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Heritage Hall – Blackstone • P.O. Box 550 • 900 S. Main Street • Blackstone, VA 23824 • (P) 434.292.5301

March 16, 2018

Office of Licensure and Certification
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–Blackstone's Corrected Plan of Correction for the State Licensure requirement as requested on 3/16/18 for F tag 641. 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 standard Licensing inspection.

If I can be of further assistance don't hesitate to contact me at (434) 292-5301.

Sincerely;

Diane Barksdale
Administrator

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495353	A. BUILDING _____ B. WING _____	C 02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BLACKSTONE	900 S MAIN ST BLACKSTONE, VA 23824

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 02/13/18 through 02/16/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/13/18 through 2/16/18. A complaint was investigated during the survey. Corrections are required for compliance with 42 Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 180 certified bed facility was 145 at the time of the survey. The survey sample consisted of 29 current Resident reviews (Residents #5, 149, 30, 98, 60, 301, 452, 122, 130, 401, 11, 78, 62, 139, 52, 66, 39, 24, 85, 40, 44, 254, 1095, 38, 22, 255, 25, 352, and 93) and three closed record reviews (Residents #151, 152 and 124).	F 000		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;	F 622	**F622** **Corrective Action(s):** The facility medical director has been notified that the physicians for residents #66, #44, #93, #254 and #78 did not document in the progress notes in those residents' respective clinical records regarding discharge and/or transfer from the facility to the hospital. Additionally, each physician who failed to make a discharge/transfer note has been notified of the missing documentation. A facility Incident & Accident Form has been completed for each resident involved.	4/2/18

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

Administrator 3-6-18

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 622	Continued From page 1 (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.	F 622	**Identification of Deficient Practices/Corrective Action(s):** All other residents discharged and/or transferred from the facility may have been affected. The DON/designee will conduct a 100% audit of all residents who have been discharged and/or transferred in the past 60 days. Residents identified at risk will be corrected at time of discovery and their attending physicians notified and the facility's medical director will be notified. A facility Incident & Accident Form will be completed for each negative finding. **Systemic Change(s):** Facility policy and procedures have been reviewed. No revisions are warranted at this time. The DON and/or Regional Nurse Consultant will inservice facility healthcare providers on the requirement that they document in the physician progress notes in the clinical record addressing resident discharges and/or transfers to the hospital or other outside health care facility. **Monitoring:** The DON/designee will be responsible for maintaining compliance. The DON and/or designee will conduct chart audits weekly of all residents who have been discharged and/or transferred from the facility. Any/all negative findings and or errors will be corrected at time of discovery. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 2, 2018**	

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F 622	Continued From page 2 (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure documentation by the physician in the clinical record when five of 31 residents in the survey sample, Resident #66,	F 622		

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F 622	Continued From page 3 #44, #93, #254 and #78, were transferred to the hospital. 1. Resident #66 was transferred to the hospital on 12/17/17. There were no physician notes regarding the reason for the transfer in the clinical record. 2. The facility staff failed to ensure the physician documented why a facility-initiated discharge was necessary for Resident #44 when the resident was discharged to the hospital on 11/19/17. 3. The facility staff failed to document a physician note when Resident #93 was transferred to the hospital on 12/22/17 for treatment of seizures. 4. The facility staff failed to ensure the physician documented a note in the clinical record for Resident #254, when the resident was transferred to the hospital on 10/11/17. 5. The facility staff failed to ensure the physician documented a note in the clinical record for Resident ##78, when the resident was discharged to the hospital on 11/19/17. The findings include: 1. Resident #66 was admitted to the facility on 7/29/14 and readmitted on 12/21/17 with diagnoses that included but were not limited to high blood pressure, neurogenic bladder [1], type two diabetes, and dementia. Resident #66's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 12/28/17. Resident #66 was coded as being moderately impaired in cognitive	F 622		

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F 622	Continued From page 4 function scoring 08 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #66 was coded in section B (Hearing, Speech, Vision) as being usually understood by staff in the ability to express ideas and wants. Resident #66 was also coded as usually understanding staff. Review of Resident #66's clinical record revealed a nursing note dated 12/17/17 that documented the following: "called (sic) to resident's room by cna (certified nursing assistant) staff, resident vomiting and producing large amount of clear liquidy (sic) stools from colostomy bag...resident c/o (complained) abdominal discomfort to lower right abdomin (sic) w/left (with left) sided tenderness. upon (sic) assessment resident has hypo bowel sounds to left/right quadrant. No bowel sounds noted to bil lower (sic) quadrants...resident right lower quadrant is very firm to touch as well as his left lower quadrant. resident (sic) does show expression of discomfort during this assessment. Nursing suppervisor (sic) notified and called on call md (medical doctor). per md (medical doctor) order was received to send resident out to (Name of Hospital) for evaluation to r/o (rule/out) blockage. Responsible Party notified and wanted resident to be sent out as well. AT (sic) 0800 (8:00 a.m.) (Name of transport) service was notified and was sending a truck with a eta (estimated time of arrival) of 45 min (minutes). resident (sic) noted to not be in distress at this time...will continue to monitor until transferred to ER (emergency room)." Further review of the clinical record revealed, Resident #66 returned to the facility on 12/21/17 at 3:46 p.m. with a diagnosis of a UTI (urinary tract infection). There were no physician notes regarding the reason for transfer in the clinical	F 622		

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F 622	Continued From page 5 record. On 2/15/18 at 2:48 p.m., an interview was conducted with ASM (administrative staff member) #4, Resident #66's physician. When asked about his role when a resident is transferred to the hospital, ASM #4 stated that it depended on the situation. ASM #4 stated if he is not in the building, facility staff would contact him or the on-call physician to explain what is going on clinically with the resident. ASM #4 stated that a hospital transfer is usually for a change in the resident's condition. When asked his responsibility as far as documenting a resident transfer, ASM #4 stated most of the time the order is given over the phone to send a resident out to the hospital. ASM #4 stated if he is in the building at the time of transfer, he will write a note because he would have evaluated the resident prior to transfer. ASM #4 stated he does not normally write a note for every resident transfer to the hospital. On 2/15/18 at 4:03 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #5, the ADON (assistant director of nursing) were made aware of the above concerns. The facility policy titled, "Transfer or Discharge, Emergency," did not address the above concerns. No further information was presented prior to exit. [1] Neurogenic bladder is bladder dysfunction caused by neurological damage/injury. The most common complications of neurogenic bladder are UTI, urinary stones, and renal impairment. These complications are associated with the pathology of bladder dysfunction itself or occur as a	F 622		

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F 622	Continued From page 6 consequence of the use of urinary catheters for drainage. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4467746/. 2. The facility staff failed to ensure the physician documented why a facility-initiated discharge was necessary for Resident #44 when the resident was discharged to the hospital on 11/19/17. Resident #44 was admitted to the facility on 6/21/04 and readmitted to the facility on 11/29/17. Resident #44's diagnoses included but were not limited to vascular dementia (1) with behavior disturbance, schizophrenia (2) and unspecified intellectual disabilities. Resident #44's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 12/6/17, coded Resident #44's cognitive skills for daily decision-making as severely impaired. Review of Resident #44's clinical record revealed a nurse's note dated 11/19/17 that documented the resident was sent to the hospital due to an elevated temperature. Further review of Resident #44's clinical record failed to reveal documentation by the physician to explain why the discharge was necessary. Resident #44 was readmitted to the facility on 11/29/17. On 2/14/18 at 1:42 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked if the physician writes a note when a resident is discharged to the hospital. RN #1 stated she did not think the physician	F 622		

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F 622	Continued From page 7 documented anything unless the resident is readmitted to the facility. On 2/15/18 at 2:46 p.m., a telephone interview was conducted with ASM (administrative staff member) #4 (Resident #44's physician). ASM #4 was asked his role when a resident is sent to the hospital and asked what and when he documents. ASM #4 stated it depends on the situation. ASM #4 stated if a resident experiences an acute change in condition then the facility staff contacts him or the physician on call and tells them the situation. ASM #4 stated that once in a while he will have the resident directly admitted to the hospital if the situation is not an emergency but the resident needs to go to the hospital. ASM #4 stated most the time emergency medical services are called to transfer the resident to a hospital of their choice. When asked what documentation he was responsible for, ASM #4 stated many times he makes the decision to send a resident to the hospital over the phone (without seeing the resident) but he will write a note if he is in the building. ASM #4 stated he also works at a hospital and sometimes, if the resident is sent to that hospital, he sees the resident in the hospital and sends a copy of the history and physical to the facility. On 2/15/18 at 4:27 p.m. ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the administrator in training) and ASM #5 (the assistant director of nursing) were made aware of the above concern. No further information was presented prior to exit. (1) "Dementia is a gradual and permanent loss of brain function. This occurs with certain diseases.	F 622		

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F 622	Continued From page 8 It affects memory, thinking, language, judgment, and behavior. Vascular dementia (VaD) is caused by a series of small strokes over a long period." This information was obtained from the website: https://medlineplus.gov/ency/article/000746.htm (2) "Schizophrenia is a serious brain illness. People who have it may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=schizophrenia&_ga=2.244128775.343831570.1519130579-139120270.1477942321 3. The facility staff failed to document a physician note when Resident #93 was transferred to the hospital on 12/22/17 for treatment of seizures. Resident #93 was admitted to the facility on 6/14/16 with a readmission on 12/27/17 with diagnoses that include, but not limited to stroke, anoxic brain damage (lack of oxygen to brain), aphasia (difficulty speaking), dysphagia (difficulty swallowing) and left sided paralysis. Resident #93's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 12/27/17 coded Resident #93 as being unable to answer the questions on the BIMS (brief interview for mental status), the staff assessment coded him as being severely impaired to make decisions.	F 622		

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F 622	Continued From page 9 A review of Resident #93's clinical record revealed, in part, that he was transferred to the hospital on 12/22/17 to treat seizures. A review of Resident #93's physician progress notes did not reveal any documentation by the physician on or around the date of transfer indicating the reason for transfer and why the facility was unable to continue to meet Resident #93's needs on 12/22/17. On 2/14/18 at 1:35 p.m., an interview was conducted with RN (registered nurse) #2, a unit manager. RN #2 was asked if the medical doctor documented the reason for transfer to the hospital in the progress notes. RN #2 stated, "He (the medical doctor) doesn't do anything unless they (the resident) comes back as a readmit, then a progress note or H&P (history and physical) will be done, but nothing at the time of transfer." On 2/15/18 at 10:32 a.m., an interview was conducted with OSM (other staff member) #3, the social worker, and OSM #5, the director of admissions. OSM #3 and OSM #5 were asked what documentation was required to be in the resident's clinical record when a resident was transferred to the hospital. OSM #3 stated, "The nurses handle all transfers to the community, communicating with the MD (medical doctor), hospital and family. I am not involved in the transfers." On 2/15/18 at 3:00 p.m., an interview was conducted with ASM (administrative staff member) #4, the MD (medical doctor). ASM #4 was asked to describe his role when a resident is transferred to the hospital. ASM #4 stated, "It depends on the situation, if it is an acute change	F 622		

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F 622	Continued From page 10	F 622		

the nursing staff contacts the doctor (myself) and explains the situation. I may direct admit to the hospital rather than the ER (emergency room) as I have privileges at the local hospital. For a change in the condition of the resident we determine the needs and contact EMS (emergency medical service)." When asked what he (the doctor) would document regarding the transfer, ASM #4 stated, "I am often not in the facility and generally have not seen the patient prior to transfer. If I am in the facility, I will write a note but I do not usually write a note, as I generally will see them in the hospital. I was not aware that a note had to be written at the time of the transfer."

An end of day meeting was conducted on 2/15/18 at 4:00 p.m. with ASM #1, the administrator, ASM #2, the director of nursing /assistant administrator, ASM #3, the administrator in training, and ASM #5, the assistant director of nursing. ASM #1, ASM #2, ASM #3, and ASM #5 were made aware of the above concerns and a facility policy was requested at this time.

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

4. The facility staff failed to ensure the physician documented a note in the clinical record for Resident #254, when the resident was transferred to the hospital on 10/11/17.

Resident #254 was admitted to the facility on 4/19/17 with a recent readmission on 10/23/17, with diagnoses that included but were not limited to: diabetes, heart disease, anemia (blood counts below normal levels) (1), dementia, kidney stones, and depression.

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F 622	Continued From page 11 The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 11/20/18, coded the resident as scoring a 7 on the BIMS (brief interview for mental status) score, indicating that she was severely impaired to make daily cognitive decisions. The resident was coded as being totally dependent upon one or more staff members for all of her activities of daily living. The clinical record revealed the following documented entry dated, 10/11/17 at 9:19 p.m., "4:30 p.m. Resident vomit x1 (one time) - prn (as needed) Zofran (used to treat nausea and vomiting) (2) given. Resident vomit again x2 (times two) - (name of doctor) in to see Resident - new order - liquid diet for 24 hours and KUB (kidneys, ureters, bladder - x-ray). Resident continue to vomit again x1 (one time). 8:15 p.m. T.O. (telephone order) from (name of doctor) to send to E.R. (emergency room) for eval (evaluation). Resident sent to Hosp (hospital) per MD (medical doctor) request - resident left at 8:45 p.m." Review of the clinical record did not reveal any documentation by the physician of his seeing the resident on 10/11/17 or a note related to why she was transferred to the hospital and how the facility could not meet her needs. An interview was conducted with RN (registered nurse) #2 on 2/14/18 at 1:41 p.m. When asked what documentation is required when a resident is transferred from the facility to the hospital, RN #2 stated, "The nurse writes a note describing who and why they are being sent out. We use a SBAR (Situation, Background, Assessment, Response) if there is time, how urgently the	F 622		

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F 622	Continued From page 12	F 622		

resident needs to go out. The nurse's role is to notify the RP (responsible party) and the MD (medical doctor)."

An interview was conducted with other staff member (OSM) #3, the social worker and OSM #5, the admissions person, on 2/15/18 at 10:32 a.m. regarding their role when the facility initiates a resident transfer to the hospital. OSM #3 stated, "If the resident goes to the hospital the nursing staff notifies the family." OSM #3 stated, "I don't do anything if they go to the hospital, the nurses handle that end of calling the doctor and the RP."

An interview was conducted with administrative staff member (ASM) #9, the physician that saw the resident on 10/11/17 and gave the order to send Resident #254 to the hospital. When asked if he wrote a note when he saw Resident #254 on 10/11/17, ASM #9 stated he did not as he was not rounding on her but he spoke with the husband and daughter who were in the room. ASM #9 stated they had informed the him of what they do when she gets this way at home. When asked if he wrote a note after she was transferred to the hospital documenting why the facility could not meet her needs, ASM #9 stated, "I was told that if I wrote a note I had to bill Medicare for the services." ASM #9 was asked if he was aware of the regulations regarding resident transfer and the physician's responsibility to document why a resident was transferred to the hospital and why the facility could not meet the resident's needs at the facility. ASM #9 stated, he was not aware of that regulation.

The administrator, director of nursing, the administrator in training, the assistant director of

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F 622	Continued From page 13 nursing and the social worker were made aware of the above findings on 2/15/18 at 4:30 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader; Rothenberg and Chapman, page 33. (2) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d9a71b42-ddfc-49d5-7280-0fc0041dba41 5. The facility staff failed to ensure the physician documented a note in the clinical record for Resident #78, when the resident was discharged to the hospital on 11/19/17. Resident #78 was admitted to the facility on 10/21/09 with a recent readmission on 12/21/17, with diagnoses that included but were not limited to: cerebral palsy (a loss or deficiency of muscle control due to permanent, no progressive brain damage occurring before or at the time of birth) (1), intellectual disabilities (Intellectual disability refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness.) (2), seizures, and dysphagia (a condition in which swallowing is difficult or painful, due to obstruction of the esophagus or muscular abnormalities) (3).	F 622		

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F 622	Continued From page 14 The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 2/16/18, coded the resident as scoring an eight on the BIMS (brief interview for mental status) score, indicating he is moderately impaired to make daily cognitive decisions. The resident was coded as being dependent on one or more staff members for all of his activities of daily living. Review of the clinical record was conducted. The nurse's notes dated, 12/20/17 at 11:42 p.m. documented in part, "CNA (certified nursing assistant) called this nurse to come to this room and check on this resident. Upon assessment - resident observed with hyper-active (sic) bowel sounds and a large amount of mucus coffee like drainage with foul odor coming from his Peg - site (feeding tube site). Resident denies pain...(Name of doctor) notified (in the building at this time). New order - per MD (medical doctor) - Send to E.R (emergency room) for Eval (evaluation) R/P (responsible party) aware. Supervisor spoke with E.R. staff - Resident is waiting to have a CT scan (computerized tomography) done at this time, information passed on to on coming nurse to follow up with E.R. staff." Review of the clinical record did not reveal any documentation by the physician of his seeing the resident on 10/11/17 or a note related to why she was transferred to the hospital and how the facility could not meet her needs. An interview was conducted with RN (registered nurse) #2 on 2/14/18 at 1:41 p.m. When asked what documentation is required when a resident is transferred from the facility to the hospital, RN	F 622		

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F 622	Continued From page 15 #2 stated, "The nurse writes a note describing who and why they are being sent out. We use a SBAR (Situation, Background, Assessment, Response) if there is time, how urgently the resident needs to go out. The nurse's role is to notify the RP (responsible party) and the MD (medical doctor)." An interview was conducted with other staff member (OSM) #3, the social worker and OSM #5, the admissions person, on 2/15/18 at 10:32 a.m. regarding their role when the facility initiates a resident transfer to the hospital. OSM #3 stated, "If the resident goes to the hospital the nursing staff notifies the family." OSM #3 stated, "I don't do anything if they go to the hospital, the nurses handle that end of calling the doctor and the RP." An interview was conducted with administrative staff member (ASM) #9, the physician who was in the building and who gave the order to send the resident to the hospital on 12/20/17. When asked if he wrote a note after Resident #78 was transferred to the hospital indicating why the facility could not meet the resident's needs, ASM #9 stated, "I was told that if I wrote a note I had to bill Medicare for the services." ASM #9 was asked if he was aware of the regulations regarding resident transfer and the physician's responsibility to document why a resident was transferred to the hospital and why the facility could not meet the resident's needs at the facility. ASM #9 stated, he was not aware of that regulation. The administrator, director of nursing, the administrator in training, the assistant director of nursing and the social worker were made aware	F 622		

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F 622	Continued From page 16 of the above findings on 2/15/18 at 4:30 p.m. No further information was provided prior to exit. (1)Barron's Dictionary of Medical Terms for the Non-Medical Reader; Rothenberg and Chapman, page 114. (2) This information was obtained from the following website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100 (3)Barron's Dictionary of Medical Terms for the Non-Medical Reader; Rothenberg and Chapman, page 178.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be	F 623	F623 Corrective Action(s): Resident #66's responsible party and the state ombudsman office have been notified that the facility failed to provide a discharge/transfer notice for the resident's transfer to the hospital on 12/17/17. Resident #85's responsible party and the state ombudsman office have been notified that the facility failed to provide a discharge/transfer notice for the resident's transfer to the hospital on 12/9/17. The state ombudsman office has been notified that the facility failed to provide a discharge/transfer notice for resident #44's discharge to the hospital on 11/19/17.	4/2/18

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F 623	Continued From page 17 made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related	F 623	Resident #93's responsible party and the state ombudsman office have been notified that the facility failed to provide a discharge/transfer notice for the resident's transfer to the hospital on 12/22/17. Resident #78's responsible party and the state ombudsman office have been notified that the facility failed to provide a discharge/transfer notice for the resident's transfer to the hospital on 12/20/17. Resident #254's responsible party and the state ombudsman office have been notified that the facility failed to provide a discharge/transfer notice for the resident's transfer to the hospital on 10/11/17. **Identification of Deficient Practices/Corrective Action(s):** All other residents discharged and/or transferred from the facility may have been affected. The Social Services Director and/or Admissions Director will conduct a 100% audit of all residents who have been discharged and/or transferred in the past 60 days. Residents identified at risk will be corrected at time of discovery and the required notifications to the residents' responsible party and the state ombudsman will be made. A facility Incident & Accident Form will be completed for each negative finding. **Systemic Change(s):** Facility policy and procedures have been reviewed. No revisions are warranted at this time. The Administrator and/or Regional Nurse Consultant will inservice the facility's social worker(s) and nursing	

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F 623	Continued From page 18 disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined the facility staff failed to provide the required written notifications at the time of a facility initiated transfer for six of 31 residents in the	F 623	administration on the requirement that a resident's responsible party and the state ombudsman be notified of resident discharges/transfers. **Monitoring:** The Social Services Director will be responsible for maintaining compliance. The Social worker, and/or Admissions Director will conduct chart audits weekly of all residents who have been discharged and/or transferred from the facility. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 2, 2018**	

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F 623	Continued From page 19 survey sample, Resident #66, #85, #44, #93, #78, #254. 1. The facility staff failed to provide the required written notifications to the responsible party (RP) and the ombudsman when Resident #66 was transferred to the hospital on 12/17/17. 2. The facility staff failed to notify the ombudsman and responsible party in writing of a facility-initiated transfer and admission to the hospital on 12/9/17 for Resident #85. 3. Resident #44 discharged to the hospital on 11/19/17. The facility staff failed to provide written notification of the facility initiated discharge to the ombudsman. 4. The facility staff failed to provide the required written notifications to the responsible party (RP) and the ombudsman when Resident #93 was transferred to the hospital on 12/22/17. 5. The facility staff failed to provide written documentation that the resident's representative and the ombudsman were notified, in writing, when Resident #78 was transferred to the hospital on 12/20/17. 6. The facility staff failed to provide written documentation that the resident's representative and the ombudsman were notified, in writing, when Resident 254 was transferred to the hospital on 10/11/17. The findings include: 1. The facility staff failed to provide the required written notifications to the responsible party (RP)	F 623		

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F 623	Continued From page 20 and the ombudsman when Resident #66 was transferred to the hospital on 12/17/17. Resident #66 was admitted to the facility on 7/29/14 and readmitted on 12/21/17 with diagnoses that included but were not limited to high blood pressure, neurogenic bladder [1], type two diabetes, and dementia. Resident #66's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 12/28/17. Resident #66 was coded as being moderately impaired in cognitive function scoring 08 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #66 was coded in section B (Hearing, Speech, Vision) as being usually understood my staff in the ability to express ideas and wants. Resident #66 was also coded as usually understanding staff. Review of Resident #66's clinical record revealed a nursing note dated 12/17/17 that documented the following: "called (sic) to resident's room by cna (certified nursing assistant) staff, resident vomiting and producing large amount of clear liquidy (sic) stools from colostomy bag...resident c/o (complained) abdominal discomfort to lower right abdomin (sic) w/left (with left) sided tenderness. upon (sic) assessment resident has hypo (hypoactivve) bowel sounds to left/right quadrant. No bowel sounds noted to bil (bilateral) lower (sic) quadrants...resident right lower quadrant is very firm to touch as well as his left lower quadrant. resident (sic) does show expression of discomfort during this assessment. Nursing suppervisor (sic) notified and called on call md (medical doctor). per md (medical doctor) order was received to sent resident out to (Name of Hospital) for evaluation to r/o (rule/out) blockage. Responsible Party notified and wanted	F 623		

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F 623	Continued From page 21 resident to be sent out as well. AT (sic) 0800 (Name of transport) service was notified and was sending a truck with a eta (estimated time of arrival) of 45 min (minutes). resident (sic) noted to not be in distress at this time...will continue to monitor until transferred to ER (emergency room)." Further review of the clinical record revealed that Resident #66 returned to the facility on 12/21/17 at 3:46 p.m. with a diagnosis of a UTI (urinary tract infection). Further review of Resident #66's clinical record failed to evidence Resident #66, the RP (responsible party) were notified in writing of the reason for the transfer, and that the ombudsman received a copy of this written notification. On 2/14/18 at 1:42 p.m., an interview was conducted with RN (registered nurse) #2. When asked about the process followed when a resident is transferred to the hospital, RN #2 stated the nurses should be notifying the medical doctor after an assessment was made of the resident. RN #2 stated the responsible party would be made aware of a resident transfer, and she would document the resident was transferred to the hospital in a nursing note. RN #2 would also document the resident's change of condition in a SBAR (situation, background, assessment, response) note. RN #2 stated that she would document the assessment, vital signs, that the MD (medical doctor) and RP (responsible party) were made aware and the time the squad (Emergency Medical Service) was called and arrived. RN #2 stated she would not provide anything in writing to the responsible party. RN #2 also stated she does not notify the	F 623		

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F 623	Continued From page 22 ombudsman when a resident is transferred to the hospital. On 2/15/18 at 10:33 a.m., an interview was conducted with OSM (other staff member) #3. The social worker. OSM #3 stated nursing handles resident transfers to the hospital. OSM #3 stated she does not notify the ombudsman with facility-initiated transfers to the hospital. On 2/15/18 at 4:03 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #5, the ADON (assistant director of nursing) were made aware of the above concerns. The facility policy titled, "Transfer or Discharge, Emergency," did not address the above concerns. No further information was presented prior to exit. [1] Neurogenic bladder is bladder dysfunction caused by neurological damage/injury. The most common complications of neurogenic bladder are UTI, urinary stones, and renal impairment. These complications are associated with the pathology of bladder dysfunction itself or occur as a consequence of the use of urinary catheters for drainage. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4467746/. 2. The facility staff failed to notify the ombudsman and responsible party in writing of a facility-initiated transfer and admission to the hospital on 12/9/17 for Resident #85.	F 623		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 23 Resident #85 was admitted to the facility on 9/13/16 with the diagnoses of but not limited to dementia with behaviors, anxiety disorder, bipolar disorder, high blood pressure, gout, asthma, benign prostatic hyperplasia, and high cholesterol. The most recent MDS (Minimum Data Set) was 30-day assessment status/post hospitalization, with an ARD (Assessment Reference Date) of 1/10/18. Resident #85 was coded as severely cognitively impaired in ability to make daily life decisions. The resident required total care for bathing and hygiene; extensive assistance with toileting; limited assistance with eating, dressing, and transfers; and was occasionally incontinent of bowel and bladder. A review of the clinical record revealed a nurse's note dated 12/9/17 at 8:44 a.m., which documented, "Unit charge nurse came over and made this nurse aware that resident was throwing up an [sic] black like substance....call made to ASM #9 (Administrative Staff Member, the physician) to make aware of resident condition message left no return call at this time...call made to (ASM #4 Medical Director) and made aware of resident condition order obtained to send resident to er (emergency room) [sic] for eval (evaluation)..." A nurse's note dated 12/9/17 at 2:59 p.m., documented, "0815 (8:15 a.m.) Resident awaken to take medicine told writer he felt sick. Resident began to gag writer instructed Resident to head towards the sink. Resident vomited black bile. Supervisor notified and Resident was prepared for transfer...." Further review of the clinical record failed to	F 623		

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F 623	Continued From page 24 reveal any evidence that the ombudsman and Responsible Party (RP) were notified in writing of the discharge to the hospital. On 2/14/18 at 1:41 PM in an interview with OSM (Other Staff Member) #3, the social worker. OSM #3 provided a notebook of ombudsman notification of facility discharges. However, one for Resident #85's discharge to the hospital was not in the book. She stated she sends notification of discharges to the community but not of discharges to the hospital. OSM #3 stated she did not know that the ombudsman had to be notified of hospital discharges. Regarding notification to the RP, OSM #3 stated the nurses call the RP and notify them by phone when a resident was sent to the hospital (attempts of this notification were not documented in the nurse's notes). OSM #3 stated that nothing is provided in writing to the RP or resident about the discharge to the hospital, she did not know that written notification had to be provided. OSM #3 stated in this case the RP could not be reached by phone due to her having moved and the facility did not have the correct current number for her, so a certified letter was sent that the resident was sent to the hospital and to call the facility. A review of the certified letter revealed, the letter had been returned to the facility, unopened and undelivered. OSM #3 stated the facility did not have the current address for the RP either but thought the letter would have been forwarded to the current address, which it was not. OSM #3 opened the envelope and a review of the letter, which was dated 12/15/17 (6 days after the resident went to the hospital and 1 day after the resident returned from the hospital) documented, "The staff at our facility has been attempting to contact to [sic] but have not been successful.	F 623		

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F 623	Continued From page 25 The number we have on file for you is no longer in service. Please contact us as soon as possible." The letter, did not mention that the resident had been transferred or in the hospital at all, and did not document notification of the transfer and hospitalization. On 2/15/18 at approximately 4:00 p.m., at the end of day meeting, the Administrator (ASM #1) the Director of Nursing (ASM #2) were made aware of the findings. No further information was provided by the end of the survey. 3. Resident #44 discharged to the hospital on 11/19/17. The facility staff failed to provide written notification of the facility initiated discharge to the ombudsman. Resident #44 was admitted to the facility on 6/21/04 and readmitted to the facility on 11/29/17. Resident #44's diagnoses included but were not limited to vascular dementia (1) with behavior disturbance, schizophrenia (2) and unspecified intellectual disabilities. Resident #44's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 12/6/17, coded Resident #44's cognitive skills for daily decision-making as severely impaired. Review of Resident #44's clinical record revealed a nurse's note dated 11/19/17 that documented the resident was sent to the hospital due to an elevated temperature. Further review of Resident #44's clinical record failed to reveal documentation that the ombudsman was notified of the discharge. Resident #44 was readmitted to the facility on	F 623		

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F 623	Continued From page 26 11/29/17. On 2/14/18 at 1:42 p.m., an interview was conducted with RN (registered nurse) #1. In regards to a resident discharge to the hospital, RN #1 stated nurses document why the resident was discharged, who was called regarding the discharge and when they were called. RN #1 stated the physician and responsible party are called when a resident is sent to the hospital. When asked if the ombudsman is notified, RN #1 stated the ombudsman is not notified. On 2/15/18 at 10:33 a.m. an interview was conducted with OSM (other staff member) #3 (the social worker) and OSM #5 (the admissions coordinator). OSM #5 stated the nursing staff notifies residents' family members when a resident is sent to the hospital and OSM #3 is responsible for discharge planning when a resident is discharged home. When asked what documentation should be placed in the clinical record when a resident is sent to the hospital, OSM #3 stated she has nothing to do with hospital discharges. When asked if the ombudsman is notified when a resident is sent to the hospital, OSM #3 stated she was under the impression that the ombudsman had to be notified when a resident was discharged to the community, not to the hospital. On 2/15/18 at 4:27 p.m. ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the administrator in training) and ASM #5 (the assistant director of nursing) were made aware of the above concern. No further information was presented prior to exit.	F 623		

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F 623	Continued From page 27 (1) "Dementia is a gradual and permanent loss of brain function. This occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. Vascular dementia (VaD) is caused by a series of small strokes over a long period." This information was obtained from the website: https://medlineplus.gov/ency/article/000746.htm (2) "Schizophrenia is a serious brain illness. People who have it may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=schizophrenia&_ga=2.244128775.343831570.1519130579-139120270.1477942321 4. The facility staff failed to provide the required written notifications to the responsible party (RP) and the ombudsman when Resident #93 was transferred to the hospital on 12/22/17. Resident #93 was admitted to the facility on 6/14/16 with a readmission on 12/27/17 with diagnoses that include, but not limited to stroke, anoxic brain damage (lack of oxygen to brain), aphasia (difficulty speaking), dysphagia (difficulty swallowing) and left sided paralysis. Resident #93's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 12/27/17 coded Resident #93 as being unable to answer	F 623		

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the questions on the BIMS (brief interview for mental status), the staff assessment coded him as being severely impaired to make decisions.

A review of Resident #93's clinical record revealed, in part, that he was transferred to the hospital on 12/22/17 to treat seizures.

Further review of Resident #93's clinical record did not reveal any evidence of written notification to the resident's RP or the ombudsman regarding the transfer on 12/22/17.

A review of Resident #93's comprehensive care plan dated 1/2/18 did not reveal any documentation related to the hospitalization on 12/22/17.

On 2/14/18 at 1:35 p.m., an interview was conducted with RN (registered nurse) #2, a unit manager. RN #2 was asked what documentation nursing was responsible for completing at the time of a resident's transfer to the hospital. RN #2 stated, "We document the situation and that the RP and MD (medical doctor) were notified." RN #2 was asked if the RP was notified in writing regarding the transfer, RN #2 stated that she just called. RN #2 was asked if nursing was responsible for notifying the ombudsman when a resident was transferred. RN #2 stated she did not notify the ombudsman.

On 2/15/18 at 10:32 a.m., an interview was conducted with OSM (other staff member) #3, the social worker, and OSM #5, the director of admissions. OSM #3 and OSM #5 were asked who was responsible for notifying the RP and ombudsman in writing when a resident was transferred to the hospital. OSM #3 stated, "I do

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F 623	Continued From page 29	F 623		

not do anything with transfers to the hospital. The nurses handle all transfers to the hospital, communicating with the MD, hospital and family." When asked about the ombudsman notification, OSM #3 stated, "I was under the impression that we notify the ombudsman if there is a discharge to the community/home not to the hospital."

An end of day meeting was conducted on 2/15/18 at 4:00 p.m. with ASM #1, the administrator, ASM #2, the director of nursing /assistant administrator, ASM #3, the administrator in training, and ASM #5, the assistant director of nursing. ASM #1, ASM #2, ASM #3, and ASM #5 were made aware of the above concern. ASM #1 was asked who was responsible for notifying the RP and ombudsman in writing when a resident was transferred to the hospital, ASM #1 stated, "The social worker." A policy was requested at this time regarding transfers.

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

5. The facility staff failed to provide written documentation that the resident's representative and the ombudsman were notified, in writing, when Resident #78 was transferred to the hospital on 12/20/17.

Resident #78 was admitted to the facility on 10/21/09 with a recent readmission on 12/21/17, with diagnoses that included but were not limited to: cerebral palsy (a loss or deficiency of muscle control due to permanent, non progressive brain damage occurring before or at the time of birth) (1), intellectual disabilities (Intellectual disability refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive

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F 623	Continued From page 30 behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness.) (2), seizures, and dysphagia (a condition in which swallowing is difficult or painful, due to obstruction of the esophagus or muscular abnormalities) (3). The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 2/16/18, coded the resident as scoring an eight on the BIMS (brief interview for mental status) score, indicating he is moderately impaired to make daily cognitive decisions. The resident was coded as being dependent of one or more staff members for all of his activities of daily living. Review of the clinical record was conducted. The nurse's notes dated, 12/20/17 at 11:42 p.m. documented in part, "CNA (certified nursing assistant) called this nurse to come to this room and check on this resident. Upon assessment - resident observed with hyper-active (sic) bowel sounds and a large amount of mucus coffee like drainage with foul odor coming from his Peg - site (feeding tube site). Resident denies pain...(Name of doctor) notified (in the building at this time). New order - per MD (medical doctor) - Send to E.R (emergency room) for Eval (evaluation) R/P (responsible party) aware. Supervisor spoke with E.R. staff - Resident is waiting to have a CT scan (computerized tomography) done at this time, information passed on to on coming nurse to follow up with E.R. staff." Further review of the clinical record for Resident	F 623		

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F 623	Continued From page 31 #78 failed to evidence documentation that the ombudsman and Resident #78's representative received written notification of Resident #78's transfer to the hospital. An interview was conducted with RN (registered nurse) #2 on 2/14/18 at 1:41 p.m., regarding the nurse's role in notifying the representative, doctor and ombudsman of a resident transfer. RN #2 stated, "We contact the RP (responsible party) and the doctor, we don't notify the ombudsman." When asked how they notify the RP, RN #2 stated, "We call them." When asked if the resident representatives are given anything in writing, RN #2 stated they were not given anything in writing, they just call the RP. An interview was conducted with other staff member (OSM) #3, the social worker and OSM #5, the admissions coordinator, on 2/15/18 at 10:32 a.m. When asked who notifies the ombudsman of a facility initiated transfer/discharge, OSM #3 stated, "I was unaware the ombudsman was to be notified of transfers to the hospital, I only notify them when a resident is discharged to the community or home." ASM #1, the administrator, ASM #2, the director of nursing /assistant administrator, ASM #3, the administrator in training, and ASM #5, the assistant director of nursing and the social worker, OSM #3 were made aware of the above findings on 2/15/18 at 4:30 p.m. No further information was provided prior to exit. (1)Barron's Dictionary of Medical Terms for the Non-Medical Reader; Rothenberg and Chapman,	F 623		

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F 623	Continued From page 32 page 114. (2) This information was obtained from the following website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100 (3)Barron's Dictionary of Medical Terms for the Non-Medical Reader; Rothenberg and Chapman, page 178. 6. The facility staff failed to provide written documentation that the resident's representative and the ombudsman were notified, in writing, when Resident 254 was transferred to the hospital on 10/11/17. Resident #254 was admitted to the facility on 4/19/17 with a recent readmission on 10/23/17, with diagnoses that included but were not limited to: diabetes, heart disease, anemia (blood counts below normal levels) (1), dementia, kidney stones, and depression. The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 11/20/17, coded the resident as scoring a 7 on the BIMS (brief interview for mental status) score, indicating that she was severely impaired to make daily cognitive decisions. The resident was coded as being totally dependent upon one or more staff members for all of her activities of daily living. The clinical record revealed a documented entry dated, 10/11/17 at 9:19 p.m., "4:30 p.m. Resident vomit x1 (one time) - prn (as needed) Zofran (used to treat nausea and vomiting) (2) given. Resident vomit again x2 (times two) - (name of	F 623		

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F 623	Continued From page 33 doctor) in to see Resident - new order - liquid diet for 24 hours and KUB (kidneys, ureters, bladder - x-ray). Resident continue to vomit again x1 (one time). 8:15 p.m. T.O. (telephone order) from (name of doctor) to send to E.R. (emergency room) for eval (evaluation). Resident sent to Hosp (hospital) per MD (medical doctor) request - resident left at 8:45 p.m." Further review of the clinical record for Resident #254 failed to evidence documentation that the ombudsman and Resident #254's representative received written notification of Resident #254's transfer to the hospital. An interview was conducted with RN (registered nurse) #2 on 2/14/18 at 1:41 p.m., regarding the nurse's role in notifying the representative, doctor and ombudsman of a resident transfer. RN #2 stated, "We contact the RP (responsible party) and the doctor, we don't notify the ombudsman." When asked how they notify the RP, RN #2 stated, "We call them." When asked if the resident representatives are given anything in writing, RN #2 stated they were not given anything in writing, they just call the RP. An interview was conducted with other staff member (OSM) #3, the social worker and OSM #5, the admissions coordinator, on 2/15/18 at 10:32 a.m. When asked who notifies the ombudsman of a facility initiated transfer/discharge, OSM #3 stated, "I was unaware the ombudsman was to be notified of transfers to the hospital, I only notify them when a resident is discharged to the community or home." ASM #1, the administrator, ASM #2, the director	F 623		

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F 623	Continued From page 34 of nursing /assistant administrator, ASM #3, the administrator in training, and ASM #5, the assistant director of nursing and the social worker, OSM #3 were made aware of the above findings on 2/15/18 at 4:30 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader; Rothenberg and Chapman, page 33. (2) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setid=d9a71b42-ddfc-49d5-7280-0fc0041dba41	F 623		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to document the preparation and orientation of the resident / RP (responsibility party) prior to transfer to the hospital for one of 31 residents in the survey sample, Resident # 66. The facility staff failed to document that Resident #66 was prepared and oriented for a hospital	F 624	**F624** **Corrective Action(s):** Resident #66's physician has been notified that the facility failed to document that Resident #66 was prepared and oriented for the transfer that occurred on 12/17/17. **Identification of Deficient Practices/Corrective Action(s):** All other residents discharged and/or transferred from the facility may have been affected. The DON/designee will conduct a 100% audit of all residents who have been discharged and/or transferred in the past 60 days. Residents identified at risk will be corrected at time of discovery and those resident's physicians have been notified of the missing documentation that the resident's were prepared and oriented for the transfer/discharge. A facility Incident & Accident Form will be completed for each negative finding.	4/2/18

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F 624	Continued From page 35 transfer that occurred on 12/17/17. The findings include: Resident #66 was admitted to the facility on 7/29/14 and readmitted on 12/21/17 with diagnoses that included but were not limited to high blood pressure, neurogenic bladder [1], type two diabetes, and dementia. Resident #66's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 12/28/17. Resident #66 was coded as being moderately impaired in cognitive function scoring 08 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #66 was coded in section B (Hearing, Speech, Vision) as being usually understood by staff in the ability to express ideas and wants. Resident #66 was also coded as usually understanding staff. Review of Resident #66's clinical record revealed a nursing note dated 12/17/17 that documented the following: "called (sic) to resident's room by cna (certified nursing assistant) staff, resident vomiting and producing large amount of clear liquidy (sic) stools from colostomy bag...resident c/o (complained) abdominal discomfort to lower right abdomin (sic) w/left (with left) sided tenderness. upon (sic) assessment resident has hypo (hypoactive) bowel sounds to left/right quadrant. No bowel sounds noted to bil (bilateral) lower (sic) quadrants...resident right lower quadrant is very firm to touch as well as his left lower quadrant. resident (sic) does show expression of discomfort during this assessment. Nursing suppervisor (sic) notified and called on call md (medical doctor). per md (medical doctor) order was received to sent (sic) resident out to (Name of Hospital) for evaluation to r/o	F 624	**Systemic Change(s):** Facility policy and procedures have been reviewed. No revisions are warranted at this time. The DON and/or Regional Nurse Consultant will inservice the facility's social worker(s) and nursing administration on the requirement that a facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer/discharge from the facility. **Monitoring:** The DON/designee will be responsible for maintaining compliance. The DON, social worker, and/or designee will conduct chart audits weekly of all residents who have been discharged and/or transferred from the facility. Any/all negative findings and or errors will be corrected at time of discovery, Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 2, 2018**	

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F 624	Continued From page 36 (rule/out) blockage. Responsible Party notified and wanted resident to be sent out as well. AT (sic) 0800 (8:00 a.m.) (Name of transport) service was notified and was sending a truck with a eta (estimated time of arrival) of 45 min (minutes). resident (sic) noted to not be in distress at this time...will continue to monitor until transferred to ER (emergency room)." Further review of the clinical record revealed that Resident #66 returned to the facility on 12/21/17 at 3:46 p.m. with a diagnosis of a UTI (urinary tract infection). There was no documentation evidencing that Resident #66 was prepared and oriented for the transfer to the hospital that occurred on 12/17/17. On 2/14/18 at 1:42 p.m., an interview was conducted with RN (registered nurse) #2. When asked about the process followed when a resident is transferred to the hospital, RN #2 stated nurses should be notifying the medical doctor after an assessment was made of the resident. RN #2 stated the responsible party would be made aware of a resident transfer, and she would document that resident was transferred to the hospital in a nursing note. RN #2 would also document the resident's change of condition in a SBAR (situation, background, assessment, response) note. When asked what her nursing note would entail, RN #2 stated she would document the assessment, vital signs, that the MD and RP were made aware and the time the squad (Emergency Medical System) was called and arrived. RN #2 stated that she and other nurses do not usually document the resident was prepared and oriented for a transfer to the hospital.	F 624		

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F 624	Continued From page 37 On 2/15/18 at 10:33 a.m., an interview was conducted with OSM (other staff member) #3. The social worker. OSM #3 stated that nursing handles transfers to the hospital. On 2/15/18 at 4:03 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #5, the ADON (assistant director of nursing) were made aware of the above concerns. The facility policy titled, "Transfer or Discharge, Emergency," did not address the above concerns. No further information was presented prior to exit. [1] Neurogenic bladder is bladder dysfunction caused by neurological damage/injury. The most common complications of neurogenic bladder are UTI, urinary stones, and renal impairment. These complications are associated with the pathology of bladder dysfunction itself or occur as a consequence of the use of urinary catheters for drainage. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4467746/.	F 624		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that	F 625	F625 **Corrective Action(s):** Residents #149, #93, #98, #254, #85 and their RP's have been notified of the facilities bed-hold policy and procedure and the requirement that it reviewed and issued in writing to the resident and the RP when discharge to the hospital or when going out on therapeutic leave. An Incident and Accident report has been completed for each resident identified in the review.	4/2/18

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F 625	Continued From page 38 specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide a notice of bed hold prior to transfer to the hospital for five of 31 residents in the survey sample, Resident #149, #93, #98, #254 and #85. 1. The facility staff failed to provide Resident #149 and or the RP (responsible party) a bed hold notification when Resident #149 was transferred emergently to the hospital on 1/13/18. 2. The facility staff failed to provide Resident #93 and or the RP a bed hold notification when Resident #93 was transferred emergently to the hospital on 12/22/17.	F 625	**Identification of Deficient Practice(s) and Corrective Action(s):** All other residents could potentially be affected. The Bed-Hold policy and forms are now kept at the nursing station for after hour's transfers to the hospital to be completed by the charge nurse. The Social Services director/Admissions director will be responsible for normal business hour transfer notification of all bed-holds to residents and/or Responsible parties. **Systemic Change(s):** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The Social Services Director, Admissions Director and licensed staff have been inserviced by the administrator on the bed-hold requirement and the proper use and notification of Bed-Hold policy. **Monitoring:** The Admissions Director and Social Service Director are responsible for compliance. All transfers/discharges from the facility will be audited the by the Social service director and/or Admissions Director to ensure proper bed-hold notification was completed at the time of transfer or therapeutic leave. Any/all negative findings will be corrected at time of discovery. The results of these audits will be forwarded to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 2, 2018**	

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F 625	Continued From page 39 3. The facility staff failed to provide Resident #98 or the resident's representative written notification of the bed hold policy when the resident was discharged to the hospital on 1/5/18. 4. The facility staff failed to provide a notice of bed hold, prior to transfer, to Resident #254 or RP (responsible party) when the resident was emergently transferred to the hospital on 10/11/17. 5. The facility staff failed to provide a written bed hold policy/notification to Resident #85 and/or responsible party, within 24 hours of a transfer and admission to the hospital on 12/9/17. The findings include: 1. The facility staff failed to provide Resident #149 / RP (responsible party) a bed hold notification when Resident #149 was transferred emergently to the hospital on 1/13/18. Resident #149 was admitted to the facility on 2/23/17 with a readmission on 1/26/18 with diagnoses that include, but not limited to high blood pressure, acid reflux, diabetes, depression, cognitive communication deficit, encephalopathy (brain injury) and difficulty swallowing. Resident #149's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/14/17, coded Resident #149 as scoring nine out of a possible 15 on the BIMS (brief interview for mental status) indicating that Resident #149 is moderately impaired with decisions of daily living.	F 625		

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F 625	Continued From page 40 A review of Resident #149's clinical record revealed that on 1/13/18 he was transferred to the hospital for admission. Further review of Resident #149's clinical record did not reveal any evidence that Resident #149 and / or his RP were provided the bed hold notice when he was transferred to the hospital on 1/13/18. On 2/14/18 at 1:35 p.m., an interview was conducted with RN (registered nurse) #2, a unit manager. RN #2 was asked who was responsible for providing the bed hold notice, when a resident was transferred to the hospital. RN #2 stated, "On a weekend we can, it doesn't happen often, but normally admissions / social worker handle this. We may have asked in the past (maybe on a weekend) if they (the resident/RP) wanted to do a bed hold and we were allowed to give rates." RN #2 was asked if she did offer a bed hold, if she would document this in the progress notes, RN #2 stated that she did not remember. On 2/15/18 at 10:32 a.m., an interview was conducted with OSM (other staff member) #3, the social worker, and OSM #5, the admissions director. OSM #3 and OSM #5 were asked who was responsible for providing bed hold notices. OSM #5 stated she would handle the bed holds. OSM #5 was asked to describe the process. OSM #5 stated, "I wait until I know the resident has been admitted and at that time I contact the RP to ask them about the bed hold. If they want the bed hold then they come in and sign a bed hold agreement form. I document the conversation in the progress notes if they decline the bed hold. If they accept the bed hold the	F 625		

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F 625	Continued From page 41 signed agreement is in the admission file in my office." OSM #5 was asked to provide evidence Resident #149 and his RP were offered a bed hold on 1/13/18. On 2/15/18 at 1:30 p.m. ASM (administrative staff member) #1, the administrator, approached this writer and stated there was no documentation that a bed hold was offered to Resident #149 or his RP on 1/13/18. An end of day meeting was conducted on 2/15/18 at 4:00 p.m. with ASM #1, the administrator, ASM #2, the director of nursing /assistant administrator, ASM #3, the administrator in training, and ASM #5, the assistant director of nursing. ASM #1, ASM #2, ASM #3, and ASM #5 were made aware of the above concerns and a facility policy for bed holds was requested at this time. A review of the facility policy titled "Bed-Holds and Returns" revealed, in part, the following documentation: "Policy Statement. Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy. Policy Interpretation and Implementation. 3. Prior to a transfer, written information will be given to the residents and the resident representatives that explains in detail: a. The rights and limitations of the resident regarding bed-holds. b. The reserve bed payment policy as indicated by the state plan. c. The facility per diem rate required to hold a bed, or to hold a bed beyond the state bed-hold period; and d. The details of the transfer (per the Notice of Transfer). " No further information was provided prior to the	F 625		

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F 625	Continued From page 42 end of the survey process. 2. The facility staff failed to provide Resident #93 and or the RP a bed hold notification when Resident #93 was transferred emergently to the hospital on 12/22/17. Resident #93 was admitted to the facility on 6/14/16 with a readmission on 12/27/17 with diagnoses that include, but not limited to stroke, anoxic brain damage (lack of oxygen to brain), aphasia (difficulty speaking), dysphagia (difficulty swallowing) and left sided paralysis. Resident #93's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 12/27/17 coded Resident #93 as being unable to answer the questions on the BIMS (brief interview for mental status), the staff assessment coded him as being severely impaired to make decisions. A review of Resident #93's clinical record revealed, in part, that he was transferred to the hospital on 12/22/17 to treat seizures. Further review of Resident #93's clinical record did not reveal any evidence that the bed hold policy was provided to Resident #93 and or his RP prior to the transfer to the hospital on 12/22/17. A review of Resident #93's comprehensive care plan dated 1/2/18 did not reveal any documentation related to the hospitalization on 12/22/17. On 2/14/18 at 1:35 p.m., an interview was	F 625		

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F 625	Continued From page 43 conducted with RN (registered nurse) #2, a unit manager. RN #2 was asked who was responsible for providing the bed hold notice, when a resident was transferred to the hospital. RN #2 stated, "On a weekend we can, it doesn't happen often, but normally admissions / social worker handle this. We may have asked in the past (maybe on a weekend) if they (the resident/RP) wanted to do a bed hold and we were allowed to give rates." RN #2 was asked if she did offer a bed hold, if she would document this in the progress notes, RN #2 stated that she did not remember. On 2/15/18 at 10:32 a.m., an interview was conducted with OSM (other staff member) #3, the social worker, and OSM #5, the admissions director. OSM #3 and OSM #5 were asked who was responsible for providing bed hold notices. OSM #5 stated she would handle the bed holds. OSM #5 was asked to describe the process. OSM #5 stated, "I wait until I know the resident has been admitted and at that time I contact the RP to ask them about the bed hold. If they want the bed hold then they come in and sign a bed hold agreement form. I document the conversation in the progress notes if they decline the bed hold. If they accept the bed hold the signed agreement is in the admission file in my office." OSM #5 was asked to provide evidence that Resident #93 and his RP were offered a bed hold on 12/22/17. On 2/15/18 at 1:30 p.m. ASM (administrative staff member) #1, the administrator, approached this writer and stated that there was no documentation that a bed hold was offered to Resident #93 or his RP on 12/22/17.	F 625		

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F 625	Continued From page 44 An end of day meeting was conducted on 2/15/18 at 4:00 p.m. with ASM #1, the administrator, ASM #2, the director of nursing /assistant administrator, ASM #3, the administrator in training, and ASM #5, the assistant director of nursing. ASM #1, ASM #2, ASM #3, and ASM #5 were made aware of the above concerns and a facility policy for bed holds was requested at this time. No further information was provided prior to the end of the survey process. 3. The facility staff failed to provide Resident #98 or the resident's representative written notification of the bed hold policy when the resident was discharged to the hospital on 1/5/18. Resident #98 was admitted to the facility on 2/8/16. Resident #98's diagnoses included but were not limited to diabetes, alcohol dependence and pneumonia. Resident #98's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 1/16/18, coded the resident as cognitively intact. Review of Resident #98's clinical record revealed a nurse's note dated 1/5/18 that documented the resident was discharged to the hospital due to respiratory complications. Further review of Resident #98's clinical record (including interdisciplinary notes) failed to reveal the resident was provided written information regarding the facility bed-hold policy. Resident #98 was re-admitted to the facility on 1/9/18. On 2/15/18 at 10:33 a.m. an interview was conducted with OSM (other staff member) #3 (the social worker) and OSM #5 (the admissions	F 625		

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F 625	Continued From page 45 coordinator). OSM #5 stated the admissions department is responsible for providing bed hold information to residents and their representatives. OSM #5 stated she waits until she knows a resident has been admitted to the hospital then she contacts the resident's representative to ask them if they would like a bed hold. OSM #5 stated if the representative wants a bed hold then he/she is asked to come to the facility and sign a bed hold agreement form. OSM #5 stated if the representative does not want a bed hold then she documents this in a nurse's note. OSM #5 was asked to provide evidence that Resident #98 was offered a bed hold when the resident discharged to the hospital on 1/5/18. On 2/15/18 at 1:30 p.m. ASM (administrative staff member) #1 (the administrator) was made aware OSM #5 was asked to provide bed hold documentation for several residents including Resident #98. ASM #1 presented a bed hold agreement regarding another resident and stated that was the only documentation that could be found. On 2/15/18 at 4:27 p.m. ASM #1, ASM #2 (the director of nursing), ASM #3 (the administrator in training) and ASM #5 (the assistant director of nursing) were made aware of the above concern. On 2/16/18 at 8:28 a.m., an interview was conducted with Resident #98. Resident #98 was asked if the facility staff explained the bed hold policy to him when he was discharged to the hospital in January 2018. Resident #98 stated, "They told me about it before. They said if you go out and stay out for a certain amount of days then you ain't got your bed when you get back." Resident #98 was asked if facility staff talked to	F 625		

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F 625	Continued From page 46	F 625		

him about the bed hold policy the most recent time he went to the hospital. Resident #98 stated, "No."

No further information was presented prior to exit.
4. The facility staff failed to provide a notice of bed hold, prior to transfer, to Resident #254 or RP (responsible party) when the resident was emergently transferred to the hospital on 10/11/17.

Resident #254 was admitted to the facility on 4/19/17 with a recent readmission on 10/23/17, with diagnoses that included but were not limited to: diabetes, heart disease, anemia (blood counts below normal levels) (1), dementia, kidney stones, and depression.

The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 11/20/18, coded the resident as scoring a 7 on the BIMS (brief interview for mental status) score, indicating that she was severely impaired to make daily cognitive decisions. The resident was coded as being totally dependent upon one or more staff members for all of her activities of daily living.

The clinical record revealed the following documented entry dated, 10/11/17 at 9:19 p.m., "4:30 p.m. Resident vomit x1 (one time) - prn (as needed) Zofran (used to treat nausea and vomiting) (2) given. Resident vomit again x2 (times two) - (name of doctor) in to see Resident - new order - liquid diet for 24 hours and KUB (kidneys, ureters, bladder - x-ray). Resident continue to vomit again x1 (one time). 8:15 p.m. T.O. (telephone order) from (name of doctor) to send to E.R. (emergency room) for eval

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495353	A. BUILDING _____ B. WING _____	C 02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BLACKSTONE	900 S MAIN ST BLACKSTONE, VA 23824

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 47 (evaluation). Resident sent to Hosp (hospital) per MD (medical doctor) request - resident left at 8:45 p.m." Further review of the clinical record for Resident #254 failed to evidence documentation that the bed hold policy was presented to the resident and or the responsible party upon transfer to the hospital. An interview was conducted with RN (registered nurse) #2 on 2/14/18 at 1:41 p.m. When asked if the resident or their representative were given a copy of the bed hold policy upon transfer to the hospital, RN #2 stated, "The front office handles the bed hold policy. In the past I been asked to ask the resident or family if they would like a bed hold and gave them the rates at that time but it's been a long time since I did that." When asked if she gave the notice in writing regarding the bed hold, RN #2 stated, "No." An interview was conducted with other staff member (OSM) #3, the social worker and OSM #5, the admissions coordinator, on 2/15/18 at 10:32 a.m. When asked the process for giving the resident the bed hold policy, OSM #5 stated, "I handle that." When asked the facility process for bed holds, OSM #5 stated, "I wait until they (the resident) has been admitted and then I contact the RP (responsible party). If they want the bed hold I asked them to come into the facility and sign the paper." When asked where this is documented, OSM #5 stated, "If they decline the bed hold, I write a note in the nurse's note. If they want the bed hold, they sign the paper and it's kept in the front office." A copy of the bed hold for Resident #254 was requested of OSM #5 at this time.	F 625		

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F 625	Continued From page 48 On 2/14/18 at 4:45 p.m. ASM (administrative staff member) #1, ASM #2 (the director of nursing), ASM #3 (the administrator in training) and ASM #5 (the assistant director of nursing) and OSM #3 were made aware of the above concern. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader; Rothenberg and Chapman, page 33. (2) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d9a71b42-ddfc-49d5-7280-0fc0041dba41 5. The facility staff failed to provide a written bed hold policy/notification to Resident #85 and/or responsible party, within 24 hours of a transfer and admission to the hospital on 12/9/17. Resident #85 was admitted to the facility on 9/13/16 with the diagnoses of but not limited to dementia with behaviors, anxiety disorder, bipolar disorder, high blood pressure, gout, asthma, benign prostatic hyperplasia, and high cholesterol. The most recent MDS (Minimum Data Set) was 30-day assessment status/post hospitalization, with an ARD (Assessment Reference Date) of 1/10/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident required total care for bathing and hygiene; extensive assistance with toileting; limited assistance with eating, dressing, and transfers; and was occasionally incontinent of bowel and bladder.	F 625		

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F 625	Continued From page 49 A review of the clinical record revealed a nurses note dated 12/9/17 at 8:44 a.m., which documented the following: "Unit charge nurse came over and made this nurse aware that resident was throwing up an [sic] black like substance....call made to ASM #9 (Administrative Staff Member, the physician) to make aware of resident condition message left no return call at this time...call made to (ASM #4 Medical Director) and made aware of resident condition order obtained to send resident to er (emergency room) [sic] for eval (evaluation)..." A nurse's note dated 12/9/17 at 2:59 PM documented, "0815 (8:15 a.m.) Resident awaken to take medicine told writer he felt sick. Resident began to gag writer instructed Resident to head towards the sink. Resident vomited black bile. Supervisor notified and Resident was prepared for transfer...." Further review of the clinical record failed to reveal any evidence that a bed hold was offered. On 2/14/18 at 1:41 p.m., in an interview with OSM (other staff member) #5 (Admissions). OSM #5 stated that once she knows a resident has been admitted to the hospital, she calls the Responsible Party (RP) about the bed hold. If they wish to have a bed hold, she will then send them the form to sign, but if they decline, they do not get anything in writing about a bed hold. OSM #5 stated that she just documents in the nurses notes that they declined. There was no documentation in Resident #85's record about bed hold status or attempts to secure the bed hold status. OSM #5 stated that she attempted to call the RP for Resident #85 but was not able to	F 625		

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F 625	Continued From page 50 reach them, and did not follow up with anything in writing to the RP. OSM #5 stated she did not know the bed hold had to be provided in writing, whether or not the responsible party accepted or declined one. On 2/15/18 at approximately 4:00 PM at the end of day meeting, the Administrator (ASM #1) the Director of Nursing (ASM #2) were made aware of the findings. No further information was provided by the end of the survey.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to complete an accurate assessment for one of 31 residents in the survey sample, Resident #25. The facility staff failed to capture Resident #25's fall that occurred on 8/8/17 on the next scheduled MDS (minimum data set) with an ARD (assessment reference date) of 10/27/17. The findings include: Resident #25 was admitted to the facility on 3/24/17 with a readmission on 7/12/17 with diagnoses that include, but not limited to, diabetes, history of falling, dementia, chronic kidney disease, and difficulty in walking.	F 641	F641 **Corrective Action(s):** Resident #25 has had their most recent MDS modified and corrected by the MDS coordinator to accurately code section J for falls since last assessment while in facility. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents with a fall 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 sections J – Falls since last assessment is 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 641	Continued From page 51 Resident #25's most recent MDS, a quarterly assessment with an ARD of 1/26/18, coded Resident #25 as scoring a five out of a possible 15 on the BIMS (brief interview for mental status), indicating that Resident #25 is severely cognitively impaired with daily decision making. A review of Resident #25's clinical record revealed Resident #25 had fallen on 8/8/17. A review of Resident #25's comprehensive care plan dated 7/28/17 revealed, in part, the following documentation; "Problem/Need: Potential for falls due to residents impaire (sic) independent (sic) mobility. Comments. 8/8/17 fall. Intervention Pressure Alarm to W/C (wheelchair)." A review of Resident #25's MDS, a quarterly assessment with an ARD of 10/27/17, Section J, Health Conditions, coded Resident #25 has having "0" (zero) falls since the last assessment date, an admission assessment with an ARD of 7/28/17. On 2/15/17 at 5:35 p.m., an interview was conducted with RN (registered nurse) #3, an MDS coordinator. RN #3 was asked if a fall would be captured on the MDS. RN #3 stated that it should be. RN #3 was asked to review Resident #25's clinical record and the provide evidence that the fall experienced on 8/8/17 was captured on the following MDS assessment. RN #3 stated that she would do some research and get back to this surveyor. On 2/15/17 at 3:55 p.m. LPN (licensed practical nurse) #8, an MDS coordinator, approached this writer and stated that Resident #25's fall on 8/8/17 was not captured on the 10/27/17 MDS	F 641	**Systemic Change(s):** The MDS Coordinator has been inserviced by the Regional Nurse consultant on the proper assessment and coding of all areas of the MDS to include sections J 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/or DON 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 for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 2, 2018**	

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F 641	Continued From page 52 and should have been included on that assessment. LPN #8 was asked what guidelines / reference she used for completing the MDS. LPN #8 stated the RAI (resident assessment instrument) manual. An end of day meeting was conducted on 2/15/18 at 4:00 p.m. with ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the administrator in training, and ASM #5, the assistant director of nursing. ASM #1, ASM #2, ASM #3, and ASM #5 were made aware of the above concerns. No further information was provided prior to the end of the survey process.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services.	F 655	F655 **Corrective Action(s):** Resident #255's attending physician and RP were notified that the facility failed to develop an accurate base line care plan for resident #255 that included the resident's pain medication use and the need for anticoagulant medication use. A Facility Incident & Accident Form was completed for this incident.	4/2/18

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F 655	Continued From page 53 (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to develop an interim care plan for one of 31 residents in the survey sample, Resident #255. The facility staff failed to develop an baseline care plan to address pain and the use of an anticoagulant for Resident #255. The findings include:	F 655	**Identification of Deficient Practices & Corrective Action(s):** All new admissions to the facility may have potentially been affected. A 100% review of all new admissions in the last 30 days will be conducted by the DON, RCC and/or designee to identify residents without an accurate base line care plan within 48 hours of admission. All resident identified with inaccurate base line care plans developed after 48 hours of admission will have their care plan reviewed and updated to reflect their current interventions and appropriate approaches to address their medical and treatment needs and the attending physician and RP will be notified. A Facility Incident & Accident Form will be completed for each incident identified. **Systemic Changes:** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record and physician orders will be used to develop and revise base line care plans within 48 hours of admission to the facility. The RCC, IDT and the DON will be inserviced by the regional nurse consultant on the development and implementation process of base line care plan within 48 hours of admission.	

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F 655	Continued From page 54 Resident #255 was admitted to the facility on 2/9/18 with diagnoses that included but were not limited to right knee replacement, seizures, high blood pressure and depression. There was no MDS (minimum data set) assessment completed at the time of survey. The "Nursing Admission Assessment" dated 2/9/18 documented the resident was alert and oriented. The resident was documented to need assistance with all of her activities of daily living except eating, in which she documented as being independent. The physician orders dated, 2/10/18, documented, "Tylenol 325 MG (milligrams) Tablet - 2 tabs (tablets) PO (by mouth) Q (every) 4 hours PRN (as needed) pain. The MAR (medication administration record) documented the resident had received the Tylenol on three occasions since admission. The physician orders dated, 2/10/18, documented, "Xarelto* 10 MG (milligrams) Tablet one tab (tablet) PO (by mouth) QD (every day) at 5:00 p.m. Dx (diagnosis): DVT (deep vein thrombosis) prophylaxis." Prophylaxis of Deep Vein Thrombosis Following Hip or Knee Replacement Surgery, * XARELTO is indicated for the prophylaxis of DVT, which may lead to PE (pulmonary embolism)in patients undergoing knee or hip replacement surgery. (1) The "Interim Plan of Care" dated 2/9/18 was reviewed. There was no documentation of a plan	F 655	**Monitoring:** The RCC and DON are responsible for maintaining compliance. The DON and/or RCC will perform care plan audits on all new admissions 48 hours after admission to ensure a base line care plan has been completed timely. Any/all negative findings will be reported to the RCC for immediate correction. Detailed findings of the Care Plan audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 2, 2018**	

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F 655	Continued From page 55 of care for pain. The "Interim Care Plan" dated; 2/9/18 did not address the use of Xarelto. An interview was conducted on 2/14/18 at 1:58 p.m. with RN (registered nurse) #2. When asked where the interim care plans were located, RN #2 stated they were in the care plan book on the floor. An interview was conducted with administrative staff member (ASM) #5, the assistant director of nursing, on 2/14/18 at 2:10 p.m. ASM #5 confirmed the "Interim Plan of Care" was the interim plan of care until the full care plan is created. An interview was conducted with RN #1, on 2/14/18 at 2:14 p.m. When asked how the care needs of a newly admitted resident are communicated with the staff, RN #1 stated, "We have an interim care plan." When asked what should be on the interim care plan, RN #1 stated, "The needs of the resident with ADL (activities of daily living) care, incontinence care, and glasses or hearing aids." When asked if pain and the use of an anticoagulant, such as Xarelto should be addressed on the interim care plan, RN #1 stated, "I do believe it should be." RN #1 stated, "I don't think it would hurt. Some nurses refer to the MAR (medication administration) as part of the care plan." RN #1 was asked to review the interim care plan for Resident #255. When asked if pain or the use of an anticoagulant were addressed on the interim care plan, RN #1 stated, "No, it's not there." When asked who is responsible for creating the interim care plan, RN #1 stated, "I do it but I guess the nurses can do it." An interview was conducted with ASM #2, the	F 655		

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F 655	Continued From page 56 director of nursing, on 2/15/18 at 2:20 p.m. When asked what should be addressed on the interim care plan, ASM #2 stated, "What assistance the resident needs, toileting needs, how they are fed, how they transfer, if they are hard of hearing, if they use glasses and the incontinence status." When asked the purpose of the baseline care plan, ASM #2 stated, "It's to tell the person caring for them how to take care of them." When asked if pain and the use of an anticoagulant such as Xarelto should be on the interim care plan for a resident who had a knee replaced, ASM #2 stated, "Yes, I believe so." ASM #2 was asked to review Resident #255's baseline care plan. When asked if pain and the use of an anticoagulant was addressed on the care plan, ASM #2 stated, "No, it's not there." The facility policy, "Care Plans - Baseline" documented in part, "1. To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed with in forty-eight (48) hours of the resident's admission. 2. The interdisciplinary Team will review the healthcare practitioner's orders (e.g., dietary needs, medications, routine treatments, etc.) and implement a baseline care plan to need the resident's immediate care needs including but not limited to: a. Initial goals based on admission orders, b. physician orders. c. dietary orders. d. therapy services. e. social services...4. The resident and their representative will be provided a summary of the baseline care plan that included but is not limited to: a. The initial goals of the resident. b. A summary of the resident's medications and dietary instructions. c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility and. d. Any updated information based	F 655		

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F 655	Continued From page 57 on the details of the comprehensive care plan as necessary." ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the administrator in training, and ASM #5, the assistant director of nursing and OSM (other staff member) #3, the social worker were made aware of the above findings on 2/15/18 at 4:30 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setid=10db92f9-2300-4a80-836b-673e1ae91610	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656	F 656 **Corrective Action(s):** Resident #22's comprehensive care plan has been reviewed and revised to reflect appropriate goals and interventions and approaches to address the resident's specific medical and treatment needs to include the use of a fall mat at all times while in bed, to include during meals. A Facility Incident & Accident Form was completed for this incident. Resident #39's comprehensive care plan has been reviewed and revised to reflect appropriate goals and interventions and approaches to address the resident's specific medical and treatment needs to include the use of scheduled pain medication to manage her Arthritis. A Facility Incident & Accident Form was completed for this incident.	4/2/18

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F 656	Continued From page 58 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to develop and implement the comprehensive care plan for two of 31 residents in the survey sample, Residents #22 and Resident #39. 1. The facility staff failed to implement Resident #22's comprehensive care plan to have the fall mat down while the resident was in bed. On multiple occasions, Resident #22 was observed in bed without a fall mat on the floor. 2. The facility staff failed to develop a comprehensive care plan to address pain for	F 656	**Identification of Deficient Practices & Corrective Action(s):** All residents may have potentially been affected. A 100% review of all comprehensive care plans will be conducted by the DON, ADON, RCC and/or designee to identify residents with inaccurate or incomplete comprehensive care plans. Resident identified with inaccurate or incomplete care plans will have their care plan reviewed and updated to reflect their current interventions and appropriate approaches to address their medical and treatment needs. A Facility Incident & Accident Form will be completed for each incident identified. **Systemic Changes:** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record and physician orders will be used to develop and revise comprehensive plans of care. The RCC, IDT and the DON will be inserviced by the regional nurse consultant on the development, revision and implementation process of individualized care plans. **Monitoring:** The RCC and DON are responsible for maintaining compliance. The DON and/or RCC will perform care plan audits weekly coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be reported to the DON / RCC for immediate correction. Detailed	

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F 656	Continued From page 59 Resident #39. The findings include: 1. Resident #22 was admitted to the facility on 9/29/14 with a readmission on 1/19/17 , with diagnoses that included but were not limited to: heart disease, Parkinson's disease (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, rolling and muscle weakness) (1) and dementia. The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 2/15/18, coded the resident as scoring a "5" on the BIMS (brief interview for mental status) score, indicating she was severely impaired to make daily cognitive decisions. The resident was coded as being totally dependent upon one or more staff members for all of her activities of daily living. In Section J - Health Conditions, the resident was coded as not having had any falls since the previous assessment. Observation was made of Resident #22 on 2/14/18 at 8:52 a.m. and 9:02 a.m. The resident was in the bed, with the head of the bed elevated. The bedside table was in front of her with her breakfast tray. A fall mat was observed folded up behind the headboard of the bed. It was not on the floor next to the bed. A third observation was made of Resident #22 on 2/15/18 at 8:22 a.m. The resident was observed in the bed with the fall mat down. On 2/15/18 at 8:47 a.m., Resident # 22 was observed in bed with the head of her bed elevated. The bedside	F 656	findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 2, 2018**	

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F 656	Continued From page 60 table was in front of her with her breakfast tray. The fall mat was observed folded up behind the headboard of the bed. It was not on the floor next to the bed. The comprehensive care plan dated, 10/1/14 documented in part, "Problem/Need: Potential for Injury." The "Approaches" documented in part, "Fall mat at bedside when resident is in bed." The physician orders dated, 1/19/17, documented, "Fall mat at bedside when in bed for safety, check position Q (every) shift." The TAR (treatment administration record) for February documented, "Fall mat at bedside when in bed for safety, check position Q shift." It was documented that the fall mat was down for every shift in February. The "Fall Risk Assessment" dated, 1/26/18, coded the resident with a score of "18." The form documented, "A score greater than or equal to 10 indicates HIGH RISK, for which prevention protocol should be initiated immediately and documented on the care plan." An interview was conducted with CNA (certified nursing assistant) #4 on 2/15/18 at 1:38 p.m. CNA #4 was asked when a fall mat is used. CNA #4 stated, "When we first get an admission and if they are a fall risk, we put one down." When asked if the mat should be down when the resident is in bed, CNA #4 stated, "Yes." When asked if the fall mat should be down on the floor when the resident is in bed with the meal tray on the over bed table in front of the resident, CNA #4 stated, "We put the mat under the bedside table. If the care plan says a fall mat then we put it	F 656		

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F 656	Continued From page 61 down." When asked the purpose of the care plan, CNA #4 stated, "It's how to know how to take care of the patient. An interview was conducted with LPN (licensed practical nurse) #5 on 2/15/18 at 2:05 p.m., regarding when a fall mat should be down on the floor. LPN #5 stated, "When they are in the bed." When asked if it should make a difference if the breakfast tray is in front of the resident in the bed, LPN #5 stated, "It (the fall mat) should be there (on the floor) if the resident is in the bed." When asked the purpose of the care plan, LPN #5 stated, "It's how to care for our residents." An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 2/15/18 at 2:34 p.m., regarding when a physician ordered fall mat should be down on the floor for a resident. ASM #2 stated, "If the resident is to have a fall mat while in bed, then it should be down when they are in the bed." When asked if the fall mat should be down when the resident is in bed with a breakfast tray in front of them, ASM #2 stated, "If the resident has an order for a mat while in bed, then it should be down while the resident is in the bed." When asked if a fall mat is an intervention on a resident's care plan, should the intervention be implemented and followed, ASM #2 stated, "Yes." The facility policy, "Care Plans, Comprehensive Person - Centered" documented in part, "A comprehensive, person-centered care plan that includes measurable objective and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The Interdisciplinary Team (IDT) in conjunction with the resident and his/her	F 656		

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F 656	Continued From page 62 family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment...The comprehensive, person -centered care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being." Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care." ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the administrator in training, and ASM #5, the assistant director of nursing and OSM (other staff member) #3, the social worker were made aware of the above findings on 2/15/18 at 4:30 p.m. No further information was provided prior to exit.	F 656		

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F 656	Continued From page 63 (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader; Rothenberg and Chapman, page 437. 2. The facility staff failed to develop a comprehensive care plan to address pain for Resident #39. Resident #39 was admitted to the facility on 2/24/17 with diagnoses that included but were not limited to: history of falling, COPD - chronic obstructive pulmonary disease (a general term for chronic, non-reversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1), arthritis and anxiety disorder. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 11/22/17, coded the resident as scoring a "10" on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make cognitive daily decisions. The resident was coded as being dependent upon one staff member for her activities of daily living. In Section J - Health Conditions, the resident was coded as receiving scheduled pain medication and rating her pain as a "06" on the pain scale of 0 -10, ten being the worse pain. The comprehensive care plan, dated, 12/26/17, failed to evidence a care plan to address Resident #39's pain. The physician order dated, 1/6/18, Tylenol Arthritis ER (extended release) 650 MG (milligrams) TB (tablet) 1 PO (by mouth) Q (every) 8 hours. Dx (diagnosis): OA	F 656		

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F 656	Continued From page 64 (osteoarthritis) joint pain." The "Pain - Initial Rating Tool" dated 8/23/17, documented the resident had "No complaint or evidence of pain." The "Pain - Initial Rating Tool" dated, 11/22/17, documented the resident had "No complaint or evidence of pain." The MAR (medication administration record) for January 2018 documented, "Tylenol Arthritis ER 650 MG TB 1 PO Q 8 hours, Dx: OA joint pain." The medication was scheduled for 6:00 a.m., 2:00 p.m. and 10:00 p.m. The medication was documented for all prescribed times. The "Notes" for the administration, documented the resident's "Pre-Administration Pain Level." There were no entries for "post administration pain level" documented on the MAR. Review of the resident's pain level at the time of administration is as follows: 0 pain on 22 of 77 opportunities/assessments 1 pain level on 5 of 77 opportunities/assessments 2 pain level on 3 of 77 opportunities/assessments 3 pain level on 5 of 77 opportunities/assessments 4 pain level on 5 of 77 opportunities/assessments 5 pain level on 7 of 77 opportunities/assessments 6 pain level on 2 of 77 opportunities/assessments 7 pain level on 4 of 77 opportunities/assessments 10 pain level on 22 of 77 opportunities/assessments. The MAR (medication administration record) for February 2018 documented, "Tylenol Arthritis ER 650 MG TB 1 PO Q 8 hours, Dx: OA joint pain." The medication was scheduled for 6:00 a.m., 2:00 p.m. and 10:00 p.m. The medication was documented for all prescribed times. The "Notes"	F 656		

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F 656	Continued From page 65 for the administration, documented the resident's "Pre-Administration Pain Level." There were no entries for "post administration pain level" documented on the MAR. Review of the resident's pain level at the time of administration is as follows: 0 pain level on 11 of 43 opportunities/assessments. 1 pain level on 3 of 43 opportunities/assessments. 2 pain level on 4 of 43 opportunities/assessments. 3 pain level on 4 of 43 opportunities/assessments. 5 pain level on 6 of 43 opportunities/assessments. 6 pain level on 4 of 43 opportunities/assessments. 7 pain level on 3 of 43 opportunities/assessments. 10 pain level on 12 of 43 opportunities/assessments. An interview was conducted with LPN (licensed practical nurse) #5 on 2/15/18 at 2:07 p.m. The above order for Tylenol Arthritis was reviewed with LPN #5. LPN #5 was if she reassess residents who are on scheduled pain medication to determine if the medication was effective in reliving the resident's pain. LPN #5 stated, "Yes, I go back." When asked where the effectiveness of the Tylenol for Resident #39 is documented, LPN #5 stated, "In the nurse's notes." LPN #5 was asked if Resident #39 should be reassessed to see if medication has helped as she is documented as frequently complaining of pain at a level 10. LPN #5 stated, "Yes, but we don't want a heavy narcotic as it sedated her too much. We try to move her by the pad to minimize pain."	F 656		

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F 656	Continued From page 66 When asked if this should be on a care plan, LPN #5 stated, "Yes, it should be." LPN #5 was asked if a resident on scheduled pain medication would have a care plan to address this, LPN #5 stated, "Yes, it's part of her plan of care. She has arthritis really bed." LPN #5 was asked to review the care plan for Resident #39. When asked if she saw the resident's arthritis and pain management documented on the care plan, LPN #5 stated, "I don't see it there." When asked who is responsible for developing the care plan LPN #5 stated, "I think the MDS nurses do. We were told that we are supposed to update them, but I have not been trained to do so." An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 2/15/18 at 2:26 p.m. ASM #2 was asked if the nurses are supposed to document a pre and post pain assessment for a resident on scheduled Tylenol, ASM #2 stated, "Yes, they should be following up with the resident to see if it's working, if it's not working then a conversation should be had with the physician. When asked where the nurse should document the pre and post pain assessments, ASM #2 stated, "In the nurse's notes." When asked if pain should be addressed on a resident's care plan, ASM #2 stated, "Yes." ASM #2 was asked to review Resident #39's care plan. ASM #2 stated, "I don't see it (pain) on here." When asked who is responsible for developing the care plan, ASM #2 stated, "The MDS nurses." When asked if the nurses update or develop care plans, ASM #2 stated, "No, the nurses do not." An interview was conducted with LPN #8, the MDS nurse on 2/15/18 at 3:39 p.m. when asked who develops the care plan, LPN #8 stated, "I do	F 656		

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F 656	Continued From page 67 from the CAAs (care area assessments) and nursing notes." LPN #8 was asked to review Resident #39's care plan. When asked if a resident receiving scheduled pain medication should have pain addressed on the comprehensive care plan, LPN #8 stated, "Yes, Ma'am." When asked if pain was addressed on Resident #39's care plan, LPN #8 stated it (pain) was not on the care plan." ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the administrator in training, and ASM #5, the assistant director of nursing and OSM (other staff member) #3, the social worker were made aware of the above findings on 2/15/18 at 4:30 p.m. No further information was obtained prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition; Rothenberg and Chapman. Page 125.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to follow professional standards of practice for one of 31 residents in the survey sample, Residents #66.	F 658	F658 Corrective Action(s): Resident #66's attending physician has been notified that the facility staff failed to clarify left TBAR hand splint and right resting hand splint orders upon readmission. Resident #66's physician orders have been reviewed to ensure all medication and treatment orders are accurate. A Facility Incident & Accident Form was completed for these incidents.	4/2/18

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F 658	Continued From page 68 The facility staff failed to clarify orders on readmission to the facility for Resident #66's Left TBAR hand splint and right resting hand splint that were discontinued by the occupational therapist on 12/22/17. The findings include: Resident #66 was admitted to the facility on 7/29/14 and readmitted on 12/21/17 with diagnoses that included but were not limited to high blood pressure, neurogenic bladder [1], type two diabetes, and dementia. Resident #66's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 12/28/17. Resident #66 was coded as being moderately impaired in cognitive function scoring 08 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #66 was coded in section B (Hearing, Speech, Vision) as usually being understood by staff in the ability to express ideas and wants. Resident #66 was also coded as usually understanding staff. Review of Resident #66's POS (physician order sheet) that was signed by the physician on 1/14/18 revealed the following active orders: 1) "RNP (restorative nursing program) 7 days per week. staff (sic) to donn (sic) left Tbar [2] splint and right resting splint after am (morning) ADLS (activities of daily living) and remove at lunch. staff (sic) to then donn (sic) bilateral palm guards. Check skin q (every) shift per pt (patient tolerance)." This order was initiated on 1/30/17 and re-ordered on 12/21/17 when Resident #66 was readmitted to the facility. 2) "Bilateral palm guards apply to resident	F 658	**Identification of Deficient Practices/Corrective Action(s):** All other residents with physician ordered splinting devices may have been potentially affected. The DON, ADON and/or designee will conduct a 100% review of all resident's splinting and positioning orders to identify any residents at risk. All residents identified at risk will be corrected at time of discovery and the attending physician will be notified of each error. An Incident & Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report, documentation in the medical record, reviewing hospital information and physician orders remains the source document for the development and monitoring of care which includes, obtaining, transcribing and administering physician ordered medications and treatments per physician order upon admission and readmission. Licensed staff will be inserviced by the DON and/or regional nurse consultant on the policy & procedure for obtaining, transcribing medication and treatment orders to include the orders for splinting devices as recommended from the therapy department.	

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F 658	Continued From page 69 tolerance q day (every) day. Clean and dry and replace." Review of Resident #66's most recent ADL (activity of daily living) care plan dated 12/28/17, documented the following intervention "RNP (restorative nursing program) - splinting and prom (passive range of motion) as ordered." On 2/13/18 at 1:52 p.m., 02/13/18 at 2:56 p.m., 2/14/18 at 7:53 a.m., 2/14/18 at 11:45 a.m., and 2/14/18 at 1:01 p.m., observations were made of Resident #66. Resident #66 had bilateral palm guards in place. The ordered splints; Left T-Bar and right resting hand splint were not in place. On 2/14/18 at 12:58 p.m., an interview was conducted with LPN (licensed practical nurse) #6, Resident #66's nurse. When asked who was responsible for implementing the restorative nursing program, LPN #6 stated the nursing aides implement the restorative nursing program and the nurses ensure that the program is being followed. When asked who would be responsible for ensuring splints were in place, LPN #6 stated the nurses are ultimately responsible for ensuring that splints are in place. When asked how nursing aides are made aware a resident needs splints in place, LPN #6 stated the intervention or direction alerting the nursing aides to apply the splints would be documented on the care plan for the aides. LPN #6 stated the care plan used by the nursing aides was located in the residents' cabinets. This writer accompanied LPN #6 to Resident #66's room. The splinting program as well as the bilateral palm guards were documented on Resident #66's care plan used by the nursing aides. When asked if Resident #66 was supposed to be on any special splinting	F 658	**Monitoring:** The DON is responsible for maintaining compliance. The DON and/or ADON will review medication and treatment orders weekly coinciding with the care plan calendar in order to maintain compliance: Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 2, 2018**	

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F 658	Continued From page 70 program, LPN #6 stated she did not see splints on her TAR (treatment administration record). LPN #6 stated that palm guards were ordered to be on every shift. LPN #6 stated the order for palm guards was the only order that showed up on the TAR. LPN #6 stated she was not sure if splints had to be on Resident #66's bilateral hands. LPN #6 stated, "He has had the palm guards in place. As far as I know, that is all he has to have in place. He has only had the palm guards on today." LPN #6 confirmed that she saw the order for the splinting program on Resident #66's POS. LPN #6 stated the order should have been clarified. On 2/14/18 at 12:59 p.m., an interview was conducted with CNA (certified nursing assistant) #1, Resident #66's CNA. When asked who was responsible for ensuring the restorative nursing program was being implemented, such as applying splints to residents, CNA #1 stated, "Aides put them on." When asked if Resident #66 required splints to his bilateral hands, CNA #1 stated, "He wears palm guards. He has palm guards on. They were already on when I got here. I don't think he wears splints but I can find out." When CNA #1 was asked if Resident #66 had ever worn splints, CNA #1 stated she was not sure because she just started working with Resident #66. CNA #1 stated in the short period she has worked with Resident #66, he has not had splints, just the palm guards. On 2/14/18 at approximately 3:00 p.m., administration presented an order dated 2/14/18 at 2:20 p.m. The following was documented: "Late entry for 12/22/17 : D/C (discontinue) Left TBar splint and right resting hand splint. Pt (patient) to wear bilateral palm guards for	F 658		

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F 658	Continued From page 71 joint/skin integrity. Donn (sic) every AM. ADLS and remove prior to 1-7 shift. Wear per patient tolerance." On 2/15/18 at 12:07 p.m., an interview was conducted with OSM (other staff member) #4, the occupational therapist. OSM #4 stated Resident #66 was only supposed to have the bilateral palm guards in place. OSM #4 stated that Resident #66 had only been wearing the bilateral palm guards when he returned to the hospital on 12/21/17. OSM #4 stated on 12/22/17, she had met with the resident and the resident's wife who requested that he only use the palm guards. The splints were too bulky for the resident. OSM #4 stated she agreed for the resident to only wear the palm guards. OSM #4 stated she did not discontinue the order for splints, because she thought the order was already discontinued when he was transferred to the hospital on 12/17/17. OSM #4 stated therapy orders should never be reinstated by nursing without approval from therapy even upon return from the hospital. OSM #4 stated that the order had been riding on the physician order sheet when it shouldn't have been on the POS. OSM #4 was asked if she documented that she had spoken with the resident and resident's wife on 12/22/17, OSM #4 stated she did. This documentation was requested at this time. On 2/15/18 at approximately 12:15 p.m., OSM #4 presented a copy of her note written on 12/22/17. The following was documented, "Recommend palm guards for skin/jt (joint) integrity. Pt (patient) prefers palm guards rather than L (left) T-Bar and R (right) resting hand splint. D/C (discontinue) right resting hand splint."	F 658		

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F 658	Continued From page 72 On 2/15/18 at 1:31 p.m., an interview was conducted with LPN #5. When asked who was responsible for writing admission orders for a resident who is readmitted to the facility from the hospital, LPN #5 stated the nurse assigned to the resident was responsible for entering orders into the computer system. LPN #5 stated the charge nurse or supervisor checks behind the nurse to ensure the orders in the computer system match with the hospital discharge orders. When asked if a resident was on a restorative nursing program prior to transfer to the hospital but then was readmitted back to the facility if that same order would still be in place, LPN #5 stated, "That would be something we would have to discuss with therapy first." LPN #5 stated the resident would have to be evaluated by therapy before any therapy or restorative nursing orders are written. On 2/15/18 at 4:03 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #5, the ADON (assistant director of nursing) were made aware of the above concerns. ASM #2 stated the facility used Lippincott and or Mosby as a professional reference. A policy could not be provided regarding the above concern. According to "Fundamentals of Nursing-Lippincott, Williams and Wilkins 2007 page 169, "After you receive a written medication order, transcribe it onto a working document approved by your health care facility...read the order carefully, concentrate on copying it correctly, check it when you're finished." [1] Neurogenic bladder is bladder dysfunction	F 658		

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F 658	Continued From page 73 caused by neurological damage/injury. The most common complications of neurogenic bladder are UTI, urinary stones, and renal impairment. These complications are associated with the pathology of bladder dysfunction itself or occur as a consequence of the use of urinary catheters for drainage. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4467746/. [2] TBAR Splint- is a type of hand splint used to correct or prevent hand contractures. This information was obtained from http://www.lawsonmedicalllc.com/tbarsplints.htm.	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to provide services to promote the healing of a pressure	F 686	F686 Corrective Action(s): Resident #24's attending physician was notified that the facility staff failed to apply a physician ordered dressing for one day. Resident #24's treatment orders have been reviewed by the attending physician. LPN #6 has been inserviced on proper procedure when performing a dressing change to included following and applying physician ordered dressings during wound care. A facility Incident & Accident form was completed for this incident.	4/2/18

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F 686	Continued From page 74 sore for one of 31 residents in the survey sample, Resident #24. The facility staff failed to place the physician prescribed dressing on Resident #24's pressure ulcer. The findings include: Resident #24 was admitted to the facility on 12/15/16 with a recent readmission on 1/20/17 with diagnoses that included but were not limited to: depression, diabetes, dementia, and abnormal posture. The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 1/27/18, coded the resident as rarely understanding others and rarely making herself understood. Resident #24 was coded as having both short and long-term memory problems and was coded as being severely impaired to make daily cognitive decisions. The resident was coded as being totally dependent upon one or more staff members for all of her activities of daily living. In Section M - Skin Conditions the resident was coded as having a pressure ulcer that was unstageable - deep tissue injury. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic	F 686	**Identification of Deficient Practice(s) and Corrective Action(s):** All other residents with wound care treatments may have been potential affected. The DON, ADON and/or Unit Manager will conduct treatment pass audits to monitor for proper application of physician ordered dressings and infection control practices during wound care treatments. Any negative findings will be addressed immediately and disciplinary action taken as indicated. A facility Incident and Accident form will be completed each negative finding. **Systemic Change(s):** The facility Policy and Procedure for Wound Care has been reviewed and no changes are warranted at this time. The licensed nursing staff will be inserviced by the Wound Care Nurse and/or the DON on the facility's Pressure Ulcer Treatment and Prevention Policy and Procedure. Training will include the review and application of physician ordered dressings and wound treatments.	

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F 686	Continued From page 75 limb should not be softened or removed. Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions. (1) Observation of Resident #24's wound care provided by LPN (licensed practical nurse) #9, the wound care nurse, was made on 2/15/18 at 10:55 a.m. LPN #9 removed a dressing off Resident #24's pressure ulcer. The dressing appeared to be a foam style dressing. LPN #9 verified the dressing removed was a foam dressing. LPN #9 proceeded to clean the wound and applied the prescribed dressing of a coversite dressing. When asked if the prescribed dressing was removed from the pressure ulcer, LPN #9 stated, "No, that was a foam dressing and we are supposed to be putting on a coversite. The dressing that was removed was dated 2/14/18 with a nurse's initials.	F 686	**Monitoring:** The DON is responsible for compliance. The wound care physician will review all residents identified with pressure ulcer wounds weekly and document the progression of wound healing weekly. The DON, ADON or designee will complete two random treatment pass audits weekly to ensure physician ordered dressing and wound treatments are being followed. Any/all negative findings will be addressed at time of discovery and additional inservice training and/or disciplinary with will be administered at that time. The results of the audits will be sent to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 2, 2018**	

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F 686	Continued From page 76 The physician order dated, 2/2/18, documented, "Change sacral Tx (treatment) to cleanse sacrum with NS (normal saline), apply Santyl* and algisite**, coversite *** QD (every day and PRN (as needed)." *Santyl is a sterile enzymatic debriding ointment used to that has a unique ability to digest collagen in necrotic tissue. (2) **Algisite M Calcium Alginate Dressing is a calcium alginate dressing that when it comes in contact with wound exudate it forms a soft, integral gel. Algisite M absorbs the excess wound exudate. (3) ***Smith & Nephew Coversite Composite Cover Dressing is designed as a secondary cover dressing for gels, gel sheets, alginates, wound fillers and non-adhesive foams. (4) The TAR (treatment administration record) for February 2018 documented, "Cleanse sacrum with NS, apply Santyl, & algisite, coversite QD and PRN." The dressing was documented as changed on 2/14/18 by LPN # 6. The comprehensive care plan dated, 2/2/18, documented in part, "Problem Onset: Pressure Ulcers." The "Approaches" documented in part, "Provide treatments as ordered." On 2/15/18 at 11:08 a.m., the physician order for the pressure ulcer dressing was reviewed with RN (registered nurse) #1. When asked if a foam dressing is the physician ordered dressing, RN #1 stated, "No, foam dressings are brown and coversite is white." An interview was conducted with LPN #6 on	F 686		

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F 686	Continued From page 77 2/15/18 at 11:09 a.m. When asked if she provided Resident #24's wound care on 2/14/18, LPN #6 stated, "Yes, I don't work on that hall all the time." LPN #6 was asked to review the physician's order for Resident #24's wound care. LPN #6 stated, "I put a foam dressing on it, I didn't put the coversite. An interview was conducted with RN #1 on 2/15/18 at 11:15 a.m., regarding the expectation of the nurse for administering physician ordered treatments. RN #1 stated, "I would expect them to perform the treatment per the physician orders." An interview was conducted with administrative staff member (ASM) #7, the wound care physician, on 2/15/18 at 2:58 p.m. ASM #7 was informed of the observation of the incorrect dressing on the wound, ASM #7 stated, "The coversite adheres better to the wound than foam. It has the ability to evaporate off some of the drainage. The foam dressing has less moisture removing properties and is less adherent." When asked if the one day of the incorrect dressing would affect wound healing, ASM #7 stated, "No, it wouldn't." An interview was conducted with ASM #2, the director of nursing, on 2/15/18 at 2:37 p.m. The above observation was shared with ASM #2. When asked the expectation of the nurse for a physician prescribed treatment order, ASM #2 stated, "I would expect them to follow the physician orders." ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the administrator in training, and ASM #5, the assistant director of nursing and	F 686		

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F 686	Continued From page 78 OSM (other staff member) #3, the social worker were made aware of the above findings on 2/15/18 at 4:30 p.m. A request was made for the facility policy on following physician orders on 2/15/18 at 4:45 p.m. No further information was obtained prior to exit. (1) This information was obtained from the following website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ (2) This information was obtained from the following website: http://www.rxlist.com/santyl-drug.htm (3) This information was obtained from the following website: https://www.bing.com/search?q=aigisite+dressing&src=IE-SearchBox&FORM=IESR3N. (4) This information was obtained from the following website: https://www.bing.com/search?q=coversite+dressing&src=IE-SearchBox&FORM=IESR3N	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility	F 689	F689 Corrective Action(s): Resident #22's attending physician has been notified that facility staff failed to ensure a physician ordered fall mat was in place as ordered. A facility incident and accident form has been completed for this incident.	4/2/18

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F 689	Continued From page 79 document review and clinical record review, it was determined the facility staff failed to implement fall prevention interventions for one of 31 residents in the survey sample, Resident # 22. The facility staff failed to have a physician ordered fall mat in place when Resident #22 was in her bed. The findings include: Resident #22 was admitted to the facility on 9/29/14 with a readmission on 1/19/17 , with diagnoses that included but were not limited to: heart disease, Parkinson's disease (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, rolling and muscle weakness) (1) and dementia. The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 2/15/18, coded the resident as scoring a "5" on the BIMS (brief interview for mental status) score, indicating she was severely impaired to make daily cognitive decisions. The resident was coded as being totally dependent upon one or more staff members for all of her activities of daily living. In Section J - Health Conditions, the resident was coded as not having had any falls since the previous assessment. Observation was made of Resident #22 on 2/14/18 at 8:52 a.m. and 9:02 a.m. The resident was in the bed, with the head of the bed elevated. The bedside table was in front of her with her breakfast tray. A fall mat was observed folded up behind the headboard of the bed. It was not on	F 689	**Identification of Deficient Practices/Corrective Action(s):** All other residents with physician ordered fall mats or other preventive devices to prevent falls and injury may have been potentially affected. The DON, ADON and/or Unit Manager will conduct a 100% review of all residents with physician ordered fall mats and fall prevention devices to identify residents at risk for inconsistent application of the equipment. All residents identified at risk will be corrected at time of discovery and an Incident & Accident form will be completed for each negative finding. The attending physician will be notified of each incident. **Systemic Change(s):** The facility policy and procedure for fall prevention and management has been reviewed and no revisions are warranted at this time. The DON and/or regional nurse consultant will inservice all Licensed Nursing staff regarding proper use of and application of fall prevention equipments to include fall mats and wheelchair and bed alarms to prevent falls.	

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F 689	Continued From page 80 the floor next to the bed. A third observation was made of Resident #22 on 2/15/18 at 8:22 a.m. The resident was observed in the bed with the fall mat down. On 2/15/18 at 8:47 a.m., Resident # 22 was observed in bed with the head of her bed elevated. The bedside table was in front of her with her breakfast tray. The fall mat was observed folded up behind the headboard of the bed. It was not on the floor next to the bed. The physician orders dated, 1/19/17, documented, "Fall mat at bedside when in bed for safety, check position Q (every) shift." The TAR (treatment administration record) for February documented, "Fall mat at bedside when in bed for safety, check position Q shift." It was documented that the fall mat was down for every shift in February. The "Fall Risk Assessment" dated, 1/26/18, coded the resident with a score of "18." The form documented, "A score greater than or equal to 10 indicates HIGH RISK, for which prevention protocol should be initiated immediately and documented on the care plan." The care plan dated, 10/1/14 documented in part, "Problem/Need: Potential for Injury." The "Approaches" documented in part, "Fall mat at bedside when resident is in bed." An interview was conducted with CNA (certified nursing assistant) #4 on 2/15/18 at 1:38 p.m. CNA #4 was asked when a fall mat is used. CNA #4 stated, "When we first get an admission and if they are a fall risk, we put one down." When	F 689	**Monitoring:** The DON is responsible for maintaining compliance. The DON and/or Unit Manager will perform daily inspections of all residents with physician order fall prevention devices to monitor for compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these reviews will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 2, 2018**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 81 asked if the mat should be down when the resident is in bed, CNA #4 stated, "Yes." When asked if the fall mat should be down on the floor when the resident is in bed with the meal tray on the over bed table in front of the resident, CNA #4 stated, "We put the mat under the bedside table. If the care plan says a fall mat then we put it down." When asked the purpose of the care plan, CNA #4 stated, "It's how to know how to take care of the patient. An interview was conducted with LPN (licensed practical nurse) #5 on 2/15/18 at 2:05 p.m., regarding when a fall mat should be down on the floor. LPN #5 stated, "When they are in the bed." When asked if it should make a difference if the breakfast tray is in front of the resident in the bed, LPN #5 stated, "It (the fall mat) should be there (on the floor) if the resident is in the bed." When asked the purpose of the care plan, LPN #5 stated, "It's how to care for our residents." An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 2/15/18 at 2:34 p.m., regarding when a physician ordered fall mat should be down on the floor for a resident. ASM #2 stated, "If the resident is to have a fall mat while in bed, then it should be down when they are in the bed." When asked if the fall mat should be down when the resident is in bed with a breakfast tray in front of them, ASM #2 stated, "If the resident has an order for a mat while in bed, then it should be down while the resident is in the bed." The facility policy, "Falls and Fall Risk, Managing" documented in part, "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific	F 689		

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F 689	Continued From page 82 risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. 1. The staff with the input of the Attending Physician will identify appropriate interventions to reduce the risk of falls. IF a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions...The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling." In Fundamentals of Nursing, 7th edition, 2009; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc.; Page 5. "Client safety is a priority in health care. You need to protect clients from physical and emotional injury by continually assessing for and eliminating safety hazards. Clients fall due to many factors, such as improper transfer techniques, client age, side effects of medications, impaired mobility, or confusion. Learn your agency's fall prevention program for reducing client falls. Programs that use a multidimensional approach in designing fall prevention strategies have the greatest reduction in fall rates." ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the administrator in training, and ASM #5, the assistant director of nursing and OSM (other staff member) #3, the social worker were made aware of the above findings on 2/15/18 at 4:30 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader; Rothenberg and Chapman,	F 689		

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F 689	Continued From page 83 page 437.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide respiratory care per physician's order for one of 31 residents in the survey sample, Resident #40. The facility staff failed to administer oxygen at two liters per minute to Resident #40, per physician's order. The findings include: Resident #40 was admitted to the facility on 5/19/10. Resident #40's diagnoses included but were not limited to heart failure, urinary tract infection and anxiety disorder. Resident #40's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/28/17, coded the resident as being cognitively intact. Section G documented Resident #40 was totally dependent on one staff with bed mobility and totally dependent on two or more staff with transfers.	F 695	F 695 **Corrective Action(s):** Resident #40 has had their oxygen administration orders clarified with the attending physician. The attending physician has been notified that the Resident #40 did not receive oxygen at the correct flow rate as ordered by the physician. A facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All residents receiving oxygen therapy may have potentially been affected. A 100% review of all resident's oxygen orders will be conducted by the DON and/or ADON to identify residents at risk. Residents found to be at risk will be corrected at the time of discovery. A facility Incident & Accident form will be completed for each item discovered. **Systemic Change(s):** The facility policy and procedure for Oxygen administration has been reviewed and no changes were warranted at this time. All licensed nursing staff will be inserviced on the facility policy and procedure for accurate oxygen administration and monitoring per physician order. Inservices will include the delivery of oxygen per physician order and the monitoring of portable oxygen tanks throughout the shift.	

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F 695	Continued From page 84 Review of Resident #40's clinical record revealed a physician's order dated 4/10/17 for continuous oxygen at two liters per minute. Resident #40's comprehensive care plan revised on 2/8/18 documented, "Oxygen continuously at 2 lpm (liters per minute)..." On 2/13/18 at 2:47 p.m., an interview was attempted with Resident #40. The resident was unable to respond appropriately to questions. On 2/13/18 at 12:41 p.m., 2/13/18 at 2:47 p.m., 2/13/18 at 4:06 p.m. and 2/14/18 at 10:02 a.m., Resident #40 was observed lying in bed receiving oxygen via a cannula in the resident's nose. During each observation, the oxygen concentrator was set at a rate of one and a half liters as evidenced by the middle of the ball in the flow meter set at a line in between one liter and two liters. On 2/14/18 at 1:53 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked to describe where the ball in an oxygen concentrator flow meter should be if a resident has a physician's order for two liters. RN #1 stated the middle of the ball should straddle the two-liter line. RN #1 was asked if Resident #40 could move the knob on the oxygen concentrator. RN #1 stated, "Yes." When asked if Resident #40 could move the knob on the oxygen concentrator while lying in bed, RN #1 stated, "Probably not. Her bed mobility is not that good." At this time, RN #1 was asked to accompany this surveyor to Resident #40's room to observe the oxygen concentrator. Resident #40 was in a wheelchair and was observed receiving oxygen via a portable oxygen tank. RN	F 695	**Monitoring:** The DON is responsible for maintaining compliance. The DON and/or ADON will perform daily audits of all residents using oxygen to monitor for compliance. All negative findings will be corrected at time of discovery and appropriate disciplinary action will be taken as needed. All negative findings will reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 2, 2018**	

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F 695	Continued From page 85 #1 hooked the resident's oxygen tubing to the oxygen concentrator and turned the concentrator on. The ball in the flow meter was observed between the one-liter line and the one and a half liter line. On 2/14/18 at 4:52 p.m. ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #5 (the assistant director of nursing), OSM (other staff member) #3 (the social worker) and ASM #3 (the administrator in training) were made aware of the above findings. The facility oxygen administration policy failed to document specific instructions regarding adjustment of the oxygen concentrator flow meter. The manufacturer's manual for Resident #40's oxygen concentrator documented, "Chapter 2: Operating Instructions...5. Adjust the flow to the prescribed setting by turning the knob on the top of the flow meter until the ball is centered on the line marking the specific flow rate..." No further information was presented prior to exit.	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 697	F697 **Corrective Action(s):** Residents #39's attending physician was notified that the facility failed to reassess pain levels after the administration of physician ordered pain medication. A facility Incident and Accident form was completed for this incident.	4/2/18

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F 697	Continued From page 86 Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to have a complete pain management program for one of 31 residents in the survey sample, Resident #39. The facility staff failed to reassess pain levels after the administration of pain medication for Resident #39. The findings include: Resident #39 was admitted to the facility on 2/24/17 with diagnoses that included but were not limited to: history of falling, COPD - chronic obstructive pulmonary disease (a general term for chronic, non-reversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1), arthritis and anxiety disorder. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 11/22/17, coded the resident as scoring a "10" on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make cognitive daily decisions. The resident was coded as being dependent upon one staff member for her activities of daily living. In Section J - Health Conditions, the resident was coded as receiving scheduled pain medication and rating her pain as a "06" on the pain scale of 0 -10, ten being the worse pain. The comprehensive care plan, dated, 12/26/17, failed to evidence a care plan to address Resident #39's pain.	F 697	**Identification of Deficient Practices/Corrective Action(s):** All other residents receiving pain medications may have been potentially affected. The DON, ADON nurse and Unit Managers will conduct a 100% audit of all residents MAR's to identify resident at risk. Residents identified at risk will be corrected at time of discovery and their attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedures have been reviewed and no revisions are warranted at this time. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for following and administering medications per physician order. This includes reassessing residents after the administration of routine or PRN pain medications. **Monitoring:** The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Managers will audit resident MAR's weekly to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 2, 2018**	

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F 697	Continued From page 87 The physician order dated, Tylenol Arthritis ER (extended release) 650 MG (milligrams) TB (tablet) 1 PO (by mouth) Q (every) 8 hours. Dx (diagnosis): OA (osteoarthritis) joint pain." The "Pain - Initial Rating Tool" dated 8/23/17, documented the resident had "No complaint or evidence of pain." The "Pain - Initial Rating Tool" dated, 11/22/17, documented the resident had "No complaint or evidence of pain." The MAR (medication administration record) for January 2018 documented, "Tylenol Arthritis ER 650 MG TB 1 PO Q 8 hours, Dx: OA joint pain." The medication was scheduled for 6:00 a.m., 2:00 p.m. and 10:00 p.m. The medication was documented for all prescribed times. The "Notes" for the administration, documented the resident's "Pre-Administration Pain Level." There were no entries for "post administration pain level" documented on the MAR. Review of the resident's pain level at the time of administration is as follows: 0 pain on 22 of 77 opportunities/assessments 1 pain level on 5 of 77 opportunities/assessments 2 pain level on 3 of 77 opportunities/assessments 3 pain level on 5 of 77 opportunities/assessments 4 pain level on 5 of 77 opportunities/assessments 5 pain level on 7 of 77 opportunities/assessments 6 pain level on 2 of 77 opportunities/assessments 7 pain level on 4 of 77 opportunities/assessments 10 pain level on 22 of 77 opportunities/assessments. The MAR (medication administration record) for February 2018 documented, "Tylenol Arthritis ER 650 MG TB 1 PO Q 8 hours, Dx: OA joint pain."	F 697		

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F 697	Continued From page 88 The medication was scheduled for 6:00 a.m., 2:00 p.m. and 10:00 p.m. The medication was documented for all prescribed times.. The "Notes" for the administration, documented the resident's "Pre-Administration Pain Level." There were no entries for "post administration pain level" documented on the MAR. Review of the resident's pain level at the time of administration is as follows: 0 pain level on 11 of 43 opportunities/assessments. 1 pain level on 3 of 43 opportunities/assessments. 2 pain level on 4 of 43 opportunities/assessments. 3 pain level on 4 of 43 opportunities/assessments. 5 pain level on 6 of 43 opportunities/assessments. 6 pain level on 4 of 43 opportunities/assessments. 7 pain level on 3 of 43 opportunities/assessments. 10 pain level on 12 of 43 opportunities/assessments. An interview was conducted with LPN (licensed practical nurse) #5 on 2/15/18 at 2:07 p.m. The above order for Tylenol Arthritis was reviewed with LPN #5. LPN #5 was if she reassess residents who are on scheduled pain medication to determine if the medication was effective in reliving the resident's pain. LPN #5 stated, "Yes, I go back." When asked where the effectiveness of the Tylenol for Resident #39 is documented, LPN #5 stated, "In the nurse's notes." LPN #5 was asked if Resident #39 should be reassessed to see if medication has helped as she is documented as frequently complaining of pain at	F 697		

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F 697	Continued From page 89	F 697		

a level 10. LPN #5 stated, "Yes, but we don't want a heavy narcotic as it sedated her too much. We try to move her by the pad to minimize pain." When asked if this should be on a care plan, LPN #5 stated, "Yes, it should be." LPN #5 was asked if a resident on scheduled pain medication would have a care plan to address this, LPN #5 stated, "Yes, it's part of her plan of care. She has arthritis really bed." LPN #5 was asked to review the care plan for Resident #39. When asked if she saw the resident's arthritis and pain management documented on the care plan, LPN #5 stated, "I don't see it there."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 2/15/18 at 2:26 p.m. ASM #2 was asked if the nurses are supposed to document a pre and post pain assessment for a resident on scheduled Tylenol, ASM #2 stated, "Yes, they should be following up with the resident to see if it's working, if it's not working then a conversation should be had with the physician. When asked where the nurse should document the pre and post pain assessments, ASM #2 stated, "In the nurse's notes." When asked if pain should be addressed on a resident's care plan, ASM #2 stated, "Yes." ASM #2 was asked to review Resident #39's care plan. ASM #2 stated, "I don't see it (pain) on here."

An interview was conducted with Resident #39 on 2/15/18 at 3:08 p.m. When asked if the nurse comes back after giving her her Tylenol Arthritis to see if it helped, Resident #39 stated, "Not that I can remember." When asked if she was in pain at this time, Resident #39 stated, "No, not now."

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F 697	Continued From page 90 The facility policy, "Pain - Clinical Protocol" documented in part, "The physician and staff will identify individuals who have pain or who are at risk for having pain. This includes a review of each person's known diagnoses and conditions that commonly cause or predispose to pain for example, degenerative joint disease, rheumatoid arthritis, osteoporosis (with or without vertebral compression fractures), diabetic neuropathy, oral or dental pathology and post stroke syndrome. It also includes a review for any treatments that the resident currently is receiving for pain, including complementary (non-pharmacologic) treatments...The staff will reassess the individual's pain and related consequences at regular intervals; at least each shift for acute pain or significant changes in levels of chronic pain and at least weekly in stable chronic pain. Periodically the physician will evaluate and summarize the status of an individual with chronic or fluctuating pain including the status of any active conditions that exacerbate pain, consequences or complications of pain and effectiveness of current interventions for pain." Fundamentals of Nursing, 6th Edition, Potter and Perry, 2005, pages 1239-1287, "Nurses need to approach pain management systematically to understand a client's pain and to provide appropriate intervention....it is necessary to monitor pain on a consistent basis....Assessment of common characteristics of pain helps the nurse form an understanding of the type of pain, its pattern, and types of interventions that may bring relief....Onset and duration....Location....Intensity....Quality....Pain Pattern....Relief Measures....Contributing Symptoms....Pain therapy requires an individualized approach....Nurses administer and	F 697		

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F 697	Continued From page 91 monitor interventions ordered by physicians for pain relief and independently use pain-relief measures that complement those prescribed by a physician....Effective communication of a client's assessment of pain and his or her response to intervention is facilitated by accurate and thorough documentation. This communication needs to transpire from nurse to nurse, shift to shift, and nurse to other health care providers. It is the professional responsibility of the nurse caring for the client to report what has been effective for managing the client's pain. The client is not responsible for ensuring that this information is accurately transmitted. A variety of tools such as a pain flow sheet or diary will help centralize the information about pain management. ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the administrator in training, and ASM #5, the assistant director of nursing and OSM (other staff member) #3, the social worker were made aware of the above findings on 2/15/18 at 4:30 p.m. No further information was obtained prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition; Rothenberg and Chapman. Page 125.	F 697		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.	F 745	F745 **Corrective Action(s):** Resident #44 has been assessed by social services director and the department of social services to appoint a guardian for resident #44. Resident #44's comprehensive care plan has been revised to reflect the current guardian appointed to resident #44. A Facility Incident & Accident Form has been completed for this incident.	4/2/18

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F 745	Continued From page 92 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide medically related social services for one of 31 residents in the survey sample, Resident #44. The facility staff failed to ensure a representative was appointed to promote and protect Resident #44's rights and legal interests. The findings include: Resident #44 was admitted to the facility on 6/21/04 and readmitted to the facility on 11/29/17. Resident #44's diagnoses included but were not limited to vascular dementia (1) with behavior disturbance, schizophrenia (2) and unspecified intellectual disabilities. Resident #44's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 12/6/17, coded the resident as rarely/never understood and as rarely/never able to understand others. Section C coded Resident #44's cognitive skills for daily decision-making as severely impaired. Review of Resident #44's face sheet failed to reveal contact information for a responsible party or representative. Resident #44's comprehensive care plan revised on 2/7/18 documented, "Absence of personal contact with family/friends...Social Services to evaluate and visit with resident at least quarterly..." The care plan failed to document information regarding a representative. A social services note dated 3/21/17 documented,	F 745	**Identification of Deficient Practice(s) & Corrective Action(s):** All other residents who do not have a guardian or resident representative may have been potential affected. The social service director and/or admission coordinator will be conducted a 100% review of all residents to identify residents at risk. Any residents identified at risk for not having a resident representative will be assessed by Social Services to have a guardian and/or representative appointed. Any/All care plans will be updated to reflect the resident's guardian/representative that is appointed. **Systemic Change(s):** The Admission Director and Social Services director will receive additional in-service training from the administrator on ensuring all residents have a guardian or resident representative upon admission and/or readmission to the facility and as warranted based on resident need or changes. **Monitoring:** The Administrator and the Social Services Director are responsible for maintaining compliance. The Social Service Director will audit resident records monthly coinciding with the care plan calendar to monitor for compliance. The results of these audits will be provided to the Quality Assurance Committee for review, analysis, and make recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 2, 2018**	

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F 745	Continued From page 93	F 745		

"Resident does not recieve (sic) visitors and does not have family involved in care..." A social services note dated 6/16/17 documented, "Resident does not have any family nor receive (sic) visitors..." A social services note dated 10/11/17 documented, "Resident does not have any family and recieves (sic) few visitors..." A social services note dated 12/8/17 documented, "Resident does not have any family and recieves (sic) few visitors..." None of the social services notes documented attempts were made to have a representative appointed for Resident #44.

On 2/13/18 at 3:31 p.m., Resident #44 was observed lying in bed. Two staff members were in the room. One staff member spoke to Resident #44 but the resident did not respond. When asked if Resident #44 typically did not respond when spoken to, the staff member stated the resident has good days and bad days.

On 2/15/18 at 10:33 a.m. an interview was conducted with OSM (other staff member) #3 (the social worker) and OSM #5 (the admissions coordinator). OSM #3 and OSM #5 were asked to provide evidence that the bed hold policy was explained to Resident #44's representative when the resident was most recently hospitalized. OSM #5 stated she could not provide the requested evidence because Resident #44 did not have a representative. When asked if there was no one to make decisions on Resident #44's behalf, OSM #3 and OSM #5 stated there was not. OSM #3 stated Resident #44 was admitted to the facility years before her employment. When asked who makes medical decisions on Resident #44's behalf, OSM #3 stated the facility staff leaves those decisions up to the physician and she thought two physicians discuss those

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F 745	Continued From page 94 decisions. Who asked who makes decisions regarding Resident #44's rights and interests, OSM #3 stated, "Us." When asked if anyone was legally responsible for Resident #44, OSM #3 stated, "No." When asked if she had reached out to anyone to have, a representative appointed for Resident #44, OSM #3 stated she had spoken to the corporate lawyer about guardianship and she thought the process of having a guardian appointed was approximately one thousand dollars. OSM #3 stated she had not received any further feedback. When asked who was responsible for ensuring Resident #44 had a representative, OSM #3 stated, "She's the only person we have ever had this trouble with since I have been here." OSM #3 stated she had also conducted research to try to find family members. When asked to provide evidence of this research and documentation of her conversation with the corporate lawyer, OSM #3 stated she could not. On 2/15/18 at 1:33 p.m., another interview was conducted with OSM #3. When asked for a facility policy regarding the above matter, OSM #3 stated she was not aware of a policy but she had calls out to the community. OSM #3 stated she called the local social services department to see if someone there could help and was told they did not know. OSM #3 was asked how Resident #44's rights were being protected and promoted if the resident could not make decisions and no one was appointed to make decisions. OSM #3 stated she had never encountered a resident who could not make decisions and had no family but the resident's rights were protected and promoted by using the resident rights that are in place in the facility. On 2/15/18 at 4:27 p.m. ASM (administrative staff	F 745		

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F 745	Continued From page 95 member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the administrator in training) and ASM #5 (the assistant director of nursing) were made aware of the above concern. The facility policy titled, "Resident Rights" documented, "1. Federal and state laws guarantee certain basic rights to all residents of this facility. The rights include the resident's right to...f. communication with and access to people and services, both inside and outside the facility...appoint a legal representative of his or her choice, in accordance with state law...5. Inquiries concerning residents' rights should be referred to the Social Services Director." The facility policy titled, "Social Services" documented, "2. The social worker, or social service designee, will pursue the provision of any identified need for medically-related social services of the resident. Attempts to meet the needs of the resident will be handled by the appropriate discipline(s). Services to meet the resident's needs may include...e. Assisting residents with financial and legal matters..." No further information was presented prior to exit. (1) "Dementia is a gradual and permanent loss of brain function. This occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. Vascular dementia (VaD) is caused by a series of small strokes over a long period." This information was obtained from the website: https://medlineplus.gov/ency/article/000746.htm (2) "Schizophrenia is a serious brain illness. People who have it may hear voices that aren't	F 745		

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F 745	Continued From page 96 there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=schizophrenia&_ga=2.244128775.343831570.1519130579-139120270.1477942321	F 745		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any,	F 756	**F756** **Corrective Action(s):** Resident's #5& #105 have had their medication regimes reviewed by the attending physician and the consulting pharmacist for unnecessary Medications and Gradual Dosage reduction. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents receiving multiple medications (9 or more) and psychotropic medications may have been potentially affected. The pharmacy consultant will conduct a 100% review of all current resident's medication regimens to ensure that timely physician interventions and actions have been taken on all pharmacy recommendations. Any/all negative findings will be corrected at time of discovery. A Risk Management Incident/Accident form will be completed for each incident identified.	4/2/18

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F 756	Continued From page 97 action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to include all required components of the monthly pharmacy medication regimen review policy for 2 of 31 residents in the survey sample; Residents #5, and #105. 1. The facility staff failed to develop and implement policies that addressed the time frames of the steps of the medication regimen review to guide staff on the process for acting on gradual dose reduction recommendations by the pharmacist for Resident #5. 2. The facility staff failed to develop and implement policies that addressed the time frames of the steps of the medication regimen review to guide staff on the process for acting on gradual dose reduction recommendations by the pharmacist for Resident #105 The findings include:	F 756	**Systemic Change(s):** The facility Policy and Procedure has been reviewed and changes have been made to include the time frame for which pharmacy recommendations need to be delivered to the facility and physician and the time frame the physician and facility have to act on those pharmacy recommendations. All licensed nursing staff will be inserviced by the DON and/or regional nurse consultant on the updated policy and procedure for the time frames required for the review and completion of pharmacy recommendations. The DON and/or ADON will review all pharmacy recommendations monthly to ensure that any/all pharmacy recommendations have been addressed and proper notification to attending physicians has been completed. **Monitoring:** The DON is responsible for maintaining compliance. The DON, and/or designee will perform monthly audits of the pharmacy recommendations to ensure that the recommendations are being completed and followed up on timely per facility policy. Any/all negative findings will be corrected at time of discovery. Detail findings of this review will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 2, 2018**	

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F 756	Continued From page 98 1. The facility staff failed to develop and implement policies that addressed the time frames of the steps of the medication regimen review to guide staff on the process for acting on gradual dose reduction recommendations by the pharmacist for Resident #5. Resident #5 was admitted to the facility on 7/8/16 with the diagnoses of but not limited to dementia with behaviors, psychosis, depression, insomnia, high blood pressure, and high cholesterol. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 1/12/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, hygiene, toileting and dressing; limited assistance with transfers and eating; supervision for ambulation; and was incontinent of bowel and bladder. A review of the clinical record for the use of unnecessary medications revealed the pharmacy made the following medication recommendations: 9/5/17 for a reduction in the mirtazapine [1] 7.5 mg (milligrams) daily: "If clinically appropriate, please consider a gradual dose reduction, perhaps decreasing to 3.75 mg for 1 week followed by a trial discontinuation, or consider documenting dose reduction as clinically contraindicated." The physician declined this recommendation on 9/12/17, approximately 7 days after the recommendation was made. 11/3/17 for a reduction in risperidone [2] 0.5 mg every evening and 1 mg at bedtime: "If clinically appropriate, please consider a gradual dose reduction (GDR), perhaps decreasing to 1.25 mg	F 756		

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F 756	Continued From page 99 once daily in the evening, or consider documenting dose reduction as clinically contraindicated at this time." The physician declined this recommendation on 11/9/17, approximately 6 days after the recommendation was made. 1/8/18 for a reduction in risperidone 0.5 mg every evening and 1 mg at bedtime: "If clinically appropriate, please consider a gradual dose reduction (GDR), perhaps decreasing to 1.25mg once daily in the evening, or consider documenting dose reduction as clinically contraindicated at this time." The physician declined this recommendation on 1/9/18, approximately 1 day after the recommendation was made. On 2/15/18 at 11:16 AM in an interview with OSM #7 (Other Staff Member, the pharmacist). OSM #7 stated, regarding the medication regimen review and gradual dose reduction (GDR) recommendations, the time frames regarding GDR's is that he has 3 days to get them to the staff, and the staff then has 2 weeks (14 days) to get recommendations to provider and act on it. A review of the facility policy, "Medication Regimen Review" and the facility policy, "Medication Therapy" failed to include any guidance regarding the time frames that a GDR is required to be provided to the physician and acted upon by the physician. Although the above GDR recommendations were acted upon in the time frame specified by OSM #7, the policy did not meet regulatory requirements of specifying those time frames.	F 756		

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F 756	Continued From page 100 On 2/16/18 at 10:00 a.m., in an interview with the Administrator, (ASM #1 - Administrative Staff Member) she stated that the physicians usually looks at the pharmacy recommendations on their next visit. She was not aware of any specific time frame in which the physician was required to address the recommendations. She stated she did not have any other policies regarding the monthly medication regimen review and GDR's and verified that the policies provided did not specify time frames as required by the regulations. No further information was provided by the end of the survey. References: [1] Mirtazapine is used to treat depression. Information obtained from https://medlineplus.gov/druginfo/meds/a697009.html [2] Risperidone is an antipsychotic used to treat schizophrenia, episodes of mania, or mixed episodes of mania and depression with bipolar disorder, and behavior problems such as aggression, self-injury, and sudden mood changes. Information obtained from https://medlineplus.gov/druginfo/meds/a694015.html 2. The facility staff failed to develop and implement policies that addressed the time frames of the steps of the medication regimen review to guide staff on the process for acting on gradual dose reduction recommendations by the	F 756		

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F 756	Continued From page 101 pharmacist for Resident #105 Resident #105 was admitted to the facility on 2/27/17 with the diagnoses of but not limited to dementia with behaviors, anxiety disorder, depression, insomnia, benign prostatic hyperplasia, heart disease, hepatitis C, and high blood pressure. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 12/23/17. The resident was coded as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, hygiene, toileting and dressing; limited assistance with eating, transfers and ambulation; and as incontinent of bowel and bladder. A review of the clinical record for the use of unnecessary medications revealed that the pharmacy made the following medication recommendations: 10/3/17 for a reduction in Seroquel (quetiapine) [1] 50 mg (milligram) twice daily and 100 mg at bedtime for BPSD (Behavioral and Psychological Symptoms of Dementia) [2]: "Please consider re-evaluating whether quetiapine remains necessary at this time, perhaps considering a dose reduction or discontinuation." The physician declined this recommendation on 10/10/17, approximately 7 days after the recommendation was made. 12/6/17 for a reduction in Namenda [3] XR (extended release) 28 mg and Donepezil [4] 10 mg: "Please evaluate whether discontinuing Namenda / donepezil and initiating the combination memantine-donepezil (Namzaric) [5] 28mg/10mg daily in the evening." The physician	F 756		

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F 756	Continued From page 102 accepted this recommendation on 1/19/18, approximately 44 days after the recommendation was made. 1/3/18 for a reduction in quetiapine 50 mg twice daily and 100 mg at bedtime for BPSD: "Please consider a gradual dose reduction (GDR), perhaps decreasing to 75mg QAM (every morning) and 100mg QHS (every night at bedtime), or consider documenting dose reduction as clinically contraindicated." The physician declined this recommendation on 1/24/18, approximately 21 days after the recommendation was made. On 2/15/18 at 11:16 a.m., in an interview with OSM #7 (Other Staff Member, the pharmacist). OSM #7 stated, regarding the medication regimen review and gradual dose reduction (GDR) recommendations, that the time frames regarding GDR's is that he has 3 days to get them to the staff, and the staff then has 2 weeks (14 days) to get recommendations to provider and act on it. A review of the facility policy, "Medication Regimen Review" and the facility policy, "Medication Therapy" failed to include any guidance regarding the time frames that a GDR is required to be provided to the physician and acted upon by the physician. On 2/16/18 at 10:00 AM in an interview with the Administrator, (ASM #1 - Administrative Staff Member) she stated that the physicians usually look at the pharmacy recommendations on their next visit. She was not aware of any specific time frame in which the physician was required to address the recommendations. She stated she	F 756		

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F 756	Continued From page 103 did not have any other policies regarding the monthly medication regimen review and GDR's and verified that the policies provided did not specify time frames as required by the regulations. No further information was provided by the end of the survey. References: [1] Seroquel: Black Box Warning: "Studies have shown that older adults with dementia (a brain disorder that affects the ability to remember, think clearly, communicate, and perform daily activities and that may cause changes in mood and personality) who take antipsychotics (medications for mental illness) such as quetiapine have an increased risk of death during treatment. Quetiapine is not approved by the Food and Drug Administration (FDA) for the treatment of behavioral problems in older adults with dementia. " Quetiapine tablets and extended-release (long-acting) tablets are used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). Quetiapine tablets and extended-release tablets are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). In addition,	F 756		

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F 756	Continued From page 104 quetiapine tablets and extended-release tablets are used with other medications to prevent episodes of mania or depression in patients with bipolar disorder. Quetiapine extended-release tablets are also used along with other medications to treat depression. Information obtained from https://medlineplus.gov/druginfo/meds/a698019.html [2] BPSD - Behavioral and Psychological Symptoms of Dementia. "Management of BPSD is a key component of a comprehensive approach to the treatment of dementia requiring the judicious combination of pharmacological and non-pharmacological interventions. Treatment of these symptoms remains problematical, with an increased risk of psychotropic medication misuse, and, thus, represents an important challenge for clinicians. Current guidelines recommend non-pharmacological interventions as first-line treatment followed by the least harmful medication for the shortest time possible." Information obtained from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3345875/ [3] Namenda: "Memantine (Namenda) is used to treat the symptoms of Alzheimer's disease...." Information obtained from https://medlineplus.gov/druginfo/meds/a604006.html [4] Donepezil: "Donepezil is used to treat dementia..." Information obtained from https://medlineplus.gov/druginfo/meds/a697032.html	F 756		

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F 756	Continued From page 105 [5] Namzaric: "Namzaric contains a combination of donepezil and memantine.....used to treat moderate to severe dementia of the Alzheimer's type...." Information obtained from https://www.drugs.com/namzaric.html	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a	F 758	F 758 **Corrective Action(s):** Resident #25 & #105's attending physicians were notified that resident #25 & #105 received Seroquel without an appropriate medical diagnosis or clinical indication to support its use. Resident #25 & #105's physicians have reviewed resident #25 & #105's medication regime and made adjustments to their psychotropic medications. A facility Incident & Accident form and a medication error form was completed for this incident. Resident 93's attending physician was notified that resident #93 received Haldol without an appropriate medical diagnosis or clinical indication to support its use. Resident #93's physician reviewed resident #93's medication regime and made adjustments to their psychotropic medications. A facility Incident & Accident form and a medication error form was completed for this incident..	4/2/18

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F 758	Continued From page 106 diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure that residents were free from unnecessary psychotropic medications for three of 31 residents in the survey sample, Resident #s 25, 93 and 105. 1. For Resident #25 the facility staff failed to assess or provide an acceptable clinical indication for the use of Seroquel [1] (an antipsychotic medication). 2. For Resident #93 the facility staff failed to assess or provide an acceptable clinical indication for the use of Haldol [1] (a hypnotic medication). 3. For Resident #105, the facility staff failed to assess or provide clinical indication for the use of Seroquel (an antipsychotic medication).	F 758	**Identification of Deficient Practice(s) and Corrective Action(s):** All other residents receiving antipsychotic medications may have been potentially affected. The DON, ADON, and/or Pharmacy consultant will review the medication orders of all residents receiving psychotropic/antipsychotic medications to ensure that no unnecessary medications have been ordered and that all antipsychotic medications have an appropriate medical diagnosis and/or clinical indication for their use. 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 consultant and issued a copy of the facility policy and procedure for proper administration and monitoring of psychotropic medication to include antipsychotic medications. This includes having an appropriate medical diagnosis or clinical indication for its use. **Monitoring:** The DON is responsible for maintaining compliance. The DON, Unit Manager and/or designee will complete monthly	

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F 758	Continued From page 107 The findings include: 1. For Resident #25 the facility staff failed to assess or provide an acceptable clinical indication for the use of Seroquel [1] (an antipsychotic medication). Resident #25 was admitted to the facility on 3/24/17 with a readmission on 7/12/17 with diagnoses that include, but not limited to, diabetes, history of falling, dementia, chronic kidney disease, and difficulty in walking. Resident #25's most recent MDS (minimum data set), a quarterly assessment with an ARD of 1/26/18, coded Resident #25 as scoring a five out of a possible 15 on the BIMS (brief interview for mental status), indicating that Resident #25 is severely cognitively impaired with daily decision making. The facility staff coded Resident #25 as receiving antipsychotic medications in Section N, Medications, on a routine basis. A review of Resident #25's MAR (medication administration record) dated February 2018 revealed the following orders: -"QUETIAPINE FUMERATE (Seroquel) 50 MG (milligrams) TAB (tablet) 1 PO (by mouth) QD (every day) AT 0600 (6:00 a.m.) AND 2200 (10:00 p.m.) DX (diagnosis) BPSD (Behavioral and Psychological Symptoms of Dementia)." -"QUETIAPINE FUMERATE (Seroquel) 25 MG TAB 1 ALONG WITH 50 MG TAB = 75 MG PO QD AT 1400 (2:00 p.m.) DX = BPSD." Further review of Resident #25's MAR dated February 2018 revealed, in part, notations regarding behaviors that are described as	F 758	audits of resident physician orders coinciding with the Care plan calendar 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: April 2, 2018**	

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F 758	Continued From page 108 cursing, disruptive sounds, grabbing and hitting. A review of Resident #25's Physician Orders dated February 2018 revealed, in part, an increase in Seroquel from 150 mg per day total to 175 mg. The changes were put into place on 2/3/18. Further review of Resident #25's clinical record did not reveal any documentation regarding a clinical indication for the use of Seroquel as treatment for behaviors. There was no documentation of a clinical indication for the increase in Seroquel on 2/3/18. A review of Resident #25's physician progress notes since February 2017 revealed, in part, the following note dated 8/12/17: "Psychoactive Medications. Currently on Medications, (Yes box checked). Reduction Attempted (No box checked). (Symbol for change) made for (upward pointing arrow) behavior - agitation." Further review of Resident #25's clinical record did not reveal any documentation that supports an increase in behavior in August 2017. A review of the gradual dose reduction recommendations made by pharmacy reveal, in part, the following recommendations: -"(Name of Resident #25) was recently admitted with an order for antipsychotic medications, quetiapine (Seroquel) 12.5 mg and haloperidal (haldol) injection PRN with an associated indication of "agitation." Physician's Response: I decline the recommendation (s) above and do not wish to implement any changes due to the reasons DOCUMENTED BELOW. Status continues of agitated behavior. Dated 4/7/17."	F 758		

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F 758	Continued From page 109 - "(Name of Resident #25) receives quetiapine (Seroquel) 12.5 mg QAM (each morning) and 25 mg QHS (each evening) as well as Haldol [2] (a hypnotic) PRN (as needed). Physician's response: I have re-evaluated this therapy and wish to implement the following changes: Off PRN Haldol. Dated 8/8/17." A review of Resident #25's comprehensive care plan provided by the facility dated 1/26/18 reveals, in part, the following documentation; "Problem: Verbally swears at staff. Approaches: Approach resident warmly and positively. Do not argue with resident. Remove resident from public area when behavior is disruptive." An interview was conducted with OSM (other staff member) #7, the pharmacist, on 2/15/18 at 11:17 a.m. OSM #7 was asked to describe his process for the medication regimen review. OSM #7 stated, "I look at the diagnosis first. If there is a dementia diagnosis then I am going to look for the physician documentation that it (the antipsychotic) is clinically appropriate to use. The resident may have dementia with a primary psychotic disorder to go along with that. I ask for a re-evaluation of the (antipsychotic) medication every three months. I make my recommendations to the doctor but he repeatedly declines documenting his clinical indication as "documented behaviors." OSM #7 further stated, "I haven't been satisfied with the documentation, it is a valid concern. The point of the GDR (gradual dose reduction) is to try a lower dose and see what happens." OSM #7 was asked what the diagnosis BPSD meant. OSM #7 stated, "It reflects random behaviors associated with dementia." When asked if BPSD was an appropriate diagnosis for the use of Seroquel.	F 758		

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F 758	Continued From page 110 OSM #7 stated, "Seroquel is used to treat behavioral symptoms and it is not indicated by FDA (federal drug association) to use as a treatment for dementia." An interview was conducted with ASM (administrative staff member) #4, the physician on 2/15/18 at 3:00 p.m. ASM #4 was asked to describe his process for managing residents who were taking an antipsychotic. ASM #4 stated, "The residents may be admitted with an antipsychotic and I have to look for a valid diagnosis." ASM #4 was asked to state a "valid diagnosis" for the use of Seroquel. ASM #4 stated, "Psychosis that is demonstrated or in their past." ASM #4 was asked if dementia was a valid diagnosis for the use of Seroquel. ASM #4 stated, "We don't usually have that unless there is a substantial behavior." ASM #4 was asked to describe "substantial behaviors." ASM #4 stated, "Hallucinations with psychotic features that may / may not be a result of medical illness. There should be a diagnosis of some type of psychosis." ASM #4 was asked to describe his process when the pharmacist recommended a GDR (gradual dose reduction). ASM #4 stated, "I keep track of positive/negative behaviors. If I feel like they (the residents) are on a low dose and they are stable I just leave it." ASM #4 was asked about Resident #25 and her orders for Seroquel that had been increased since 4/17/17 from 12.5 mg each morning to 175 mg administered throughout the day. ASM #4 stated, "In her case, when she was in the hospital, she had a terrible time, pulling out her IVs (intravenous lines)." When asked when Resident #25 was in the hospital, ASM #4 stated, "2 years ago." ASM #4 further stated, "She is a different person than she was two years ago. I can definitely revisit her." When asked about	F 758		

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F 758	Continued From page 111 Resident #25's clinical indication for the use of Seroquel ASM #4 did not have an answer. An end of day meeting was conducted on 2/15/18 at 4:00 p.m. with ASM #1, the administrator, ASM #2, the director of nursing /assistant administrator, ASM #3, the administrator in training, and ASM #5, the assistant director of nursing. ASM #1, ASM #2, ASM #3, and ASM #5 were made aware of the above concerns and a facility policy was requested at this time regarding the use of antipsychotic medications. A review of the facility policy titled "Antipsychotic Medication Use" revealed, in part, the following documentation: "Policy Statement. Antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed. Antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time, are subject to gradual dose reduction, and re-review. Policy Interpretation and Implementation. 1. Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. 3. The Attending Physician will identify, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications. 7. Antipsychotic medications shall generally be used only for the following conditions/diagnoses as documented in the record, consistent with the definition (s) in the Diagnostic and Statistical Manual of Mental Disorders (current or subsequent editions): a. Schizophrenia; b. Schizo-affective disorder; c.	F 758		

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F 758	Continued From page 112 Schizophreniform disorder; d. Delusional disorder; e. Mood disorders (e.g. bipolar disorder, depression with psychotic features and treatment refractory major depression); f. Psychosis in the absence of dementia; g. Medical illnesses with psychotic symptoms and / or treatment - related psychosis or mania; h. Tourette's Disorder I. Huntington Disease; J. Hiccups; K. Nausea and vomiting. 12. All antipsychotic medications will be used within the dosage guidelines listed in (F329) or clinical justification will be documented for dosages that exceed the listed guidelines for more than 48 hours. 18. The Physician shall respond appropriately by changing or stopping problematic doses or medications, or clearly documenting (based on assessing the situation) why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences." No further information was provided prior to the end of the survey process. [1] SEROQUEL (Quetiapine Fumerate) is a prescription medicine used to treat: schizophrenia in people 13 years of age or older; bipolar disorder in adults, including: depressive episodes associated with bipolar disorder; manic episodes associated with bipolar I disorder alone or with lithium or divalproex; long-term treatment of bipolar I disorder with lithium or divalproex. This information was obtained from the following website; https://www.fda.gov/downloads/Drugs/DrugSafety/ucm089126.pdf [2} Haloperidol is used to treat psychotic disorders (conditions that cause difficulty telling the difference between things or ideas that are real and things or ideas that are not real). This	F 758		

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F 758	Continued From page 113 information was obtained from the following website; https://medlineplus.gov/druginfo/meds/a682180.html 2. For Resident #93 the facility staff failed to assess or provide an acceptable clinical indication for the use of Haldol [1] (a hypnotic medication). Resident #93 was admitted to the facility on 6/14/16 with a readmission on 12/27/17 with diagnoses that include, but not limited to stroke, anoxic brain damage (lack of oxygen to brain), aphasia (difficulty speaking), dysphagia (difficulty swallowing) and left sided paralysis. Resident #93's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 12/27/17 coded Resident #93 as being unable to answer the questions on the BIMS (brief interview for mental status), the staff assessment coded him as being severely impaired to make decisions. The facility staff coded Resident #93 as receiving antipsychotic medications in Section N, Medications, on a routine basis. A review of Resident #93's physician orders revealed, in part, the following orders: - "7/12/16. Haldol [1] (a hypnotic medication) 0.5 mg (milligrams) tab (tablet) po (by mouth) TID (three times a day) Dx (diagnosis) agitation with behaviors." Signed and dated by the physician on 7/12/16. - "12/27/17 Haloperidol (Haldol) 0.5 MG tablet via peg (tube inserted into the stomach) twice a day. Dx Hepatic encephalopathy [2] (a disorder of the	F 758		

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F 758	Continued From page 114 liver)." The diagnosis was changed from BPSD (Behavioral and Psychological Symptoms of Dementia) on 2/5/18. A review of the physician progress notes did not reveal any documentation that provided the clinical indication for the continued use of haldol. A review of the pharmacy recommendations for gradual dose reductions revealed, in part, the following documentation; -"3/3/17 (Name of Resident #93) receives an antipsychotic, haloperidol (haldol) 0.5 mg BID (two times per day). Physician's response: Documented behaviors of dementia." Signed and dated by the physician on 3/17/17. -"6/5/17 (Name of Resident #93) takes haloperidol (haldol) 0.5 mg BID for BPSD. Physician's Response: I decline the recommendation above because GDR is CLINICALLY CONTRAINDICATED for this individual as indicated below. Low dose is working. Documented Behaviors." Signed and dated by the physician on 6/15/17. -"12/6/17 (Name of Resident #93) takes haloperidol 0.5 mg BID for BPSD. Physician's Response: I decline the recommendation above because GDR is CLINICALLY CONTRAINDICATED for this individual as indicated below. Hepatic encephalopathy with behaviors documented. Patient with MR (mental retardation) and has agitation. Haldol shows benefit with ADL (activities of daily living) care." Signed and dated by physician on 2/4/18. A review of Resident #93's clinical record did not reveal that behaviors are present. A review of Resident #93's comprehensive care	F 758		

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F 758	Continued From page 115 plan dated 1/2/18 revealed, in part, the following documentation; "Problem: Resident has agitation with behaviors that requires Psychological and / or psychiatric evaluation and treatment. Goal: Psychological and/or psychiatric needs will be met by next quarter. Approaches: Resident to be seen by Pschologist (sic) and / or Psychiatrist as ordered by MD (medical doctor). Problem: Combative behavior resident can be combative while staff attempts to get v/s (vital signs). Approaches: Administer behavior medications as ordered by physician." A review of Resident #93's clinical record did not reveal any orders for psychological or psychiatric evaluations. An interview was conducted with OSM (other staff member) #7, the pharmacist, on 2/15/18 at 11:17 a.m. OSM #7 was asked to describe his process for the medication regimen review. OSM #7 stated, "I look at the diagnosis first. If there is a dementia diagnosis then I am going to look for the physician documentation that it (the antipsychotic) is clinically appropriate to use. The resident may have dementia with a primary psychotic disorder to go along with that. I ask for a re-evaluation of the (antipsychotic) medication every three months. I make my recommendations to the doctor but he repeatedly declines documenting his clinical indication as "documented behaviors." OSM #7 further stated, "I haven't been satisfied with the documentation, it is a valid concern. The point of the GDR (gradual dose reduction) is to try a lower dose and see what happens." OSM #7 was asked if haldol was an appropriate medication for the treatment of hepatic encephalopathy. OSM #7 stated, "We will see some behaviors (medical	F 758		

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F 758	Continued From page 116	F 758		

illness with psychotic features), it affects cognition significantly. The documentation should be clear. We have to have a good reason to give it and haldol is not really the preferred drug to use." OSM #7 was asked if he was aware of Resident #93 receiving haldol, initially for BPSD and then more recently for hepatic encephalopathy. OSM #7 stated that Resident #93 was up for review and he had requested a GDR a number of times but the physician just never acted on it.

An interview was conducted with ASM (administrative staff member) #4, the physician on 2/15/18 at 3:00 p.m. ASM #4 was asked to describe his process for managing residents who were taking an antipsychotic. ASM #4 stated, "The residents may be admitted with an antipsychotic and I have to look for a valid diagnosis." ASM #4 was asked to state a "valid diagnosis" for the use of antipsychotic medication. ASM #4 stated, "Psychosis that is demonstrated or in their past." ASM #4 was asked if hepatic encephalopathy was a valid diagnosis for the use of haldol. ASM #4 stated, "We don't usually have that unless there is a substantial behavior." ASM #4 was asked to describe "substantial behaviors." ASM #4 stated, "Hallucinations with psychotic features that may / may not be a result of medical illness. There should be a diagnosis of some type of psychosis." ASM #4 was asked to describe his process when the pharmacist recommended a GDR (gradual dose reduction). ASM #4 stated, "I keep track of positive/negative behaviors. If I feel like they (the residents) are on a low dose and they are stable I just leave it." ASM #4 was asked about Resident #93 and the use of haldol. ASM #4 stated, "He (Resident #93) is on a low dose, he seems to have adapted well." ASM #4 was asked if he had

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F 758	Continued From page 117 documented a clinical indication for the continued use of the haldol as Resident #93's therapy, ASM #4 stated that he had not. An end of day meeting was conducted on 2/15/18 at 4:00 p.m. with ASM #1, the administrator, ASM #2, the director of nursing /assistant administrator, ASM #3, the administrator in training, and ASM #5, the assistant director of nursing. ASM #1, ASM #2, ASM #3, and ASM #5 were made aware of the above concerns and a facility policy was requested at this time regarding the use of antipsychotic medications. [1] Haloperidol is used to treat psychotic disorders (conditions that cause difficulty telling the difference between things or ideas that are real and things or ideas that are not real). This information was obtained from the following website; https://medlineplus.gov/druginfo/meds/a682180.html [2] Hepatic encephalopathy is characterized by personality changes, intellectual impairment, and a depressed level of consciousness. This information was obtained from the following website; https://emedicine.medscape.com/article/186101-overview 3. For Resident #105, the facility staff failed to assess or provide clinical indication for the use of Seroquel (an antipsychotic medication). Resident #105 was admitted to the facility on 2/27/17 with the diagnoses of but not limited to	F 758		

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F 758	Continued From page 118 dementia with behaviors, anxiety disorder, depression, insomnia, benign prostatic hyperplasia, heart disease, hepatitis C, and high blood pressure. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 12/23/17. The resident was coded as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, hygiene, toileting and dressing; limited assistance with eating, transfers and ambulation; and as incontinent of bowel and bladder. A review of the clinical record for the use of unnecessary medications revealed that the pharmacy made the following medication recommendations: A review of the clinical record revealed Resident #105 was on Seroquel [1] (quetiapine) 50 mg (milligrams) twice daily and 100 mg at bedtime for BPSD (Behavioral and Psychological Symptoms of Dementia) [2]. The medication order was dated 9/16/17. Further review of the clinical record revealed the pharmacy had recommended twice that the medication be evaluated for appropriateness of use and for a reduction or discontinuation of the medication. The physician declined in both instances: 10/3/17 for a reduction in quetiapine [3] 50 mg twice daily and 100 mg at bedtime for BPSD [2]: "Please consider re-evaluating whether quetiapine remains necessary at this time, perhaps considering a dose reduction or discontinuation." The physician declined this recommendation on 10/10/17, approximately 7 days after the recommendation was made.	F 758		

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F 758	Continued From page 119 1/3/18 for a reduction in quetiapine 50 mg twice daily and 100 mg at bedtime for BPSD: "Please consider a gradual dose reduction (GDR), perhaps decreasing to 75mg QAM (every morning) and 100mg QHS (every night at bedtime), or consider documenting dose reduction as clinically contraindicated." The physician declined this recommendation on 1/24/18, approximately 21 days after the recommendation was made. Further review of the clinical record failed to reveal an appropriate FDA (Food and Drug Administration) approved diagnosis and behaviors for the use of this medication for this resident. Review of the MAR (Medication Administration Record) for December 2017, January 2018, and February 2018, revealed documentation of resident behaviors at the time of each administration of the medication. The documented behaviors were noted to be consistently as "rummaging" and "pacing." On 2/15/18 at 2:42 p.m., in an interview with RN #1, the unit manager, she stated that there was no evidence in the record of an appropriate diagnosis for the use of Seroquel. On 2/16/18 at 8:54 a.m., with the Nurse Practitioner (ASM #8 - Administrative Staff Member) for the psychiatric services agency, she stated, that the resident was admitted with some psychosis. There was no documented diagnosis of psychosis in the clinical record. However, ASM #8 also stated that the behaviors being documented by the facility staff of rummaging and pacing was typical behaviors of people with	F 758		

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F 758	Continued From page 120	F 758		

dementia and was not behavior for which the use of Seroquel was appropriate. ASM #8 stated she does not have access to the MAR documentation and relies on the staff to provide that knowledge to her. ASM #8 stated, "It certainly helps when I am knowledgeable of the behaviors....Pacing and rummaging is typical dementia and they will do that. Unless he is having actual psychosis, we can trial off the Seroquel...."

A review of the facility policy, "Antipsychotic Medication Use" documented, "Antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional, psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed.....7. Antipsychotic medications shall generally be used only for the following conditions/diagnoses as documented in the record, consistent with the definition(s) in the Diagnostic and Statistical Manual of Mental Disorders (current or subsequent editions): a. Schizophrenia, b. Schizo-affective disorder, c. Schizophreniaform disorder, d. Delusional disorder, e. Mood disorders...f. Psychosis in the absence of dementia, g. Medical illnesses with psychotic features...h. Tourette's Disorder, i. Huntington Disease; j. Hiccups...k. Nausea and vomiting associated with cancer or chemotherapy....11. Antipsychotic medications will not be used if the only symptoms are one or more of the following: a. wandering, b. Poor self-care, c. Restlessness; d. Impaired memory, e. Mild anxiety, f. Insomnia, g. Inattention or indifference to surroundings, h. Sadness or crying alone that is not related to depression or other psychiatric disorders, i. Fidgeting, j. Nervousness, k. Uncooperativeness."

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F 758	Continued From page 121 A review of the medication information sheet used by the facility for Seroquel, documented, "There may be a slightly increased risk of serious, possibly fatal side effects (such as stroke, heart failure, fast/irregular heartbeat, pneumonia) when this medication is used by older adults with dementia. This medication is not approved for the treatment of dementia-related behavior problems....Quetiapine is used to treat certain mental/mood disorders (such as schizophrenia, bipolar disorder, sudden episodes of mania or depression associated with bipolar disorder)..." On 2/15/18 at approximately 4:00 PM at the end of day meeting, the Administrator (ASM #1) the Director of Nursing (ASM #2) were made aware of the findings. No further information was provided by the end of the survey. References: [1] Seroquel: Black Box Warning: "Studies have shown that older adults with dementia (a brain disorder that affects the ability to remember, think clearly, communicate, and perform daily activities and that may cause changes in mood and personality) who take antipsychotics (medications for mental illness) such as quetiapine have an increased risk of death during treatment. Quetiapine is not approved by the Food and Drug Administration (FDA) for the treatment of behavioral problems in older adults with dementia. " Quetiapine tablets and extended-release (long-acting) tablets are used to treat the symptoms of schizophrenia (a mental illness that	F 758		

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F 758	Continued From page 122 causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). Quetiapine tablets and extended-release tablets are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). In addition, quetiapine tablets and extended-release tablets are used with other medications to prevent episodes of mania or depression in patients with bipolar disorder. Quetiapine extended-release tablets are also used along with other medications to treat depression. Information obtained from https://medlineplus.gov/druginfo/meds/a698019.html [2] BPSD - Behavioral and Psychological Symptoms of Dementia. "Management of BPSD is a key component of a comprehensive approach to the treatment of dementia requiring the judicious combination of pharmacological and non-pharmacological interventions. Treatment of these symptoms remains problematical, with an increased risk of psychotropic medication misuse, and, thus, represents an important challenge for clinicians. Current guidelines recommend non-pharmacological interventions as first-line treatment followed by the least harmful medication for the shortest time possible." Information obtained from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3345875/	F 758		
F 812 SS=E	Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812	F 812 **Corrective Action(s):** The thickener container with the scoop in it has been discarded and replaced. A facility Incident and Accident form has been completed for this incident.	4/2/18

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F 812	Continued From page 123 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to store food in a sanitary manner. A plastic scoop used to remove thickener from a container was observed in the container with the handle touching the thickener. The findings include: On 2/13/18 at 11:35 a.m., observation of the kitchen was conducted. A plastic scoop used to remove powdered thickener (a substance used to thicken liquids) was observed in the container. The handle of the scoop was touching the thickener.	F 812	**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 and food storage area to identify any negative findings. All items identified to be out of compliance will be discarded and a Facility Incident and Accident form will be completed for each negative finding identified. Any/All negative findings may result in disciplinary action. **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 Food Service Manager and dietary staff on the proper storage and disposal of all food and beverage products per established policy and procedure to include proper storage of serving scoops and spoons when not in use. **Monitoring:** The Food Service Manager is responsible for maintaining compliance. The Food Service manager or Cook in charge will monitor the refrigerators and food storage areas for proper labeling and dating of food and beverage items and disposal of those items per policy to monitor and maintain compliance. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. **Completion Date: April 2, 2018**	

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F 812	Continued From page 124 On 2/13/18 at 11:55 a.m., an interview was conducted with OSM (other staff member) #6 (the assistant dietary manager). OSM #6 was asked how the thickener scoop should be stored. OSM #6 stated the scoop was supposed to be in a bag. When asked if the scoop should be in the container with the thickener, OSM #6 stated, "No it shouldn't be. I'll take that out." OSM #6 removed the scoop from the thickener container. On 2/14/18 at 4:52 p.m. ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #5 (the assistant director of nursing), OSM (other staff member) #3 (the social worker) and ASM #3 (the administrator in training) were made aware of the above findings. The facility food storage policy titled, "Covering, Labeling, Dating Food" failed to document information regarding the storage of scoops. No further information was presented prior to exit.	F 812		