Our family exists to care for yours.

Heritage Hall of Front Royal • 400 W. Strasburg Road • Front Royal, VA 22630 • (P) 540.636.3700 • (F) 540.636.8558

August 10, 2016

Center for Quality Health Services & Consumer Protection
Division of Long Term Care Services
9960 Mayland Drive – Suite 401
Attn: Wietske G. Weigel-Delano, Long Term Care Supervisor
Richmond, VA 23233-1463

Ms. Weigel-Delano,

Attached to this cover letter you will find Heritage Hall – Front Royals Plan of Correction and our credible allegation of compliance. The Plan of Correction addresses the corrective action, identification of deficient practices, systemic changes, and monitoring that will be implemented to address deficient practices identified during our annual survey.

If I can be of further assistance don't hesitate to contact me at (540) 636-3700.

Sincerely;

Brian Huschke
Administrator

HERITAGE HALL
HEALTHCARE AND REHABILITATION CENTERS
Managed by AMERICAN HEALTHCARE, LLC

COMMONWEALTH of VIRGINIA

Department of Health

Office of Licensure and Certification

Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner

TYY 7-1-1 OR
1-800-828-1120

9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485
FAX: (804) 527-4502

August 2, 2016

Mr. Brian Huschke, Administrator
Heritage Hall Front Royal
400 West Strasburg Road
Front Royal, VA 22630

RE: Heritage Hall Front Royal
Provider Number 495301

Dear Mr. Huschke:

An unannounced standard survey, ending July 21, 2016, was conducted at your facility by staff from the Virginia Department of Health's Office of Licensure and Certification (the State Survey Agency) to determine if your facility was in compliance with Federal long term care participation requirements for the Medicare and/or Medicaid programs and, if applicable, State licensure regulations. No complaints were investigated during the survey.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Survey Results

The results of this survey are reflected on the enclosed Statement of Isolated Deficiencies, "A" Form and/or the Statement of Deficiencies and Plan of Correction, CMS 2567. All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483.10(g), the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.

This survey found that your facility was not in substantial compliance with the participation requirements. The most serious deficiency in your facility was a pattern deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy (S/S of E), as evidenced by the attached CMS-2567L, whereby corrections are required.

Plan of Correction (PoC)

A PoC is not required for deficiencies cited on the Statement of Isolated Deficiencies, "A" Form. Nevertheless, the facility is expected to address and correct all areas of concern noted on this form.

Unless specifically otherwise indicated, a PoC for all certification and licensure deficiencies cited on the Statement of Deficiencies and Plan of Correction (CMS-2567) must be submitted within ten (10) calendar days of receipt of these survey findings to Wietske G Weigel-Delano, LTC Supervisor, at: Office of Licensure and Certification, Division of Long Term Care Services, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered acceptable, the PoC must:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and
5. Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)

The PoC will serve as the facility's allegation of compliance. If an acceptable plan is not submitted, the State Survey Agency may propose to the Center for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid agency that remedies be imposed immediately within applicable notice requirements.

Informal Dispute Resolution

Following the receipt and review of your survey report, please contact the assigned supervisor to attempt to resolve any problems or concerns you may have about the citations. If those concerns are not resolved, in accordance with §488.331, you have one opportunity to question cited federal certification deficiencies through the Office's Informal Dispute Resolution Process, which may be accessed at "http://www.vdh.state.va.us/OLC/longtermcare/".

To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: Director, Division of Long Term Care, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered, the IDR request must follow the IDR guidelines and be received at the Office within 10 calendar days of your receipt of the enclosed survey findings.

An incomplete informal dispute resolution process will not delay the effective date of the imposition of any enforcement actions.

Recommended Remedies

Based on the deficiencies cited during the survey, under Subpart F of 42 CFR Part 488 the following remedies may be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid Agency (DMAS):

- Pursuant to §488.408(c)
  - Directed Plan of Correction (PoC) (§488.424).
  - State monitoring (§488.422).
  - Directed In-Service Training (§488.425).

- Pursuant to §488.408(d)
  - Denial of payment for new admissions - (§488.417).
  - Denial of payment for all individuals - (§488.418).
  - Civil Money Penalty, $50 - $3,000 per day (§488.430, §488.438), effective on the survey ending date,

- Civil money penalties of $1,000 - $10,000 per instance of noncompliance.

Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate). A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Please note: This survey cover letter does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services or the Virginia Department of Medical Assistance Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination. If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, §488.417(b) requires the denial of payment for new Medicare or Medicaid admissions. If substantial compliance is not attained within six months from the last day of the survey, §488.412(b) provides that "CMS will and the State must terminate the facility's provider agreement."

Please be advised: The facility must maintain compliance with both the Health and the Life Safety Code requirements in order to continue provider certification.

Survey Response Form

The Survey Response Form is offered as a method to share your review of the onsite survey process. Please take a moment to complete this evaluation, which is available at: "http://www.vdh.virginia.gov/OLC/Downloadables/documents/2011/pdf/LTC%20facility%20survey%20response%20form.pdf". We will appreciate your participation.

If you have any questions concerning this letter, please contact me at (804) 367-2100.

Sincerely,

Wietske G. Weigel-Delano

Wietske G Weigel-Delano, LTC Supervisor
Division of Long Term Care

Enclosure

cc: Joani Latimer, State Ombudsman
Jaime Desper, D M A S (Sent Electronically)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495301	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL FRONT ROYAL CORRECTED COPY	400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 7/19/16 through 7/21/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 60 certified bed facility was 57 at the time of the survey. The survey sample consisted of 13 current resident reviews (Residents #1 through #13) and four closed record reviews (Residents # 14 through # 17).	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225	**F-225** **Corrective Action(s)** C.N.A. #5 involved in the allegation of abuse has received written disciplinary action for the incident that occurred. A thorough investigation into the allegations of abuse involving resident'#10 has been conducted and the outcome of the internal investigations have been reported to the appropriate State agencies. **Identification of Deficient Practices & Corrective Action(s):** All residents to include may have been potentially affected. A 100% review of all Facility Incident & Accident Forms for the previous 60 days has been reviewed to identify residents at risk. Any/all negative findings of reportable occurrences identified will result in an internal	

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

ADMINISTRATOR 8-10-16

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 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to report an allegation of abuse for one of 19 residents in the survey sample, Resident #10. The facility staff failed to immediately report to the administrator an allegation of verbal abuse by one of the facility's staff, CNA (certified nursing assistant) #5 towards Resident #10. The incident occurred on 7/5/16 and was not immediately (within 24 hours) reported to the administrator. In addition the facility failed to report the allegation of verbal abuse to the state agency. The findings include: Resident #10 was admitted to the facility on 5/22/14 with a readmission on 3/31/16 with diagnoses that included but were not limited to: chronic lung disease, obesity, heart failure, high	F 225	investigation with appropriate notification of outcomes to the State agencies, attending physician and responsible parties. **Systemic Change(s):** Policy and Procedure for reporting resident abuse & neglect has been reviewed. No changes are required. All staff will be inserviced on the facility policy and procedures regarding reporting, investigation and proper notification to state agencies of allegations of verbal or physical abuse and injuries of unknown origin by the Administrator. A copy of the facility policy and procedure will distributed to each employee. The Administrator, DON and/or designee is responsible for completing internal investigations of neglect, abuse, and/or complaints. The Administrator will review all findings and verify that the appropriate notification to the RP,	

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F 225	Continued From page 2 blood pressure, diabetes, depression and arthritis. The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/1/16, coded the resident as having scored a 15 out of 15 on the brief interview for mental status indicating the resident was intact cognitively. The resident was coded as requiring the assistance of two staff for transfer in and out of bed. A group interview was conducted on 7/19/16 at 3:45 p.m. with seven cognitively intact residents. Resident #10 was present at the interview. When the residents were asked if staff were respectful of the residents, Resident #10 stated, "A CNA (certified nursing assistant) cussed at me two weeks ago." When asked what happened, Resident #10 stated, "I put my call bell on to be put back to bed. I waited 45 minutes and I could see four staff standing at the desk so I went up there and asked them to put me to bed. The CNA said "I just (sic) done dealing with two assholes are you going to be another?" When asked if she reported this, Resident #10 stated she had. A private interview was conducted on 7/20/16 at 4:00 p.m. with Resident #10. When asked if she would discuss the incident with the CNA, Resident #10 stated, "I like to go to bed after I have my shower. At 7:30 (p.m.) I was ready to go to bed. I turned my call bell on and sat there for 45 minutes, I read a book and texted on my phone and then I sat by my door. Another resident told one of the staff that my light one was on and the staff member stated, "We know (name of resident)." I wheeled myself up to the nurse's station and told the CNA that I had been	F 225	attending physician and State agencies was completed as indicated. **Monitoring:** The Administrator is responsible for maintaining compliance. Facility Incident & Accidents forms will be reviewed daily by the Administrator and initialed as reviewed. Confidential files of reported incidents and all follow-up documentation will be maintained in the Administrator's office. The Risk Management Committee will review I&A form to identify and/or correcting negative patterns weekly. All negative findings will be reported and investigated. Aggregate findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice. **Completion Date: 9/3/2016**	

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F 225	Continued From page 3 waiting for 45 minutes to be put to bed and the CNA (CNA #5) said [I'm on my break]." The resident stated that she said that the staff had been on a break a long time and the Resident stated, "The CNA (CNA #5) told me she had already dealt with two assholes today are you going to be my third?" Resident #10 stated, "They all laughed (the staff at the desk)." When asked what staff was at the desk, the Resident stated, "(Gave the name of two CNAs (CNA #4 and CNA #5) and an LPN [licensed practical nurse (LPN #4)]. I met with (name of the director of nursing and the assistant director of nursing) with the CNA (CNA #5) and she denied saying that (she called Resident #10 an asshole) and they (the DON and ADON [assistant director of nursing]) believed her." The ADON (assistant director of nursing [administrative staff member (ASM) #4]) took me back to my room." When asked how this incident had made her feel, Resident #10 stated, "This made me out to be a liar. I finally apologized to the CNA (CNA #5) but I didn't think I needed to and the CNA held out her hand and said [truce]." The resident then said that she didn't want the CNA (CNA #5) to lose her job. Review of the facility's investigation of the incident dated 7/13/16 documented, "Problem: CNA failed to assist resident to be in a timely manner. Resident stated "CNA [name of CNA] stated I just finished taking care of 2 assholes are you going to be one of them two (sic)." spoke with CNA and resident present CNA denied that she made such a statement resident insisted that she did, then stated, "maybe I heard wrong." Incident occurred July 5th 2016. Resident reported 7/13/16." Signed by [name of ADON (ASM #4)]. Further review of the investigation documented, "Action Taken: Interviewed staff who was said to be present @	F 225		

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F 225	Continued From page 4 time. Statements (written) collected spoke with resident + staff member (accused) Additional Comments: "Resident states she loves [name of CNA] and has no problem with [name of CNA] caring for her. States she just wants to go to bed after last smoke break. Administrator and DON (director of nursing) does not wish to choose disciplinary actions @ this time. CNA Educated." Signed by the ADON (ASM #4). Review of the undated written statement from CNA #5 who the Resident accused of being rude to her documented, "On 7/5/16 I was finishing up my break at the nurses station when [room number of resident] came up very upset and wanting to go to bed. Four other employees were also at the desk as well. I stated to [room number of resident] I was finishing my break and to calm down I will come + (plus) help put her to bed. But right before she came up she actually called the facility to have someone put her in as well." Signed by the CNA (CNA #5). Review of the written statement dated 7/11/16 from CNA #4 (CNA at desk at the time of the incident) documented, "On July 10, [name of resident] asked to be put to bed right after her shower and I said yes as soon as I can find someone to help me. (Name of Resident #10) rang her call bell and I checked it to find she wanted to be put to bed. I still had to find someone. [name of CNA #5] had told me she wanted to eat a little first and then she would help me [name of resident] waited a long time and finally came up to the nurses station. [Name of resident] asked if anyone was going to put her to bed and [name of CNA #5] said in a minute. I've been busting my butt all day and dealing with pains, are you going to be another pain? [Name	F 225		

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F 225	Continued From page 5	F 225		

of resident] said no, she wanted to go to bed. CNA #5 wheeled her down and we put her to bed."

Review of the undated written statement from LPN #4, the nurse present at the time of the incident documented, "On 7-5-16. I did not hear [CNA #5\ tell [name of resident], that she was a (sic) asshole."

An interview was conducted on 7/21/16 at 9:06 a.m. with CNA #2. When asked if it was acceptable for a resident to have their call bell on for 45 minutes, CNA #2 stated, "That's rude and disrespectful." When asked if it was acceptable for a staff member to call a resident an asshole or pain, CNA #2 stated, "That's abuse. Yes I would say it was verbal abuse." When asked if a CNA was heard being rude what did staff do, CNA #2 stated, "I report it to my supervisor, if she didn't do anything I report it up to [name of ADON]."

CNA #5 and CNA # 4 were unable to be contacted. An interview was conducted on 7/21/16 at 9:20 a.m. with ASM (administrative staff member) #4, the assistant director of nursing. When asked to describe the investigation of the incident involving Resident #10, ASM #4 stated, "The social worker told me I had to speak to (Resident #10) because she had a complaint that one of the CNAs (name of CNA) had stated, "I just finished with two a-holes are you going to be the next one? I brought (the resident) to (name of director of nursing's) office. She had her shower went out to smoke and told (CNA #4) she wanted to go to bed. She came up to the desk for her meds (medications) and

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F 225	Continued From page 6	F 225		

apparently that's when CNA #5 said that to her. (When I talked to CNA #5) she started crying and saying "I would never talk to her that way. My feelings are hurt." I talked to CNA #4 about reporting it right away she knows she waited." When asked what she would have done in that situation, ASM #4 stated, "I would have told her to clock out, I told her I consider it verbal abuse." When asked what process she followed in cases of alleged verbal abuse, ASM #4 stated, "I reported it to the DON, do the investigation, report it (the results of the investigation) to administrator. [Name of DON and administrator] decide if it should be reported (to the state agency and other officials) or if we can take care of it in the facility." When asked if she had completed an incident report, ASM #4 stated, "No, I just usually fill out the grievance."

An interview was conducted on 7/21/16 with ASM #1, the administrator. When asked about the incident with Resident #10 and CNA #5, ASM #1 stated, "[Name of the DON and ADON (ASM #4)] brought the information to me. CNA #4 and LPN #4 were at the desk; (CNA #5) didn't use the word a-hole, but did call her a pain." When asked if calling a resident a pain was verbal abuse, ASM #1 stated, "I don't think its verbal abuse, I think it ' s not respectful. [CNA #5 has to be counseled]." When asked if leaving a call bell unanswered for 45 minutes was considered neglectful, ASM #1 stated, "Neglect, is someone being left not cared for, wet, soiled, not getting their medications. This was bad judgement in time allocation." When asked why he did not complete a facility reported incident report for the allegation of verbal abuse, ASM #1 stated, "I didn't view it as anything more than that [counseling CNA #5]." When asked if there was written documentation of the

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F 225	Continued From page 7 counseling of CNA #5, ASM #1 stated, [Name of DON] talked to her. I don't think she wrote up anything about it." When told that his staff felt calling a resident a pain was considered verbal abuse, ASM #1 did not respond. The director of nursing was on vacation and not available at the time of survey. Review of the facility's abuse policy documented, "STAFF TO RESIDENT ABUSE GUIDELINE. This is the protocol for staff to follow in instance of alleged staff to resident abuse/neglect, involuntary seclusion or misappropriation of property as defined in Regulations F223-226 of the federal guidelines for long term care facilities. 'Abuse' means .....intimidation, or punishment resulting physical harm, or pain, or mental anguish, or deprivation by an individual, including a caretaker of goods and services that are necessary to attain or maintain physical, mental and psychosocial well-being. This includes verbal, sexual abuse, physical abuse or mental abuse....'Neglect' means failure to provide goods, resident care and services necessary to avoid physical harm, mental anguish or mental illness. It may include, but not be limited to being left sit or lie in urine or feces, or failure to answer call bells to provide needed assistance...The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the Administrator of the facility and to the officials in accordance with State law through established procedure (including to the state survey and certification agency.)....5. If, after initial immediate investigation, the Administrator finds that there is any possibility that staff to resident abuse did	F 225		

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F 225	Continued From page 8 occur, the employee involved will be suspended until the investigation is completed. 6. An investigation by the Administrator or Director of Nursing MUST be initiated within 24 hours of their knowledge of the alleged incident. This investigation includes interviewing the resident involve, all staff involve (directly or indirectly), any family involve, other residents involved and any visitors involved. The Administrator will document a summary of all interviews. 7. An Incident/Accident Report form must be completed by the nurse in charge. 8. The Administrator MUST notify the local Adult Protective Service Agency and the local Ombudsman of any allegation of abuse within 24 hours of their knowledge of the alleged incident. APS (adult protective services) usually works with the local Ombudsman to determine if a protected environment is needed for the residents involved. 9. The State Department of Health is to be notified immediately of the facility's knowledge of any alleged incident of staff to resident abuse/neglect, and a written follow-up must be sent within five (5) working days." No further information was provided prior to exit.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by:	F 226	**F226** **Corrective Action(s):** A thorough investigation into the allegations of abuse involving resident #10 has been conducted and the outcome of the internal investigation has been reported to the appropriate State agencies.	

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F 226	Continued From page 9 Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement policies regarding reporting of an allegation of abuse for one of 19 residents in the survey sample, Resident #10. The facility staff failed to implement abuse policies to immediately report to the administrator an allegation of verbal abuse by one of the facility's staff, CNA (certified nursing assistant) #5 towards Resident #10. The incident occurred on 7/5/16 and was not immediately (within 24 hours) reported to the administrator. In addition the facility failed to report the allegation of verbal abuse to the state agency. The findings include: Resident #10 was admitted to the facility on 5/22/14 with a readmission on 3/31/16 with diagnoses that included but were not limited to: chronic lung disease, obesity, heart failure, high blood pressure, diabetes, depression and arthritis. The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/1/16, coded the resident as having scored a 15 out of 15 on the brief interview for mental status indicating the resident was intact cognitively. The resident was coded as requiring the assistance of two staff for transfer in and out of bed. A group interview was conducted on 7/19/16 at 3:45 p.m. with seven cognitively intact residents. Resident #10 was present at the interview. When the residents were asked if staff were respectful	F 226	**Identification of Deficient Practices and Corrective Action(s):** All other residents may have been potentially affected. A 100% review of all Facility Incident & Accident Forms for the previous 60 days has been reviewed to identify residents at risk. Any/all negative findings of reportable occurrences identified will result in an internal investigation with appropriate notification of outcomes to the State agencies, attending physician and responsible parties. **Systemic Change(s):** The Policy & Procedure for reporting and investigating abuse, neglect, misappropriation of resident property and injuries or unusual/unknown occurrences has been reviewed. No changes are warranted at this time. Staff will be inserviced and issued copies of the updated Abuse and Investigation Protocols.	

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F 226	Continued From page 10 of the residents, Resident #10 stated, "A CNA (certified nursing assistant) cussed at me two weeks ago." When asked what happened, Resident #10 stated, "I put my call bell on to be put back to bed. I waited 45 minutes and I could see four staff standing at the desk so I went up there and asked them to put me to bed. The CNA (CNA #5) said "I just (sic) done dealing with two assholes are you going to be another?" When asked if she reported this, Resident #10 stated she had. A private interview was conducted on 7/20/16 at 4:00 p.m. with Resident #10. When asked if she would discuss the incident with the CNA, Resident #10 stated, "I like to go to bed after I have my shower. At 7:30 (p.m.) I was ready to go to bed. I turned my call bell on and sat there for 45 minutes, I read a book and texted on my phone and then I sat by my door. Another resident told one of the staff that my light one was on and the staff member stated, "We know (name of resident)." I wheeled myself up to the nurse's station and told the CNA that I had been waiting for 45 minutes to be put to bed and the CNA (CNA #5) said [I'm on my break]." The resident stated that she said that the staff had been on a break a long time and the Resident stated, "The CNA (CNA #5) told me she had already dealt with two assholes today are you going to be my third?" Resident #10 stated, "They all laughed (the staff at the desk)." When asked what staff was at the desk, the Resident stated, "(Gave the name of two CNAs (CNA #4 and CNA #5) and an LPN [licensed practical nurse (LPN #4)]. I met with (name of the director of nursing and the assistant director of nursing) with the CNA (CNA #5) and she denied saying that (she called Resident #10 an asshole) and they (the	F 226	These educational inservices will focus on prevention, identifying, reporting, and investigating incidents and/or potential abuse that are reported. The Administrator and DON are responsible for completing internal investigations for all reported incidents of unknown origin, abuse, neglect, unusual occurrences and misappropriation of resident property. The Administrator will review all findings and verify that the appropriate notification to the RP, attending physician and State agencies was completed as indicated. **Monitoring:** The Administrator and DON are responsible for compliance. All resident to resident incidents, resident abuse and neglect allegations and unusual occurrences will be thoroughly investigated, reported to the RP, attending physicians and appropriate state agencies as	

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F 226	Continued From page 11 DON and ADON [assistant director of nursing]) believed her." The ADON (assistant director of nursing [administrative staff member (ASM) #4]) took me back to my room." When asked how this incident had made her feel, Resident #10 stated, "This made me out to be a liar. I finally apologized to the CNA (CNA #5) but I didn't think I needed to and the CNA held out her hand and said [truce]." The resident then said that she didn't want the CNA (CNA #5) to lose her job. Review of the facility's investigation of the incident dated 7/13/16 documented, "Problem: CNA failed to assist resident to be in a timely manner. Resident stated "CNA [name of CNA] stated I just finished taking care of 2 assholes are you going to be one of them two (sic)." spoke with CNA and resident present CNA denied that she made such a statement resident insisted that she did, then stated, "maybe I heard wrong." Incident occurred July 5th 2016. Resident reported 7/13/16." Signed by [name of ADON (ASM #4)]. Further review of the investigation documented, "Action Taken: Interviewed staff who was said to be present @ time. Statements (written) collected spoke with resident + staff member (accused) Additional Comments: "Resident states she loves [name of CNA] and has no problem with [name of CNA] caring for her. States she just wants to go to bed after last smoke break. Administrator and DON (director of nursing) does not wish to choose disciplinary actions @ this time. CNA Educated." Signed by the ADON (ASM #4). Review of the undated written statement from CNA #5 who the Resident accused of being rude to her documented, "On 7/5/16 I was finishing up my break at the nurses station when [room number of resident] came up very upset and	F 226	needed. Disciplinary action for staff members will be administered as warranted. Confidential files of all reported incidents and all follow-up documentation will be maintained in the Administrator's office. All facility reported incidents will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice. **Completion Date: 9/3/2016**	

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F 226	Continued From page 12 wanting to go to bed. Four other employees were also at the desk as well. I stated to [room number of resident] I was finishing my break and to calm down I will come + (plus) help put her to bed. But right before she came up she actually called the facility to have someone put her in as well." Signed by the CNA (CNA #5). Review of the written statement dated 7/11/16 from CNA #4 (CNA at desk at the time of the incident) documented, "On July 10, [name of resident] asked to be put to bed right after her shower and I said yes as soon as I can find someone to help me. (Name of Resident #10) rang her call bell and I checked it to find she wanted to be put to bed. I still had to find someone. [name of CNA #5] had told me she wanted to eat a little first and then she would help me [name of resident] waited a long time and finally came up to the nurses station. [Name of resident] asked if anyone was going to put her to bed and [name of CNA #5] said in a minute. I've been busting my butt all day and dealing with pains, are you going to be another pain? [Name of resident] said no, she wanted to go to bed. CNA #5 wheeled her down and we put her to bed." Review of the undated written statement from LPN #4, the nurse present at the time of the incident documented, "On 7-5-16. I did not hear [CNA #5\ tell [name of resident], that she was a (sic) asshole." An interview was conducted on 7/21/16 at 9:06 a.m. with CNA #2. When asked if it was acceptable for a resident to have their call bell on for 45 minutes, CNA #2 stated, "That's rude and	F 226		

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disrespectful." When asked if it was acceptable for a staff member to call a resident an asshole or pain, CNA #2 stated, "That's abuse. Yes I would say it was verbal abuse." When asked if a CNA was heard being rude what did staff do, CNA #2 stated, "I report it to my supervisor, if she didn't do anything I report it up to [name of ADON]."

CNA #5 and CNA # 4 were unable to be contacted. An interview was conducted on 7/21/16 at 9:20 a.m. with ASM (administrative staff member) #4, the assistant director of nursing. When asked to describe the investigation of the incident involving Resident #10, ASM #4 stated, "The social worker told me I had to speak to (Resident #10) because she had a complaint that one of the CNAs (name of CNA) had stated, "I just finished with two a-holes are you going to be the next one? I brought (the resident) to (name of director of nursing's) office. She had her shower went out to smoke and told (CNA #4) she wanted to go to bed. She came up to the desk for her meds (medications) and apparently that's when CNA #5 said that to her. (When I talked to CNA #5) she started crying and saying "I would never talk to her that way. My feelings are hurt." I talked to CNA #4 about reporting it right away she knows she waited." When asked what she would have done in that situation, ASM #4 stated, "I would have told her to clock out, I told her I consider it verbal abuse." When asked what process she followed in cases of alleged verbal abuse, ASM #4 stated, "I reported it to the DON, do the investigation, report it (the results of the investigation) to administrator. [Name of DON and administrator] decide if it should be reported (to the state agency and other officials) or if we can take care

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of it in the facility." When asked if she had completed an incident report, ASM #4 stated, "No, I just usually fill out the grievance."

An interview was conducted on 7/21/16 with ASM #1, the administrator. When asked about the incident with Resident #10 and CNA #5, ASM #1 stated, "[Name of the DON and ADON (ASM #4)] brought the information to me. CNA #4 and LPN #4 were at the desk; (CNA #5) didn't use the word a-hole, but did call her a pain." When asked if calling a resident a pain was verbal abuse, ASM #1 stated, "I don't think its verbal abuse, I think it ' s not respectful. [CNA #5 has to be counseled]." When asked if leaving a call bell unanswered for 45 minutes was considered neglectful, ASM #1 stated, "Neglect, is someone being left not cared for, wet, soiled, not getting their medications. This was bad judgement in time allocation." When asked why he did not complete a facility reported incident report for the allegation of verbal abuse, ASM #1 stated, "I didn't view it as anything more than that [counseling CNA #5]." When asked if there was written documentation of the counseling of CNA #5, ASM #1 stated, [Name of DON] talked to her. I don't think she wrote up anything about it." When told that his staff felt calling a resident a pain was considered verbal abuse, ASM #1 did not respond.

The director of nursing was on vacation and not available at the time of survey.

Review of the facility's abuse policy documented, "STAFF TO RESIDENT ABUSE GUIDELINE. This is the protocol for staff to follow in instance of alleged staff to resident abuse/neglect, involuntary seclusion or misappropriation of property as defined in Regulations F223-226 of

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the federal guidelines for long term care facilities. 'Abuse' means .....intimidation, or punishment resulting physical harm, or pain, or mental anguish, or deprivation by an individual, including a caretaker of goods and services that are necessary to attain or maintain physical, mental and psychosocial well-being. This includes verbal, sexual abuse, physical abuse or mental abuse....'Neglect' means failure to provide goods, resident care and services necessary to avoid physical harm, mental anguish or mental illness. It may include, but not be limited to being left sit or lie in urine or feces, or failure to answer call bells to provide needed assistance...The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the Administrator of the facility and to the officials in accordance with State law through established procedure (including to the state survey and certification agency.)....5. If, after initial immediate investigation, the Administrator finds that there is any possibility that staff to resident abuse did occur, the employee involved will be suspended until the investigation is completed. 6. An investigation by the Administrator or Director of Nursing MUST be initiated within 24 hours of their knowledge of the alleged incident. This investigation includes interviewing the resident involve, all staff involve (directly or indirectly), any family involve, other residents involved and any visitors involved. The Administrator will document a summary of all interviews. 7. An Incident/Accident Report form must be completed by the nurse in charge. 8. The Administrator MUST notify the local Adult Protective Service Agency and the local Ombudsman of any allegation of abuse within 24 hours of their

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F 226	Continued From page 16 knowledge of the alleged incident. APS (adult protective services) usually works with the local Ombudsman to determine if a protected environment is needed for the residents involved. 9. The State Department of Health is to be notified immediately of the facility's knowledge of any alleged incident of staff to resident abuse/neglect, and a written follow-up must be sent within five (5) working days." No further information was provided prior to exit.	F 226		
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. 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 and homelike environment in one of two shower rooms, the shower room located on the left side of the hall while facing the nurse's station. A reddish brown substance was observed in the shower stalls and indentations were observed on the edge molding while entering the shower stalls in the shower room located on the left side of the hall while facing the nurse's station. The findings include:	F 252	**F252** **Corrective Action(s):** The left side bathing/shower room identified during the survey has had the edge moldings repaired by the maintenance director and the floors have been power washed and the room has been thoroughly cleaned by the environmental services department. **Identification of Deficient Practice(s) and Corrective Action(s):** All other resident bathing/shower rooms may have potentially been affected. The Environmental Services Director and Maintenance Director will perform a documented walkthrough inspection of all resident	

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F 252	Continued From page 17 On 7/20/16 at 11:55 a.m., observation of the shower room located on the left side of the hall while facing the nurse's station was conducted with OSM (other staff member) #3 (the maintenance director). A reddish brown substance was observed near the base of the walls in both shower stalls. Multiple indentations were observed on the edge molding while entering both shower stalls. When asked what the reddish brown substance was, OSM #3 stated he couldn't tell this surveyor what the substance was but he knew staff had tried to clean the substance and it wouldn't come off. OSM #3 stated he had tried to caulk over the substance and the substance shows through the caulk. When asked how the indentations in the edge molding occurred, OSM #3 stated the indentations resulted from staff hitting the edge molding with shower chairs. OSM #3 stated the other shower room was remodeled last year and this shower room was due to be remodeled this year. OSM #3 stated staff had requested to remodel the shower room a few times. On 7/20/16 at 3:55 p.m., an interview was conducted with OSM #2 (the director of environmental services). OSM #2 stated she had been cleaning the shower room. OSM #2 stated she thought the substance in the shower stall was a stained residue from the pink chemical her staff used to clean. OSM #2 stated staff sprayed and rinsed the chemical but the chemical wasn't coming off. OSM #2 stated she had called the outside company that provides the chemical. OSM #2 was asked if the substance in the shower stalls was homelike. OSM #2 stated she was using a pressure washer to remove the substance. OSM #2 stated she wasn't aware of the substance until that morning. At this time,	F 252	bathing/shower rooms to identify any areas in need of repair and cleaning/disinfecting. Any/All negative findings will be corrected upon identification and reviewed with the administrator. A facility Risk Management Incident and Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure for maintaining a safe clean comfortable environment has been reviewed and no changes are warranted at this time. The Environmental Services department will be inserviced by the administrator on establishing bathing/shower room cleaning schedules daily to maintain a clean sanitary home like environment. Facility administration will conduct daily random resident care rounds of the facility to ensure sanitary conditions and a home like environment is	

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F 252	Continued From page 18 OSM #2 and this surveyor observed the shower stalls. The reddish brown substance was removed. OSM #2 stated she pressure washes the shower room every week but the pressure washer had been broke for three weeks. OSM #2 stated something else could have been used to remove the substance from the shower stalls. OSM #2 confirmed residents use that shower room. On 7/20/16 at 4:10 p.m., an interview was conducted with OSM #3 regarding the indentations in the edge molding of the shower stalls. OSM #3 stated the edge moldings had been in disrepair but he hadn't repaired them because he was waiting to complete the shower room renovations. On 7/20/16 at 6:15 p.m., ASM (administrative staff member) #1 (the administrator), ASM #3 (the regional nurse consultant) and ASM #4 (the assistant director of nursing) were made aware of the above findings. A "Lease Holder and Capital Worksheet" documented renovations were planned for the shower room. ASM #1 stated he had a project number for the shower room renovations but did not have a start date. The facility policy titled, "Quality of Life- Homelike Environment" documented in part, "Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible...2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Cleanliness and order..."	F 252	being achieved. All negative findings will be reported to the Director of Environmental Services and the Administrator for immediate correction. **Monitoring:** The Administrator and Environmental Services Director are responsible for maintaining compliance. The Administrator and/or designee will make weekly rounds using the environmental audit tool to monitor for compliance and identify any negative findings. Any/all negative findings will be corrected at time of discovery. Aggregate findings of these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 9/3/2016**	

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F 252	Continued From page 19 No further information was presented prior to exit.	F 252		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff	F 278	**F278** **Corrective Action(s):** Resident #3 has had their most recent quarterly MDS modified by the MDS coordinator to accurately code section K for weight loss on the MDS. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents may have potentially been affected. A 100% audit of all current resident assessments will be completed by the MDS Coordinator and/or designee to ensure that MDS section K – Nutrition is assessed and coded correctly. All negative findings will be reported to the MDS department for immediate correction. A Modification will be completed for each discrepancy identified on the most current MDS.	

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F 278	Continued From page 20 failed to maintain an accurate MDS (minimum data set) for one of 17 residents in the survey sample, Resident #3. The facility staff inaccurately coded Resident #3 as having a weight loss on a quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 5/5/16. The findings include: Resident #3 was admitted to the facility on 7/16/15. The resident's diagnoses included but were not limited to: major depressive disorder, anxiety disorder and dysphagia (difficulty swallowing (1)). Resident #3's most recent MDS, a quarterly assessment with an ARD of 5/5/16, coded the resident's cognition as being moderately impaired. Section K documented Resident #3 as having a weight loss of five percent or more in the last month or ten percent or more in the last six months and not being on a physician prescribed weight loss plan. Review of Resident #3's weight history report revealed the following weights: 11/3/15- 109.4 (pounds) 12/1/15- 100.6 1/5/16- 102.4 2/1/16- 110 3/1/16- 117.8 4/5/16- 117.4 5/3/16- 118 The weight history report further documented Resident #3 sustained a 0.51 percent weight gain from 4/5/16 to 5/3/16 (one month) and a 7.86 weight gain from 11/3/15 to 5/3/16 (six months).	F 278	**Systemic Change(s):** The Resident Interdisciplinary Care Team has been inserviced by the MDS coordinator on the proper assessment and coding of all areas of the MDS to include section K of the MDS. All comprehensive MDS's and quarterly MDS's will now be reviewed each week according to the MDS schedule by the RCC and the IDT Team to ensure the accuracy and integrity of resident data. **Monitoring:** The DON and RCC are responsible for monitoring compliance. The MDS assessment audit will be completed weekly coinciding with the MDS calendar to monitor for compliance. All negative findings from the audits will be reported to the DON and RCC at the time of discovery for immediate correction. Aggregate findings will be reported to the Quality Assurance Committee monthly	

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F 278	Continued From page 21 On 7/20/16 at approximately 11:30 a.m., an interview was conducted with OSM (other staff member) #1 (the dietary manager and person responsible for coding section K of Resident #3's MDS). OSM #1 stated she made a mistake while coding section K of Resident #3's quarterly MDS with an ARD of 5/5/16. OSM #1 stated she should have coded a weight gain instead of a weight loss. OSM #1 stated she uses the weight history report to determine weight losses and gains. OSM #1 stated she references the RAI (resident assessment instrument) manual when completing MDS assessments. On 7/20/16 at 6:15 p.m., ASM (administrative staff member) #1 (the administrator), ASM #3 (the regional nurse consultant) and ASM #4 (the assistant director of nursing) were made aware of the above concern. The CMS (Centers for Medicare & Medicaid Services) RAI manual documented the following: "K0300: Weight Loss DEFINITIONS 5% WEIGHT LOSS IN 30 DAYS Start with the resident's weight closest to 30 days ago and multiply it by .95 (or 95%). The resulting figure represents a 5% loss from the weight 30 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has lost more than 5% body weight. 10% WEIGHT LOSS IN 180 DAYS Start with the resident's weight closest to 180 days ago and multiply it by .90 (or 90%). The resulting figure represents a 10% loss from the weight 180 days ago. If the resident's current weight is equal to or less than the resulting figure,	F 278	for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 9/3/2016**	

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F 278	Continued From page 22 the resident has lost 10% or more body weight. This item compares the resident's weight in the current observation period with his or her weight at two snapshots in time: ·At a point closest to 30-days preceding the current weight. ·At a point closest to 180-days preceding the current weight. This item does not consider weight fluctuation outside of these two time points, although the resident's weight should be monitored on a continual basis and weight loss assessed and addressed on the care plan as necessary. DEFINITIONS PHYSICIAN-PRESCRIBED WEIGHT-LOSS REGIMEN A weight reduction plan ordered by the resident's physician with the care plan goal of weight reduction. May employ a calorie-restricted diet or other weight loss diets and exercise. Also includes planned diuresis. It is important that weight loss is intentional. BODY MASS INDEX (BMI) Number calculated from a person's weight and height. BMI is used as a screening tool to identify possible weight problems for adults. Visit http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html. Coding Instructions Mathematically round weights as described in Section K0200B before completing the weight loss calculation. ·Code 0, no or unknown: if the resident has not experienced weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is not available. ·Code 1, yes on physician-prescribed weight-loss regimen: if the resident has experienced a weight	F 278		

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F 278	Continued From page 23 loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was planned and pursuant to a physician's order. In cases where a resident has a weight loss of 5% or more in 30 days or 10% or more in 180 days as a result of any physician ordered diet plan or expected weight loss due to loss of fluid with physician orders for diuretics, K0300 can be coded as 1. ·Code 2, yes, not on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was not planned and prescribed by a physician..." No further information was presented prior to exit. (1) This information was obtained from the website: https://www.nidcd.nih.gov/health/dysphagia	F 278		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug	F 329	**F 329** **Corrective Action(s):** Resident #6's attending physician was notified that resident #6 was receiving Coumadin and Lovenox without any PT/INR monitoring. Resident #6's attending physician reviewed resident #6's Coumadin orders and ordered immediate PT/INR monitoring. A facility Incident & Accident form and a medication error form was completed for this incident. Resident #5's attending physician was notified that the facility staff failed to perform behavior monitoring prior to and after administration of an antipsychotic medication, Risperidone. A facility Incident & Accident form and a medication error form was completed for this incident.	

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F 329	Continued From page 24 therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. 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 17 residents in the survey sample, Residents #6 and #4. 1. Resident #6 received warfarin (blood thinning medication) (1) 7.5 mg (milligrams) every Monday, Tuesday, Thursday, Friday, Saturday and warfarin 9 mg every Wednesday and Sunday. The facility staff failed to monitor Resident #6's PT/INR (prothrombin time/international normalized ratio [tests to monitor the blood]) (2) since the resident's admission on 7/3/16. 2. Facility staff failed to monitor Resident #5's behaviors while the resident was being administered an antipsychotic medication, Risperidone (1). The findings include: 1. Resident #6 received warfarin (blood thinning	F 329	**Identification of Deficient Practice(s) and Corrective Action(s):** All other residents receiving Coumadin or other blood thinning agents and antipsychotic medications may have been potentially affected. The DON and/or ADON will review the medication orders of all residents receiving Coumadin or other blood thinning agents and antipsychotic medication to ensure that required monitoring is being completed. Any/all negative findings will be communicated to the attending physicians for corrective action. A Facility Incident & Accident form will be completed for each negative finding. **Systemic Change(s):** The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. All nursing staff will be inserviced by the DON and/or regional nurse	

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F 329	Continued From page 25 medication (1)) 7.5 mg (milligrams) every Monday, Tuesday, Thursday, Friday, Saturday and warfarin 9 mg every Wednesday and Sunday. The facility staff failed to monitor Resident #6's PT/INR (prothrombin time/international normalized ratio [tests to monitor the blood (2)]) since the resident's admission on 7/3/16. Resident #6 was admitted to the facility on 7/3/16. Resident #6's diagnoses included but were not limited to: left hip fracture and heart failure. Resident #6's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 7/10/16, coded the resident's cognition as being moderately impaired. Section N documented Resident #12 received anticoagulant (blood thinning) medication seven out of the last seven days. Resident #6's hospital discharge medication list documented physician's orders for warfarin 7.5 mg (milligrams) every Monday, Tuesday, Thursday, Friday and Saturday and warfarin 9 mg every Wednesday and Sunday. The discharge instructions documented, "Monitoring Your PT/INR Blood Levels After Discharge: Two tests are used to find out how your blood is clotting. One is protime (PT) and the other is the international normalized ratio (INR). Go for your blood (PT/INR) tests as often as directed. Note that diet and medication can affect your PT/INR...Get your next PT/INR blood draw within 3-5 days of discharge from the hospital..." Resident #6's admission physician's orders dated 7/3/16 documented orders for warfarin 7.5 mg Monday, Tuesday, Thursday, Friday, Saturday and warfarin 9 mg on Wednesday and Sunday.	F 329	consultant and issued a copy of the facility policy and procedure for proper administration and monitoring of all medications. This includes pre-administration and post administration monitoring of antipsychotics and routings PT/INR monitoring for residents receiving Coumadin or other blood thinning agents. **Monitoring:** The DON is responsible for maintaining compliance. The DON and/or ADON will complete 2 random medication pass audits weekly to monitor compliance. All negative findings will be corrected immediately and appropriate disciplinary action will be taken as necessary. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 9/3/2016**	

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F 329	Continued From page 26 Resident #6's July 2016 MAR (medication administration record) documented the resident was administered warfarin as prescribed from 7/3/16 through 7/19/16. Resident #6's comprehensive care plan documented, "Problem Onset: 07/17/2016- At risk for bruising/bleeding due to being on anticoagulant...Approaches: Monitor labs per order." Review of Resident #6's clinical record failed to reveal any physician's order for a PT/INR to monitor the resident's warfarin. Physician's notes dated 7/4/16, 7/7/16 and 7/18/16 failed to document information regarding a PT/INR to monitor the resident's warfarin. On 7/20/16 at 1:15 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked the facility process for ensuring residents admitted to the facility and receiving warfarin were having PT/INR monitoring. LPN #1 stated there was no typical protocol. LPN #1 stated nurses alert the physician the resident is receiving warfarin then the physician comes to the facility and orders labs (laboratory tests). On 7/20/16 at 2:45 p.m., a telephone interview was conducted with ASM (administrative staff member) #5 (the on call physician for Resident #6's physician). ASM #5 stated the physicians usually order PT/INR tests weekly and as needed for residents receiving warfarin. ASM #5 was made aware of the above information. ASM #5 stated, "He definitely needs a PT/INR now." ASM #5 stated she saw Resident #6 on the previous Monday regarding discharge and didn't realize his PT/INR wasn't being monitored. At this time, ASM #5's call was transferred to ASM #4 (the	F 329		

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F 329	Continued From page 27 assistant director of nursing). On 7/20/16 at 2:55 p.m., a telephone interview was conducted with ASM #6 (Resident #6's physician). ASM #6 stated she has standard lab orders for residents who are admitted to the facility. ASM #6 stated she orders weekly INRs for residents receiving warfarin. ASM #6 stated sometimes she writes the lab orders on a telephone order sheet instead of the physician's order summary. ASM #6 was made aware no order for an INR was written in Resident #6's clinical record. ASM #6 stated it would be unusual for her to not order an INR for a resident receiving warfarin because she (ASM #6) was "a creature of habit." On 7/20/16 at 3:25 p.m., ASM #4 confirmed no PT/INR was ordered for or obtained from Resident #6 during his stay at the facility. On 7/20/16 at 6:15 p.m., ASM #1 (the administrator), ASM #3 (the regional nurse consultant) and ASM #4 were made aware of the above findings. The director of nursing was not present during survey. Resident #6's PT/INR results collected on 7/20/16 and reported on 7/21/16 were: PT- 56.5 (with a reference range of 10-13) and INR 4.76 (with a reference range of 2.0 to 3.0). A physician's telephone order dated 7/21/16 documented orders to discontinue Lovenox (a blood thinning medication (3)), hold coumadin (warfarin) on that day, start coumadin 7.5 mg on 7/22/16 and collect an INR on Monday. The facility policy titled, "Anticoagulation-Clinical Protocol" documented in part,	F 329		

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F 329	Continued From page 28 "Treatment/Management: 2.a. The physician should stop, taper, or change medications that interact with warfarin, or monitor the PT/INR very closely while the individual is receiving warfarin, to ensure that the PT/INR stabilizes..." No further information was presented prior to exit. (1) Warfarin is used to prevent blood clots from forming or growing larger in your blood and blood vessels. It is prescribed for people with certain types of irregular heartbeat, people with prosthetic (replacement or mechanical) heart valves, and people who have suffered a heart attack. Warfarin is also used to treat or prevent venous thrombosis (swelling and blood clot in a vein) and pulmonary embolism (a blood clot in the lung). Warfarin is in a class of medications called anticoagulants ('blood thinners'). It works by decreasing the clotting ability of the blood...IMPORTANT WARNING: Warfarin may cause severe bleeding that can be life-threatening and even cause death. Tell your doctor if you have or have ever had a blood or bleeding disorder; bleeding problems, especially in your stomach or your esophagus (tube from the throat to the stomach), intestines, urinary tract or bladder, or lungs; high blood pressure; heart attack; angina (chest pain or pressure); heart disease; pericarditis (swelling of the lining (sac) around the heart); endocarditis (infection of one or more heart valves); a stroke or ministroke; aneurysm (weakening or tearing of an artery or vein); anemia (low number of red blood cells in the blood); cancer; chronic diarrhea; or kidney, or liver disease. Also tell your doctor if you fall often or have had a recent serious injury or surgery. Bleeding is more likely during warfarin treatment for people over 65 years of age, and it is also	F 329		

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F 329	Continued From page 29 more likely during the first month of warfarin treatment. Bleeding is also more likely to occur for people who take high doses of warfarin, or take this medication for a long time. The risk for bleeding while taking warfarin is also higher for people participating in an activity or sport that may result in serious injury. Tell your doctor and pharmacist if you are taking or plan to take any prescription or nonprescription medications, vitamins, nutritional supplements, and herbal or botanical products (See SPECIAL PRECAUTIONS), as some of these products may increase the risk for bleeding while you are taking warfarin...Some people may respond differently to warfarin based on their heredity or genetic make-up. Your doctor may order a blood test to help find the dose of warfarin that is best for you...Keep all appointments with your doctor and the laboratory. Your doctor will order a blood test (PT [prothrombin test] reported as INR [international normalized ratio] value) regularly to check your body's response to warfarin..." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682277.html (2) "The PT and INR are used to monitor the effectiveness of the anticoagulant warfarin. This drug affects the function of the coagulation cascade and helps inhibit the formation of blood clots. It is prescribed on a long-term basis to people who have experienced recurrent inappropriate blood clotting. The goal of warfarin therapy is to maintain a balance between preventing clots and causing excessive bleeding. This balance requires careful monitoring. The INR can be used to adjust a person's drug dosage to get the PT into the desired range that is right for the person and his or her condition." This information was obtained from the website:	F 329		

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F 329	Continued From page 30 https://labtestsonline.org/understanding/analytes/pt/tab/test (3) Lovenox "is used to prevent blood clots in the leg in patients who are on bedrest or who are having hip replacement, knee replacement, or stomach surgery. It is used in combination with aspirin to prevent complications from angina (chest pain) and heart attacks. It is also used in combination with warfarin to treat blood clots in the leg. Enoxaparin is in a class of medications called low molecular weight heparins. It works by stopping the formation of substances that cause clots." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601210.html 2. Facility staff failed to monitor Resident #5's behaviors while the resident was being administered an antipsychotic medication, Risperidone (1). Resident #5 was admitted to the facility on 8/25/15 with diagnoses that included but were not limited to: atrial fibrillation (an irregular heartbeat), depression, anxiety and dementia. The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 5/20/16 coded the resident as having a ten out of 15 on the BIMS (brief interview for mental status) indicating the resident was moderately impaired cognitively. The resident was coded as requiring the assistance of one staff member for activities of daily living except for eating which the resident could do after the tray was prepared. In Section E titled "Behavior" the resident was coded as not having any behaviors.	F 329		

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F 329	Continued From page 31 Review of the physician's orders dated July 2016 documented, "Risperidone 0.5mg (milligrams) tab (tablet) 1 PO (by mouth) QHS (every hour of sleep) for depression with behaviors. Start date 11/19/15." There was no documentation of targeted behaviors to be monitored for the administration of this medication. Review of the psychiatric notes dated and signed 9/18/15 documented, "No evidence of mood disorder or psychosis." Review of Resident #5's care plan initiated on 4/20/16 documented, "Resident takes psychotropic* drug regimen (antidepressant, antipsychotic). Approaches. Monitor for effectiveness of the medication. Review of the March, April, May, June and July 2016 MARs (medication administration records) documented, "Risperidone 0.5mg PO QHS dx (diagnosis) depression with depression." It was documented that the resident received the medication every day except for two occasions 5/28/16 and 5/29/16 when the resident was out of the facility. There were no behaviors documented. Review of the nurse's notes from April 2016 to July 2016 did not document targeted behaviors that were being monitored for the administration of Risperidone. On 7/20/16 at 12:15 p.m. a request was made to OSM (other staff member) #4, the medical records director, for behavior monitoring sheets for Resident #5.	F 329		

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F 329	Continued From page 32 On 7/20/16 at 12:40 p.m., ASM (administrative staff member) #3, the corporate nurse, delivered the MARs to this surveyor. ASM #3 stated, "They're (the behaviors) are supposed to be there, but they're not." When asked why staff monitors behaviors when a resident is receiving Risperidone, ASM #3 stated, "To make sure the medication is effective or not effective, to do a gradual dose adjustment....they should be on the MAR." On 7/20/16 at 1:00 p.m. an interview was conducted with LPN (licensed practical nurse) #1. When asked how staff monitor a resident on an antipsychotic medication, LPN #1 stated, "If it's an antipsychotic it flags our MAR for us to document their (the residents) reaction to it." When asked why they monitor the resident, LPN #1 stated, "To see the effectiveness of the medication." On 7/21/16 at 6:15 p.m. ASM #1, the administrator and ASM #3, the corporate nurse, were made aware of the findings. Review of the facility's policy titled, "PSYCHOTROPIC DRUGS" documented, "A. STANDARD. The facility will develop and maintain a system for assuring proper use and monitoring of psychoactive agents. Psychoactive agents can only be used on receipt of physician's order to eliminate or reduce identified behavioral symptoms or to treat a specific diagnosis. 2. MONITORING ROUTINE USE OF PSYCHOACTIVE DRUGS. 1) Define and document specific behavioral problems within the nursing notes. No further information was provided prior to exit.	F 329		

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F 329	Continued From page 33 (1) Risperidone - is also used to treat behavior problems such as aggression, self-injury, and sudden mood changes in teenagers and children 5 to 16 years of age who have autism (a condition that causes repetitive behavior, difficulty interacting with others, and problems with communication). Risperidone is in a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain. The information was contained at https://medlineplus.gov/druginfo/meds/a694015.html	F 329	**F354** **Corrective Action(s):** The facility Medical Director has been notified that the facility failed to ensure Registered Nurse coverage for eight hours a day/7 days a week on 7/9/2016, 7/16/16 and 7/17/16. The facility has adjusted the nursing schedule to ensure a Registered Nurse is on duty at least 8 hours a day/7 days a week.	
F 354 SS=D	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to maintain RN (registered nurse) coverage for eight consecutive hours each day.	F 354	**Identification of Deficient Practices/Corrective Action(s):** The facility will conduct a 100% audit of the as worked schedule for the past 30 days to determine RN coverage issues. Any/all negative findings will be reported to the Facility Medical Director by the Administrator. A Risk Management Incident & Accident Form will be completed for each incident. The facility will review current staffing patterns daily to ensure that at least 8 hours of RN coverage is occurring daily.	

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F 354	Continued From page 34 The facility staff failed to use the services of an RN for eight consecutive hours on 7/9/16, 7/16/16, and 7/17/16. The findings include: Review of staffing schedules and time card details revealed the only RN in the building was clocked in for service less than eight hours on the following days: 7/9/16- 7.47 hours 7/16/16- 7.13 hours 7/17/16- 7.75 hours The Director of Nursing was unavailable for interview during the survey. On 7/20/16 at 5:06 p.m., an interview was conducted with ASM (administrative staff member) #1 (the administrator). ASM #1 confirmed there was not an RN in the facility to provide services for eight consecutive hours during the above dates. ASM #1 stated the RNs were scheduled to be in the facility for eight hours but it looked like they clocked out early. The facility document titled, "STAFFING PLAN" documented in part, "1. Nursing services are provided 24 hours a day, 7 days a week. At least one licensed nurse is on duty each shift 7 days a week and a registered nurse for at least 8 consecutive hours a day 7 days a week..." No further information was presented prior to exit.	F 354	**Systemic Change(s):** The facility Administrative Staff will be educated on the Federal requirement for Registered Nurse coverage by the Regional Nurse Consultant. The facility will review daily as worked schedules each morning during the stand up meeting to ensure 8 hours of RN coverage is being met for each day. **Monitoring:** The Administrator and DON are responsible for maintaining compliance. The Administrator and DON will review the schedule daily to ensure RN coverage. All negative findings will be corrected at time of discovery by calling outside support. Aggregate findings will be reported to the QA Committee for review, analysis, and recommendations of change in facility procedure, or practice. **Completion Date: 9/3/2016**	
F 364 SS=C	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	F 364		

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F 364	Continued From page 35 Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, it was determined that facility staff failed to serve food at a palatable temperature. Facility staff failed to serve hot food at the 7/20/16 dinner service. The findings include: Resident #12 was interviewed on 7/20/16 at 1:45 p.m. Resident #12 ' s most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/5/16. Resident #12 had a 15 out of 15 on the brief interview for mental status indicating the resident was cognitively intact to make daily decisions. At this time Resident #12 stated that her food was generally served cold by the time she received her tray. Resident #12 stated that she was at the end of the hall and "by the time we get it food is not hot." Review of the resident council minutes for April, May, June and July 2016 did not evidence documentation of dietary issues. On 7/20/16 at 4:30 p.m. an observation of the dinner food service was made. Food temperatures were taken prior to putting the food	F 364	**F 364** **Corrective Action(s):** All dietary staff has been inserviced on the proper procedure for serving, preparing, distributing food in a way that is flavorful, palatable, attractive, and at the proper temperature. The RD and CDM have reviewed the Federal and State guidelines for preparing, distributing and maintaining foods at the proper temperatures and to prepare and serve food in a palatable and nutritive manner. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have been potentially affected. The Administrator, CDM, and/or Registered Dietician will randomly monitor and sample test trays of all meals for the next 3 days prior to serving to identify any negative findings. All negative findings will be corrected at time of discovery. A Risk Management Incident	

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F 364	Continued From page 36 on the resident's plates. The food temperatures were as follows: ground ham -- 180 degrees; ham slices -- 190; pureed ham -- 160; pureed greens -- 170; pureed bean -- 170; greens -- 190; beans -- 160; squash -- 150; potatoes -- 180; pureed corn bread -- 158; chicken tenders -- 180 degrees; french fries -- 165; chopped chicken tender -- 160 and cream soup -- 145. Food was put on plates beginning at 4:40 p.m. As each cart was loaded it was left in the kitchen. A request for a test tray was made when the last food tray was completed. The tray was loaded onto the cart serving the 300 hallway. Resident #12 resided on the 300 hallway. On 7/20/16 at 5:18 p.m. the cart was taken to the unit by a CNA (certified nursing assistant). The trays were then distributed to the residents. At 6:10 p.m. all trays had been delivered and all residents were eating. Resident #12 was served her tray at 5:40 p.m. Resident #12 was asked whether or not her food was hot or cool Resident #12 stated that the soup was hot but the chicken tenders were not hot. OSM (other staff member) #1, the dietary director, was asked to obtain a temperature of the chicken tenders, they were 80 degrees. On 7/20/16 at 5:41 p.m. an interview was conducted with OSM #1. When asked what temperature food was to be served at, OSM #1 stated, "I like it to be 145 degrees." On 7/20/16 at 5:55 p.m. the test tray food temperatures were checked and sampled by OSM #1 and two surveyors. The temperatures were as follows: chicken tender -- 70; potatoes	F 364	Report will be completed for each negative finding identified. **Systemic Change(s):** Current facility policy & procedure has been reviewed and no changes are warranted at this time. The consulting Registered Dietician will inservice the CDM and dietary staff on the proper preparation to serve palatable and nutritive foods and maintaining hot and cold temperatures during meal tray set up and delivery to residents for all meals. **Monitoring:** The CDM is responsible for maintaining compliance. The Administrator and/or CDM will perform random test tray samplings weekly to monitor for compliance. The results of these reviews will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 9/3/2016**	

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F 364	Continued From page 37 60; pureed bread -- 70; french fry -- 70; squash 80; pureed beans -- 90; greens -- 100; ground ham -- 90 and ham slice -- 90. When asked how the food's temperature was, OSM #1 stated, "It needs to be reheated." When asked if the temperature of the food was acceptable, OSM #1 stated, "No." A request for a policy on food temperatures was requested. The policy was not received. On 7/21/16 at 8:27 a.m. ASM (administrative staff member) #1, the administrator stated, "About the test tray, I understand there were very small amounts of food. I question if that sample tray was representative of a normal tray because the portions were so small (that the temperature wouldn't be correct)." ASM #2 was made aware that the ham slice and beans were normal portion size and that the resident's chicken tender's temperature was checked and it was found to be 80 degrees. ASM #1 stated, "We offered to heat it but she refused." When asked if that was how they wanted to serve food to the residents, ASM #1 stated, "No." No further information was provided prior to exit.	F 364	**F 371** **Corrective Action(s):** The two undated plastic bags of meat identified in the walk-in freezer during the initial kitchen tour was immediately removed and disposed of. A facility Incident and Accident form was completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have been potentially affected. The Food Service Manager, and/or Registered Dietician will randomly monitor the kitchen preparation area before, during and after meals to identify any negative findings. The freezers and refrigerators in the kitchen will be monitored daily for proper storage of food items. Any expired food or unlabeled or undated food items identified in the kitchen freezers, refrigerators or dry storage area will be corrected at time of discovery and appropriate disciplinary action taken as	
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 38 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined facility staff failed to store food in a safe manner. The facility staff placed two undated plastic bags of opened meats in the freezer. The findings include: On 7/19/16 at 10:20 a.m. a tour of the kitchen was conducted with OSM (other staff member) #1, the dietary manager. In the walk in freezer there were two plastic bags on the shelf that had been opened and were undated. In one bag there were approximately 10 chicken tenders and in the other bag there were approximately a dozen hamburgers. When the two plastic bags were shown to OSM #1, she immediately took the two bags and threw them in the trash. On 7/19/16 at 10:40 a.m. an interview was conducted with OSM #1. When asked what process staff followed if they found opened food unlabeled in the freezer, OSM #1 stated, "If we find something without a date, we throw it out. When in doubt, throw it out." When asked why they dated opened food, OSM #1 stated, "So we know what date to throw them out. We only keep freezer food for a month (after it's opened)." Review of the facility's policy titled, "Food Storage" documented, PROCEDURE: 1. All perishable items are stored immediately in either the refrigerator or freezer. No item is to be stored on the floor. All items must be covered, labeled	F 371	needed. A facility Incident and Accident form will be completed for each negative finding identified. **Systemic Change(s):** Current facility policy & procedure has been reviewed and no changes are warranted at this time. The consulting Registered Dietician will inservice the CDM and dietary staff on the proper preparing, storing and distribution of food under sanitary conditions, as well as the policy and procedure for proper sanitation and hand washing. **Monitoring:** The CDM is responsible for maintaining compliance. The Administrator, Food service manager will complete the Dietary audit tool weekly for monitoring and maintaining compliance. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in	

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F 371	Continued From page 39 and dated. On 7/21/16 at 6:15 p.m. ASM (administrative staff member) #1, the administrator and ASM #3, the corporate nurse were made aware of the findings. No further information was provided prior to exit.	F 371	facility policy, procedure, and/or practice. **Completion Date: 9/3/2016**	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 431	**F431** **Corrective Action(s):** The unopened bottle of expired Lorazapam identified during the medication room inspection was removed and discarded. A Facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** The unit medication room and refrigerators used for the storage medications and biologicals may have been potentially affected. The DON and/or designee will conduct a 100% review of the medication room and the medication refrigerators to identify any expired or undated medications, equipment or	

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F 431	Continued From page 40 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to ensure the proper storage of medications in one of one medication rooms in the facility. One 30 cc (cubic centimeters) unopened bottle of Lorazepam was found stored with other medications in a cabinet with an expiration date of April 2016. The expired Lorazepam medication was available for resident use. The findings include: On 7/20/16 at 3:40 p.m. an observation was made of the nursing medication storage room. The observation was conducted with LPN (licensed practical nurse) #2 during which all medications and supplies stored in the medication room was inspected for expiration dates. One 30 cc (cubic centimeters) unopened bottle of Lorazepam was found stored with other medications in a cabinet with an expiration date of April 2016. At this time LPN #2 verified that the bottle of Lorazepam was outdated and she removed the bottle from the cabinet and stated that the bottle had to go to the DON (director of nursing) for disposal. LPN #2 was asked at this time what staff inspected the medication room for outdated medications and supplies. LPN #2 stated that the DON inspected the medication	F 431	biologicals. Any/all negative findings will be corrected at time of discovery. A Facility Incident and Accident Form will be completed for each incident identified. **Systemic Change(s):** Facility policy and procedure for medication and biological storage have been reviewed and no changes are warranted at this time. All licensed nurses will be inserviced by the DON on the facility policy and procedure for storing medications and biologicals. The nursing staff will also be inserviced on the Medication Administration Policy and Procedure to include weekly review of all refrigerated medications to include injectables and unrefrigerated medications and biologicals that may be expired or opened with no date. In addition, The Pharmacy consultant will check each medication room for improper storage of medications monthly during scheduled visits	

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F 431	Continued From page 41 room for expired meds (medications) but (LPN #2) did not know how often. On 7/20/16 at 4:10 p.m. an interview was conducted with ASM (administrative staff member) #4, the assistant director of nursing. ASM #4 was asked how often the medication room was checked for outdated medications, ASM #4 stated that the room was checked daily. ASM #4 stated, "I don't understand how the Lorazepam was overlooked." A review of the facility policy titled "Storage of Medications" revealed, in part, the following documentation. "4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. On 7/20/16 at 6:10 p.m. an end of day meeting was held with ASM #1, the administrator, ASM #2, the corporate nurse and ASM #4, the assistant director of nursing. At this time the administrative staff in attendance, were made aware of the above findings. No further information was provided prior to the end of the survey process. (1) "Lorazepam is used to relieve anxiety. Lorazepam is in a class of medications called benzodiazepines. It works by slowing activity in the brain to allow for relaxation." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682053.html	F 431	**Monitoring:** The DON is responsible for maintaining compliance. The DON and/or ADON will perform weekly Medication room audits to monitor for compliance. All discrepancies found in these audits will be corrected at the time of discovery and disciplinary action taken as appropriate. Results of these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 9/3/2016** **F 441** **Corrective Action(s):** The medical director was notified that the facility failed to implement a comprehensive infection control program and failed to accurately complete infection control tracking logs. A facility Incident & Accident form has been completed for each of these incidents.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 42 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441	**Identification of Deficient Practice(s) and Corrective Action(s):** All other residents may have potentially been affected. A 100% review of all residents with infections will be conducted to identify whether the infection was a community acquired or a nosocomial infection. All identified infections will be listed on the infection control tracking logs to monitor for trends, improvement, last culture with organism (if any) and to prevent and control the development of nosocomial infections in the facility. Any/all negative findings related to infection control tracking and trending will be corrected at time of discovery and a facility Incident & Accident form will be completed. **Systemic Change(s):** The facility Infection Control policy and procedure has been reviewed and no changes are warranted at this time. The DON and ADON will be	

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F 441	Continued From page 43 Based on staff interview and facility document review, it was determined that the facility failed to implement a complete infection control program. The facility staff failed to complete monthly infection control logs to include culture information and infecting organisms on multiple occasions February 2016 through July 2016. There were no tracking logs prior to February 2016. The findings include: A review of the monthly facility infection logs from February 2016 through July 2016 revealed no information regarding culture status and infecting organisms for all residents listed with infections each of these months. For the months from July 2015 through February 2016 the facility did not have a tracking log. On 7/21/16 at approximately 9:00 a.m. an interview was conducted with ASM (administrative staff member) #1, the administrator, and ASM #4, the assistant director of nursing. ASM #1 and ASM #4 provided the policies and procedures for their infection control program and they provided a tracking log that covered the time period of February 2016 through July 2016. The tracking log provided listed all residents who had an infection, the category of the infection and whether or not the resident received an antibiotic as treatment along with the outcome. There were no pathogens (a bacterium, virus, or other microorganism that can cause disease). ASM #1 was asked if there was another log in which the pathogens were listed, ASM #1 stated, "No." ASM #1 stated, "The Infection log was started in February 2016 and the nurse who was entering	F 441	inserviced by the Regional Nurse Consultant on the facility's infection control tracking logs for maintaining proper infection control standards and prevention or facility acquired infections. All staff will be inserviced by the DON and/or Regional Nurse Consultant on the infection Control Policy standard for hand washing to prevent the spread or infections. **Monitoring:** The DON is responsible for maintaining compliance. The facility has an infection control tracking log for monitoring and tracking infections to maintain compliance. The DON and/or ADON will complete the infection control tracking log weekly and review/report all findings to the Risk Management Committee for review and recommendations. Aggregate findings of the reports will be submitted to the Quality Assurance Committee quarterly for review, analysis, and	

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F 441	Continued From page 44 the information in the computer did not enter all the information, she didn't realize that there were other screens. Another nurse monitors that the laboratory tests that are done but we don't have that in a log." ASM #1 was asked how the pathogens are monitored, ASM #1 stated, "We do that currently in the morning meeting, we talk about infections. We also have a weekly risk meeting, we don't write it down but if we have a breakout we act on it." ASM #1 was asked where the tracking was for the months prior to February 2016 up to the last survey which occurred in July 2015. ASM #1 stated that prior to February 2016 there were no tracking logs, "We just looked in the lab book." A policy was requested at this time regarding monitoring and surveillance of infections in the facility. A review of the facility policy titled "Infection Control" revealed, in part, the following documentation: " Policy Interpretation and Implementation: 1. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically (medical science that deals with the incidence, distribution, and control of disease in a population) significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. Data Collection and Recording. 1. For residents with infections that meet the criteria for definition of infection for surveillance, collect the following data as appropriate: 3. Pathogens. Gathering Surveillance Data: 5. In addition to collecting data on the incidence of infections, the surveillance system is designed to capture certain epidemiologically (medical science that deals with the incidence, distribution, and control of disease in a population) important data that may influence	F 441	recommendations for change in the facility policy and procedure. **Compliance Date: 9/3/2016**	

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F 441	Continued From page 45 how the overall surveillance data is interpreted." No further information was provided prior to the end of the survey process. No further information was provided prior to exit.	F 441	**F502** **Corrective Action(s):** Resident #4's attending physician has been notified that the facility failed to obtain a urine drug test as ordered by the physician. A Facility Incident & Accident form has been completed for the missing labs. **Identification of Deficient Practice(s) & Corrective Action(s):** All other residents who had physician ordered lab tests may have potentially been affected. A 100% audit of all resident's lab orders will be completed to identify residents at risk. All negative findings will be corrected at the time of discovery. The attending physicians will be notified of the missing labs, labs not obtained timely and labs obtained without a physician order. A facility Incident & Accident Form will be completed.	
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. 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 obtain a physician ordered laboratory test for one of 17 residents in the survey sample, Resident #4. The facility staff failed to obtain a urine drug test ordered by the physician for Resident #4. The findings include: Resident #4 was admitted to the facility on 5/16/13 and readmitted on 6/16/16 with diagnoses that included but were not limited to: high blood pressure, paralysis, chronic pain, anxiety and elevated cholesterol. The most recent MDS (minimum data set), a five day assessment, with an ARD (assessment reference date) of 6/23/16, coded Resident #4 as having a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The	F 502		

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F 502	Continued From page 46 resident was coded as requiring the assistance of one to two staff for activities of daily living, except for being independent in eating after set up of the meal tray. A review of the physician's orders dated 6/29/16 at 2:00 p.m. documented, "Expanded urine drug screen -- AMS (altered mental status)." Review of the care plan initiated on 6/28/16 did not evidence documentation regarding altered mental status. Review of the nurse's notes dated 6/29/16 at 4:49 p.m. documented, "Resident displayed cont (continuous) gradual decrease in interaction, sluggish, Appropriate in interaction as far as orientation. Noted to have delay in response. MD (medical doctor) aware and gave new orders for UA (urinalysis), Expned (sic) Urine drug screen. Lab (laboratory) slip completed." Review of Resident #4's laboratory test results did not evidence documentation of the urine expanded drug test. On 7/20/16 at 11:15 a.m. a request was made to OSM (other staff member) #4, the medical records director for a copy of Resident #4's urine drug test. On 7/20/16 at 11/45 a.m. ASM (administrative staff member) #3, the corporate nurse stated that the urine drug screen was not done. An interview was conducted on 7/20/16 at 1:00 p.m. with LPN (licensed practical nurse) #1, the nurse who wrote the order. When asked the process staff followed to obtain a laboratory	F 502	**Systemic Changes:** The facility policy and procedure has been reviewed and no changes are warranted at this time. The laboratory tracking system has been reviewed and implemented to track and validate that required lab work has been completed per physician order and policy and procedure. The DON and/or Nurse Consultant will inservice all licensed staff on physician ordered laboratory-testing, protocols, & tracking system used. **Monitoring:** The DON is responsible for maintaining compliance. The DON or ADON will complete the Facility Lab audit tool weekly to monitor for compliance. Any negative findings will be reported to the attending physician and disciplinary action will be taken as warranted. The results of these audits will be reported to the Quality Assurance Committee for review, analysis,	

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F 502	Continued From page 47 specimen, LPN #1 stated, "Typically if it's a routine lab (laboratory), take the order, process the order and put it into the lab book." When asked how staff track if a laboratory test was completed, LPN #1 stated, "There's a monthly lab audit that occurs. If we notice something is missed we notify the doctor and see if she wants to run it or discontinue it. A lot of time we find it in the monthly audit unless it's something we're looking for....like a urine test." When asked if she knew why the urine drug screen for Resident #4 was not completed, LPN #1 stated, "Honestly, I'm not sure 100%. I understood that the urine was obtained and that the lab hadn't run the test. They did not report to us that they didn't run it." On 7/20/16 at 6:15 p.m. ASM (administrative staff member) #1, the administrator and ASM #3, the corporate nurse were made aware of the findings. Review of the facility's policy titled, "Lab and Diagnostic Test Results -- Clinical Protocol" documented, "2. The staff will process test requisitions and arrange for tests." No further information was received prior to exit.	F 502	& recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 9/3/2016**	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the	F 514	**F514** **Corrective Action(s):** Resident #3's attending physician has reviewed resident #3's medication regime and continued behaviors to assess the continued use of Celexa for anxiety and depression and documented any changes to the medication regime in a physician progress note. Resident #3's attending physician was notified that facility staff failed to file physician progress notes timely in the medical record for resident #3. A facility incident and accident form has been completed for this incident.	

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F 514	Continued From page 48 resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. 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 maintain a complete medical record for two of 17 residents in the survey sample, Residents #3 and #7. 1.a. The physician failed to document review of Resident #3's anxiety, depression and continued use of the medication Celexa (an antidepressant medication (1)) prescribed on 1/17/16. b. The facility staff failed to obtain and file Resident #3's physician progress note dated 5/4/16, prior to 7/20/16. 2. The facility staff failed to obtain and file in the clinical record the 5/4/16 physician's visit for Resident #7. The findings include: 1.a. The physician failed to document review of Resident #3's anxiety, depression and continued use of the medication Celexa (an antidepressant medication (1)) prescribed on 1/17/16. Resident #3 was admitted to the facility on 7/16/15. The resident's diagnoses included but were not limited to: major depressive disorder, anxiety disorder and dysphagia (difficulty swallowing (2)). Resident #3's most recent MDS	F 514	Resident #7's attending physician has been notified that the facility staff failed to file a physician progress note timely in the medical record. A facility incident and accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have potentially been affected. A 100% audit of resident's medical records for the last 30 days will be conducted by the DON, ADON and/or Medical records to identify residents at risk for inaccurate, missing or misfiled documentation. All negative findings will be clarified and/or correct as applicable at time of discovery. A facility Incident & Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff	

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F 514	Continued From page 49 (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/5/16, coded the resident's cognition as being moderately impaired. Resident #3's most recently signed physician's order summary, signed by the physician on 6/13/16, documented an order dated 1/17/16 for Celexa 10 mg (milligrams) every day for anxiety and depression. Review of nurse's notes from 1/17/16 through 7/18/16 revealed notes that documented the resident presented with anxiety, tearfulness and/or tearless crying on the following dates: 1/30/16 1/31/16 2/13/16 3/12/16 3/26/16 4/23/16 6/5/16 6/19/16 7/2/16 7/9/16 7/16/16 Further review of the above nurse's notes revealed staff were redirecting Resident #3 and the resident frequently participated in activities. Resident #3's physician progress notes from 1/17/16 through 7/18/16 failed to document information regarding evaluation of the resident's anxiety, depression or use of Celexa, despite the resident's continued behaviors as documented in the above nurse's notes. Resident #3's comprehensive care plan	F 514	will be inserviced by the DON on the clinical documentation standards per facility policy and procedure. This training will include the standards for maintaining accurate medical records and clinical documentation to include accurate documentation of medical information in the medical record, the Physician Orders, the MAR's and the TAR's according to the acceptable professional standards and practices. In addition, the attending physicians has been inserviced by the administrator and issued a copy of the State and Federal guidelines for Physicians visits and services to include physician required admission visits, and required routine 60 days visits, writing and dating progress notes at each visit and the timely availability of those progress notes. Any physician identified to be out of compliance will be notified by fax and phone of the untimely physician visit.	

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F 514	Continued From page 50 documented, "Problem Onset: 05/05/2016- At risk for periods of sadness/anxiousness r/t (related to) Dx (diagnosis) of Anxiety/Depression...Approaches: Observe for change in mental status. Encourage verbalization. Give medication as ordered. Encourage participation in activities of interest. Provide encouragement and emotional support as needed..." On 7/20/16 at 1:15 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated Resident #3 can get quite anxious and tearful. LPN #1 stated the resident gets fixated on certain things; thinks she needs to go places and thinks she needs to take care of banking issues. LPN #1 stated the resident had a history of pacing the hall in her wheelchair and wanted to use the phone to call her granddaughter (who according to LPN #1 had a reported history of taking the resident's checkbook). LPN #1 stated at times, Resident #3 presented with tearless crying where she cried out but didn't develop any tears. LPN #1 stated staff tried comfort techniques with the resident, redirection, assisted the resident with calling her family and encouraged Resident #3 to participate in activities. LPN #1 stated usually the resident was easily redirected and the behaviors did not last all day. LPN #1 stated the nursing staff initiated a conversation with Resident #3's physician regarding the resident's behaviors when the physician prescribed Celexa. LPN #1 stated she would like to say she had discussed Resident #3's anxiety and depression with the resident's physician since the Celexa was initiated but she could not pin point a specific time she had done so.	F 514	**Monitoring:** The DON is responsible for maintaining compliance. The DON, and/or Medical records clerk will audit medical records and physician progress notes weekly coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be clarified and corrected at time of discovery and disciplinary action will be taken as needed. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 9/3/2016**	

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F 514	Continued From page 51 On 7/20/16 at 2:55 p.m., a telephone interview was conducted with ASM (administrative staff member) #6 (Resident #3's physician). ASM #6 stated she conducts an involved medication review for each resident every four months. ASM #6 stated while completing her reviews, she talks to nurses at the nurse's station. ASM #6 stated she had evaluated Resident #3's anxiety, depression and continued use of Celexa and decided to continue current treatment but had not documented this information. On 7/20/16 at 6:15 p.m., ASM #1 (the administrator), ASM #3 (the regional nurse consultant) and ASM #4 (the assistant director of nursing) were made aware of the above findings. The facility policy titled, "MEDICAL RECORDS" documented in part, "There is a separate medical record for each resident in the facility. Such record contains sufficient information to justify the diagnoses, to reflect the treatment given, and to describe any results obtained. All entries in the records are signed and dated with month, day, and year and are typed or written in ink. All records are complete and accurate. The resident's Medical Record is kept at the Nursing Unit until the resident is discharged, at which time it is filed in the Medical Records Department..." No further information was presented prior to exit. (1) This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=6c96373f-6744-49d4-aec5-3720bc993fab (2) This information was obtained from the	F 514		

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F 514	Continued From page 52 website: https://www.nidcd.nih.gov/health/dysphagia b. The facility staff failed to obtain and file Resident #3's physician progress note dated 5/4/16, prior to 7/20/16. Review of Resident #3's clinical record on 7/19/16 failed to reveal a physician's progress note from 3/8/16 through 7/13/16. Review of Resident #3's clinical record on 7/20/16 revealed a physician's progress note dated 5/4/16 that was not in the clinical record during the previous day. The 5/4/16 progress note had a fax confirmation at the bottom of the page that documented the note was faxed/received on 7/20/16 at 1:01 p.m. On 7/20/16 at 1:15 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated Resident #3's physician writes progress notes in the office then faxes the notes to the medical records employee. When asked how nurses utilized the physician's progress notes, LPN #1 stated nurses look back at the progress notes as needed to see how the physician addressed concerns. On 7/20/16 at 1:45 p.m., an interview was conducted with OSM (other staff member) #4 (the medical records employee). OSM #4 stated she reviews residents' clinical records and gives the physician a list of residents who need to be seen the last week of each month. OSM #4 stated the list documents the dates of the progress notes that are in each resident's clinical record. OSM #4 stated she also gives a copy of the list to the director of nursing and the MDS coordinator. OSM #4 stated the physician writes her progress	F 514		

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F 514	Continued From page 53 notes in the office and then has the notes faxed to the facility. OSM #4 stated the facility did have a problem with the physician's progress notes being faxed to the facility in a timely manner at times. OSM #4 stated there have been a couple of times when she has called the physician and told her she (OSM #4) needed her (the physician's) notes but that was very rare. The Director of Nursing was unavailable for interview during survey. On 7/20/16 at 6:15 p.m., ASM #1 (the administrator), ASM #3 (the regional nurse consultant) and ASM #4 (the assistant director of nursing) were made aware of the above findings. The facility policy titled, "MEDICAL RECORDS" documented in part, "There is a separate medical record for each resident in the facility. Such record contains sufficient information to justify the diagnoses, to reflect the treatment given, and to describe any results obtained. All entries in the records are signed and dated with month, day, and year and are typed or written in ink. All records are complete and accurate. The resident's Medical Record is kept at the Nursing Unit until the resident is discharged, at which time it is filed in the Medical Records Department...Physician Progress Note: 2. Physician's Progress Notes..." No further information was presented prior to exit. 2. Facility staff failed to obtain and file in the clinical record the 5/4/16 physician's visit for Resident #7.	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495301	A. BUILDING _____ B. WING _____	07/21/2016

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F 514	Continued From page 54 Resident #7 was admitted to the facility on 7/23//12 and readmitted on 12/17/15 with diagnoses that included but were not limited to: high blood pressure, depression, arthritis, diabetes, breast cancer and dementia. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 6/13/16 coded the resident as being cognitively intact. The MDS further coded the resident as requiring the assistance of one staff member for activities of daily living except for eating which the resident could do after the tray was prepared. Review of the physician's progress notes documented that the resident was seen on 3/9/16 and 7/10/16. Review of the progress notes did not evidence a physician's note within the required 60 days. On 7/20/16 at 12:15 p.m. a request for all physician progress notes between 3/9/16 and 7/10/16 was requested from OSM (other staff member) #4, the medical record director. An interview was conducted on 720/16 at 1:00 p.m. with LPN (licensed practical nurse) #1. When asked if she reviewed the physician's progress notes, LPN #1 stated, "Yes, I look at them as needed. The PA (physician's assistant) writes on them the day he's here. (Name of doctor) takes them to her office and faxes them, it can be a couple days delay before she faxes it to us" When asked if it was important to have the physician's progress notes available, LPN #1 stated, "Sometime we can gather information (from the notes). Sometimes we (the doctor and the nurse) have a conversation in the hallway	F 514		

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F 514	Continued From page 55 about an order for a resident and when I don't see the order I look at the notes to see what her (the doctor's) thinking was." On 7/20/16 at 1:45 p.m. OSM #4 gave this surveyor a copy of a physician note dated 5/4/16. At the bottom of the page it was documented, "Received Time Jul. 20. 2016 12:43 p.m." When asked if the note had been faxed to the facility on that day, OSM #4 stated it had. When asked the process staff follows to obtain physician progress notes, OSM #4 stated that at the beginning of every month she wrote down the names of the residents who were to be seen. She gave a list to the doctor and when she received the faxed progress note from the doctor she would note it on her monthly paper and file the note into the chart. When asked what process she followed if she did not receive a progress note, OSM #4 stated that on the last week of the month she gave a copy of her list to the doctor so she could compare it to what she had. OSM #4 stated that the director of nursing and the MDS coordinator also received a copy of the list. When asked if the note was missing or late was the doctor called, OSM #4 stated, "There's been a couple times I've call her, its very rare. I don't want to hound her." When asked if she had difficulties receiving the progress notes in a timely manner, OSM #4 stated, "We have problems with that at times, having her (the physician) to fax them in." On 7/21/16 at 6:15 p.m. ASM (administrative staff member) #1, the administrator, and ASM #2, the corporate nurse, were made aware of the findings. No further information was provided prior to exit.	F 514		

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