Section V, Column B for Resident #4's MDS was checked for Dehydration.

A review of the CAA worksheet dated 1/4/17 revealed, in part, the following documentation: "Care Plan Considerations: Will Dehydration/Fluid Maintenance - Functional Status be addressed in the care plan? Yes. If care planning for this problem, what is the overall objective? Improvement; Minimize risks."

A review of Resident #4's comprehensive care plan dated 7/6/16 did not reveal a care plan to address dehydration.

An interview was conducted on 1/25/17 at 8:45 a.m. with RN (registered nurse) #4, MDS Coordinator and RN #5, MDS Coordinator. RN #5 was asked to describe the process for developing a care plan from the CAAs worksheet. RN #5 stated, "Our care plan person (name of RN #1) completes the care plans. She adds the triggered areas. RN #5 was asked whether or not she and RN #4 communicate the triggered areas to RN #1. RN #5 stated, "If something is out of the ordinary I will tell her (RN #1) otherwise she

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can just look at the CAA worksheet." RN #4 and RN #5 were asked to review Resident #4's care plan and to verify whether or not there was a care plan developed for dehydration. RN #4 stated, "I do not see one, I will look in my office and let you know."

An interview was conducted on 1/25/17 at 10:20 a.m. with RN #1. RN #1 was asked to describe her process for developing a comprehensive care plan. RN #1 stated, "If it's a new admission I care plan the resident conditions." RN #1 was asked if she looks at the CAA triggers on the MDS assessments. RN #1 stated, "I have only been on the job for three weeks. (Name of RN #2) is training me."

An interview was conducted with RN #2 on 1/25/17 at 10:30 a.m. RN #2 was asked what information she used to develop a comprehensive care plan. RN #2 stated, "We use the admission paperwork, we talk to the nurses and obtain information given during morning meeting." RN #2 was asked whether or not she looked at the CAA triggers on MDS assessments to develop the care plan. RN #2 stated that she was not looking at them. RN #2 was asked what she used for a reference to complete the care plan process. RN #2 stated that she used a nursing diagnosis handbook, a personal book from home. RN #2 was asked whether or not she used the RAI (resident assessment instrument) as a resource, RN #2 stated that she had used the RAI manual in the past but generally did not use it when completing care plans.

On 1/25/17 at 5:10 p.m. an end of day meeting was held with ASM (administrative staff member)

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#1, the administrator and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above referenced concerns. A policy regarding the completion of care plans was requested at this time.

A review of the facility policy titled "Policy and procedure for interdisciplinary assessments and care plans" revealed, in part, the following documentation, "It is the policy of (name of facility) that an assigned team will assure that each resident achieves the highest practical, social, mental and emotional well-being, directed by the development of a comprehensive assessment and care plan that meets professional standards of quality care. 5. From these completed assessments each department will then developed and implement a comprehensive plan of care."

No further information was provided prior to the end of the survey process.

3. For Resident #15, the facility staff failed to develop a comprehensive care plan based on triggered areas from the CAA Summary (Section V) of the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/5/16.

Resident #15 was admitted to the facility on 9/29/16 with the diagnoses of but not limited to high blood pressure, dementia, pain, vitamin D deficiency, and pressure ulcer of the left ankle. The admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/5/16, coded the resident as being severely cognitively impaired in ability to make daily life decisions, scoring a 3 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The

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resident was coded as requiring extensive care for all areas of ADL's (Activities of Daily Living) and was coded as incontinent of bowel and bladder.

A review of the above identified MDS revealed in Section V - Care Area Assessment (CAA) Summary, that the resident was triggered in Column A (Care Area Triggered) and was to be care planned as evidence by an "X" in Column B (Care Planning Decision) for the areas of: 02. Cognitive Loss/Dementia, 03. Visual Function, 04. Communication, 06. Urinary Incontinence and Indwelling Catheter; 09. Behavioral Symptoms, 11. Falls, 12. Nutritional Status, and 16. Pressure Ulcer. In addition the resident was checked to be care planned for the area of 07. Psychosocial Well-Being, although this was not a triggered area.

A review of the care plan failed to reveal any evidence that the triggered areas of 03. Visual Function, 04. Communication, and 06. Urinary Incontinence and Indwelling Catheter had been care planned for Resident #15.

On 1/26/17 at 8:45 a.m., in an interview with RN #2 (Registered Nurse #2), the care plan coordinator, she stated that the MDS staff never told her about the triggers. RN #2 stated she was not an MDS nurse and didn't know about trigger areas and care planning them. She reviewed the care plan and verified the above identified triggered areas as not being care planned for Resident #15. When asked about a policy or guidelines used in how to develop a care plan, she stated she was not aware of any.

On 1/26/17 at 9:04 a.m., in an interview with RN

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F 279	Continued From page 30 #4, the MDS nurse. RN #4 was asked how the MDS staff ensures that triggered areas of the MDS assessment are being care planned. RN #4 stated that she did not know the answer to that. A policy was requested at that time for the development of care plans. On 1/26/17 at 9:40 a.m., RN #4 stated that she had no further information. On 1/26/17 at 9:37 a.m., ASM #2 (Administrative Staff Member #2, the Director of Nursing) was made aware of the findings. No further information was provided by the end of the survey.	F 279		
F 280 SS=E	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the 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.	F 280	F-280 1. Corrective action has been accomplished for the alleged deficient practice in regards to Residents #10, #18, #3, #5, #2, #1 and #9. Resident #10's comprehensive care plan has been reviewed and revised pertaining to falls on 10/27/16, 12/6/16, 12/23/16, 1/8/17, 1/12/17, and 1/15/17. Resident #18's comprehensive care plan has been reviewed and revised pertaining to the discontinuation of the antibiotic on 11/20/16, G-tube feeding on 1/11/17, and contact isolation on 12/23/16. Resident #3's comprehensive care plan has been reviewed and revised pertaining to a fall on 1/8/17. Resident # 5's comprehensive care plan has been reviewed and revised pertaining to a position boot. Resident #2's comprehensive care plan has been reviewed and revised pertaining to presentation of UTI on 10/22/16 and 10/24/16. Resident #1's comprehensive care plan has been reviewed and revised to reflect the initiation of an anti-psychotic medication on 12/14/16. Resident #9's comprehensive care plan has been reviewed and revised pertaining to a fall on 12/23/16. The Care Plan Coordinator was in-serviced on 1/25/17 on revising/updating care plans.	

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F 280	Continued From page 31 (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (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.	F 280	**2.** Current facility residents have the potential to be affected by the alleged deficient practice. A comprehensive review of resident care plans for antibiotics, falls, antipsychotics, positioning boot, UTI, G-tube feedings, and droplet isolation has been completed to ensure all areas have been care planned. **3.** Measures put into place to assure alleged deficient practice does not recur include: The Director of Nursing and/or nursing administration team will audit the 24 hour report beginning 1/1/17 through 2/10/17 to ensure care plan revisions have been made. The 24 hour report will be reviewed 5 days per week by the Care Plan Coordinator and/or designee to ensure that revisions are made. The Care Plan Team will audit 5 residents per week for 4 weeks then 10 residents per month for 4 months to validate revisions have been made. A random sample of residents will be audited quarterly thereafter to ensure continued compliance. **4.** The Director of Nursing and/or designee will analyze audits/reviews for patterns/trends and report in the Quality Assurance Committee meeting quarterly for six months to evaluate the effectiveness of the plan, and will adjust the plan as the committee may recommend, based on outcomes/trends identified from trend data. **5.** Completion Date: 3/3/17	

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

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

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, observation, and clinical record review, it was determined that the facility staff failed to review and revise the comprehensive care plan for seven of 27 residents in the survey sample, Resident #10, Resident #18, Resident #3, Resident #5, Resident #2, Resident #1 and Resident #9.

1. The facility staff failed to review and revise Resident #10's comprehensive care plan after falls on 10/27/16, 12/6/16, 12/23/16, 1/8/17,1/12/17 and 1/15/17.

2. The facility staff failed to review and revise Resident #18's comprehensive care plan after the discontinuation of the following: antibiotic used for treatment of a urinary tract infection was discontinued on 11/20/16, gastric tube feedings discontinued on 12/11/16, and droplet isolation (1)

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discontinued on 12/23/16.

3. The facility staff failed to review and revise the comprehensive care plan after a fall on 1/8/17 for Resident #3.

4. The facility staff failed to review and revise the comprehensive care plan regarding a positioning boot for Resident #5.

5. The facility staff failed to review and revise Resident #2's comprehensive care plan following the resident's presentation of a UTI (urinary tract infection) on 10/3/16 and 10/24/16.

6. For Resident #1, facility staff failed to revise the comprehensive care plan to reflect the initiation of an anti-psychotic medication Risperdal 0.25 milligrams [1] ordered by the physician on 12/14/16.

7. The facility staff failed to update Resident # 9's comprehensive care plan after a fall.

The findings include:

1. The facility staff failed to review and revise Resident #10's comprehensive care plan after falls on 10/27/16, 12/6/16, 12/23/16, 1/12/17 and 1/15/17.

Resident #10 was admitted to the facility on 1/15/16 with diagnoses that included but were not limited to: Parkinson's disease (1), falls, dementia, depression, anxiety and hallucinations.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment

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reference date) of 12/28/16 coded the resident as having a 1 out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as requiring supervision with walking in the corridors and the assistance of one staff member for dressing and toileting. In Section J 1800 titled, "Any Falls Since Admission/Entry or Entry or Reentry or Prior Assessment....Enter Code (there was a 1 in the box) 1. Yes -- Continue to Section J900 Number of Fall Since Admission Entry or Reentry or Prior Assessment ....was documented, "Coding: 0. None; 1. One; 2 Two or more (indicating the number of falls that occurred). A. No injury. 1 (was coded indicating the resident had one fall with no injury). B. Injury (except major) 2 (was coded indicating that two or more falls with injury occurred.)."

Review of Resident #10's nurses notes documented:
10/27/16 at 3:48 p.m. "This Nurse was called to this Resident's room @ 2:45 p.m. Resident found by the CNA (certified nursing assistant) lying on the floor in her room, on her (R) [right] side, in front of her bed."
12/6/16 at 10:45 a.m. "Resident got up from bed, alarm was sounding. CNA shut alarm off and walked into the bathroom with her. Resident was walking back to the bed when she sat down; she sat down before she reached the bed on to the floor."
12/23/16 at 5:35 a.m. "0500 (5:00 a.m.) CNA reported to this nurse that resident's alarm sounded and when resident (sic) went to room, resident was observed on the floor beside bed."
1/8/17 at 3:31 p.m. "Resident was ambulating in hall of wing and lost balance, restorative aids where (sic) present and tried catching resident,

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resident slightly fell on floor, no injuries noted." 1/12/17 at 10:17 a.m. "At 0950 (9:50 a.m.) resident was witnessed by staff tripping on the bed controls at the foot of the bed. She landed on her buttock with no injury noted." 1/15/17 at 10:24 a.m. "Staff was serving and assisting others with Breakfast, when one CNA observed this Resident stand up, before the CNA could get to her, she turned to walk away, and fell onto the floor."

Review of Resident #10's comprehensive care plan initiated on 10/19/16 and revised on 10/24/16 did not evidence documentation regarding the above falls.

An interview was conducted on 1/25/17 at 9:15 a.m. with RN (registered nurse) #5, the MDS coordinator. RN #5 was asked when a resident care plan would be updated. RN #5 stated, "Every time there's an assessment (MDS assessment) or a change." When asked who updates the residents care plans, RN #5 stated, "The care plan coordinator." When asked who uses the care plan, RN #5 stated, "It should be all staff." RN #5 was asked why Residents have care plans. RN #5 stated, "To assist with the POC (plan of care), to notify staff of their (the resident's) needs and to give them (the residents), good quality care, to the best of our ability or their ability." When asked how the care plan coordinator would know when to update the care plan, RN #5 stated, "She would update the care plan when we have a care plan meeting." When asked how often the care plan meeting occurred, RN #5 stated, "Weekly."

An interview was conducted on 1/25/17 at 10:05 a.m. with RN #1, the care plan coordinator. When

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how she would know to update a resident's care plan, RN #1 stated, "So every morning we do a 24 hour shift report and part of my job is to do any changes and do updates (on the care plans)." When asked when a resident care plan would be updated, RN #1 stated, "Any changes in condition, new medication, behaviors, whatever changes affect the patient so we can stay current." When asked who uses the care plan, RN #1 stated, "The staff has access to them." When asked about the importance of a care plan, RN #1 stated, "Care plans are important because it's important to know the condition of the resident to get the best outcomes as possible and quality of life." RN #1was asked about Resident #10's falls and asked if those would be added to the care plan. RN #1 stated, "Yes and no. Her care plan would have been reflective had she had an actual fall. It would not be updated unless there were any injuries. We add any interventions after the fall meeting weekly." When asked to review Resident #10's care plan, RN #1 stated, "You can't tell if there have been any falls since 10/19/16." When asked if it would be important to know that information, RN #1 stated, "Yes, ma'am."

An interview was conducted on 1/25/17 at 3:40 p.m. with LPN (licensed practical nurse) #11, the unit manager. When asked who used the care plan, LPN #11 stated, "Anybody who provides care." When asked why the residents have a care plan, LPN #11 stated, "So we know how to care for them." When asked when care plans were updated, LPN #11 stated, "After any incident or episode." When asked to review Resident #10's care plan in comparison to the fall dates, LPN #11 stated, "Doesn't look like it's on this one." When asked if there was another care plan, LPN #11

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stated, "I don't think so."

On 1/25/17 at 5:25 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled, "Care Plan" documented, "GUIDELINE The company's guideline is to ensure interdisciplinary care plans (CP) are accurate and reflective of the patient/residents current medical needs. Care plans are to be periodically reviewed for accuracy and updated as needed. PROCEDURE 2. CP will be monitored and reviewed and open to revision as circumstances change, quarterly, annually, and with significant changes. 10. The Care plan will serve as a guide for all staff in delivery in care and services to meet the needs of each patient/resident and in helping achieve the highest level of practicable well being."

No further information was provided prior to exit.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..."
(1) Parkinson's disease -- Parkinson's disease (PD) is a type of movement disorder

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<https://medlineplus.gov/movementdisorders.html>. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine. This information was obtained from: https://medlineplus.gov/parkinsonsdisease.html

2. The facility staff failed to review and revise Resident #18's comprehensive care plan after the discontinuation of the following: an antibiotic used for treatment of a urinary tract infection discontinued on 11/20/16, gastric tube feedings discontinued on 12/11/16, and droplet isolation (1) discontinued on 12/23/16.
Resident #18 was admitted to the facility on 7/25/16 and readmitted on 10/28/16 with diagnoses that included but were not limited to: stroke, difficulty walking, depression, retention of urine and difficulty sleeping.
The most recent MDS, a significant change assessment, with an ARD of 11/4/16 coded the resident as having scored 15 out of 15 on the BIMS indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.
An observation of Resident #18 was made on 1/25/17 at 1:05 p.m. The resident was sitting up in bed. She was in a two bed room and had a roommate who was present in the room.
Review of Resident #18's care plan documented: Date initiated 11/3/16 -- "Focus The resident requires a G (gastric)-tube r/t (related to) Dysphagia (2). Interventions/Tasks The resident needs the HOB (head of bed) elevated 45 degrees during and thirty minutes after tube feed. Provide bolus feeding as ordered." (There was no documentation of any revisions evidenced.)
Date initiated 11/3/16 -- "Focus The resident has MRSA (methicillin-resistant Staphylococcus

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aureus (3)) in the sputum. Interventions/Tasks Maintain droplet precautions: Wear gowns, masks and gloves when in room. Place soiled linens in bags marked biohazard. Bag linens and close bag tightly before taking to laundry." (There was no documentation of any revisions evidenced.)
Date initiated 11/14/16 -- "Focus The resident has a Urinary Tract Infection. Interventions/Tasks Give antibiotic as ordered. Monitor for side effects and effectiveness to the medication." (There was no documentation of any revisions evidenced.)
Review of the physician's orders dated 1/1/2016 did not evidence documentation regarding gastric tube feedings, current antibiotic therapy or isolation.
Review of the November 2016 MAR (medication administration record) documented, "Bactrim DS (4) Tablet...Give 1 tablet by mouth two times a day for (sic) UTI (urinary tract infection) for 10 days. -Start Date- 11/10/2016." The medication was documented as being given from 1/10/16 to 1/20/16.
Review of the December 2016 MAR documented, "JEVITY (5) if less than 75% of meal is consumed PO (by mouth) administer 1 can of Jevity...-Start Date- 11/11/16 -D/C (discontinue) Date- 12/2/2016."
Review of the December 2016 MAR documented, "Droplet Isolation precautions every shift for MRSA in the lungs - Start Date - 10/28/2016 -D/C Date- 12/23/2016."
An interview was conducted on 1/25/17 at 9:15 a.m. with RN (registered nurse) #5, the MDS coordinator. RN #5 was asked about when a resident care plan would be updated. RN #5 stated, "Every time there's an assessment (MDS assessment) or a change." When asked who updated the care plan, RN #5 stated, "The care

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plan coordinator." When asked who uses the care plan, RN #5 stated, "It should be all staff." RN #5 was asked why Residents have care plans. RN #5 stated, "To assist with the POC (plan of care), to notify staff of their (the resident's) needs and to give them (the residents), good quality care, to the best of our ability or their ability." When asked how the care plan coordinator would know when to update the care plan, RN #5 stated, "She would update the care plan when we have a care plan meeting." When asked how often the care plan meeting occurred, RN #5 stated, "Weekly."

An additional interview was conducted on 1/26/17 at 8:40 a.m. with RN #2, the care plan coordinator. When asked about the process staff follows to update a care plan for an issue that has resolved, RN #2 stated, "If the nurse puts it in her notes or if the unit manager tells us." When asked to review Resident #18's care plan for the urinary tract infection, RN #2 stated, "That should have been resolve when she got off her antibiotics." When asked to review the tube feeding care plan, RN #2 stated, "She came in on tube feedings. It's been d/c'd (discontinued)." When asked to review the resident's care plan for the droplet isolation precautions, RN #2 stated, "It should have been resolved."

On 1/26/17 at 10:25 a.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

(1) Droplet isolation - Airborne transmission occurs by dissemination of droplet nuclei over

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long distance from infectious patients (for more details on respiratory droplets. Preventing the spread of airborne infections involves implementing airborne precautions, which requires the three controls (see above in section 1.2): administrative controls; environmental and engineering controls - patient room with special air handling and ventilation; and PPE - the use of particulate respirators by health-care workers whenever possible (WHO, 2007 </books/n/whoventil/references.rl1/?report=reader>). This information was obtained from: https://www.ncbi.nlm.nih.gov/books/NBK143287/?report=reader

(2) Dysphagia - People with dysphagia have difficulty swallowing and may even experience pain while swallowing (odynophagia). Some people may be completely unable to swallow or may have trouble safely swallowing liquids, foods, or saliva. When that happens, eating becomes a challenge. This information was obtained from: https://www.nidcd.nih.gov/health/dysphagia

(3) MRSA - MRSA stands for methicillin-resistant Staphylococcus aureus. It causes a staph infection <https://medlineplus.gov/staphylococcalinfections.html> (pronounced "staff infection") that is resistant to several common antibiotics <https://medlineplus.gov/antibiotics.html>. This information was obtained from: https://medlineplus.gov/mrsa.html

(4) Bactrim - BACTRIM (sulfamethoxazole and trimethoprim) is a synthetic antibacterial combination product available in DS (double strength) tablets, each containing 800 mg sulfamethoxazole and 160 mg. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setid=0138A156-859A-48A3-BF5A-E2DB0CC

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(5) Jevity - Fiber-fortified feedings in immobile patients. This information was obtained from: https://www.ncbi.nlm.nih.gov/pubmed/8173521 3. The facility staff failed to review and revise the comprehensive care plan after a fall on 1/8/17 for Resident #3.

Resident #3 was admitted to the facility on 10/25/04 with diagnoses that included but were not limited to: intellectually disabled, high blood pressure, dementia, psychosis, anxiety disorder, diabetes, and benign prostatic hypertrophy (enlargement of the prostate (1)).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 11/18/17, coded the resident as severely impaired to make daily cognitive decisions. Resident #3 was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living except eating in which he was coded as independent after set up assistance was provided. In Section J - Health Conditions, Resident #3 was coded as having had two falls during the look back period with no injuries.

The nurse's notes dated, 1/8/17 at 8:12 p.m. documented, "CNA (certified nursing assistant) alerted this nurse around 19:45 (7:45 p.m.) about an abrasion in (sic) resident's back area and also reported that resident almost slid out of his bed earlier this shift. Upon assessment, abrasion found to be 35 cm (centimeters) long, no open area noted. Barrier cream applied to affected area and tolerated well. NP (nurse practitioner) notified and family notified about this. Resident not in any acute distress. No pain offered at this

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time. Neurological checks for unwitnessed fall started around 19:55 (7:55 p.m.) BP (blood pressure) 100/70 mmHg (millimeters of mercury), Pulse 74 bpm (beats per minute), RR (respiratory rate) 18 rpm (respirations per minute), Temp (temperature) 97.6 F (Fahrenheit), O2 saturation (oxygen) 94% (percent)."

The MD/NP (medical doctor/nurse practitioner) note dated, 1/9/17 at 1:10 p.m. documented, "Staff reported pt (patient) found next to bed over weekend, has superficial abrasion back area. no pain noted. no sob (shortness of breath)...s/p (status post) fall - abrasion back - continue to monitor."

There was no further documentation in the nurse's notes related to the fall.

The comprehensive care plan dated, 10/5/16, and revised on 11/29/16, documented, "Focus: The resident has had an actual fall with no injury. Poor balance, unsteady gait." The "Interventions" were reviewed. The last interventions were dated 11/29/16.

The facility "Fall Incident Report" dated, 1/8/17, documented in part, "Incident description: CNA alerted this nurse around 19:45 (7:45 p.m.) about an abrasion in (sic) resident's back area and also reported that resident almost slid out of his bed earlier this shift. Upon assessment, abrasion found to be 35 cm long, no open area noted. Barrier cream applied to affected area and tolerated well. NP notified and family notified about this. Resident not in any acute distress. No pain offered at this time. Neurological checks for unwitnessed fall started around 19:55 (7:55 p.m.) BP 100/70 mmHg, Pulse 74 bpm, RR 18

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rpm, Temp 97.6 F, O2 saturation, 94%." Immediate Action Taken: Barrier cream applied to affected area and tolerated well. NP notified and family notified about this. Resident not in any acute distress. No pain offered at this time. Neurological checks for unwitnessed fall started around 19:55.....Mental Status: no records found. Predisposing Environmental Factors: No Records Found. Predisposing Physiological Factors: No Records Found. Predisposing Situation Factors: No Records Found. Other Information: Un-Witnessed. Incident location: Resident's Room. Witnesses: No witnesses found. Agencies/People Notified: No Notifications found. Notes: No notes found."

An interview was conducted with RN (registered nurse) #4, MDS nurse, on 1/25/17 at 9:00 a.m. When asked who updates the care plans, RN #4 stated, "The care plan team. Each discipline is responsible for their section." When asked who updates the care plan after a resident has had a fall, RN #4 stated, "That would be (RN #1) the care plan coordinator."

An interview was conducted with RN #1, the care plan coordinator, on 1/25/17 at 10:05 a.m. When asked who updates the care plan after an actual fall, RN #1 stated, "They tell me in our morning meeting that a fall has occurred. They tell me what the cause of the fall, if known was." RN #1 was asked to review Resident #3's care plan to see if she could find the fall on 1/8/17 documented on the care plan. RN #1 stated, "Based on the information I see here, it's not on there." RN #1 further stated, "The fall committee meets and discusses every fall. They are supposed to be writing a note."

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Review of the clinical record did not reveal any fall committee meeting notes.

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 1/25/17 at 10:37 a.m. When asked who is responsible for updating the care plan, ASM #2 stated, "The care plan coordinator." On 1/25/17 at 4:12 p.m. the concern of the care plan not being updated for Resident #3 on 1/8/17 after a fall was revealed. ASM #2 stated he'd look into it and get back with this surveyor. On 1/25/17 at 4:50 p.m. ASM #2 returned and stated, "I have no information to give you related to (Resident #3)'s fall."

The administrator and ASM #2 were made aware of the above concern on 1/25/17 at 5:30 p.m.

No further information was provided prior to exit.

(1) Barron's Medical Dictionary for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 282.

4. The facility staff failed to review and revise the comprehensive care plan regarding a positioning boot for Resident #5.

Resident #5 was admitted to the facility on 12/15/16 with diagnoses including, but not limited to: history of a stroke, dementia with behaviors, difficulty swallowing, high blood pressure, and diabetes. On the most recent MDS (minimum data set), a 30-day Medicare assessment with an assessment reference date of 1/12/17, Resident #5 was coded as being severely cognitively impaired for making daily decisions.

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A review of the clinical record for Resident #5 revealed the following order dated 1/13/17: "Nursing to apply multi podus boot (1) while resident is in bed every shift."

A review of Resident #5's comprehensive care plan dated 12/15/16 revealed no information related to the multipodus boot.

On 1/25/17 at 9:10 a.m., RN (registered nurse) #5, the MDS coordinator, was interviewed. RN #5 stated: "We have a morning stand up meeting every day." She stated at that morning meeting, the interdisciplinary team reviews the last 24 hours of resident orders and nurses notes. RN #5 stated the care plan nurse attends these meetings, takes notes, and updates the care plans.

On 1/25/17 at 10:15 a.m., RN (registered nurse) #1, the care plan nurse, was interviewed. She stated: "We have a stand up meeting every morning." She stated unit managers review the past 24 hours with their residents at these stand up meetings. RN #1 stated: "I take that information and update the care plan." When asked to locate the multipodus boots on Resident #5's care plan, she reviewed the care plan and stated: "I don't see it. I must have just missed it."

On 1/25/17 at 5:15 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.

(1) "The multi podus boot is a foot and ankle

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orthosis made of plastic and lined with soft material to protect the skin. It is used while the patient is on bed rest to hold the ankle in a neutral position (90 degree angle) and can control rotation." This information is obtained from the manufacturer's website http://www.plor.net/downloads/resources/orthotics/lower-extremity/Orthotics.MultiPodusBoot.pdf.

5. The facility staff failed to review and revise Resident #2's comprehensive care plan following the resident's presentation of a UTI (urinary tract infection) on 10/3/16 and 10/24/16.

Resident #2 was admitted to the facility on 1/8/01 and readmitted to the facility on 6/27/16. Resident #2's diagnoses included but were not limited to: urinary tract infection, heart failure and pain. Resident #2's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/12/17, coded the resident's cognition as being moderately impaired. Section I failed to document the resident as having a UTI during the last 30 days.

Review of Resident #2's clinical record revealed the following notes signed by the NP (nurse practitioner) and physician's orders:

10/3/16 NP note- "Note Text: reviewed lab (laboratory) results. Urine C&S (culture and sensitivity) shows + (positive) Providencia stuartii (1). Sensitive to Bactrim DS (double strength)

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(2)...UTI- will start Bactrim DS 1 tab PO (by mouth) BID (twice a day) x (times) 7 days..."

10/3/16 physician's order- "Bactrim DS 800-160 MG (milligrams). Give 1 tablet by mouth two times a day related to URINARY TRACT INFECTION... for 7 days."

10/24/16 NP note- "Note text: urinalysis results show E. coli (3); will start Tobramycin (4) IM (intramuscular) every eight hours x seven days..."

10/24/16 physician's order- "Tobramycin IM every 8 hours for 7 days..."

Review of Resident #2's comprehensive care plan effective 1/20/15 and active during October 2016 failed to document any information regarding the resident's UTI diagnoses on 10/3/16 and 10/24/16.

On 1/25/17 at 10:34 a.m., an interview was conducted with RN (registered nurse) #1 (the current care plan coordinator- employed for approximately three weeks) and RN #2 (the former care plan coordinator- prior to RN #1). RN #2 confirmed care plans should be updated after each UTI. RN #2 was asked to review Resident #2's care plan that was active during October 2016 and show this surveyor where the care plan had been updated to reflect the UTIs diagnosed on 10/3/16 and 10/24/16. RN #2 stated she didn't see where the care plan was updated. When asked if the care plan should have been updated, RN #2 stated, "Of course." RN #2 was asked if the care plan should be updated after each newly diagnosed UTI. RN #2 stated the care plan should be updated after each newly diagnosed UTI unless the resident had a history of UTIs then

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the care plan would reflect that history. At this time, RN #2 confirmed Resident #2's care plan had not been revised to reflect a history of UTIs.

On 1/25/17 at 12:55 p.m., a telephone interview was conducted with RN #3 (the former care plan coordinator prior to RN #1 and RN #2 who currently held a different position at the facility). RN #3 stated care plans should be updated after each newly diagnosed UTI. RN #3 stated she didn't remember anything regarding the changes made to Resident #2's care plan and she changed positions at the end of October 2016.

On 1/25/17 at 5:25 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Care Plan" documented, "GUIDELINE: The company's guideline is to ensure interdisciplinary care plans (CP) are accurate and reflective of the patient/residents current medical needs. Care plans are to be periodically reviewed for accuracy and updated as needed..."

No further information was presented prior to exit.

(1) Providencia stuartii is a bacterium that can be found in the urinary tract. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmed/3081988

(2) Bactrim DS is an antibiotic medication used to treat infections. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setid=1BA409B6-8DCD-41D2-AA9E-81B77F8

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(3) E. Coli is a bacterium that can be found in the urinary tract. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmed/3081988

(4) Tobramycin is an antibiotic medication used to treat infections. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=49151a62-191a-4ba8-8b8c-bd8535f2fdb3

6. For Resident #1, facility staff failed to revise the comprehensive care plan to reflect the initiation of an anti-psychotic medication Risperdal 0.25 milligrams [1] ordered by the physician on 12/14/16.
Resident #1 was admitted to the facility on 5/4/14 and readmitted on 5/13/16 with diagnoses that included but were not limited to mood disorder, high blood pressure, chronic kidney disease (stage 3), atrial fibrillation, stroke, and COPD (chronic obstructive pulmonary disease).
Resident #1's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/9/16.
Resident #1 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #1 was coded as requiring extensive assistance from staff with most ADLS (activities of daily living) including transfers, locomotion, toileting, and personal hygiene; total dependence on staff with bathing, and independent with meals.
Review of Resident #1's clinical record revealed

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the following note from the psychologist dated 12/14/16, "...This is an 81 year old Caucasian female who appears of her stated age. She was sitting in a chair I her room and a normal posture. She was cooperative, easily engage able and made poor eye contact during the interview. She was dressed in casual attire and her grooming and hygiene were fair. No evidence of aggression or agitation. Her speech was spontaneous with normal rate, volume and tone. She described her mood was "Depressed and her affect was tearful and dysphoric. Thought process was linear and goal directed. She denied and demonstrated no evidence if suicidal, homicidal or psychotic ideation. She was alert and oriented to herself and place ...PLAN: I woul (sic) add Risperdal 0.25 mg at bedtime for mood disorder and discontinue Nuedexta [2] as it does not seem to be beneficial at this time ..."

Further review of Resident #1's clinical record revealed the following order dated 12/14/16: "Risperdal Tablet 0.25 MG (milligrams) (Risperidone) Give 1 mg by mouth at bedtime for psychosis." This order was written by LPN (licensed practical nurse) #1.

Review of Resident #1's depression, behavior, and mood care plan dated 11/21/16 and updated 12/6/16 failed to address the use of anti-psychotic medications and that Resident #1 was receiving an anti-psychotic medication.

On 1/25/17 at 9:13 a.m., an interview was conducted with RN (registered nurse) #4, the MDS nurse. RN #4 was asked when a resident care plan is updated. RN #4 stated that every morning the facility has a stand up meeting where new orders or incidents from the last 24 hours are reviewed. RN #4 stated that the CP (care plan) coordinator takes notes on these updates such as new falls, new physician orders; and updates

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the care plan for that resident. RN #4 stated that typically floor nurses do not update the care plan. When asked if a care plan should be in place if a resident receives a new order for an anti-psychotic medication, RN #4 stated yes. When asked what types of interventions would be seen on an anti-psychotic medication care plan, RN #4 stated that anti-psychotic medication side effects and targeted behaviors should be listed on the care plan. RN #4 could not find an anti-psychotic medication care plan for Resident #1.

On 1/25/17 at 11:01 a.m., an interview was conducted with RN #2, the care plan nurse. RN #2 was asked when a resident care plan is updated. RN #2 stated that a care plan is updated with any new orders. When asked if a care plan should be in place for a resident with a new order for anti-psychotic medication, RN #2 stated yes, and social services was responsible for updating any mood or behavior care plan. When asked what type of interventions would be in place for a resident on a new anti-psychotic medication, RN #2 stated that the medication side effects and behavior monitoring should be in place to see if the medication is working for the resident. RN #2 stated that LPN (licensed practical nurse) #1, the nurse who makes rounds with the psychiatrist would also be responsible for updating the resident's care plan for a new anti-psychotic medication.

On 1/25/17 at 11:33 a.m., an interview was conducted with OSM (other staff member) #9, the social worker. OSM #9 stated that she has updated a care plan when a resident was placed on a new anti-psychotic medication but it was the care plan coordinator's responsibility. OSM #9 stated, "I would have to ask and make sure. I don't want to assume."

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F 280	Continued From page 53 On 1/25/17 at 12:00 p.m., an interview was conducted with LPN #1, the clinical nurse. LPN # 1 stated that it was not her responsibility to update the care plan with a new anti-psychotic medication. LPN #1 stated, "The Care Plan Coordinator is responsible for updating an anti-psychotic care plan." On 1/25/17 at 5:25 p.m., ASM #1, the Administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was provided regarding the above concern by the completion of the survey process. [1] Risperdal- anti-psychotic used to treat symptoms of schizophrenia, bipolar disorder or irritability associated with autistic disorder. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012012/?report=details. [2] Nuedexta- Used to treat uncontrollable laughing or crying. This information was obtained from The National Institutes of Health. <https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009896/?report=details>. 7. The facility staff failed to update Resident # 9's comprehensive care plan after a fall. Resident # 9 was admitted to the facility on 7/8/14 with diagnoses including, but not limited to: diabetes, depression, hypertension, hyperlipidemia, gastroesophageal reflux disease, irritable bowel syndrome, and vitamin D	F 280		

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deficiency. On the most recent MDS (minimum data set), a significant change assessment with ARD (assessment reference date) of 12/30/16, Resident # 9 was coded as scoring a 15 out of a possible 15 on the BIMS (brief interview of mental status) indicating that he was cognitively intact.

Review of the compressive care plan for falls with a "Date Initiated: 10/05/16" did not document Resident # 9's most recent fall or any interventions related to that fall.
Further review of the clinical record revealed a physician order dated 12/23/16 that documented: "Bed alarm at all times to alert staff members of attempts pt (patient) unsafe transfers ..." and another dated 12/23/16 that documented: "Chair alarm to alert staff members of attempts of unsafe transfers ..." Neither the fall nor the new interventions were on the resident care plan.
During an interview on 1/25/17 at 11:00 a.m. with RN (registered nurse) # 2, a unit manager, and RN # 1, the care plan coordinator, RN # 1 stated that she now does the updates for the care plans for new orders. RN # 2 stated that the assistant director of nurses would normally do the care plan updates for falls but she is out on leave. RN # 2 further stated that [name of LPN (licensed practical nurse) # 1] now is doing the care plan updates for falls. RN # 2 stated that nurses on the floors can view the care plans but they do not update the care plans.

During an interview on 1/25/17 at 4:30 p.m. with LPN (licensed practical nurse) # 1, the quality assurance nurse, Resident # 9's care plan was discussed. LPN # 1 stated that she did not update the care plans but agreed to review Resident # 9's care plan. LPN # 1 confirmed that the Resident's care plan was not updated since

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F 280	Continued From page 55 11/21/16. During an interview on 1/25/17 at 5:00 p.m. with LPN # 6, LPN # 6 was asked what the purpose of the care plan was. LPN # 6 related that the care plan tells one everything about the resident it is the plan of care. When asked about updating the care plan LPN # 6 stated that there is a nurse in the building that updates the care plans but further stated that staff could go in and update in the case of a fall and could put new interventions in the care plan. During the end of day interview on 1/25/17 at 5:10 p.m. with ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nurses, this concern was reviewed. No further information was provided prior to exit.	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide care in accordance with the written plan of care for three of 27 residents in the survey sample, Residents #4, 6, and 5.	F 282	F-282 1. Corrective action has been accomplished for the alleged deficient practice in regards to Residents #4, #6, and #5. Resident #4's intake and output has been discontinued. Resident #6's heels were floated on 1/25/17, nurse was educated on 1/25/17 on attempting non-pharmacological methods before medicating resident for pain. On 1/26/17, glove and splint was placed on Resident #5. 2. Current facility residents have the potential to be affected by the alleged deficient practice. The Director of Nursing and/or nursing administration team educated all licensed nursing staff on the importance of reviewing and following each resident's care plan.	

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F 282	Continued From page 56 1. The facility staff failed to obtain and document intake and output as instructed in the written comprehensive plan of care for Resident #4 on eleven of 54 shifts in January 2017. 2 a. The facility staff failed to "float" the resident's heels per the comprehensive care plan for Resident #6. b. The facility staff failed to follow the resident's written comprehensive care plan for the treatment of Resident #6's pain. 3. The facility staff failed to follow the comprehensive plan of care for applying a glove to prevent edema and arm splint to Resident #5's right arm. The findings include: 1. The facility staff failed to obtain and document intake and output as instructed in the written comprehensive plan of care for Resident #4 on eleven of 54 shifts in January 2017. Resident #4 was admitted to the facility on 7/6/16 with a readmission on 10/1/16 with diagnoses that included, but were not limited to, hip fracture, hyperlipidemia (elevated lipid levels in the blood stream), dysphagia (difficulty with swallowing), hypothyroidism (low functioning thyroid) and dementia. Resident #4's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 10/5/16. Resident #4 was coded on the MDS as having a BIMs (Brief Interview for Mental Status) score of 6	F 282	3. Measures put into place to assure alleged deficient practice does not recur include: The Director of Nursing and/or nursing administration team will audit 10 residents per week for 4 weeks and 15 residents per month for 3 months to ensure care plans are being followed. A random sample of residents will be audited quarterly thereafter to ensure continued compliance. 4. The Director of Nursing and/or designee will analyze audits/reviews for patterns/trends and report in the Quality Assurance Committee meeting quarterly for six months to evaluate the effectiveness of the plan, and will adjust the plan as the committee may recommend, based on outcomes/trends identified from trend data. 5. Completion Date: 3/3/17	

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out of 15. The MDS manual documents that a score of 6 indicates that the resident's cognition is severely impaired.

A review of Resident #4's clinical record revealed, in part, the following physician's order, "Order Date: 1/2/17 0855 (8:55 a.m.) Communication Method: Verbal. Ordered By: (name of physician). Description: Intake and Output. Frequency: every shift. Schedule Type: Everyday."

Further review of Resident #4's clinical record revealed, in part, a TAR (treatment administration record) for January 2017. The January TAR contained columns for each day in the month of January, and a space for three shifts on each day to document Resident #4's intake and output. The following dates and shifts were blank; 1/4/17 night shift, 1/6/17 day shift, 1/7/17 and 1/8/17 night shift, 1/12/17 night shift, 1/13/17 day shift and evening shift, 1/15/17 and 1/16/17 day shift, 1/18/17 and 1/19/17 night shift.

On 1/25/17 at 11:45 a.m. an interview was conducted with LPN (licensed practical nurse) #11, a unit manager. LPN #11 was asked to describe the process when there was an order for intake and output. LPN #11 stated that the nurse was to document the resident's total fluid intake and document the resident's total fluid output. LPN #11 was asked where the intake and output was documented; LPN #11 stated that it was documented in the TAR. LPN #11 was asked whether or not there should be blank spots on the TAR for intake and output. LPN #11 stated, "There should not be blank spots. This means that it was not charted or there was no input or output for the shift. If there was no input or output

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then there should be a notation in the blank areas and a note in the progress notes." LPN #11 was shown Resident #4's TAR and was asked about the blank spots for intake and output on the previously noted dates. LPN #11 stated that it was not done.

On 1/25/17 at 1:00 p.m. an interview was conducted with LPN #2, a unit manager who had worked with Resident #4. LPN #2 was asked to review Resident #4's TAR and explain why there were blank spots for the intake and output. LPN #2 stated that the intake and output had not been completed as ordered on each shift. LPN #2 was asked whether or not the intake and output was to have been obtained on each shift and documented at each shift. LPN #2 stated that it should have been done and it did not appear that it had been done.

A review of Resident #4's comprehensive care plan dated 7/6/16 revealed, in part, the following documentation; "Problem: The resident has an indwelling Foley r/t (related to) urinary retention. Date initiated: 10/13/20106. Interventions/Tasks: Monitor and document intake and output as per facility policy. Date initiated: 10/13/2016."

A review of the facility policy titled, "Policy and procedure relating to intake and output" revealed, in part, the following documentation, "Standard: Intake and output is monitored accurately to insure optimal hydration levels of certain residents and to assist in their assessment and management by using the Intake and Output Record. 1. Record all p.o. (by mouth) fluids in proper column as soon as possible to maintain accuracy. 2. If resident does not take any p.o. fluids during a given shift, write zero in the shift

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total column. 4. Use a urinal or graduate to measure outputs from Indwelling catheters to insure accuracy."

On 1/25/17 at 5:10 p.m. an end of day meeting was held with ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above referenced concerns.

No further information was provided prior to the end of the survey process.

2 a. The facility staff failed to "float" the resident's heels per the written comprehensive plan of care for Resident #6.

Resident #6 was admitted to the facility on 11/4/11 with a recent readmission on 11/22/16, with diagnoses that included but were not limited to: cough repeated falls, spinal stenosis, high blood pressure, peripheral vascular disease (any abnormal condition affecting blood vessels outside the heart (1)), neuropathy (any abnormal condition of the peripheral nerves (2)), benign prostatic hypertrophy (enlargement of the prostate (3)) and gout.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 10/20/16, coded the resident as scoring a 15 on his BIMS (brief interview for mental status) score, indicating that he was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for most of his activities of daily living. He was coded as requiring supervision after set up assistance for moving on and off the unit and

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eating. In Section J - Health Conditions, the resident was coded as receiving scheduled and PRN (as needed) pain medication. It was coded, during the resident interview for pain that the resident had pain almost constantly and the pain was rated as a "5" on a pain scale of zero to ten, ten being the worse pain he was ever in.

Resident #6 was observed on 1/25/17 at 8:08 a.m. and 9:45 a.m. He was lying in the bed, on his back. His heels were resting directly on the surface of the mattress.

The heels were observed by the nurse practitioner on 1/25/17. She documented the following: "Bilateral heels - very dry and cracked skin in areas. no s/s (signs and symptoms) of infection. area balanceable (sic). see nursing note for measurements, no drainage. Pt (patient) is African American and hard to determine if heels at this point is any darker in color, did express to unit coordinator that I want heels off loaded from mattress. SO WE DON'T OBTAIN A DTI (DEEP TISSUE INJURY), at this point it's not will add to weekly wound rounds."

Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration
Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the

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actual extent of tissue injury, or may resolve without tissue loss. (4)
The comprehensive care plan dated, 5/11/16 and reviewed on 11/11/16, documented in part, "Problem: Skin Integrity: At risk for skin breakdown - At risk for skin breakdowns related to receiving Plavix and diagnosis of PVD (peripheral vascular disease)." The "Interventions" documented in part, "Float heels as resident allows."
An interview was conducted with LPN (licensed practical nurse) #16 on 1/25/17 at 10:37 a.m. When asked the purpose of the care plan, LPN #16 stated, "It's the different interventions of what to do to care for a resident."
An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 1/25/17 at 10:47 a.m. When asked the purpose of the care plan, ASM #2 stated, "It's how we base our care for each resident." When asked if the staff should be following the care plan, ASM #2 stated, "Yes."
The facility policy, "Care Plan," documented in part, "Guideline:...10. The Care Plan will serve as a guide for all staff in delivery of care and services to meet the needs of each patient/resident and in helping achieve the highest level of practicable well-being."

The administrator and ASM #2 were made aware of the above concerns on 1/25/17 at 5:30 p.m. No further information was provided prior to exit.
(1) Barron's Medical Dictionary for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 447.
(2) Barron's Medical Dictionary for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 402
(3) Barron's Medical Dictionary for the

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Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 282.
(4)This information was taken from the following website:
http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/

b. The facility staff failed to follow the resident's written comprehensive care plan for the treatment of Resident #6's pain.

The comprehensive care plan, dated, 5/11/16 and reviewed on 11/11/16, documented in part, "Problem: Pain Management - Alteration in comfort - pain related to Peripheral Neuropathy and chronic back pain and gout pain." The "Interventions" documented in part, "On-going assessment of the resident's pain with emphasis on the onset, location, description, intensity of pain and alleviating and aggravating factors. Administer medications as ordered by MD (medical doctor)."

The physician orders dated, 10/03/16, documented, "Hydrocodone - Acetaminophen (used to treat moderate to severely moderate pain (1)) 5 mg (milligrams) - 325 mg tablet. Give 1 tablet orally every 8 hours as needed for pain level 1 -10."

The medication administration record (MAR) for December 2016 documented, "Hydrocodone - Acetaminophen 5 mg - 325 mg tablet; give 1 tablet orally every 8 hours as needed for pain level 1 -10." The MAR documented the resident received the medication on the following dates and times:
12/5/16 at 2:42 a.m. and 11:12 a.m.

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12/11/16 at 12:35 p.m.
12/15/16 at 9:01 p.m.
1216/16 at 6:19 p.m.
12/19/16 at 9:56 p.m.
12/20/16 at 2:41 p.m.
12/29/16 at 10:49 p.m.
12/30/16 at 11:13 a.m. and 9:49 p.m.

The December MAR documented, "Document Pain level Q (every) shift using a scale of 1 -10 every shift." The documented pain assessment for the dates and shifts that the medication was administered above were all documented as having "0" pain.

The nurse's notes were reviewed. The nurse's note dated, 12/5/16 at 3:50 a.m., 12/5/16 at 12:19 p.m., 12/11/16 at 1:36 p.m.,12/15/16 at 10:43 p.m., 12/16/16 at 7:00 p.m., 12/19/16 at 10:39 p.m., 12/20/16 at 5:19 p.m.,12/29/16 at 11:10 p.m., 12/30/16 at 12:51 p.m. and 10:12 p.m., documented, "Administration Note: Hydrocodone - Acetaminophen 5 mg - 325 mg tablet. PRN administration was: Effective." There was no documentation of the location, intensity and non-pharmacological interventions attempted prior to the administration of medication.

The January 2017 MAR documented, " "Hydrocodone - Acetaminophen 5 mg - 325 mg tablet; give 1 tablet orally every 8 hours as needed for pain level 1 -10." The MAR documented the resident received the medication on the following dates and times:
1/1/17 at 4:24 a.m. and 10:40 p.m.
1/4/17 at 4:00 a.m.
1/8/17 at 12:46 p.m.
1/12/17 at 2:39 a.m.
1/13/17 at 2:03 a.m. and 1:17 p.m.

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1/25/17 at 8:39 a.m.

The January MAR documented, "Document Pain level Q (every) shift using a scale of 1 -10 every shift." The documented pain assessment for the following dates and shift was documented as zero, no pain:
1/1/17 - evening shift (3:00 p.m. - 11:00 p.m.)
1/4/17 - night shift (11:00 p.m. - 7:00 a.m.)
1/12/17 - night shift
1/13/17 - night shift
1/25/17 - day shift (7:00 a.m. - 3:00 p.m.)

The nurse's notes dated, 1/1/17 at 4:56 a.m., 1/1/17 at 11:12 p.m. 1/4/17 at 5:05 a.m., 1/8/17 at 1:43 p.m.,1/12/17 at 3:34 a.m. 1/13/17 at 2:18 a.m., 1/25/17 at 9:19 a.m., documented, "Administration Note: Hydrocodone - Acetaminophen 5 mg - 325 mg tablet. PRN administration was: Effective." There was no documentation of the location, intensity and non-pharmacological interventions attempted prior to the administration of medication.

The nurse's note dated, 1/13/17 at 1:53 p.m. documented, "Administration Note: Hydrocodone - Acetaminophen 5 mg - 325 mg tablet. PRN administration was: Effective. Resident stated bilateral legs bothering him today." There was no documentation of non-pharmacological interventions attempted prior the administration of medication.

Observation was made of Resident #6 on 1/25/17 at 8:08 a.m. in bed. His heels were resting directly on the surface of the mattress. When asked how he was feeling this morning, Resident #6 stated, "My heels hurt really bad." LPN

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(licensed practical nurse) #16, Resident #6's nurse, on 1/25/17, was alerted to the resident's complaint. LPN #16 then medicated Resident #6 for pain at 8:39 a.m.

An interview was conducted with LPN #16, Resident #6's nurse, on 1/25/17 at 10:25 a.m., regarding the process staff follows when a resident complains of pain. LPN #16 stated, "I ask them what level of pain it is, where it hurts and then give them a pain pill." When asked if she offers any non-medication interventions, LPN #16 stated, "Not routinely." When asked if she assessed Resident #6's heels when he complained of pain this morning, LPN #6 stated, "No." LPN #16 was asked if that was part of assessing a resident for pain. LPN #16 stated, "I guess so." When asked the purpose of the care plan, LPN #16 stated, "It's the different interventions of what to do to care for a resident."
An interview was conducted with administrative staff member (ASM) #2, the director of nursing; on 1/25/17 at 10:47 a.m. ASM #2 was asked about the process staff follows for a resident complaining of pain. ASM #2 stated, "First the nurse should assess the resident, ask the pain scale, and the location of the pain. They should offer non-pharmacological interventions first, such as repositioning, snack or back rub. Then if that doesn't help, we check the physician's orders and give a pain medication per the orders, if no order, contact the nurse practitioner or physician and get an order." ASM #2 was asked where staff documents the resident's complaint of pain, assessment of pain, location, intensity and the non-pharmacological interventions provided. ASM #2 stated, "That should all be in the nurse's notes." When asked the purpose of the care plan, ASM #2 stated, "It's how we base our care for

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each resident." When asked if the staff should be following the care plan, ASM #2 stated, "Yes."

An interview was conducted with Resident #6 on 1/25/17 at 12:48 p.m. Resident #6 was asked if the nurses ask him a pain scale when he complains of pain, the resident stated they did. When asked if they offered to reposition him or offer a back rub when he complains of pain, Resident #6 stated, "No."

The resident was observed self-propelling in the hallway on 1/25/17 at 1:58 p.m., and was interviewed at this time. Resident #6 was asked if the nurses come back after they've given him a pain pill to see if it helps. Resident #6 stated, "No, my feet are still hurting me from this morning." The resident proceeded up the hall to talk to the nurse. The nurse documented on 1/25/17 at 9:19 a.m. that the medication was effective.

The administrator and ASM #2 were made aware of the above concerns on 1/25/17 at 5:30 p.m. No further information was provided prior to exit.
(1)This information was taken from the following website:
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010590/

3. The facility staff failed to follow the comprehensive plan of care for applying a glove to prevent edema and arm splint to Resident #5's right arm.

Resident #5 was admitted to the facility on 12/15/16 with diagnoses including, but not limited

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to: history of a stroke, dementia with behaviors, difficulty swallowing, high blood pressure, and diabetes. On the most recent MDS (minimum data set), a 30-day Medicare assessment with an assessment reference date of 1/12/17, Resident #5 was coded as being severely cognitively impaired for making daily decisions.

On the following dates and times, Resident #5 was observed without a glove to prevent edema (swelling) and a splint on her right arm: 1/24/17 at 11:55 a.m. and 4:55 p.m.; 1/25/17 at 8:35 a.m., 9:30 a.m., 11:15 a.m., 12:20 p.m., and 1:30 p.m.

A review of the physician's orders for Resident #5 revealed the following order written and signed by the physician on 1/18/17: "Place edema glove and splint on right arm in am (morning) and off at hs (evening). Monitor skin and for circulation while glove and splint on every day and evening shift."

A review of Resident #5's comprehensive care plan dated 12/15/16 and updated 1/19/17 revealed, in part, the following: "Resident has an edema glove and splint for right arm, use as ordered."

On 1/25/17 at 1:45 p.m. at 1:45 p.m., CNA (certified nursing assistant) #5 and LPN (licensed practical nurse) #13 accompanied the surveyor to Resident #5's bedside. Both staff members were asked if they were aware of anything Resident #5 should have had on her right arm. CNA #5 stated: "I don't know. I don't know she's supposed to have anything." LPN #13 stated: "I know she's supposed to have something. A glove, maybe, I'm not sure why it's not on."

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On 1/25/17 at 1:50 p.m., LPN #14 was interviewed. She stated she was working as the treatment nurse on the unit. LPN #14 stated she noticed that Resident # 5 was not wearing her glove or splint. When asked if she investigated this or notified anyone about it, LPN #14 stated: "To be honest, I did not."

On 1/27/17 at 1:55 p.m., OSM (other staff member) #8, the speech therapist, was interviewed. When asked if she had worked with Resident #5 on 1/25/17, OSM #8 stated: "Yes, just a little while ago." When asked if she was aware of anything Resident #5 was supposed to be wearing on her right arm, OSM #8 stated: "I know she is supposed to have a glove." When asked if Resident #5 had been wearing the glove, OSM #8 stated: "No, she didn't." OSM #8 stated: "I asked one of the aides about it. They told me someone else was responsible for putting the glove on." OSM #8 stated she was not aware that Resident #5 was also ordered to wear a splint on her right arm."

On 1/25/17 at 4:20 p.m., LPN #5 was interviewed. When asked who is ultimately responsible for implementing a resident's care plan, LPN #5 stated: "The nurse. I am." When asked the process she follows for implementing a care plan, LPN #5 stated: "We have the care plan in the computer. I can always check the care plan against the orders."

On 1/25/17 at 5:15 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.

A review of the facility policy entitled "Care Plan"

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F 282	Continued From page 69 revealed, in part, the following: "The care plan will serve as a guide for all staff in delivery of care and services to meet the needs of each patient/resident and in helping achieve the highest level of practicable well being." No further information was provided prior to exit.	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical	F 309	F-309 1. Corrective action has been accomplished for the alleged deficient practice in regards to Residents #6, #4, and #5. Resident #6's heels were floated on 1/25/17, nurse was educated on 1/25/17 on attempting non-pharmacological methods before medicating resident for pain. Resident #4's intake and output has been discontinued. On 1/26/17, the glove and splint was placed on Resident #5. 2. Current facility residents have the potential to be affected by the alleged deficient practice. The Director of Nursing and/or nursing administration team educated all licensed nursing staff on the importance of reviewing and following physician's orders. 3. Measures put into place to assure alleged deficient practice does not recur include: The Director of Nursing and/or nursing administration team will audit 10 residents per week for 4 weeks and 15 residents per month for 3 months to ensure physician's orders are being followed. A random sample of residents will be audited quarterly thereafter to ensure continued compliance. 4. The Director of Nursing and/or designee will analyze audits/reviews for patterns/trends and report in the Quality Assurance Committee meeting quarterly for six months to evaluate the effectiveness of the plan, and will adjust the plan as the committee may recommend, based on outcomes/trends identified from trend data. 5. Completion Date: 3/3/17	

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record review, it was determined that the facility staff failed to maintain the highest level of well-being for three of 27 residents in the survey sample, Residents #6, #4, and #5.

1. For Resident #6, the facility staff failed to document the location and intensity of pain, offer non-pharmacological interventions prior to the administration of pain medication and follow up with the resident for the medication effectiveness.

2. The facility staff failed to follow a physician's order to obtain and document Resident #4's intake and output every shift.

3. The facility staff failed to apply a glove to prevent swelling and an arm splint as ordered by the physician for Resident #5.

The findings include:

1. Resident #6 was admitted to the facility on 11/4/11 with a recent readmission on 11/22/16, with diagnoses that included but were not limited to: cough repeated falls, spinal stenosis, high blood pressure, peripheral vascular disease (any abnormal condition affecting blood vessels outside the heart (1)), neuropathy (any abnormal condition of the peripheral nerves (2)), benign prostatic hypertrophy (enlargement of the prostate (3)) and gout.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 10/20/16, coded the resident as scoring a 15 on his BIMS (brief interview for mental status) score, indicating that he was capable of making daily cognitive decisions. The resident was coded as requiring

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extensive assistance of one or more staff members for most of his activities of daily living. He was coded as requiring supervision after set up assistance for moving on and off the unit and eating. In Section J - Health Conditions, the resident was coded as receiving scheduled and PRN (as needed) pain medication. It was coded, during the resident interview for pain that the resident had pain almost constantly and the pain was rated as a "5" on a pain scale of zero to ten, ten being the worse pain he was ever in.

The physician orders dated, 10/03/16, documented, "Hydrocodone - Acetaminophen (used to treat moderate to severely moderate pain (4)) 5 mg (milligrams) - 325 mg tablet. Give 1 tablet orally every 8 hours as needed for pain level 1 -10."

The "Pain Assessment Quarterly/Annual" dated, 1/11/17, documented in part:
A. Pain Presence: Yes was documented.
B. Pain Frequency: Occasionally was documented.
C. Pain effect on function: Over the past 5 days, has pain made it hard for you to sleep at night? No was documented. Over the past 5 days, have you limited your day-to day activities because of pain? No was documented.
D. Pain Intensity: Pain intensity scale 1 -10: a 9 was documented. Verbal pain descriptor code: very severe, horrible was documented.
E. Staff assessment for pain: A check mark was documented next to "vocal complaints of pain (that hurts, ouch, stop). Frequency with which resident complains/shows evidence of pain/possible pain. Observed 1-2 days was documented.
F. Pain Management: Is resident on a scheduled

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pain medication regimen? No was documented. Received PRN medications? Yes was documented. List medications, dose, frequency, side effects and effectiveness: Hydrocodone-Acetaminophen (used to treat moderate to moderately severe pain) 5 mg - 325 mg tablet; give 1 tablet orally every 8 hours as needed for pain level 1 -10. Received non-medication interventions for pain? Yes was documented. Describe interventions: a check mark was documented next to, repositioning and diversional activities.
G. Assessing complaints of pain: Where is the pain? "Bilateral lower extremities and back." When does pain occur? "Mostly in early AM (morning) upon wake up." Does anything make it better? "Stretching, getting OOB (out of bed) into chair." Does anything make it worse? "Remaining in bed."

The comprehensive care plan dated, 5/11/16 and review on 11/11/16, documented, "Problem: Pain Management - Alteration in comfort - pain related to (peripheral neuropathy and chronic pain and gout pain - bilateral knee pain at times." The "Interventions" documented in part, "On-going assessment of the resident's pain with emphasis on the onset, location, description, intensity of pain and alleviating and aggravation factors. Administer medications as ordered by MD (medical doctor)."

The medication administration record (MAR) for December 2016 documented, "Hydrocodone - Acetaminophen 5 mg - 325 mg tablet; give 1 tablet orally every 8 hours as needed for pain level 1 -10." The MAR documented the resident received the medication on the following dates and times:

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12/5/16 at 2:42 a.m. and 11:12 a.m.
12/11/16 at 12:35 p.m.
12/15/16 at 9:01 p.m.
1216/16 at 6:19 p.m.
12/19/16 at 9:56 p.m.
12/20/16 at 2:41 p.m.
12/29/16 at 10:49 p.m.
12/30/16 at 11:13 a.m. and 9:49 p.m.

The December MAR documented, "Document Pain level Q (every) shift using a scale of 1 -10 every shift." The documented pain assessment for the dates and shifts that the medication was administered above were all documented as having "0" pain.

The nurse's notes were reviewed. The nurse's note dated, 12/5/16 at 3:50 a.m., 12/5/16 at 12:19 p.m., 12/11/16 at 1:36 p.m.,12/15/16 at 10:43 p.m., 12/16/16 at 7:00 p.m., 12/19/16 at 10:39 p.m., 12/20/16 at 5:19 p.m.,12/29/16 at 11:10 p.m., 12/30/16 at 12:51 p.m. and 10:12 p.m., documented, "Administration Note: Hydrocodone - Acetaminophen 5 mg - 325 mg tablet. PRN administration was: Effective." There was no documentation of the location, intensity and non-pharmacological interventions attempted prior to the administration of medication.

The January 2017 MAR documented, "Hydrocodone - Acetaminophen 5 mg - 325 mg tablet; give 1 tablet orally every 8 hours as needed for pain level 1 -10." The MAR documented the resident received the medication on the following dates and times:
1/1/17 at 4:24 a.m. and 10:40 p.m.
1/4/17 at 4:00 a.m.
1/8/17 at 12:46 p.m.
1/12/17 at 2:39 a.m.

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1/13/17 at 2:03 a.m. and 1:17 p.m.
1/25/17 at 8:39 a.m.

The January MAR documented, "Document Pain level Q (every) shift using a scale of 1 -10 every shift." The documented pain assessment for the following dates and shift was documented as zero, no pain:
1/1/17 - evening shift (3:00 p.m. - 11:00 p.m.)
1/4/17 - night shift (11:00 p.m. - 7:00 a.m.)
1/12/17 - night shift
1/13/17 - night shift
1/25/17 - day shift (7:00 a.m. - 3:00 p.m.)

The nurse's notes dated, 1/1/17 at 4:56 a.m., 1/1/17 at 11:12 p.m. 1/4/17 at 5:05 a.m., 1/8/17 at 1:43 p.m.,1/12/17 at 3:34 a.m. 1/13/17 at 2:18 a.m., 1/25/17 at 9:19 a.m., documented, "Administration Note: Hydrocodone - Acetaminophen 5 mg - 325 mg tablet. PRN administration was: Effective." There was no documentation of the location, intensity and non-pharmacological interventions attempted prior to the administration of medication.

The nurse's note dated, 1/13/17 at 1:53 p.m. documented, "Administration Note: Hydrocodone - Acetaminophen 5 mg - 325 mg tablet. PRN administration was: Effective. Resident stated bilateral legs bothering him today." There was no documentation of non-pharmacological interventions attempted prior the administration of medication.

Observation was made of Resident #6 on 1/25/17 at 8:08 a.m. in bed. His heels were resting directly on the surface of the mattress. When asked how he was feeling this morning, Resident

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#6 stated, "My heels hurt really bad." LPN (licensed practical nurse) #16, Resident #6's nurse, on 1/25/17, was alerted to the resident's complaint. LPN #16 then medicated the resident for pain at 8:39 a.m.

An interview was conducted with LPN #16, Resident #6's nurse, on 1/25/17 at 10:25 a.m., regarding the process staff follows when a resident complains of pain. LPN #16 stated, "I ask them what level of pain it is, where it hurts and then give them a pain pill." When asked if she offers any non-medication interventions, LPN #16 stated, "Not routinely." When asked if she assessed Resident #6's heels when he complained of pain this morning, LPN #6 stated, "No." LPN #16 was asked if that was part of assessing a resident for pain. LPN #16 stated, "I guess so."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing; on 1/25/17 at 10:47 a.m. ASM #2 was asked about the process staff follows for a resident complaining of pain. ASM #2 stated, "First the nurse should assess the resident, ask the pain scale, and the location of the pain. They should offer non-pharmacological interventions first, such as repositioning, snack or back rub. Then if that doesn't help, we check the physician's orders and give a pain medication per the orders, if no order, contact the nurse practitioner or physician and get an order." ASM #2 was asked where staff documents the resident's complaint of pain, assessment of pain, location, intensity and the non-pharmacological interventions provided. ASM #2 stated, "That should all be in the nurse's notes."

An interview was conducted with Resident #6 on

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1/25/17 at 12:48 p.m. Resident #6 was asked if the nurses ask him a pain scale when he complains of pain, the resident stated they did. When asked if they offered to reposition him or offer a back rub when he complains of pain, Resident #6 stated, "No."

The resident was observed self-propelling in the hallway on 1/25/17 at 1:58 p.m., and was interviewed at this time. Resident #6 was asked if the nurses come back after they've given him a pain pill to see if it helps. Resident #6 stated, "No, my feet are still hurting me from this morning." The resident proceeded up the hall to talk to the nurse. The nurse documented on 1/25/17 at 9:19 a.m. that the medication was effective.

The facility policy, "Policy for Pain Assessments" documented, "Policy: To assist residents to attain his/her highest practicable level of well-being and quality of life, (Name of facility) will recognize when a resident has or has the potential to experience pain. Procedure: 1. A comprehensive pain assessment will be completed on admission, readmission, quarterly and with any significant change that may impact pain status. 2. A numbered scale to describe pain will be used for the resident that can effectively articulate by verbal means; "0" being no pain and "10" being unbearable pain. IN addition the resident will be asked the intensity, location, duration, variation and quality of the pain level experienced. This will be documented on the MAR. 3. If a resident is unable to articulate his or her pain level verbally or otherwise, staff will assess resident pain level through the Pain Assessment in Advanced Dementia Scale. This will be documented on the MAR. 4. Upon assessment of lain level an

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appropriate pain management program will be implemented. The care plan will be updated to reflect the pain management program."

Fundamentals of Nursing, 6th Edition, Potter and Perry, 2005, pages 1239-1287, "Nurses need to approach pain management systematically to understand a client's pain and to provide appropriate intervention....it is necessary to monitor pain on a consistent basis....Assessment of common characteristics of pain helps the nurse form an understanding of the type of pain, its pattern, and types of interventions that may bring relief....Onset and duration....Location....Intensity....Quality....Pain Pattern....Relief Measures....Contributing Symptoms....Pain therapy requires an individualized approach....Nurses administer and monitor interventions ordered by physicians for pain relief and independently use pain-relief measures that complement those prescribed by a physician....Effective communication of a client's assessment of pain and his or her response to intervention is facilitated by accurate and thorough documentation. This communication needs to transpire from nurse to nurse, shift to shift, and nurse to other health care providers. It is the professional responsibility of the nurse caring for the client to report what has been effective for managing the client's pain. The client is not responsible for ensuring that this information is accurately transmitted. A variety of tools such as a pain flow sheet or diary will help centralize the information about pain management.

The administrator and ASM #2 were made aware of the above concerns on 1/25/17 at 5:30 p.m. No further information was provided prior to exit.

(1) Barron's Medical Dictionary for the

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Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 447.
(2) Barron's Medical Dictionary for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 402
(3) Barron's Medical Dictionary for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 282.
(4) This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010590/

2. The facility staff failed to follow a physician's order to obtain and document Resident #4's intake and output every shift.

Resident #4 was admitted to the facility on 7/6/16 with a readmission on 10/1/16 with diagnoses that included, but were not limited to, hip fracture, hyperlipidemia (elevated lipid levels in the blood stream), dysphagia (difficulty with swallowing), hypothyroidism (low functioning thyroid) and dementia.

Resident #4's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 10/5/16. Resident #4 was coded on the MDS as having a BIMs (Brief Interview for Mental Status) score of 6 out of 15. The MDS manual documents that a score of 6 indicates that the resident's cognition is severely impaired.

A review of Resident #4's clinical record revealed, in part, the following physician's order, "Order Date: 1/2/17 0855 (8:55 a.m.) Communication

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Method: Verbal. Ordered By: (name of physician). Description: Intake and Output. Frequency: every shift. Schedule Type: Everyday."

Further review of Resident #4's clinical record revealed, in part, a TAR (treatment administration record) for January 2017. The January TAR contained columns for each day in the month of January, and a space for three shifts on each day to document Resident #4's intake and output. The following dates and shifts were blank; 1/4/17 night shift, 1/6/17 day shift, 1/7/17 and 1/8/17 night shift, 1/12/17 night shift, 1/13/17 day shift and evening shift, 1/15/17 and 1/16/17 day shift, 1/18/17 and 1/19/17 night shift.

On 1/25/17 at 11:45 a.m. an interview was conducted with LPN (licensed practical nurse) #11, a unit manager. LPN #11 was asked to describe the process when there was an order for intake and output. LPN #11 stated that the nurse was to document the resident's total fluid intake and document the resident's total fluid output. LPN #11 was asked where the intake and output was documented; LPN #11 stated that it was documented in the TAR. LPN #11 was asked whether or not there should be blank spots on the TAR for intake and output. LPN #11 stated, "There should not be blank spots. This means that it was not charted or there was no input or output for the shift. If there was no input or output then there should be a notation in the blank areas and a note in the progress notes." LPN #11 was shown Resident #4's TAR and was asked about the blank spots for intake and output on the previously noted dates. LPN #11 stated that it was not done.

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On 1/25/17 at 1:00 p.m. an interview was conducted with LPN #2, a unit manager who had worked with Resident #4. LPN #2 was asked to review Resident #4's TAR and explain why there were blank spots for the intake and output. LPN #2 stated that the intake and output had not been completed as ordered on each shift. LPN #2 was asked whether or not the intake and output was to have been obtained on each shift and documented at each shift. LPN #2 stated that it should have been done and it did not appear that it had been done.

A review of Resident #4's comprehensive care plan dated 7/6/16 revealed, in part, the following documentation; "Problem: The resident has an indwelling Foley r/t (related to) urinary retention. Date initiated: 10/13/20106. Interventions/Tasks: Monitor and document intake and output as per facility policy. Date initiated: 10/13/2016."

A review of the facility policy titled, "Policy and procedure relating to intake and output" revealed, in part, the following documentation, "Standard: Intake and output is monitored accurately to insure optimal hydration levels of certain residents and to assist in their assessment and management by using the Intake and Output Record. 1. Record all p.o. (by mouth) fluids in proper column as soon as possible to maintain accuracy. 2. If resident does not take any p.o. fluids during a given shift, write zero in the shift total column. 4. Use a urinal or graduate to measure outputs from Indwelling catheters to insure accuracy."

On 1/25/17 at 5:10 p.m. an end of day meeting was held with ASM (administrative staff member) #1, the administrator and ASM #2, the director of

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nursing. ASM #1 and ASM #2 were made aware of the above referenced concerns. A policy was requested regarding the completion of physician orders.

On 1/26/17 at approximately 9:00 a.m. ASM #2 stated that they did not have a policy that addressed following the physician orders.

No further information was provided prior to the end of the survey process.

3. Resident #5 was admitted to the facility on 12/15/16 with diagnoses including, but not limited to: history of a stroke, dementia with behaviors, difficulty swallowing, high blood pressure, and diabetes. On the most recent MDS (minimum data set), a 30-day Medicare assessment with assessment reference date 1/12/17, Resident #5 was coded as being severely cognitively impaired for making daily decisions.

On the following dates and times, Resident #5 was observed without a glove to prevent edema (swelling) and a splint on her right arm: 1/24/17 at 11:55 a.m. and 4:55 p.m.; 1/25/17 at 8:35 a.m., 9:30 a.m., 11:15 a.m., 12:20 p.m., and 1:30 p.m.

A review of the physician's orders for Resident #5 revealed the following order written and signed by the physician on 1/18/17: "Place edema glove and splint on right arm in am (morning) and off at hs (evening). Monitor skin and for circulation while glove and splint on every day and evening shift."

A review of Resident #5's comprehensive care plan dated 12/15/16 and updated 1/19/17

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revealed, in part, the following: "Resident has an edema glove and splint for right arm, use as ordered."

On 1/25/17 at 1:45 p.m. at 1:45 p.m., CNA (certified nursing assistant) #5 and LPN (licensed practical nurse) #13 accompanied the surveyor to Resident #5's bedside. Both staff members were asked if they were aware of anything Resident #5 should have had on her right arm. CNA #5 stated: "I don't know. I don't know she's supposed to have anything." LPN #13 stated: "I know she's supposed to have something. A glove, maybe, I'm not sure why it's not on."

On 1/25/17 at 1:50 p.m., LPN #14 was interviewed. She stated she was working as the treatment nurse on the unit. LPN #14 stated she noticed that Resident # 5 was not wearing her glove or splint. When asked if she investigated this or notified anyone about it, LPN #14 stated: "To be honest, I did not."

On 1/27/17 at 1:55 p.m., OSM (other staff member) #8, the speech therapist, was interviewed. When asked if she had worked with Resident #5 on 1/25/17, OSM #8 stated: "Yes, just a little while ago." When asked if she was aware of anything Resident #5 was supposed to be wearing on her right arm, OSM #8 stated: "I know she is supposed to have a glove." When asked if Resident #5 had been wearing the glove, OSM #8 stated: "No, she didn't." OSM #8 stated: "I asked one of the aides about it. They told me someone else was responsible for putting the glove on." OSM #8 stated she was not aware that Resident #5 was also ordered to wear a splint on her right arm."

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F 309	Continued From page 83 On 1/25/17 at 4:20 p.m., LPN #5 was interviewed. When asked who is ultimately responsible for implementing a resident's care plan, LPN #5 stated: "The nurse. I am." When asked the process she follows for implementing a care plan, LPN #5 stated: "We have the care plan in the computer. I can always check the care plan against the orders." On 1/25/17 at 5:15 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. Policies regarding following physician orders were requested. On 1/26/17 at 8:15 a.m., ASM #2 informed the survey team that there were no policies specific to following physician's orders. No further information was provided prior to exit. In Fundamentals of Nursing, 6th edition, 2005, Patricia A. Potter and Anne Griffin Perry, Mosby, Inc; Page 419: "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."	F 309		
F 319 SS=D	483.40(b)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES (b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being	F 319	F- 319 1. Corrective action has been accomplished for the alleged deficient practice in regards to Residents #1 and #7. On 1/26/17 the Social Worker was educated on the suicide prevention policy. On 1/26/17, a clarification order was obtained from the psychiatrist for Resident #7's antipsychotic medication, and resident's POA was notified.	

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F 319	Continued From page 84 (as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide treatment and services for psychosocial difficulties for two of 27 residents in the survey sample, Resident #1 and #7. 1. The facility staff failed to notify the psychiatrist of Resident #1's verbalized statement regarding having thoughts of self-harm and failed to provide necessary psychological care and services after this was reported to the social worker on 11/10/16. 2. The facility staff failed to reduce an antipsychotic medication for Resident #7 as ordered by the psychiatrist. The findings include: 1. Resident #1 was admitted to the facility on 5/4/14 and readmitted on 5/13/16 with diagnoses that included but were not limited to mood disorder, high blood pressure, chronic kidney disease (stage 3), atrial fibrillation, stroke, and COPD (chronic obstructive pulmonary disease). Resident #1's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/9/16. Resident #1 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #1 was coded as requiring extensive assistance from staff with most ADLS (activities of daily living) including transfers, locomotion, toileting, and personal hygiene; total dependence on staff with bathing, and independent with meals.	F 319	**2.** Current facility residents have the potential to be affected by the alleged deficient practice. The Director of Nursing and/or nursing administration team completed 100% audit of all resident orders to validate each resident has an order for a psychiatric consult as needed. **3.** Measures put into place to ensure the alleged deficient practice does not recur include: The Director of Nursing and/or nursing administration team began re-in-service education for licensed nursing staff regarding suicide prevention policy, following physician orders, and notifying the psychiatrist of any resident who expresses thoughts of self-harm. The Quality Assurance nurse and/or designee will review all psychiatrist's notes received, checking for any new orders; entering new orders; notifying POAs; and, notifying unit managers of any changes. The Director of Nursing and/or nursing administration team will audit 4 residents per week for 4 weeks then 10 residents per month for 3 months, then random quarterly audits thereafter to ensure continued compliance. **4.** The Director of Nursing and/or designee will analyze reviews/observations for patterns/trends and report in the Quality Assurance Committee quarterly for six months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. **5.** Completion Date: 3/3/17	

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Section D (Mood) of the 11/9/16 quarterly MDS assessment documented the following for Resident #1: "Say to the Resident: "Over the last 2 weeks, have you been bothered by any of the following problems? ...I. Thoughts that you would be better off dead, or of hurting yourself in some way." A "1" was documented under "Symptom Presence" indicating "Yes." A "0" (zero) was documented under "Symptom Frequency" indicating the resident never had these thoughts or had these thoughts for one day.

Review of the clinical record revealed the following social services note dated 11/10/16, "This worker went in to talk to see how she (Resident #1) is doing. Resident was sad. We talked about different things. This worker asked resident if she had a thought of hurting herself and resident said yes but she has no plan. Resident says she wants a medication for her depression during the day that would help her. Resident takes Wellbutrin [1] 150 mg (milligrams) per day. Resident is seen by (Name of Psychiatrist). Resident said she is interested in talking one on one with a counselor. Resident would feel better if her daughter would visit her. Resident says her daughter called the other day and said she will come to see her but did not say when. Resident talked about doing exercises in the restorative program. This worker told the nurse on duty all of the above information. This information will be given to the clinical Nurse who works with (Name of Psychiatrist)."

The next note dated 11/11/16 from the social worker documented the following:
"Quarterly review. Resident is alert and oriented X3. Resident is compliant with her care. Resident has a diagnosis of Depression. Resident is seen by (Name of Psychiatrist). For this review, this worker talked with resident to see how she was

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doing. Resident had some sadness. Resident was sad because her daughter has not been in to see her. This worker asked resident if she had a thought of hurting herself and resident said yes but she has no plan. It would make her feel better if her daughter visited her. Resident says her daughter called the other day and said she will come to see her but did not say when. Resident said she is interested in meeting with a Counselor one on one. The above information was told to the Nurse on duty after this conversation on 11-10-16. The above information was given to the clinical nurse who works with (Name of Psychiatrist)."
No other notes or assessments could be found regarding the above situation. There was no evidence that the Medical doctor, Psychiatrist or clinical nurse were made aware of the above events. There was no evidence that facility staff provided necessary psychological care and services after this was reported to the social worker on 11/10/16.
Review of the Resident #1's clinical record revealed that the Psychiatrist had visited Resident #1 on 12/14/16 (over one month after the reported thoughts of self-harm) for a routine visit. The psychiatrist's note did not address the thoughts of self-harm reported on 11/10/16. The following was documented, "...This is an 81 year old Caucasian female who appears of her stated age. She was sitting in a chair I (Sic.) her room and a normal posture. She was cooperative, easily engage able and made poor eye contact during the interview. She was dressed in casual attire and her grooming and hygiene were fair. No evidence of aggression or agitation. Her speech was spontaneous with normal rate, volume and tone. She described her mood was "Depressed and her affect was tearful and

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dysphoric. Thought process was linear and goal directed. She denied and demonstrated no evidence if suicidal, homicidal or psychotic ideation. She was alert and oriented to herself and place ...PLAN: I woul (sic) add Risperdal [2] 0.25 mg at bedtime for mood disorder and discontinue Nuedexta [3] as it does not seem to be beneficial at this time ..."

On 1/25/17 at 9:22 a.m., an interview was conducted with OSM (Other Staff Member) #9, the social worker. When asked about the process staff follows when a resident reports thoughts of self harm, OSM #9 stated that she would speak with the resident to see if they had a plan of self-harm. OSM #9 stated she would also report this to the nurse manager or nurse on shift. OSM #9 stated that if the resident was not already seeing the psychiatrist, she would have the psychiatrist evaluate the resident. OSM #9 stated that if the resident was already under the care of the psychiatrist, she would have the psychiatrist come in for an as needed visit. OSM #9 stated that Resident #1 is often tearful, and has a diagnosis of depression. When OSM #9 was asked if she could recall when Resident #1 reported thoughts of self harm, OSM #9 stated, "It's been awhile back. I think I told the nurse on duty, [name of nurse (LPN -- licensed practical nurse-- #17) 7-3 (7:00 a.m. to 3:00 p.m.) shift, and (name of nurse (LPN #1)." OSM #9 stated that LPN #1 worked directly with the Psychiatrist, and made rounds with him. When asked how often the psychiatrist visited the facility, OSM #9 stated, "Once a week." When asked who was responsible for notifying the responsible party, medical doctor or psychiatrist when there are reports of verbalizations regarding self harm from a resident, OSM #9 stated that the nurses were responsible. OSM #9 stated, "I am not sure if the

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nurses notified the RP (responsible party) or doctor. I don't think I did. I personally didn't make the (name of psychiatrist) aware. I don't know if (Name of LPN #1) did. You would have to ask her."

On 1/25/17 at 9:35 a.m., an interview was conducted with LPN (licensed practical) #1, the clinical nurse. LPN #1 was asked about her role when following the psychiatrist. LPN #1 stated that she takes notes during rounding and writes orders when the psychiatrist recommends certain medications, and monitoring etc. When asked how often the psychiatrist visits the facility, LPN #1 stated that he comes in every week, unless he is on vacation. LPN #1 was asked about the process staff is to follow if a resident reports thoughts of self harm to the social worker. LPN #1 stated that if a resident was already under psychiatric services then (Name of Psychiatrist) would follow up that week with the resident on a prn (as needed) basis or a psychological evaluation would be requested if the resident was not receiving psychological services. LPN #1 stated that she would notify (Name of psychiatrist). When asked who was responsible for notifying the responsible party, LPN #1 stated that if the thoughts of self-harm were reported to the social worker, than the social worker should be notifying the RP. LPN #1 stated that facility staff usually could not get a hold of Resident #1's RP. When asked if she could recall when Resident #1 reported thoughts of self-harm to the social worker, LPN #1 stated, "I can't remember." LPN #1 stated that if Resident #1 reported thoughts of self harm and the psychiatrist was made aware, there should have been a progress summary from when the psychiatrist came to visit on a prn basis. LPN #1 stated, "Let me see if I

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can find that." When asked if she could recall if the responsible party was made aware, LPN #1 stated, "No, not if the social worker didn't document."

On 1/25/17 at 10:45 p.m., LPN #1 stated, "He (Psychiatrist) did not see her until December." When asked if he was made aware of Resident #1's reports of self harm, LPN #1 stated, "I don't know because I'm not sure if I was even made aware."

On 1/25/17 at 2:13 p.m., an interview was conducted with ASM (administrative staff member) #4, the Psychiatrist. ASM #4 stated that he would expect nursing staff to contact him when a resident reports any thoughts of self harm or suicide. ASM #4 stated that LPN #1 usually prompts him. ASM #4 stated that if it is reported to him that a resident has thoughts of self-harm, he would visit with that resident that week. ASM #4 stated that he did not recall Resident #1 reporting any thoughts of self-harm. ASM #4 did not recall being notified.

On 1/25/17 at 4:08 p.m., an interview was conducted with LPN #17, the nurse the social worker stated that she reported Resident #1's thoughts of self-harm to. LPN #17 was asked about the process followed when it is reported to her that a resident has thoughts of self-harm. LPN #17 stated that she would sit down and talk with the resident to figure out the cause of these thoughts, review current medications, request family come in, and continue to monitor. LPN #17 stated that she would also check the room for any objects that could inflict harm. LPN #17 stated that she would call the doctor, supervisor, and notify the family or any close relatives. LPN

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#17 stated that she would also follow up with (Name of Psychiatrist). LPN #17 stated she remembered hearing about the above events, but she was not the nurse that this was reported to. LPN #17 stated she could not recall the nurse on duty that day who was assigned to Resident #1.

On 1/25/17 at 5:25 p.m., an interview was conducted with ASM #2, the DON (Director of Nursing). ASM #2 stated that he would expect nursing staff to assess and interview the resident for a plan of self-harm; and notify himself, the administrator, MD (medical doctor) or NP (nurse practitioner) on call. ASM #2 stated that if nursing staff felt that the resident was at risk for self-harm, they would need to be monitored or sent to the hospital for a psychological evaluation, depending on the severity of the situation. ASM #2 stated that he may recall an incident with Resident #1. ASM #2 stated, "I'll look into that and provide information tomorrow."

On 1/26/17 at 8:45 a.m., an interview was conducted with ASM #1, the administrator. ASM #1 stated that she would expect nursing to notify the responsible party, physician, psychiatrist and administration if a resident reports any thoughts of self-harm. She could not recall the above events. ASM 1 stated, "We are going to look into it."

On 1/26/17 at 9:04 a.m. and 9:26 a.m., an interview was attempted with ASM #3, the primary physician. He could not be reached for an interview.

On 1/26/17 at 10:11 a.m., an interview was conducted with LPN #16, a nurse who worked on 10/11/16 7-3 shift. She could not recall the above events.

On 1/26/17 at 10:25 a.m., an interview was

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attempted with LPN #19, a nurse who worked on 10/11/16 7-3 shift. She could not be reached.
On 1/25/17 at 4:25 p.m., ASM #1, the administrator and ASM#2, the DON (Director of Nursing) were made aware of the above concerns.
Review of facility policy titled, "Suicide prevention policy" documents in part, the following: "
PURPOSE: The primary purpose of the suicide prevention policy is to identify resident who are depressed and who are at risk and then to take measures to assist the resident and prevent any injury. IDENTIFYING FACTORS OF THOSE AT High RISK: 1. The elderly. 2. Loss of a loved one. 3. Young adults especially males enduring unusual stress or loss. 4. Losses such as, unemployment, the newly divorced, living alone. 5. People who have previously attempted suicide or who have experienced suicide in the family. 6. Psychiatric illness. Symptoms: May include weight loss, sleep disturbance, somatic complaints, suicidal preoccupation ...Intervention: If the staff feels a resident is at risk for suicide the attending physician or POA (power of attorney) should be notified and a psychological consult as needed. 2. If the risk seems to be acute, a recommendation should be made by the facility to admit the resident to an acute psychiatric facility. 3. Care plan will be implemented. 4. Resident will be checked every 30 minutes."
No further information was presented prior to exit.
[1] Wellbutrin-antidepressant, used to treat depression. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009361/?report=details.
[2] Risperdal- antipsychotic used to treat symptoms of schizophrenia, bipolar disorder or irritability associated with autistic disorder. This

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information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012012/?report=details.
[3] Nuedexta- Used to treat uncontrollable laughing or crying. This information was obtained from The National Institutes of Health. <https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009896/?report=details>.

2. The facility staff failed to reduce an antipsychotic medication for Resident #7 as ordered by the psychiatrist.

Resident #7 was admitted to the facility on 7/22/13 with a readmission date of 9/28/16 with diagnoses that included, but were not limited to, dysphagia (difficulty swallowing), communication deficit, dementia, psychosis and Alzheimer's.

Resident #7's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/13/17. Resident #7 was coded on the MDS as having a BIMs (Brief Interview for Mental Status) score of 9 out of 15. The MDS manual documents that a score of 9 indicates that the resident's cognition is moderately impaired. Resident #7 was also coded as having received an antipsychotic medication during the seven day look back period.

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A review of Resident #7's clinical record revealed, in part, a note written by ASM (administrative staff member) #4, the psychiatrist, dated 11/30/16. The psychiatry note revealed, in part, the following documentation, "Problem List: 12/1/16 Dementia in other diseases classified elsewhere without behavioral disturbance. 12/1/16. Unspecified psychosis not due to a substance or known physiological condition. Current Medications: Risperdal (an antipsychotic medication (1)) 0.5 mg (milligrams) at bedtime. Procedure Notes: Decrease Risperdal to 0.25 mg at bedtime and gradually discontinue."

Further review of Resident #7's clinical record revealed, in part, MARs (medication administration records) dated 12/1/16 - 12/31/16 and 1/1/17 - 1/31/17 that documented, in part, the following order to be administered to Resident #7, "Risperdal Tablet 0.5 MG (Risperidone) Give 1 (one) tablet by mouth at bedtime for paranoid. Start Date 10/4/2016. 2100 (9:00 p.m.)." Each box for each day between 12/1/16 and 1/24/17 was checked as administered to Resident #7.

A review of Resident #7's order summary report revealed, in part, the following active order; "Risperdal Tablet 0.5 MG (RisperiDONE) Give 1 (one) tablet by mouth at bedtime for paranoid. Communication method: Phone. Order Status: Active. Order Date: 10/4/2016. Start Date: 10/4/2016."

A review of Resident #7's nursing progress notes did not reveal any entries regarding the psychiatrist visit on 11/30/16.

A review of Resident #7's comprehensive care

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plan dated 7/22/13 revealed, in part, the following documentation, "Goal: The resident will be / remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation / impaction or cognitive / behavioral impairment through review date. Date initiated: 10/24/2016. Target Date: 4/6/2017. Interventions / Tasks: Administer PSYCHOTROPIC medications as ordered by physician. Date initiated: 10/24/2016."

On 1/25/17 at 11:50 a.m. an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked what her role was at the facility, LPN #1 stated, "I do rounds with the psychiatrist when he sees the residents." LPN #1 was asked what did "doing rounds" entail. LPN #1 stated, "I go into the resident rooms with him (the psychiatrist) and he gives me orders, I put those orders into the EMR (electronic medical record) and complete a nurses note and notify the RP (responsible party)." LPN #1 was asked whether or not the primary physician was notified, LPN #1 stated she did not as "they (the facility) just allow the psychiatrist to do whatever he feels is necessary. The nurse practitioner signs off on the psych (psychiatrist) orders when I put them in the system." LPN #1 was asked who receives the psychiatrists' notes following the visits. LPN #1 stated that the psychiatrist would fax over his completed note within a day or two. LPN #1 was asked if the notes ever differed from what the discussion / plan was during the visit. LPN #1 stated, "No, not usually, he tells me the orders at the time he sees them." LPN #1 was shown the psychiatrists note for Resident #7, specifically the "Procedure Notes." LPN #1 stated, "I will have to look in my book for that visit. I write down each

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visit in a note book I keep and write down any orders for each resident." LPN #1 was asked whether or not she reviewed the psychiatrist's notes when he faxed them to the facility and compared them with her notes. LPN #1 stated, "Not all the time, he usually writes down on the back of the resident face sheet what he wants to do and then uses that to write his final note." LPN #1 was asked whether or not the orders discussed during the visit would be likely to change once he wrote his note. LPN #1 stated that it was not likely for his orders to differ from what was discussed and what he wrote in his note. LPN #1 asked to go get her book and review her notes for the psychiatrists' visit on 11/30/16.

On 1/25/17 at 12:10 p.m. LPN #1 brought her note book (not part of the medical record) to this surveyor. LPN #1 stated, "I reviewed the note book and I wrote "no changes" for that visit (11/30/16)." LPN #1 was asked when she received the psychiatrist's final note. LPN #1 stated, "It was signed and dated on 12/1/16 so it was sent to us then. It goes to the medical records person and she gives it to me." LPN #1 was asked whether or not she read the psychiatrists note for Resident #7 when she received it. LPN #1 stated, "I don't read his notes. I look at the last thing documented to see when he wants the follow up appointment. I did not look at the procedure notes. There were no changes made to (name of Resident #7) Risperdal orders." LPN #1 was asked whether or not the procedure notes at the bottom of the psychiatrists' notes were considered orders. LPN #1 stated, "It is a recommendation." LPN #1 was asked whether or not she would/should act on the recommendations. LPN #1 stated that she

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would. LPN #1 was asked if she acted on the "last thing" on the note (the follow up appointment date), LPN #1 stated that she did. LPN #1 was asked whether or not a request for a follow up visit was an order. LPN #1 stated that it was.

On 1/25/17 at 2:05 p.m. an interview was conducted with ASM (administrative staff member) #4, the psychiatrist. ASM #4 was asked to describe his process when visiting the facility to see residents. ASM #4 stated that he would round on the residents to be seen and that LPN #1 would round with him and make notes of any orders / changes that he provided during the rounds. ASM #4 was asked whether or not the orders provided at the time of rounds could change once he was back in his office writing his note. ASM #4 stated, "When I go back to my office I may change the orders after I review everything from the visit and the past history." ASM #4 was asked how those changes would be communicated to the nursing staff at the facility. ASM #4 stated, "(Name of LPN #1) receives my notes and understands that there have been changes." ASM #4 was asked whether his procedure notes were understood as recommendations or orders. ASM #4 stated, "(Name of LPN #1) knows that they are orders and she (LPN #1) should act on them as such." ASM #4 was asked whether or not he was aware that the order to decrease Resident #7's Risperdal had not been followed. ASM #4 stated he was not aware, "I wrote it to be decreased and it should have been done."

On 1/25/17 at 5:10 p.m. an end of day meeting was held with ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware

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F 319	Continued From page 97 of the above referenced concerns. A policy was requested regarding visits by the psychiatrist. On 1/26/17 at approximately 9:00 a.m. ASM #2 provided two facility policies titled "Transcribing Physician Orders" and "Policy for psychiatric consults." Neither policy addressed the process for the psychiatric visit and the completion of the psychiatric orders. No further information was provided prior to the end of the survey process. (1) Risperdal (also known as Risperidone) is used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions) in adults and teenagers 13 years of age and older. This information was obtained from the following website https://medlineplus.gov/druginfo/meds/a694015.html	F 319		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (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	F 323	F-323 1. Corrective action has been accomplished for the alleged deficient practice in regards to Residents #10, and #3. Resident #10's comprehensive care plan has been reviewed and revised and interventions put into place pertaining to falls on 12/6/16, 12/23/16, and 1/8/17. Resident #3's comprehensive care plan has been reviewed and revised and interventions put into place pertaining to a fall on 1/8/17. 2. Current facility residents have the potential to be affected by the alleged deficient practice. Fall reports are being reviewed 5 days per week and care plans are being updated for fall interventions. All licensed staff have been educated on initiating interventions immediately after a fall. Interventions are being reviewed during fall team meeting weekly and readjusted as needed.	

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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 staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure interventions were implemented to prevent accidents after a fall for two of 27 residents in the survey sample, Resident #10 and Resident #3.

1. Facility staff failed to initiate interventions to prevent falls after Resident #10's falls on 12/6/16, 12/23/16 and failed to investigate and initiate interventions following a fall on 1/8/17.

2. The facility staff failed to investigate and initiate interventions for falls after Resident #3 had a fall on 1/8/17.

The findings include:

1. Resident #10 was admitted to the facility on 1/15/16 with diagnoses that included but were not limited to: Parkinson's disease (1), falls, dementia, depression, anxiety and hallucinations.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 12/28/16 coded the resident as

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having a 1 out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as requiring supervision with walking in the corridors and the assistance of one staff member for dressing and toileting. In Section J 1800 titled, "Any Falls Since Admission/Entry or Entry or Reentry or Prior Assessment....Enter Code (there was a 1 in the box) 1. Yes -- Continue to Section J900 Number of Fall Since Admission Entry or Reentry or Prior Assessment ....was documented, "Coding: 0. None; 1. One; 2 Two or more (indicating the number of falls that occurred). A. No injury. 1 (was coded indicating the resident had one fall with no injury). B. Injury (except major) 2 (was coded indicating that two or more falls with injury occurred.)."

Review of Resident #10's nurses notes documented:
12/6/16 at 10:45 a.m. "Resident got up from bed, alarm was sounding. CNA shut alarm off and walked into the bathroom with her. Resident was walking back to the bed when she sat down; she sat down before she reached the bed on to the floor."
12/23/16 at 5:35 a.m. "0500 (5:00 a.m.) CNA reported to this nurse that resident's alarm sounded and when resident (sic) went to room, resident was observed on the floor beside bed."
1/8/17 at 3:31 p.m. "Resident was ambulating in hall of wing and lost balance, restorative aids where (sic) present and tried catching resident, resident slightly fell on floor, no injuries noted."
There was no evidence or documentation of interventions put into place following these falls in the clinical record.

Review of Resident #10's care plan initiated on

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10/19/16 and revised on 10/24/16 did not evidence documentation regarding the above falls.

An interview was conducted on 1/25/17 at 9:15 a.m. with RN (registered nurse) #5, the MDS coordinator. RN #5 was asked when a resident care plan would be updated. RN #5 stated, "Every time there's an assessment (MDS assessment) or a change." When asked who updates the residents care plans, RN #5 stated, "The care plan coordinator." When asked who uses the care plan, RN #5 stated, "It should be all staff." RN #5 was asked why Residents have care plans. RN #5 stated, "To assist with the POC (plan of care), to notify staff of their (the resident's) needs and to give them (the residents), good quality care, to the best of our ability or their ability." When asked how the care plan coordinator would know when to update the care plan, RN #5 stated, "She would update the care plan when we have a care plan meeting." When asked how often the care plan meeting occurred, RN #5 stated, "Weekly." A copy of the fall committee minutes was requested at this time.

An interview was conducted on 1/25/17 at 10:05 a.m. with RN #1, the care plan coordinator. When how she would know to update a resident's care plan, RN #1 stated, "So every morning we do a 24 hour shift report and part of my job is to do any changes and do updates (on the care plans)." When asked when a resident care plan would be updated, RN #1 stated, "Any changes in condition, new medication, behaviors, whatever changes affect the patient so we can stay current." When asked who uses the care plan, RN #1 stated, "The staff has access to them."

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When asked about the importance of a care plan, RN #1 stated, "Care plans are important because it's important to know the condition of the resident to get the best outcomes as possible and quality of life." RN #1was asked about Resident #10's falls and asked if those would be added to the care plan. RN #1 stated, "Yes and no. Her care plan would have been reflective had she had an actual fall. It would not be updated unless there were any injuries. We add any interventions after the fall meeting weekly." When asked to review Resident #10's care plan, RN #1 stated, "You can't tell if there have been any falls since 10/19/16." When asked if it would be important to know that information, RN #1 stated, "Yes, ma'am."

On 1/25/17 at 11:10 a.m. RN #5 provided the falls committee meeting minutes to this surveyor. There were no minutes for the weeks of the 12/6/16, 12/23/16 or 1/8/17 falls. When asked if these were all of the minutes available, RN #5 stated, "Yes."

An interview was conducted on 1/25/17 at 3:40 p.m. with LPN (licensed practical nurse) #11, the unit manager. When asked who used the care plan, LPN #11 stated, "Anybody who provides care." When asked why the residents have a care plan, LPN #11 stated, "So we know how to care for them." When asked when care plans were updated, LPN #11 stated, "After any incident or episode." When asked to review Resident #10's care plan in comparison to the fall dates, LPN #11 stated, "Doesn't look like it's on this one." When asked if there was another care plan, LPN #11 stated, "I don't think so."

On 1/25/17 at 5:25 p.m. ASM (administrative staff

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member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

On 1/26/17 at 8:00 a.m. a request was made to ASM #2 for a copy of Resident #10's fall incident reports.

Review of Resident #10's incident reports dated 12/6/16 and 12/23/16 did not evidence documentation regarding fall interventions. There was no incident report dated 1/8/17.

On 1/26/17 at 10:25 a.m. ASM #2, the director of nursing stated, "We don't have an incident report for the fall on 1/8/17."

Review of the facility's policy titled, "Care Plan" documented, "GUIDELINE The company's guideline is to ensure interdisciplinary care plans (CP) are accurate and reflective of the patient/residents current medical needs. Care plans are to be periodically reviewed for accuracy and updated as needed. PROCEDURE 2. CP will be monitored and reviewed and open to revision as circumstances change, quarterly, annually, and with significant changes. 10. The Care plan will serve as a guide for all staff in delivery in care and services to meet the needs of each patient/resident and in helping achieve the highest level of practicable well being."

No further information was provided prior to exit.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of

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care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..."
(1) Parkinson's disease -- Parkinson's disease (PD) is a type of movement disorder <https://medlineplus.gov/movementdisorders.html>. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine. This information was obtained from: https://medlineplus.gov/parkinsonsdisease.html

2. The facility staff failed to investigate and initiate interventions for falls after the resident had a fall on 1/8/17, for Resident #3.

Resident #3 was admitted to the facility on 10/25/04 with diagnoses that included but were not limited to: intellectually disabled, high blood pressure, dementia, psychosis, anxiety disorder, diabetes, and benign prostatic hypertrophy (enlargement of the prostate (1)).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 11/18/17, coded the resident as severely impaired to make daily cognitive decisions. Resident #3 was coded as requiring extensive assistance of one or more staff members for all of his activities of living except eating in which he was coded as independent after set up assistance was provided. In Section J - Health Conditions, Resident #3 was coded as having had two falls

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during the look back period with no injuries.

The nurse's notes dated, 1/8/17 at 8:12 p.m. documented, "CNA (certified nursing assistant) alerted this nurse around 19:45 (7:45 p.m.) about an abrasion in (sic) resident's back area and also reported that resident almost slid out of his bed earlier this shift. Upon assessment, abrasion found to be 35 cm (centimeters) long, no open area noted. Barrier cream applied to affected area and tolerated well. NP (nurse practitioner) notified and family notified about this. Resident not in any acute distress. No pain offered at this time. Neurological checks for unwitnessed fall started around 19:55 (7:55 p.m.) BP (blood pressure) 100/70 mmHg (millimeters of mercury), Pulse 74 bpm (beats per minute), RR (respiratory rate) 18 rpm (respirations per minute), Temp (temperature) 97.6 F (Fahrenheit), O2 saturation (oxygen) 94% (percent)."

The MD/NP (medical doctor/nurse practitioner) note dated, 1/9/17 at 1:10 p.m. documented, "Staff reported pt (patient) found next to bed over weekend, has superficial abrasion back area. no pain noted. no sob (shortness of breath)...s/p (status post) fall - abrasion back - continue to monitor."

There was no further documentation in the nurse's notes related to the fall.

The comprehensive care plan dated, 10/5/16, and revised on 11/29/16, documented, "Focus: The resident has had an actual fall with no injury. Poor balance, unsteady gait." The "Interventions" were reviewed. The last interventions were dated 11/29/16.

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The facility "Fall Incident Report" dated, 1/8/17, documented in part, "Incident description: CNA alerted this nurse around 19:45 (7:45 p.m.) about an abrasion in (sic) resident's back area and also reported that resident almost slid out of his bed earlier this shift. Upon assessment, abrasion found to be 35 cm long, no open area noted. Barrier cream applied to affected area and tolerated well. NP notified and family notified about this. Resident not in any acute distress. No pain offered at this time. Neurological checks for unwitnessed fall started around 19:55 (7:55 p.m.) BP 100/70 mmHg, Pulse 74 bpm, RR 18 rpm, Temp 97.6 F, O2 saturation, 94%." Immediate Action Taken: Barrier cream applied to affected area and tolerated well. NP notified and family notified about this. Resident not in any acute distress. No pain offered at this time. Neurological checks for unwitnessed fall started around 19:55.....Mental Status: no records found. Predisposing Environmental Factors: No Records Found. Predisposing Physiological Factors: No Records Found. Predisposing Situation Factors: No Records Found. Other Information: Un-Witnessed. Incident location: Resident's Room. Witnesses: No witnesses found. Agencies/People Notified: No Notifications found. Notes: No notes found."

The most recent completed, "Fall Risk Assessment" was dated 8/16/16, documented the resident to be a "High Risk" for falls.

An interview was conducted with RN (registered nurse) #4, MDS nurse, on 1/25/17 at 9:00 a.m. When asked who updates the care plans, RN #4 stated, "The care plan team. Each discipline is responsible for their section." When asked who updates the care plan after a resident has had a

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fall, RN #4 stated, "That would be (RN #1) the care plan coordinator."

An interview was conducted with RN #1, the care plan coordinator, on 1/25/17 at 10:05 a.m. When asked who updates the care plan after an actual fall, RN #1 stated, "They tell me in our morning meeting that a fall has occurred. They tell me what the cause of the fall, if known was." RN #1 was asked to review Resident #3's care plan to see if she could find the fall of 1/8/17 on the care plan. RN #1 stated, "Based on the information I see here, it's not on there." RN #1 further stated, "The fall committee meets and discusses every fall. They are supposed to be writing a note."

Review of the clinical record did not reveal any fall committee meeting notes.

An interview was conducted with LPN (licensed practical nurse) #1, on 1/25/17 at 12:18 p.m. When asked how resident falls are reviewed and new interventions are developed, LPN #1 stated, "They are discussed in the fall committee meeting." When asked if she was in charge of this committee, LPN #1 stated, "No. We just reconstructed the falls committee last Thursday (1/19/17)."

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 1/25/17 at 10:37 a.m. When asked how falls are investigated, ASM #2 stated, "All falls are reported in morning meeting." When asked who updates the care plan with new interventions, ASM #2 stated, "The care plan coordinator." When asked how the facility reviews, investigates and implements new interventions after a fall to prevent further falls,

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F 323	Continued From page 107 ASM #2 stated, "There is a falls team meeting once a week that discusses any falls, reviews causative factors and puts into place any new interventions." When ASM #2 was informed of the above concern, no documentation on the care plan regarding Resident #3's fall of 1/8/17, ASM #2 stated he'd look into it and get back with this surveyor. ASM #2 returned on 1/25/17 at 4:50 p.m. and stated he had no information regarding Resident #3's fall on 1/8/17. The administrator and ASM #2 were made aware of the above concern on 1/25/17 at 5:30 p.m. No further information was provided prior to exit. (1) Barron's Medical Dictionary for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 282.	F 323		
F 329 SS=D	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or	F 329	F-329 1. Corrective action has been accomplished for the alleged deficient practice in regards to Residents #3 and #7. Nurse #16 was educated on the importance of offering non-pharmacological interventions prior to the administration of Lorazepam. A clarification order was obtained on 1/26/17 from the psychiatrist in relation to reducing the Risperdal and the POA was made aware. 2. Current facility residents have the potential to be affected by the alleged deficient practice. The Director of Nursing and/or Nursing Administration team will review all current residents who have received prn antipsychotic medications to validate non-pharmacological interventions were attempted before administration of medication. The Quality Assurance nurse will review all psychiatrist's notes received checking for any new orders related to dose reduction; entering new orders; notifying POAs; and, notifying unit managers of any changes.	

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F 329	Continued From page 108 discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure residents were free of unnecessary medications for two of 27 residents in the survey sample, Residents #3 and #7. 1. For Resident #3 the facility staff failed to offer non-pharmacological interventions prior to the administration of Lorazepam (used to treat anxiety). 2. The facility staff failed to reduce Risperdal (an antipsychotic medication (1)) for Resident #7 as ordered by the psychiatrist. The findings include: 1. Resident #3 was admitted to the facility on 10/25/04 with diagnoses that included but were not limited to: intellectually disabled, high blood pressure, dementia, psychosis, anxiety disorder, diabetes, and benign prostatic hypertrophy (enlargement of the prostate (1)). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 11/18/17, coded the resident as severely impaired to make daily cognitive decisions. Resident #3 was coded as requiring extensive assistance of one or more staff members for all of his activities of living except eating in which he was coded as	F 329	**3.** Measures put into place to ensure the alleged deficient practice does not recur include: The Director of Nursing and/or nursing administration team will audit 10 residents per week for 4 weeks, then 15 residents per month for three months to validate accuracy of orders and use of non-pharmacological interventions. A random sample of residents will be audited quarterly thereafter to ensure continued compliance. **4.** The Director of Nursing and/or designee will analyze reviews/observations for patterns/trends and report in the Quality Assurance Committee monthly for three months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. **5.** Completion Date: 3/3/17	

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F 329	Continued From page 109 independent after set up assistance was provided. In Section N - Medications, Resident #3 was coded as not having received any anti-anxiety medications during the lookback period. The physician order dated 3/15/16, documented, "Lorazepam 0.5 mg (milligrams) tablet; give 1 tablet every 12 hours as needed for anxiety related to unspecified psychosis (a mental disorder in which the person is usually detached from reality and has impaired perceptions, thinking, responses and interpersonal relationships (2)) not due to a substance or known physiological condition." The December 2016 medication administration record (MAR) documented, "Lorazepam (used to treat anxiety (3)) 0.5 mg tablet; give 1 tablet every 12 hours as needed for anxiety related to unspecified psychosis not due to a substance or known physiological condition." The MAR documented the medication had been administered on 12/16/16 at 10:01 a.m. and 12/20/16 at 4:05 p.m. The January 2017 MAR documented, "Lorazepam 0.5 mg tablet; give 1 tablet every 12 hours as needed for anxiety related to unspecified psychosis not due to a substance or known physiological condition." The MAR documented the medication had been administered on the following dates and times: 1/6/17 at 1:01 a.m. 1/9/17 at 4:35 p.m. 1/13/17 at 8:11 p.m. 1/15/17 at 3:55 p.m. 1/17/17 at 8:22 a.m. 1/22/17 at 10:10 p.m.	F 329		

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The psychiatrist note dated, 10/18/16, documented in part, "According to the staff, patient is doing better. No aggressive behaviors note (sic). No evidence of aggression or agitation."

The nurse's note dated, 12/16/16 at 10:59 a.m. documented, "Administration Note: Lorazepam 0.5 mg tablet. PRN (as needed) administration was: Effective." There was no documentation of why the medication was administered and if any non-pharmacological interventions were attempted prior to the administration of the Lorazepam.

The nurse's note dated, 12/20/16 at 6:02 p.m. documented, "Administration Note: Lorazepam 0.5 mg tablet. PRN (as needed) administration was: Effective." There was no documentation of why the medication was administered and if any non-pharmacological interventions were attempted prior to the administration of the Lorazepam.

The nurse's note dated, 1/6/17 at 2:10 a.m. documented, "Administration Note: Lorazepam 0.5 mg tablet. PRN (as needed) administration was: Effective." There was no documentation of why the medication was administered and if any non-pharmacological interventions were attempted prior to the administration of the Lorazepam.

The nurse's note dated, 1/9/17 at 4:39 p.m. documented in part, "Administration Note: Resident aggressive with staff, making a buzzing sound like a bee. Swinging his arms occasionally." There was no documentation of

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any non-pharmacological interventions provided prior to the administration of the Lorazepam. The note dated, 1/9/17 at 6:00 p.m. documented in part, "Administration Note: PRN administration was: Effective."

The nurse's note dated, 1/13/17 at 9:30 p.m. documented in part, "Administration Note: Lorazepam 0.5 mg tablet. PRN (as needed) administration was: Effective." There was no documentation of why the medication was administered and if any non-pharmacological interventions were attempted prior to the administration of the Lorazepam.

The nurse's note dated, 1/15/17 at 4:53 p.m. documented in part, "Administration Note: Lorazepam 0.5 mg tablet. PRN (as needed) administration was: Effective." There was no documentation of why the medication was administered and if any non-pharmacological interventions were attempted prior to the administration of the Lorazepam.

The nurse's note dated, 1/17/17 at 9:26 a.m. documented in part, "Administration Note: Lorazepam 0.5 mg tablet. PRN (as needed) administration was: Effective." There was no documentation of why the medication was administered and if any non-pharmacological interventions were attempted prior to the administration of the Lorazepam.

The nurse's note dated, 1/20/17 at 1:54 a.m. documented in part, "Administration Note: Lorazepam 0.5 mg tablet. PRN (as needed) administration was: Effective." There was no documentation of why the medication was administered and if any non-pharmacological

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interventions were attempted prior to the administration of the Lorazepam.

The comprehensive care plan dated, 11/29/16, documented in part, "Focus: The resident is physically aggressive and verbally abusive towards staff and other residents." The "Interventions" documented, "Administer PRN anti-anxiety medications as ordered. Remove the resident from the situation that triggered the behavior. When the resident becomes agitated: Intervene before agitation escalates: Guide away from source of distress, engage calmly in conversation, if response is aggressive, staff to walk calmly away and approach later."

An interview was conducted with LPN (licensed practical nurse) #16 on 1/25/17 at 10:42 a.m. LPN #16 was asked what happens when Resident #3 gets agitated. LPN #16 stated, "I try to give him pudding, he likes pudding, diet cokes. We just try to let him be." LPN #16 was asked when staff would administer the antianxiety medication Lorazepam to Resident #3. LPN #16 stated, "Once I've tried to redirect him and it wasn't helping." LPN #16 was asked where staff documents what the resident was doing to require medications and what interventions were tried prior to giving the medication. LPN #16 stated, "It should be in the nurse's notes but I don't always chart that."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing on 1/25/17 at 10:47 a.m. ASM #2 was asked what a nurse should do when a resident is exhibiting anxious and aggressive behaviors. ASM #2 stated, "First, they should try non-pharmacological interventions, such as

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offering a snack, redirect them, maybe a change in scenery. If that doesn't work then they should check the physician orders and administer the medication per the physician's order." When asked if the residents behavior and any interventions provided or attempted should be documented, ASM #2 stated, "Yes." When asked where the staff documents this information, "ASM #2 stated, "In the nurse's notes."

The administrator and ASM #2 were made aware of the above findings on 1/25/17 at 5:30 p.m. A policy was requested at this time on the administration of PRN anti -anxiety medications.

On 1/26/17 at approximately 8:25 a.m. ASM #2 stated he could not find a policy on the administration of PRN anti-anxiety medications.

No further information was provided prior to exit.
(1) Barron's Medical Dictionary for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 282.
(2) Barron's Medical Dictionary for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 483
(3) This information was taken from the following website:
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010988/?report=details

2. The facility staff failed to reduce an antipsychotic medication for Resident #7 as ordered by the psychiatrist.

Resident #7 was admitted to the facility on 7/22/13 with a readmission date of 9/28/16 with diagnoses that included, but were not limited to,

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dysphagia (difficulty swallowing), communication deficit, dementia, psychosis and Alzheimer's.

Resident #7's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/13/17. Resident #7 was coded on the MDS as having a BIMs (Brief Interview for Mental Status) score of 9 out of 15. The MDS manual documents that a score of 9 indicates that the resident's cognition is moderately impaired. Resident #7 was also coded as having received an antipsychotic medication during the seven day look back period.

A review of Resident #7's clinical record revealed, in part, a note written by ASM (administrative staff member) #4, the psychiatrist, dated 11/30/16. The psychiatry note revealed, in part, the following documentation, "Problem List: 12/1/16 Dementia in other diseases classified elsewhere without behavioral disturbance. 12/1/16. Unspecified psychosis not due to a substance or known physiological condition. Current Medications: Risperdal (an antipsychotic medication (1)) 0.5 mg (milligrams) at bedtime. Procedure Notes: Decrease Risperdal to 0.25 mg at bedtime and gradually discontinue."

Further review of Resident #7's clinical record revealed, in part, MARs (medication administration records) dated 12/1/16 - 12/31/16 and 1/1/17 - 1/31/17 that documented, in part, the following order to be administered to Resident #7, "Risperdal Tablet 0.5 MG (Risperidone) Give 1 (one) tablet by mouth at bedtime for paranoid. Start Date 10/4/2016. 2100 (9:00 p.m.)." Each box for each day between 12/1/16 and 1/24/17 was checked as administered to Resident #7.

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A review of Resident #7's order summary report revealed, in part, the following active order; "Risperdal Tablet 0.5 MG (RisperiDONE) Give 1 (one) tablet by mouth at bedtime for paranoid. Communication method: Phone. Order Status: Active. Order Date: 10/4/2016. Start Date: 10/4/2016."

A review of Resident #7's nursing progress notes did not reveal any entries regarding the psychiatrist visit on 11/30/16.

A review of Resident #7's comprehensive care plan dated 7/22/13 revealed, in part, the following documentation, "Goal: The resident will be / remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation / impaction or cognitive / behavioral impairment through review date. Date initiated: 10/24/2016. Target Date: 4/6/2017. Interventions / Tasks: Administer PSYCHOTROPIC medications as ordered by physician. Date initiated: 10/24/2016."

On 1/25/17 at 11:50 a.m. an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked what her role was at the facility, LPN #1 stated, "I do rounds with the psychiatrist when he sees the residents." LPN #1 was asked what did "doing rounds" entail. LPN #1 stated, "I go into the resident rooms with him (the psychiatrist) and he gives me orders, I put those orders into the EMR (electronic medical record) and complete a nurses note and notify the RP (responsible party)." LPN #1 was asked whether or not the primary physician was notified, LPN #1 stated she did not as "they (the facility)

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just allow the psychiatrist to do whatever he feels is necessary. The nurse practitioner signs off on the psych (psychiatrist) orders when I put them in the system." LPN #1 was asked who receives the psychiatrists' notes following the visits. LPN #1 stated that the psychiatrist would fax over his completed note within a day or two. LPN #1 was asked if the notes ever differed from what the discussion / plan was during the visit. LPN #1 stated, "No, not usually, he tells me the orders at the time he sees them." LPN #1 was shown the psychiatrists note for Resident #7, specifically the "Procedure Notes." LPN #1 stated, "I will have to look in my book for that visit. I write down each visit in a note book I keep and write down any orders for each resident." LPN #1 was asked whether or not she reviewed the psychiatrist's notes when he faxed them to the facility and compared them with her notes. LPN #1 stated, "Not all the time, he usually writes down on the back of the resident face sheet what he wants to do and then uses that to write his final note." LPN #1 was asked whether or not the orders discussed during the visit would be likely to change once he wrote his note. LPN #1 stated that it was not likely for his orders to differ from what was discussed and what he wrote in his note. LPN #1 asked to go get her book and review her notes for the psychiatrists' visit on 11/30/16.

On 1/25/17 at 12:10 p.m. LPN #1 brought her note book (not part of the medical record) to this surveyor. LPN #1 stated, "I reviewed the note book and I wrote "no changes" for that visit (11/30/16)." LPN #1 was asked when she received the psychiatrist's final note. LPN #1 stated, "It was signed and dated on 12/1/16 so it was sent to us then. It goes to the medical

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records person and she gives it to me." LPN #1 was asked whether or not she read the psychiatrists note for Resident #7 when she received it. LPN #1 stated, "I don't read his notes. I look at the last thing documented to see when he wants the follow up appointment. I did not look at the procedure notes. There were no changes made to (name of Resident #7) Risperdal orders." LPN #1 was asked whether or not the procedure notes at the bottom of the psychiatrists' notes were considered orders. LPN #1 stated, "It is a recommendation." LPN #1 was asked whether or not she would/should act on the recommendations. LPN #1 stated that she would. LPN #1 was asked if she acted on the "last thing" on the note (the follow up appointment date), LPN #1 stated that she did. LPN #1 was asked whether or not a request for a follow up visit was an order. LPN #1 stated that it was.

On 1/25/17 at 2:05 p.m. an interview was conducted with ASM (administrative staff member) #4, the psychiatrist. ASM #4 was asked to describe his process when visiting the facility to see residents. ASM #4 stated that he would round on the residents to be seen and that LPN #1 would round with him and make notes of any orders / changes that he provided during the rounds. ASM #4 was asked whether or not the orders provided at the time of rounds could change once he was back in his office writing his note. ASM #4 stated, "When I go back to my office I may change the orders after I review everything from the visit and the past history." ASM #4 was asked how those changes would be communicated to the nursing staff at the facility. ASM #4 stated, "(Name of LPN #1) receives my notes and understands that there have been changes." ASM #4 was asked whether his

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EVERGREEN HEALTH AND REHAB	380 MILLWOOD AVENUE WINCHESTER, VA 22601

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F 329	Continued From page 118 procedure notes were understood as recommendations or orders. ASM #4 stated, "(Name of LPN #1) knows that they are orders and she (LPN #1) should act on them as such." ASM #4 was asked whether or not he was aware that the order to decrease Resident #7's Risperdal had not been followed. ASM #4 stated he was not aware, "I wrote it to be decreased and it should have been done." On 1/25/17 at 5:10 p.m. an end of day meeting was held with ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above referenced concerns. A policy was requested regarding visits by the psychiatrist. On 1/26/17 at approximately 9:00 a.m. ASM #2 provided two facility policies titled "Transcribing Physician Orders" and "Policy for psychiatric consults." Neither policy addressed the process for the psychiatric visit and the completion of the psychiatric orders. No further information was provided prior to the end of the survey process. (1) Risperdal (also known as Risperidone) is used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions) in adults and teenagers 13 years of age and older. This information was obtained from the following website https://medlineplus.gov/druginfo/meds/a694015.html	F 329		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 119 (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 by: Based on observation, staff interview and facility document review, it was determined that facility staff failed to store food in a safe manner. Facility staff failed to ensure that a 25 gallon liquid lard container was labeled with its contents and the date it was opened. The findings include: An observation of the kitchen was conducted on 1/24/17 at 12:00 p.m. with OSM (other staff member) #5, the dietary manager. In the dry	F 371	F371 1. The container of liquid Crisco was discarded on 1/25/2017. 2. No resident was directly affected by this deficiency. 3. Dietary Manager will in-service cooks and stock clerk on policy and procedure for food storage of all foods that have been received, opened, and used the first time. Those shall be dated with use by date and sealed before returning to the storage area. 4. Dietary Manager/designee will monitor one delivery weekly for 30 days to ensure proper receiving and use by dates are in place. On an ongoing basis, Dietary Manager or dietitian will monitor storeroom monthly to ensure proper receiving of supplies and dating of such. Any ongoing problems will be brought to the attention of the Risk Management committee so that a plan of action can be developed. 5. Completion Date: 3/3/17	

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storage area on the lowest shelf of the wire rack was a 25 gallon container that contained approximately 20 gallons of an opaque light yellow liquid. OSM #5 picked the container off the shelf and displayed the entire container to this surveyor. There was no evidence of labeling as to what the product was. Written on the container's lid was "12-15". When asked when the container had been opened, OSM #5 stated, "On 12/15/16." When asked how she was sure that the container had been opened in 2016, OSM #5 stated she was sure. When asked what the expiration date for the product was, OSM #5 stated, "Normally we keep it (the container) in the box (it comes in). It would have the expiration date on it. I'll get the information for you." When asked what was in the container OSM #5 stated, "It's Crisco. It's what we use to fry potatoes."

An interview was conducted on 1/25/17 at 1:20 p.m. with OSM #6, a dietary cook. When asked to look at the container in the storage area, OSM #6 stated, "I don't know what it is." When informed OSM #5 had stated it was oil to fry potatoes, OSM #6 stated, "I only cook in the evenings, I don't fry much at all." When asked what she would do if she had to fry potatoes, OSM #6 stated, "I'd call (name of OSM #5) to see what it was." When asked what the "12-15" on the lid meant, OSM #6 stated, "I would assume it got here on 12/15 of 2016."

An interview was conducted on 1/25/17 at 1:23 p.m. with OSM #7, a dietary aide. When asked what the liquid was in the container, OSM #7 stated, "its white lard." When asked about the process staff follows for an unlabeled product, OSM #7 stated, "Don't use it. We should throw it away. Would you go to the store and buy

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F 371	Continued From page 121 something without a label on it?" On 1/25/17 at 5:25 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. Review of the facility's policy titled, "III Storage." documented, "POLICY: After products have been received, they should be immediately taken to proper, secure storage areas. PROCEDURE: 6. All foods that have been opened and partially used shall be dated and sealed before returning to a storage area." Review of a form provided by OSM #5, the dietary manager titled, "HOW LONG CAN I KEEP CRISCO PRODUCTS ON MY SHELF?" documented in part, "Crisco Oil. Opened about 1 year. Freshness Tip: To keep track of how long a container's been opened, you might write the date on the package when you first break the seal." No further information was provided prior to exit.	F 371		
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;	F 514	F-514 1. Corrective action has been accomplished for the alleged deficient practice in regards to Residents #1, #9, #14 and #27. Nurses #10 and #6 were educated on the importance of offering non-pharmacological interventions prior to the administration of prn pain medication. Resident #27 has been discharged from the facility.	

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F 514	Continued From page 122 (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 (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, resident interview, facility document review and clinical record review, it was determined that facility staff failed to maintain a complete and accurate clinical record for four of 27 residents in the survey sample, Resident #1, #9, #14, and #27. 1. The facility staff failed to document non-pharmacological interventions prior to administering Tylenol [1] 325 mg (milligrams) prn (as needed) to Resident # 1 on several occasions during the month of January 2017. 2. The facility staff did not document that non-pharmacological pain relieving methods were attempted for Resident # 9.	F 514	**2.** Current facility residents have the potential to be affected by the alleged deficient practice. The Director of Nursing and/or Nursing Administration team will review all current residents who have received prn pain medications to validate non-pharmacological interventions were attempted before administration of medication and that physical assessments were completed. **3.** Measures put into place to ensure the alleged deficient practice does not recur include: Nurses will be in-serviced on the importance of documenting non-pharmacological interventions for pain so that the resident's clinical record is complete and accurate. The Director of Nursing and/or nursing administration team will audit 10 residents per week for 4 weeks, then 15 residents per month for three months to validate the use of non-pharmacological interventions and the completion of physical assessments. A random sample of residents will be audited quarterly thereafter to ensure continued compliance. **4.** The Director of Nursing and/or designee will analyze reviews/observations for patterns/trends and report in the Quality Assurance Committee monthly for three months to evaluate the effectiveness of the plan and will adjust the plan based on outcomes/trends identified. **5.** Completion Date: 3/3/17	

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3. The facility staff did not document that non-pharmacological pain relieving methods were attempted for Resident # 14.

4. The facility staff failed to document their physical assessment of Resident #27 after Resident #27 alleged that she was injured by a staff member.

The findings include:

1. Resident #1 was admitted to the facility on 5/4/14 and readmitted on 5/13/16 with diagnoses that included but were not limited to mood disorder, high blood pressure, chronic kidney disease (stage 3), atrial fibrillation, stroke, and COPD (chronic obstructive pulmonary disease).
Resident #1's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/9/16.
Resident #1 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #1 was coded as requiring extensive assistance from staff with most ADLS (activities of daily living) including transfers, locomotion, toileting, and personal hygiene; total dependence on staff with bathing, and independent with meals.
Review of Resident #1's POS (physician order sheet) dated 1/24/17 documented the following order: "Acetaminophen 325 mg tablet Give 2 tablet orally every 6 hours as needed for Pain Level 1-5, Pain level 6-10. Not to exceed 4 gm (grams) in 24 hours." This order was initiated on 5/13/16.
Review of Resident #1's January 2017 MAR (Medication Administration Record) revealed that Resident #1 received Tylenol 325 mg, 2 tablets

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on the following dates and times:
1/1/17 at 6:42 a.m., 1/2/17 at 12:56 p.m., 1/4/17 at 4:15 p.m., 1/5/17 at 6:39 a.m., 1/6/17 at 7:01 a.m., 1/7/17 at 9:14 a.m., 1/8/17 at 8:10 a.m., 1/9/17 at 6:51 a.m. and 4:26 p.m., 1/10/17 at 6:08 a.m. and 4:28 p.m., 1/12/17 at 5:28 a.m., 1/14/17 at 12:53 p.m., 1/15/17 at 2:42 a.m. and 8:02 a.m., 1/16/17 at 3:18 a.m. and 2:06 p.m., 1/17/17 at 7:51 a.m., 1/18/17 at 7:38 a.m. and 1:38 p.m., 1/19/17 at 9:58 a.m., 1/20/17 at 5:53 p.m., 1/21/17 at 4:15 p.m., and 1/22/17 at 8:48 a.m.
Review of the nurses ' notes failed to reveal that non-pharmacological interventions were attempted or offered prior to the administration of Tylenol.
On 1/25/17 at 3:50 p.m., an interview was conducted with LPN #10, a nurse who administered Tylenol to Resident #1 on several occasions in January. LPN #10 stated that she would attempt non-pharmacological interventions prior to administering pain medications. LPN #10 stated, "You can reposition them, or message the area. I would try things like that before." LPN #10 stated that non-pharmacological interventions attempted should be documented in the nurses notes. When asked what type of interventions does she offer to Resident #1 prior to administering pain medications, LPN #10 stated, "I talk to her, she has depression so sometimes just talking makes her pain feel better." When asked if she documented non-pharmacological interventions for Resident #10 prior to administering medication, LPN #10 stated, "I always do it, I probably didn't document."
On 1/25/17 at 5:25 p.m., ASM #1, the administrator and ASM #2, the DON (Director of Nursing were made aware of the above concerns. No further information was presented prior to exit.
The following quotation is found in Potter and

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Perry's Fundamentals of Nursing 6th edition (2005, p. 477): "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to the clients."

[1] Tylenol Tablet 325 mg (Acetaminophen) - Treats minor aches and pains and also reduces fever. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008785/?report=details
2. For Resident # 9 the facility staff did not document that non-pharmacological pain relieving methods were attempted.

Resident # 9 was admitted to the facility on 7/8/14 with diagnoses including, but not limited to: diabetes, depression, hypertension, hyperlipidemia, gastroesophageal reflux disease, irritable bowel syndrome, and vitamin D deficiency. On the most recent MDS (minimum data set), a significant change assessment with ARD (assessment reference date) of 12/30/16, Resident # 9 was coded as scoring a 15 out of a possible 15 on the BIMS (brief interview of mental status) indicating that he was cognitively intact.

Review of Resident # 9's clinical record revealed a physician order dated 12/22/16 for: "Hydrocodone-Acetaminophen (1) Tablet 5-325 MG (milligrams) Give 1 tablet by mouth every 6

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hours as needed for Pain."

Review of Resident # 9's eMARs (electronic medication administration records) and nurses' notes for the month of December 2016 revealed staff failed to document that non-pharmacological pain relieving methods were attempted.

For December 2016 the eMAR documented the following: Resident # 9 received the ordered pain medication (Hydrocodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth every 6 hours as needed for Pain) nine times.

Review of Resident # 9's eMARs (electronic medication administration records) and nurses' notes for the month of January 2017 revealed staff failed to document that non-pharmacological pain relieving methods were attempted.

For January 2017 the eMAR documented the following: Resident # 9 received the ordered pain medication (Hydrocodone-Acetaminophen Tablet 5-325 MG Give 1 tablet by mouth every 6 hours as needed for Pain) 50 times.

Review of Resident # 9's care plan revealed a care plan that was updated on 11/21/16. Under Focus: The resident has the potential for pain. Interventions/Tasks:

- Encourage the resident to try non-pharmacological pain relieving methods i.e. positioning, relaxation therapy, bathing, heat and cold application.

An interview was attempted on 1/25/17 at approximately 11:45 a.m. with Resident # 9 concerning his pain and the staff offering non-pharmacological interventions. This

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interview was unsuccessful.

During an interview on 1/25/17 at 4:20 p.m. with LPN (licensed practical nurse) # 10, a nurse that has cared for Resident # 9, LPN # 10 was asked what she would do when a resident complains of pain. LPN # 10 was specifically asked if staff were to try non-pharmacological pain relieving methods. LPN # 10 stated, "Yes, I do." When LPN # 10 was asked where this would be documented LPN # 10 stated that it would be documented in the nurses notes, and further stated, "I have not (documented) - this is where I fall short."

During an interview on 1/25/17 at 5:00 p.m. with LPN # 6, LPN # 6 was asked what she would do when a resident complains of pain. LPN # 6 was specifically asked if staff were to try non-pharmacological pain relieving methods. LPN # 6 stated, "Yes, I do." When LPN # 6 was asked where this would be documented LPN # 6 stated that when clicking on the pain medication, a window opens up and that is where things like pain scale, location of pain, and non-pharmacological pain relieving methods is documented. LPN # 6 stated that she did all these.

During the end of day interview on 1/25/17 at 5:10 p.m. with ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nurses, this concern was reviewed.

Fundamentals of Nursing, 6th Edition, Potter and Perry, 2005, pages 1239-1287, "Effective communication of a client's assessment of pain and his or her response to intervention is facilitated by accurate and thorough

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documentation. This communication needs to transpire from nurse to nurse, shift to shift, and nurse to other health care providers. It is the professional responsibility of the nurse caring for the client to report what has been effective for managing the client's pain. The client is not responsible for ensuring that this information is accurately transmitted. A variety of tools such as a pain flow sheet or diary will help centralize the information about pain management."

No further information was provided prior to exit.

(1) Hydrocodone-Acetaminophen: Hydrocodone and acetaminophen combination is used to relieve moderate to moderately severe pain. Acetaminophen is used to relieve pain and reduce fever in patients. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010590/

3. For Resident # 14 the facility staff did not document that non-pharmacological pain relieving methods were attempted.

Resident # 14 was admitted to the facility on 12/4/16 with diagnoses including, but not limited to: hypertension, congestive heart failure, chronic obstructive pulmonary disease, depression, coronary artery disease, and gastroesophageal reflux disease. On the most recent MDS (minimum data set), an admission assessment with ARD (assessment reference date) of 12/10/16, Resident # 14 was coded as scoring an 8 out of a possible 15 on the BIMS (brief interview of mental status) indicating that he was moderately cognitively impaired.

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Review of Resident # 14's clinical record revealed a physician order dated 12/4/16 for: "Acetaminophen Tablet Give 650 mg by mouth every 4 hours as needed for pain/fever."

Review of Resident # 14's eMARs (electronic medication administration records) and nurses' notes for the month of December 2016 revealed staff failed to document that non-pharmacological pain relieving methods were attempted.

For December 2016 the eMAR documented the following: Resident # 14 received the ordered pain medication (Acetaminophen Tablet Give 650 mg by mouth every 4 hours as needed for pain/fever) ten times.

Review of Resident # 14's eMARs (electronic medication administration records) and nurses' notes for the month of January 2017 revealed staff failed to document that non-pharmacological pain relieving methods were attempted.

For January 2017 the eMAR documented the following: Resident # 14 received the ordered pain medication (Acetaminophen (1) Tablet Give 650 mg (milligram) by mouth every 4 hours as needed for pain/fever) 14 times.

Review of Resident # 14's care plan revealed a care plan that was updated on 12/05/2016. Under Focus: The resident has chronic pain. Interventions/Tasks:

- Encourage the resident to try non-pharmacological pain relieving methods i.e. positioning, relaxation therapy, bathing, heat and cold application.

During an interview on 1/25/17 at approximately

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(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
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4:00 p.m. with Resident # 14 concerning his pain and the offering non-pharmacological interventions, Resident # 14 stated that the nurses do offer other things before giving him his pain pills.

During an interview on 1/25/17 at 4:20 p.m. with LPN (licensed practical nurse) # 10, a nurse that has cared for Resident # 14, LPN # 10 was asked what she would do when a resident complains of pain. LPN # 10 was specifically asked if staff were to try non-pharmacological pain relieving methods. LPN # 10 stated, "Yes, I do." When LPN # 10 was asked where this would be documented LPN # 10 stated that it would be documented in the nurses notes, and further stated, "I have not (documented) - this is where I fall short."

During an interview on 1/25/17 at 5:00 p.m. with LPN # 6, LPN # 6 was asked what she would do when a resident complains of pain. LPN # 6 was specifically asked if staff were to try non-pharmacological pain relieving methods. LPN # 6 stated, "Yes, I do." When LPN # 6 was asked where this would be documented LPN # 6 stated that when clicking on the pain medication a window opens up and that is where things like pain scale, location of pain, and non-pharmacological pain relieving methods is documented. LPN # 6 stated that she did all these.

During the end of day interview on 1/25/17 at 5:10 p.m. with ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nurses, this concern was reviewed.

No further information was provided prior to exit.

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	495142	A. BUILDING _____ B. WING _____	C 01/26/2017

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(1) Acetaminophen: Treats minor aches and pain and reduces fever. https://www.ncbi.nlm.nih.gov/pubmedhealth/?term=Acetaminophen

4. The facility staff failed to document their physical assessment of Resident #27 after Resident #27 alleged that she was injured by a staff member.

Resident #27 was admitted to the facility on 2/28/11, and most recently readmitted after a brief hospitalization on 6/10/16, with the diagnoses of but not limited to atrial fibrillation, chronic obstructive pulmonary disease, chronic kidney disease, dysphagia, high blood pressure, neuropathy, diabetes, lupus, sarcoidosis, peripheral vascular disease, nephrolithiasis, coronary atherosclerosis, adult failure to thrive, and hypopituitarism. The resident was discharged on 7/6/16 and expired at the hospital on 7/13/16.

The most recent MDS (Minimum Data Set) prior to discharge was a 14-day assessment with an ARD (Assessment Reference Date) of 6/23/16. The resident was coded as being cognitively intact in ability to make daily life decisions, scoring a 15 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident was coded as requiring total care for all areas of ADL's (Activities of Daily Living) and was coded as being incontinent of bowel and bladder.

As part of a complaint investigation, a Facility Reported Incident (FRI) about the incident was reviewed. The FRI documented, "Resident c/o

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(complained of) hip pain on 3/31/16. (results [of x-ray] difficult to exclude undisplaced fracture). Sent for CT on 4/4/16. + (positive for) impacted fracture of left femoral neck. On 4//7/16 resident reported to DON (Director of Nursing) that her hip was broke because 'that boy (name of CNA #2 - Certified Nursing Assistant) hit her on the hip with his fist.' Investigation started."

A review of the investigation report documented, "Interview with (name of LPN #3 - Licensed Practical Nurse): (Resident #27) reported to (LPN #3) that (CNA #2) was caring for her when she developed hip pain but stated "he did not do it on purpose." No allegations or suspicious treatment noted. (LPN #3) stated the resident did not have any bruising or edema noted. Unit Manager was made aware and NP (nurse practitioner) notified...."

A review of the clinical record failed to reveal any notes or evidence of LPN #3's physical assessment of the resident.

A review of the nurse's notes revealed one dated 3/31/16 at 12:45 p.m., that documented, "(Nurse Practitioner) assessed, resident c/o increased L-leg (left leg) pain, N/O (new order) xray, to L-hip 2 view (two views), and L-knee 2 view. Increased hydrocodone (used for pain (1)) to q6hr (every 6 hours), Rp (responsible party - and name of responsible party) notified of new orders." This note was written by LPN #4.

This note was the first note written for 3/31/16. There was no evidence of the nursing assessment of the resident regarding her complaints of the left hip pain for that date prior to the nurse practitioner being notified.

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On 1/25/17 at approximately 10:20 a.m., an interview was conducted with LPN #4. She did not recall the incident and stated that she started work at the facility "around the end of April" which was approximately one month after she wrote the above note. (The administrator verified that LPN #4's first date of duty was 3/29/16, not April).

A review of the internal incident report revealed that at the time of the incident, LPN #3 documented resident vital signs on the report, in addition to her conversation with Resident #27. The incident report did not contain any physical assessment apart from the vital signs. The vital signs were not documented in the nursing notes.

On 1/25/17 at 10:22 a.m., an interview was conducted with LPN #3. She stated that the resident did not have any redness or edema. She stated that she should have documented her physical assessment of the resident in the clinical record.

On 1/26/17 at 9:30 a.m., the Administrator and Director of Nursing (DON) (ASM #1 and #2 - Administrative Staff Member) were made aware of the findings. The DON stated he expects nurses to document physical assessments they obtain on residents. On 1/26/17 at approximately 8:15 a.m., the DON stated there were no policies for a complete and accurate clinical record.

No further information was provided by the end of the survey.

(1) Information obtained from https://medlineplus.gov/druginfo/meds/a614045.html

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