STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF WILLIAMSBURG, LLC	**1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185**

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 5-8-18 through 5-11-18. The facility was in substantial compliance with 42 CFR Part 483.73, (emergency preparedness) Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 5-8-18 through 5-11-18. Four complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Life Safety Code survey/report will follow. The census in this 130 bed certified facility was 120 at the time of the survey. The survey sample consisted of 41 current resident reviews and 8 closed record reviews.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		6/19/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/01/2018

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

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to provide a dignified living experience for five residents (Resident #5, 99, 12, 18, and #81) in a survey sample of 41 residents. 1. For Resident #5, the staff left the Resident slumped over in her wheel chair sleeping on 5-8-18 for 4 hours, and 5-9-18 for 4 hours in front of her room mates bed, while the room mate, and visitors stared at her. 2. Resident #99 complained that the staff was	F 550	F550 Dignified living experience has been provided for residents #5, 99, 12, 18, and 81. Resident #5 sleep preferences have been reviewed/revised. Staff assignments for resident #99 have been reviewed, staff assigned to resident #99 have been re-educated on customer service. Random Customer Service Observations and Resident interview have been conducted with resident #99 resulting in confirmation of resident knowing staff member names/staff listening to residents	

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F 550	Continued From page 2 rude, would not give them their names and that staff does not listen to him when he has respiratory difficulty. 3. Resident #12 complained that staff can be rude, talking on their cell phones while in her room and they are not professional. 4. For Residents #18, the facility staff failed to provide privacy for toileting. 5. For Resident #81, the facility staff failed to provide privacy for toileting. The findings included: 1. Resident #5 was admitted to the facility on 4-20-16. Diagnoses included; Hospice, heart disease, chronic respiratory failure, peripheral vascular disease, chronic kidney failure, anxiety, dementia with behavioral disturbance, angina, atrial fibrillation, chronic gout, history of falling, and hypertension. Resident #5's most recent MDS (minimum data set) with an ARD (assessment reference date) of 2-3-18 was coded as an annual assessment. Resident #5 was coded with a Brief Interview for Mental Status (BIMS) score off "99" indicating unable to complete. The Resident was also coded as needing extensive to total assistance of one staff member to perform her activities of daily living, with the exception of eating. For eating the Resident required supervision assistance by staff. Resident #5 was incontinent of bowel and bladder. Resident #5 had no range of motion limitations and her primary mode of mobility was her wheelchair. Resident #5 was coded for no behaviors and no wandering. The Resident was	F 550	requests/no cell phone usage. Residents #18 and 81 have had privacy observed with toileting. Director of Nursing (DON)/Designee have conducted Quality Improvement Observations of current residents to ensure receipt of a dignified living experience. A re-evaluation of resident□s bathroom privacy curtains has been conducted by Reginal Director of Maintenance and Regional Director of Safety. (Follow up based on findings) Executive Director/Director of Nursing/Designee provided re-education to current facility staff regarding resident care and services provided to promote a dignified life experience. Executive Director/Director of Nursing/Designee to conduct Quality Improvement Monitoring of resident care and services provided promote a dignified life experience 5x/week x 2weeks, 3x/week x 2weeks, weekly x 1 month, then monthly and prn. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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severely cognitively impaired.

Initial surveyor observations for this Resident began on 5-8-18 at 12:30 p.m., during initial tour of the building, and continued until 4:30 p.m. The Resident was observed in her room sitting slumped over to her right side in her wheel chair, drooling slightly, with her back to her bed and facing the door. There was a black hair net laying in the seat of the wheel chair partially under the Resident's left buttock. The Resident's bed was located by the window, with the head of the bed against one wall and the foot facing the other wall. The window in the room was located to the left side of the bed and the entrance of the room to the right of the bed, if the bed were viewed from the foot.

The room mates bed was turned in the opposite direction to Resident #5's bed, as the head of the bed faced the room entrance, and the foot of the bed faced the window. The foot of the room mates bed was so close to Resident #5's bed side, that Resident #5 could not sit beside her bed in her wheel chair with the curtain drawn for privacy. Resident #5 sat directly beside the foot of the room mates bed, with the room mate laying in her own bed, staring at Resident #5, and able to be viewed by all visitors passing in the hallway. Resident #5 was afforded no privacy while sleeping for this 4 hour period, and received no incontinence care nor was she repositioned during this time as her position never changed, and the hairnet remained in place undisturbed.

A second series of observations was conducted by surveyors on 5-9-18 resuming at 9:00 a.m., and continuing until 1:00 p.m.. The Resident was again found in her room slumped over to her right

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side sleeping in her wheel chair in exactly the same location in the room as the day before, and the room mate was in exactly the same position as the day before, staring at Resident #5. Resident #5 had food particles on the front of the blue sweat suit she wore, which appeared to be dry bread crumbs, or cracker crumbs, and oatmeal, or some tan creamy substance. During these observations the food particles remained on the Resident and were never brushed off. On both days during the observations the room mate was found to be alert, smiling, non-verbal, however, nodded yes and no appropriately to questioning.

On 5-10-18, and 5-11-18 at the end of day debrief the Administrator and Director of Nursing were made aware of the observations, and findings, and stated that the situation was not a dignified one for Resident #5. The facility presented no further information.

2. Resident #99 complained that the staff was rude, would not give them their names and that staff does not listen to him when he has respiratory difficulty.

Resident #99 was admitted to the facility on 4/14/17 with diagnoses which included, but not limited to, quadriplegia at C-5 to C-7, depression and anxiety.

Resident #99's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 4/20/18. Resident #99 was coded with a Brief Interview of Mental Status score of "15 out of a

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possible 15 indicating no cognitive impairment. Resident #99 required total assistance of one to two members for bed mobility and bathing and toileting.

05/09/18 09:15 AM: During an interview with Resident #99, the resident stated he does not feel he is "not being treated with dignity" so he does not have to treat the staff with dignity. He stated that the staff would not introduce themselves, that it was told to him that it "was a privacy issue."

Review of the nurse's notes on 1/1/18 revealed the following note: "Complained of having difficulty breathing and having mucus in his throat and can't get out. O2 (oxygen) sats (saturation) a little low at 88%. No issues breathing or talking." There was no documentation of any interventions such as administration of oxygen, chest physiotherapy (Chest physiotherapy (CPT) a broad term for treatments using clapping or percussion techniques to help remove mucus from breathing passages. This can be done by nursing or Respiratory Therapy (RT).

Review of the Emergency Room (ER) records for the date of 1/1/18 revealed the resident had "mucus plugging of bronchi." The assessment by the physician read: "Patient well known to me. Cervical spine fracture from motor vehicle accident resulting in quadriplegia. He frequently has difficulty clearing chest secretions and requires chest physical therapy." Patient reports feeling much improved after cough induction performed by RT." The report goes on to say that a second cough induction was performed by RT.

Review of the care plan (no date) revealed: "The resident has a potential for an ineffective

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breathing pattern related to intervals of mucous." Interventions included: "Arrange ADL's (activities of daily living) to allow adequate rest, Keep call bell in easy reach, Medication as per physician order, Monitor lung sounds as ordered, and suction as ordered." The care plan also included this entry: "Resident has intervals of falsely accusing staff of not providing care or assessments when he alleges he is dying or needs ER care when assessment does not indicate emergency. Also accuses staff of not caring when he believes he is dying." One of the interventions for this issue is: "Assess behaviors for underlying cause."

3. Resident #12 complained that staff can be rude, talking on their cell phones while in her room and they are not professional.

Resident #12 was admitted to the facility on 12/15/16 with diagnoses which included, but not limited to, End Stage Renal Disease, diabetes and anemia.
Resident #12's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 2/9/18. Resident #12 was coded with a Brief Interview of Mental Status score of "15 out of a possible 15 indicating no cognitive impairment. Resident #12 required set up assistance of one member for bed mobility and bathing and toileting.

05/10/18 10:21 AM: An interview was conducted with Resident #12. She stated that staff is "very unprofessional", and will ask "What do you want, that staff will come in cursing and, staff will use their cell phones in the resident room.

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On 5/10/18 at approximately 4:45 PM, the Administrator and DON (director of nursing) were notified of the above findings.

Surveyor; Nathan Cass

. For Residents #18, the facility staff failed to provide privacy for
toileting.

Resident #18, an 81-year-old, was admitted on 2/2/17. Her diagnoses
included Chronic Obstructive Pulmonary Disease, generalized anxiety,
Polyneuropathy, Dementia without behaviors, Major Depressive Disorder,
Hypertension, Gastro-Esophageal Reflux Disease, Chronic Pain, and
Abdominal Aortic Aneurysm. Her most recent Minimum Data Set (MDS)
assessment was a Quarterly Assessment with an Assessment Reference
Date (ARD) of 2/14/18. The Brief Interview for Mental Status scored
Resident #18 as a 15, indicating no impairment. Resident #18 required
setup assistance of one staff member for eating and was independent in
other ADLs.

On 5/8/18 at 12:42 p.m. Resident #18 was interviewed in her room.
Resident #18 expressed general dissatisfaction with the facility. When
asked to elaborate, Resident #18 stated a significant factor was that

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the bathrooms in each resident room did not have doors, instead having
opaque curtains. Resident #18 stated that it was very embarrassing to
use the restroom if a roommate was in the room. She also stated that
if a staff member entered the resident room, the door to the room
swinging open causes the bathroom curtain to sway, and in some cases
causes a resident in the bathroom to become exposed.

Upon examination, the resident's bathroom was found to have an opaque
plastic curtain hanging from a rod in the bathroom door frame. The
bathroom entry was immediately adjacent to the doorway between the
room and outer hallway.

The Administrator and Director of Nursing were informed of the
findings at the end of day meeting on 5/10/18. The administrator
stated that in the past, folding screens had been trialed to replace
the curtains, but concerns about the screens falling led to the
curtains being brought back. The Administrator went on to state that
the layout of the room would make installing proper doors to the
bathrooms difficult. No further documents were provided.

5. For Resident #81, the facility staff failed to provide privacy for toileting.

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Resident #81, a 60-year-old, was admitted on 8/13/07. Her diagnoses included Carcinoma in situ, hypertension, Diabetes Mellitus II, Hypothyroidism, Hyperlipidemia, Major Depressive Disorder, Chronic Kidney Disease, Anxiety, Vitamin D Deficiency, and Obesity. Resident #81's most recent Minimum Data Set (MDS) assessment was an Annual Assessment with an Assessment Reference Date (ARD) of 4/5/18. The Brief Interview for Mental Status scored Resident #81 as a 15, indicating no impairment. Resident #81 required supervision and setup assistance of one staff member for Transfers, Ambulation, Dressing, Hygiene, and Toileting, and required setup only for Eating.

On 5/9/18 at 11:09 a.m. a Group Interview of 5 residents was conducted. Resident #81 was in attendance. During the meeting, Resident #81 stated "you have no privacy at all". When prompted for more information, Resident #81 stated that the bathrooms don't have doors, just curtains. She went on to describe how using the bathroom can be very awkward, especially if the outer room door is opened unexpectedly, causing the curtain to blow. Resident #81 stated that staff sometimes enter to assist her roommate while she is in the bathroom. She stated that she asks if they can

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F 550	Continued From page 10 come back in a moment, but they enter anyway, and that this makes her feel exposed. Resident #81 stated "it upsets me when they do that". Upon examination, the resident's bathroom was found to have an opaque plastic curtain hanging from a rod in the bathroom door frame. The bathroom entry was immediately adjacent to the doorway between the room and outer hallway. The Administrator and Director of Nursing were informed of the findings at the end of day meeting on 5/10/18. The administrator stated that in the past, folding screens had been trialed to replace the curtains, but concerns about the screens falling led to the curtains being brought back. The Administrator went on to state that the layout of the room would make installing proper doors to the bathrooms difficult. No further documents were provided.	F 550		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;	F 582		6/19/18

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F 582	Continued From page 11 (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.	F 582		

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F 582	Continued From page 12 (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on Staff interview and facility documentation review, the facility staff failed to complete a skilled nursing facility (SNF) Advanced Beneficiary Notice (ABN) for two residents, (Resident #110, and #53), in a sample of 41 residents. 1. For Resident #110, no SNF/ABN was provided prior to discharge from skilled services. 2. For Resident #53, no SNF/ABN was provided prior to discharge from skilled services. The findings included: 1. Resident #110 was admitted to skilled nursing care in the facility on 1-1-2018. The last Medicare covered day for the Resident was 1-15-2018. The Resident's benefit days had not been exhausted, however, the Resident had reached a plateau, and it was felt that he no longer required skilled nursing care and that level of care was discontinued without the Resident receiving notice of the change in time to appeal the decision. 2. Resident #53 was admitted to skilled nursing care in the facility on 1-19-2018. The last Medicare covered day for the Resident was 2-21-2018. The Resident's benefit days had not been exhausted, however, the Resident had reached a plateau, and it was felt that she no longer required skilled nursing care and that level	F 582	F582 Resident #110 and Resident #53 along with their responsible parties have been contacted, discharge plan and skilled services discussed. Belated SNF/ABN provided. Business Office Manager/Designee conducted a Quality Review of residents discharged over the last 30 days for SNF/ABN provided per regulation. Follow up based on findings. Executive Director (ED) provided re-education to Business Office Manager and Social Services Director regarding SNF/ABN regulation/standards. Executive Director/Designee to conduct Quality Improvement Monitoring of SNF/ABN provided per regulation to residents who are completing skilled services weekly x 2weeks, then monthly and prn. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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F 582	Continued From page 13 of care was discontinued without the Resident receiving notice of the change in time to appeal the decision. On 5-10-18, a review of the facility's ABN/NOMNC forms issued during the last six months was conducted. Three discharged residents were chosen for review. Of the 3 chosen, two residents, (Resident #110, & # 53), did not have a SNF/ABN immediately available. The Facility Administrator was asked to review the facility records and locate these documents for review. On 5-10-18, at 4:00 p.m., at the end of day meeting, the Facility Administrator informed surveyors that the two documents for Residents #110, and #53 were not completed. The Facility Administrator provided no further information.	F 582		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		6/19/18

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F 584	Continued From page 14 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, family interview and resident interview, the facility staff failed to provide a comfortable environment for residents on two (Liberty and Freedom Units) of three units in the facility and failed to provide a homelike environment for one resident in a survey sample of 41 residents. 1. Foul odors were noted on 2 of 3 units during survey (Liberty and Freedom Units). During the initial tour of the facility on 5/8/2018 at 12:15 PM, foul odors were noted on 2 of 3 units on the Liberty and Freedom Unit. During the course of the survey, foul odors persisted on the Freedom Unit.	F 584	F584 Foul odors on Liberty and Freedom units have been addressed. Stained ceiling tiles in resident #40□s room have been replaced. Maintenance Director/maintenance staff and housekeeping manager have conducted facility Quality Improvement Rounds to identify/address lingering foul odors and damaged ceiling tiles. Follow up based on findings. Executive Director has provided maintenance staff, housekeeping manager re-education on regulation for safe/comfortable/clean environment including but not limited to a focus on	

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Continued From page 15

2. For Resident #40, a ceiling tile in the Resident's room exhibited water damage stains.

Findings included:

1. Foul odors were noted on 2 of 3 units during survey (Liberty and Freedom Units).

On 5/8/2018 at 12:15 PM during the initial tour of the facility, several surveyors noticed foul odors on two units (Liberty and Freedom Units) in the facility.

On 5/8/2018 at 1:45 PM, two surveyors were walking near the nurses station on the Freedom Unit. A very pungent, foul urine smell was noted. An interview was conducted with the nurse, who stated there was a resident on the Freedom unit who was incontinent of urine, often refused to bathe or shower and that she thought that might be the smell. The nurse also stated the nursing staff had just provided incontinence care for a few other residents and that maybe that was contributing to the smell.

On 5/8/2018 at 3:20 PM, the Director of Nursing came to the Freedom Unit with the Surveyor and stated she did notice a foul smell. The Director of Nursing (DON) stated the Soiled Utility room was near the area where the smell was most pungent and that the smell could be coming from there. The DON and Surveyor opened the Soiled Utility Room and noted the room did not have any foul smell. The DON stated there was a resident that resided in a room close to the nurses station who refused regular showers. The DON stated she would have the Housekeeping staff clean that room again.

F 584

damaged ceiling tiles and odor management.
Executive Director/Maintenance Director/Designee to conduct random Quality Improvement Monitoring facility rounds for lingering odors and damaged ceiling tiles daily x 2weeks, 3x/week x 2 weeks, weekly x 2 weeks, then monthly and prn. Findings to be reviewed at monthly QAPI Committee Meeting.
Monitoring schedule modified based on findings.

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The Housekeeping Staff (Employee) stated she had cleaned the room earlier during her shift and that the smell was in that Resident's clothes and wheelchair.

On 5/9/2018 at 8:45 AM, foul smell of urine was noted on the Liberty Unit.

On 5/9/2018 at approximately 10 AM, an interview was conducted with the Administrator who stated the Housekeeping and nursing staff had identified several rooms in the facility including rooms on the Liberty and Freedom Units for targeted cleaning to help diminish foul odors.

On 5/9/2018 at 4:40 PM, the Administrator stated she also noted the pungent odor on the Freedom Unit and was aware of a resident on that unit who often refused showers and baths. The Administrator stated she and the staff used creative interventions to encourage the resident to consent to showers. The Administrator stated she had developed a rapport with that resident to encourage her to shower and allow the staff to clean the room when the resident left to eat meals or attend activities. The Administrator stated the nursing staff had tried many measures to determine if the resident would allow the staff to clean her room to include changing the mattress.

The Administrator stated the Housekeeping Department utilized a schedule where"hot" rooms were cleaned regularly.

The Administrator stated "hot" rooms were rooms that the staff had identified as having persistent smells and had residents who refused showers,

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had frequent incontinence and/or hoarding.

On 5/10/2018 at 9:10 AM, the foul odor was not as prominent on the Freedom Unit.

On 5/10/2018 at 9:30 AM, an interview was conducted with the Housekeeping staff (Employee G) who stated there were a couple of residents on the Liberty and Freedom Units who often refused to shower. Employee G stated the Housekeeping staff cleaned the rooms and halls daily.

During the end of day debriefing on 5/10/2017 at 12:10 PM, the facility Administrator, Director of Nursing and Corporate Consultant (Admin D) were informed of the findings. The Administrator presented a copy of a "Hot Rooms" form for one room on the Liberty Unit. The form showed documentation by the Housekeeping staff that the room was cleaned several times each day between 6:00 a.m. and 2:00 p.m. during 5/6/2018 and 5/10/2018.

During tours of the Liberty and Freedom units on the last day of survey on 5/11/2018, foul odors of urine were diminished on the Liberty and Freedom units. Several housekeeping staff persons were observed cleaning rooms and mopping hallways during the four days of survey.

No further information was provided.

2. For Resident #40, a ceiling tile in the Resident's room exhibited water damage stains.

Resident #40, a 61-year-old, was admitted on

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F 584	Continued From page 18 6/10/14. Her most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 3/3/18. The Brief Interview for Mental Status (BIMS) scored her at 15, indicating no impairment. Resident #40's diagnoses included Diabetes Mellitus II, Hypertension, Gastro-Esophageal Reflux Disease, Morbid Obesity, Osteoarthritis, and Schizophrenia. Resident #40 was independent in her ADLs. On 5/8/18 at 1:01 p.m., Resident #40 was observed in bed during initial tour of the facility. Resident #40 agreed to an interview. She stated she had been a resident at the facility for "about 3 years". Resident #40 stated that the facility was "alright", but that the ceiling leaks when heavy rain occurs. Resident #40 identified a particular ceiling tile that is replaced "from time to time". The ceiling tile she pointed out was found to have a brown circular water stain. Resident #40 stated that the "maintenance man" was good about replacing the tiles, but that the leak itself comes back regularly. The Administrator and Director of Nursing were informed of the findings at the end of day meeting on 5/10/18. The Administrator stated that the ceiling tile would be replaced. No further information was provided.	F 584		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and	F 607		6/19/18

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F 607	Continued From page 19 misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on facility document review, employee record review and staff interview, the facility staff failed to implement policies and procedures to prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. Specifically, the facility failed to obtain a criminal background check before employment for 3 of 25 employee records reviewed. (employee #9, 14, and 18) The findings include: A review of the provider's Abuse, Neglect, Exploitation and Misappropriation Policy (effective 11/30/2014 and revised 11/28/2017) states (on page 5 of 8): 1. Screening: Persons applying for employment with the center will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. This includes, but is not limited to: " Employment history " Criminal background check " Abuse check with appropriate licensing board and registries, prior to hire " Sworn disclosure statement prior to hire	F 607	F607 Employees #9, 14, and 18 were no longer employed at the facility prior to May of 2018. Human Resources Coordinator/Designee have conducted a Quality Review of current employee files for criminal background check validating eligibility for employment. Follow up based on findings. Executive Director provided re-education to Human Resources Coordinator and Interdisciplinary Management Team regarding obtaining criminal background checks on potential employees prior to hire. Executive Director/Human Resource Coordinator to conduct Quality Improvement Monitoring of new employee files for valid criminal background check weekly x2 weeks, then monthly and prn. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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F 607	Continued From page 20 " Licensure or registration verification prior to hire " Documentation of status of any disciplinary actions from licensing or registration boards and other registries " Information from former employers On 5/10/2018, a review of employment records was conducted for 25 current and prior facility staff. Employee records did not include a criminal background check before the hiring of Employee # 9 and Employee #14. Additionally, there was no employee record at all for Employee #18. At 1:15 PM on 5/10/2018, the Administrator was asked to confirm that employee records for employees # 9 and #14 were complete. She stated that facility human resources staff were searching for additional employee records. At the end of the day conference on 5/10/2018, the employee records were returned to the Administrator, with a note listing which employee documentation was not found in the record. On 5/11/2018 at 10:10am, the Administrator returned the employee records to the surveyor and stated "if we found it, it is on the front of the file". There were no criminal background checks amended to these employee records, and employee #18 had no available documentation at all. The Administrator also stated "we found some more missing documentation, and have already done a plan of correction". No further information was provided prior to exit.	F 607		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		6/19/18

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F 641	Continued From page 21 §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 observation, Resident interview, clinical record review, facility record review, and staff interview, the facility staff failed to accurately code the Minimum Data Set (MDS) for 1 Residents (Resident #5, and #22) in a survey sample of 41 residents. 1. For Resident #5, a staff assessment was conducted instead of a resident interview for Section C, Cognition. The findings included; 1. Resident #5 was admitted to the facility on 4-20-16. Diagnoses included; Hospice, heart disease, chronic respiratory failure, peripheral vascular disease, chronic kidney failure, anxiety, dementia with behavioral disturbance, angina, atrial fibrillation, chronic gout, history of falling, and hypertension. Resident #5's most recent MDS (minimum data set) with an ARD (assessment reference date) of 2-3-18 was an annual assessment. Resident #5 was coded with a Brief Interview for Mental Status (BIMS) score off "99" indicating unable to complete. The Resident was also coded as needing extensive to total assistance of one staff member to perform her activities of daily living, with the exception of eating. For eating the Resident required supervision assistance by staff. Resident #5 was incontinent of bowel and bladder. Resident #5 had no range of motion limitations and her primary mode of mobility was	F 641	F641 Resident #5 and #22s MDS have been reviewed for accurate BIMS score and revised as applicable. Regional Director of MDS/Designee has conducted a Quality Review of current residents MDS for accurate BIMS score. Follow up based on findings. Regional Director of MDS has provided re-education to MDS department and Social Service department regarding BIMS testing and accurate scoring. Regional Director of MDS to conduct Quality Improvement Monitoring of resident assessments for accurate BIMS score weekly x 4 weeks, then monthly x 2 months, quarterly and prn. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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her wheelchair. Resident #5 was coded for no behaviors and no wandering.

Section C of the MDS captures the resident's cognitive status, and includes the Brief Interview for Mental Status (BIMS). The answers listed on the MDS, in the BIMS, are added together to give a cognitive score which can be used to compare the resident's status over time. The BIMS summary score is recorded in MDS field C 0500, and is a total of the responses for C 0200 through C 0400. Res #5 had a Quarterly MDS with an Assessment Reference Day (ARD) of 11/06/2017. She was recorded as a "0" for fields C 0200 through C 0400, which includes 7 total questions. The BIMS summary score was listed as "99". The Resident Assessment Instrument (RAI) manual provides instruction on completion of the MDS, and page C-4 states:

page C-15(instructions for completing item C 0500) states:
Coding Instructions
Enter the total score as a two-digit number. The total possible BIMS score ranges from 00 to 15.
O If the resident chooses not to answer a specific question(s), that question is coded as incorrect and the item(s) counts in the total score. If, however, the resident chooses not to answer four or more items, then the interview is coded as incomplete and a staff assessment is completed.
O To be considered a completed interview, the resident had to attempt and provide relevant answers to at least four of the questions included in C 0200-C 0400. To be relevant, a response only has to be related to the question (logical); it does not have to be correct. See general coding tips on page C-4 for residents who choose not to participate at all.

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Code 99, unable to complete interview: if (a) the resident chooses not to participate in the BIMS, (b) if four or more items were coded 0 because the resident chose not to answer or gave a nonsensical response, or (c) if any of the BIMS items is coded with a dash.
- Note: a zero score does not mean the BIMS was incomplete. To be incomplete, a resident had to choose not to answer or give completely unrelated, nonsensical responses to four or more items.

A staff interview was completed on 5-10-18 at 9:45 a.m., with Employee B, and Employee C (EMP B, and C) social workers). EMP B, and C, described Resident #5 as 'able to verbalize her needs'. When asked why the Staff Assessment for Mental Status was completed for this MDS, instead of the Resident interview, facility staff stated "she can't answer the questions", "her answers are incorrect". When asked what the coding instructions are for the BIMS, facility staff stated "you answer 99 if all the answers are 0 and do the staff assessment". When asked if Resident #5 will converse with staff, facility staff stated "yes, she will talk but needs short direct statements". Note that per the RAI manual coding instructions for these items, a 0 refers to an incorrect answer, and is a valid response. A 0 in fields C 0200-C 0400 would result in a score of 0 in C 0500. Facility staff were asked if they went in and attempted to interview Resident #5, and replied "no, I did the staff assessment".

The Communication Care Area Assessment (CAA) for the 2-3-18 Annual MDS stated: "impaired communication r/t (related to) dementia. She is sometimes able to make herself understood and sometimes able to understand

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F 641	Continued From page 24 others. She is able to make basic daily needs known." The Cognition CAA for the 2-3-18 Annual MDS stated: "On a physician note dated 12-11-2018, it was reported that (redacted but stated the resident's name) has dementia and Alzheimer's disease. (redacted, but stated the resident's name) could not complete a BIMS assessment. A staff interview was performed." A Psychosocial evaluation dated 1-31-18 stated Resident #5 had "no communication problems". On 5-10-18 at 4:00 p.m. at the end of day debrief, the Administrator and Director of nursing (DON) were made aware of the deficient practice. No further information was provided by staff.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a	F 644		6/19/18

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F 644	Continued From page 25 related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on Staff interview and clinical record review, facility staff failed to refer residents with a possible serious mental illness for a level 2 Pre-Admission Screening and Resident Review (PASARR) for 2 Residents (Resident #119 and #15), in a survey sample of 41 Residents. 1. For Resident #119, a PASARR II was not conducted despite a diagnosis of serious Mental Illness, schizoaffective disorder and bipolar disorder. 2. Resident #15's Level I PASARR from the admitting hospital was coded incorrectly as the resident did have a serious MI (mental illness), bipolar disorder. The findings included: 1. Resident #119, a 64-year-old, was admitted on 4/1/18. Her diagnoses included Left Hip Arthroplasty, Bipolar Disorder, Anxiety, Schizoaffective Disorder, Gastro-Esophageal Reflux Disease, Major Depressive Disorder with psychotic symptoms, Hyperlipidemia, Hypertension, and Urinary Tract Infection. Her most recent Minimum Data Set (MDS) Assessment was a Change of Therapy Assessment with an Assessment Reference Date (ARD) of 5/6/18. The Brief Interview for Mental Status scored her a 15, indicating no impairment. Resident #119 required extensive assistance of one staff member for bed mobility, transfers, and toileting; and setup assistance for eating.	F 644	F644 Resident # 119 was discharged to ALF as planned. Resident #15 has been referred for a level 2 Pre-Admission Screening and Resident Review (PASARR). Social Service Director/Designee has conducted a Quality Review of current facility residents for level 2 PASARR. Follow up based on findings. Executive Director provided re-education to Admissions and Social Services Departments regarding level 2 Pre-Admission Screening and Resident Review (PASARR). Executive Director or designee to conduct Quality Improvement Monitoring of residents for level 2 PASARR utilizing the Morning Meeting Process weekly x 2weeks, monthly x 2 months, then quarterly and prn. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule based on findings.	

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On 5/9/18, a review of Resident #119's record was conducted. Her diagnoses of Schizoaffective Disorder, Major Depressive Disorder, and Bipolar Disorder were noted. The Director of Nursing was asked to located Resident #119's Pre-Admission Screening and Resident Review (PASARR) Level I and/or II. She stated that these documents were usually kept in the Business Office.

On 5/10/18 at 2:44 p.m., Admin F, the Business Office Manager, stated that there was no PASARR for Resident #119.

On 5/10/18 at 3:30 p.m., the Administrator, provided surveyors with a PASARR I for Resident #119. This document was dated 3/30/18. For question #2, "DOES THE INDIVIDUAL HAVE A CURRENT SERIOUS MENTAL ILLNESS?", the answer "No" is circled. For question #5, "RECOMMENDATION", answer "B" is circled: "No referral for active treatment needs assessment required because individual:". None of the options listed below line B are marked.

No Level II PASARR was provided.

The Administrator and Director of Nursing were informed of the findings at the end of day meeting on 5/10/18. No further information was provided.

2. Resident #15's Level I PASARR from the admitting hospital was coded incorrectly as the resident did have a serious MI (mental illness), bipolar disorder.

Resident #15 was admitted to the facility on

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10/4/17 with diagnoses which included, but not limited to, Bipolar disorder, anxiety and diabetes.

Resident #15's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 2/12/18. Resident #15 was coded with a Brief Interview of Mental Status score of "15 out of a possible 15 indicating no cognitive impairment. Resident #15 required standby assistance of one staff member for bed mobility and dressing and toileting.

On 5/8/18 at approximately 11:30 AM, Resident #15 was observed in his room, lying in bed.

On 05/10/18 at 3:57 PM, review of the clinical record revealed a Level I PASARR was completed on 10/2/17, but is incorrect as the resident has a MI (bipolar disorder) and question #2 was checked that a Level II is not indicated as the resident does not have a mental illness. The resident was diagnosed with bipolar disorder. Bipolar disorder is a disease listed in the DSM (diagnostic and statistical manual of mental disorders). The resident was not referred for a Level II PASARR.

On 5/11/18 at 4:25 PM, an interview with the SW (social worker). She stated, "The Level I PASARR comes from the hospital."

On 5/11/18 at approximately 4:35 PM, the Administrator and DON (director of nursing) were notified of the above findings.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION DATE
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3)	F 645		6/19/18

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F 645	Continued From page 28 §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was	F 645		

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F 645	Continued From page 29 transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation and clinical record review, the facility staff failed to, for one resident (Resident #15) in a survey sample of 41 residents, ensure the resident was referred for a Level II PASARR as the resident did have a serious MI (mental illness), bipolar disorder. The findings included: Resident #15 was admitted to the facility on	F 645	F645 Resident # 15 has been referred for a level 2 Pre-Admission Screening and Resident Review (PASARR). Social Service Director/Designee has conducted a Quality Review of current facility residents for level 2 PASARR. Follow up based on findings. Executive Director provided re-education to Admissions and Social Services Departments regarding level 2	

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F 645	Continued From page 30 10/4/17 with diagnoses which included, but not limited to, Bipolar disorder, anxiety and diabetes. Resident #15's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 2/12/18. Resident #15 was coded with a Brief Interview of Mental Status score of "15 out of a possible 15 indicating no cognitive impairment. Resident #15 required standby assistance of one staff member for bed mobility and dressing and toileting. On 5/8/18 at approximately 11:30 AM, Resident #15 was observed in his room, lying in bed. On 05/10/18 at 3:57 PM, review of the clinical record revealed a Level I PASARR was completed on 10/2/17, but is incorrect as the resident has a MI (bipolar disorder) and question #2 was checked that a Level II is not indicated as the resident does not have a mental illness. The resident was diagnosed with bipolar disorder. Bipolar disorder is a disease listed in the DSM (diagnostic and statistical manual of mental disorders). The resident was not referred for a Level II PASARR. On 5/11/18 at 4:25 PM, an interview with the SW (social worker). She stated, "The Level I PASARR comes from the hospital." On 5/11/18 at approximately 4:35 PM, the Administrator and DON (director of nursing) were notified of the above findings.	F 645	Pre-Admission Screening and Resident Review (PASARR). Executive Director or designee to conduct Quality Improvement Monitoring of residents for level 2 PASARR utilizing the Morning Meeting Process weekly x 2weeks, monthly x 2 months, then quarterly and prn. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule based on findings.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		6/19/18

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F 656	Continued From page 31 §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 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	F 656		

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F 656	Continued From page 32 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review, the facility staff failed to complete a comprehensive care plan for one resident in a survey sample of 41 residents (Resident #68) and failed to implement the care plan for two residents (Resident #109, #5) of 41 sampled residents. 1. For Resident # 68, the care plan did not list interventions for hoarding food. 2. For Resident #109 the facility staff did not implement the care plan for a communication dry erase board. The Resident was unable to hear and could not use sign language or read lip movements. 3. For Resident #5, the facility did not implement ADL care for 4 hours on 5-8-18, and 5-9-18 and did not implement the care plan for bed rests. Findings included: 1. For Resident # 68, the care plan did not list interventions for hoarding food. Resident #68 was admitted to the facility on 4/13/2016 with the diagnoses of, but not limited to, Schizoaffective Disorder, Bipolar Type, Diabetes, Hypertension, Chronic Kidney Disease, Stage 3, Polyarthritis, Gastroesophageal Reflux Disease, Bipolar Disorder, current episode Manic severe with Psychotic Features, and Adult Failure to Thrive.	F 656	F656 Comprehensive care plan has been completed for resident #68. Residents # 109 no longer resides in facility. Resident #5 s comprehensive care plan interventions implementation has been verified. Regional MDS Coordinator/Designee conducted a Quality Review of current facility residents to ensure have a complete comprehensive care plan with interventions that are implemented. Follow up based on findings. Regional MDS Coordinator provided re-education for MDS Department regarding completion of comprehensive care plans. Director of Nursing/Designee provided re-education for Nursing Staff (Licensed Nurses and Certified Nursing Assistants) regarding implementation of comprehensive care plan interventions. Regional MDS Coordinator to conduct Quality Improvement Monitoring of facility residents for comprehensive care plans weekly x 2 weeks, monthly x 2 months, then quarterly and prn. Director of Nursing/Designee to conduct Quality Improvement Monitoring of residents for implementation of comprehensive care plan interventions daily x 2 weeks, weekly x 2 weeks, monthly x 2 months, then quarterly and prn. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 3/31/2018. The MDS coded Resident # 68 with a cognitive status of moderately impaired; Resident # 68 was coded as independent for Activities of Daily Living except required set up only for eating and supervision for bathing; Resident # 68 was coded as always continent of bowel and occasionally incontinent of bladder.

During the initial tour of the facility on 5/8/2018 at 12:25 p.m., Resident # 68's room was noted with lots of clutter. There were several items on two overbed tables, a night stand, closet and on the floor. An untouched Lunch food tray (with turkey, dressing, gravy) was noted on an overbed table located on the opposite side of the room from the bed, dated 5/8/18. There was also a sandwich dated 5/6/2018 with one bite taken out of it laying on that table. There was a purple bin on an overbed table near the bed. Inside that bin was a baked chicken breast in plastic wrap. There was no date on the chicken breast wrapper. There was a sandwich in plastic wrap labeled "meat sandwich" and dated 5/5/18 lying on the overbed table near the purple bin. All of the food items were at room temperature.

Further observation of the room revealed another "meat sandwich" dated 5/7/18, uneaten, lying on a nightstand. Inspection of the closet revealed one "meat sandwich" dated 4/30/18 wrapped in plastic and uneaten.

On 5/8/2018 at 12:40 p.m., Resident # 68 was observed to be eating lunch in the dining room.

On 5/8/2018 at 2:14 p.m., Review of Resident #

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68's clinical record was conducted.

On 5/8/2018 at 2:38 p.m., the Director of Nursing and surveyor inspected Resident # 68's room together. All of the food items were still in the room. The lunch tray was untouched. The four meat sandwiches dated 4/30/18, 5/5/18, 5/6/18 and 5/7/18 were still in the room. The baked chicken breast was still in the purple bin.

On 5/8/2018 at 2:40 p.m., an interview was conducted with the Director of Nursing who stated that "food should not be left in the residents room but this resident hoards food and won't let staff take it out."

On 5/8/2018 at 2:42 p.m., an interview was conducted with the Assistant Director of Nursing , Registered Nurse (RN C) who stated she had a rapport with Resident # 68. RN C stated she saw food in Resident # 68's room during rounds that morning (5/8/18) and had planned to remove the food later when Resident # 68 allowed her. RN C stated she made rounds on Resident # 68 daily and removed any foods each day.

Review of the care plan revealed no documentation of interventions to address the hoarding of food. The care plan did list a focus area of "history of barricading self in room with furniture, hoarding foods..." There were no noted interventions regarding the hoarding of foods.

An interview was conducted with the Dietary Director who stated Resident # 68 sometimes ate in her room and sometimes ate in the dining room. The Dietary Director stated the dietary staff always put a tray on the cart to go to the Freedom Unit for Resident # 68 but provided a

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tray in the dining room if Resident # 68 came to the dining room. The Dietary Director stated the dietary staff delivered snacks which included sandwiches to the units each evening. The Dietary Director stated the nursing staff was responsible for delivering the snacks to the residents.

During the end of day debriefing on 5/10/2018, the facility Administrator, Director of Nursing and Corporate Consultant (Admin D) were informed of the findings. The Administrator stated food should not be left in residents rooms and care plans should be complete.

No further information was provided.

2. For Resident #109 the facility staff did not implement the care plan for a communication dry erase board. The Resident was unable to hear and could not use sign language or read lip movements.

Resident #109 was originally admitted to the facility on 6-17-14, and recently readmitted on 4-17-18. The Resident's diagnoses included, but were not limited to; Cataracts, dysphagia, bipolar disorder, severe depression, anemia, stroke, chronic viral hepatitis, and human immuno-deficiency virus.

Resident #109's most recent Minimum Data Set (MDS) assessment was a significant change assessment with an Assessment Reference Date (ARD) of 5-2-18. Resident #109 was coded with a Brief Interview of Mental Status score of severe cognitive impairment. Resident #109 required total assistance of one to two staff members for

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bed mobility and dressing and toileting. The Resident was incontinent of bowel & bladder.

On 5-10-18 at 2:05 p.m., Resident #109 was observed in her room in bed. The Resident was awake, and alert. The Resident did not respond to questioning, and a staff member in the hallway stated that the Resident could not hear. A sign was observed over the head of the bed tacked to the wall which said "use dry erase board to communicate." The Activity Director (Employee E) entered the room, and was asked if she could find the dry erase board. Employee E searched all of the room, and the Resident's belongings, and stated it is not here, I will go to rehab and get one." A few minutes later Employee E returned with a dry erase board.

Review of the clinical care plan revealed an intervention for "communication" - "Resident is non-verbal and has a history of moderate hearing loss - does not wear a hearing aid. Resident has dry erase board to aide with communications she is able. Also an intervention for, "hearing impairment: gestures, place near speaker, written instructions."

On 5-10-18 at 4:00 p.m. at the end of day debrief, the Administrator and Director of Nursing were informed of the lack of the dry erase board for Resident #109, and they stated she should have had one. The facility provided no further information.

3. For Resident #5, the facility did not implement ADL care for 4 hours on 5-8-18, and 5-9-18 and did not implement the care plan for beds rest.

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Resident #5 was admitted to the facility on 4-20-16. Diagnoses included; Hospice, heart disease, chronic respiratory failure, peripheral vascular disease, chronic kidney failure, anxiety, dementia with behavioral disturbance, angina, atrial fibrillation, chronic gout, history of falling, and hypertension.

Resident #5's most recent MDS (minimum data set) with an ARD (assessment reference date) of 2-3-18 was coded as an annual assessment. Resident #5 was coded with a Brief Interview for Mental Status (BIMS) score off "99" indicating unable to complete. The Resident was also coded as needing extensive to total assistance of one staff member to perform her activities of daily living, with the exception of eating. For eating the Resident required supervision assistance by staff. Resident #5 was incontinent of bowel and bladder. Resident #5 had no range of motion limitations and her primary mode of mobility was her wheelchair. Resident #5 was coded for no behaviors and no wandering. The Resident was severely cognitively impaired.

Initial surveyor observations for this Resident began on 5-8-18 at 12:30 p.m., during initial tour of the building, and continued until 4:30 p.m. The Resident was observed in her room sitting slumped over to her right side in her wheel chair, drooling slightly, with her back to her bed and facing the door. There was a black hair net laying in the seat of the wheel chair partially under the Resident's left buttock. The Resident's bed was located by the window, with the head of the bed against one wall and the foot facing the other wall. The window in the room was located to the left side of the bed and the entrance of the room to the right of the bed, if the bed were viewed

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from the foot.

The room mates bed was turned in the opposite direction to Resident #5's bed, as the head of the bed faced the room entrance, and the foot of the bed faced the window. The foot of the room mates bed was so close to Resident #5's bed side, that Resident #5 could not sit beside her bed in her wheel chair with the curtain drawn for privacy. Resident #5 sat directly beside the foot of the room mates bed, with the room mate laying in her own bed, staring at Resident #5, and able to be viewed by all visitors passing in the hallway. Resident #5 was afforded no privacy while sleeping for this 4 hour period, and received no incontinence care nor was she repositioned during this time as her position never changed, and the hairnet remained in place undisturbed.

A second series of observations was conducted by surveyors on 5-9-18 resuming at 9:00 a.m., and continuing until 1:00 p.m. The Resident was again found in her room slumped over to her right side sleeping in her wheel chair in exactly the same location in the room as the day before, and the room mate was in exactly the same position as the day before, staring at Resident #5. Resident #5 had food particles on the front of the blue sweat suit she wore, which appeared to be dry bread crumbs, or cracker crumbs, and oatmeal, or some tan creamy substance. During these observations the food particles remained on the Resident and were never brushed off. On both days during the observations the room mate was found to be alert, smiling, non-verbal, however, nodded yes and no appropriately to questioning.

Both days of observations resulted in Resident #5

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not implement the incontinence care plan or repositioning for a 4 hour observed time frame. On 5-10-18 during the end of day debriefing, the Administrator, and Director of Nursing (DON), stated that the expectation for Resident's ADL, repositioning, and incontinence care provision by staff should occur at least every two hours, and more often as needed.

The Resident's Clinical record was reviewed and revealed a care plan which directed interventions for incontinence care which included the following;
1. Assist with toileting and incontinence care frequently each shift.
2. Keep skin clean and dry.
3. Follow facility policy/protocols for the prevention/treatment of skin breakdown.
4. Check resident frequently and assist with toileting as needed.
5. Provide peri care after each incontinent episode.
6. Check for incontinence, wash rinse and dry soiled areas.
7. Assist the resident to transfer from bed to wheel chair in the morning after ADL care. Assist with transfers from wheel chair to bed for rest periods and sleep daily as needed. Resident requires weight bearing assistance of 1-2 staff for transfers.

It is notable to mention that this Resident was a hospice Resident, and the Resident was allowed to sleep in a wheel chair for 4 hours on two consecutive days. The Care plan was not implemented during survey observations, as the Resident was not transferred back to bed for rest periods.

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F 656	Continued From page 40 The administrator, DON, and corporate consultant were informed on 5-10-18 at 4:00 p.m., at the end of day debrief. No further information was provided by the facility.	F 656		
F 657 SS=D	COMPLAINT DEFICIENCY Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		6/19/18

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Based on interview, facility documentation, and clinical record review the facility failed for 1 resident (Resident #10) in a survey sample of 41 to update and revise care plan.

For Resident #10, the facility failed to update the care plan in the area of discharge planning after psychiatric evaluation on 3/9/18.

The findings included:

Resident # 10 a 79 year old female was admitted to the facility on 3/4/17. She was admitted from the hospital post stroke and in need of nursing services. At that time and currently she has a Guardian Ad Litem for medical and financial decision making.

Review of document provided by the Director of Nursing (DON) on 5/10/18 revealed that Resident #10 had Psychiatric evaluation on 3/9/18 . The evaluation stated that the reason for evaluation was Request for Capacity evaluation for the resident to make treatment decisions, financial decisions and possible rescinding of the guardianship.

The psychiatrist stated in the evaluation report that Resident #10 is deemed to have capacity to make informed treatment decisions. She is deemed to have the capacity to make decisions regarding her medical care, financial affairs decisions regarding disposition and will not need a surrogate decision maker to assist with such decisions. Please consider rescinding Guardianship.

An interview with the Social Workers revealed that the Social Workers had no knowledge of the

F 657

F657
Resident #10s care plan regarding discharge planning has been updated and revised.
Regional MDS Coordinator/Designee conducted a Quality Review of current resident care plans for discharge planning reflective of current resident status. Follow up based on findings.
Regional MDS Coordinator provided re-education to MDS Department and social service staff regarding timely updating/revising of resident discharge care plans.
Regional MDS Coordinator/Designee to conduct Quality Improvement Monitoring of current resident care plans for discharge planning reflective of current resident status weekly x2 weeks, monthly x 2 months, then quarterly and prn.
Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.

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F 657	Continued From page 42 evaluation done on 3/09/18. When asked the expectation of action once receiving this evaluation she stated the expectation was that upon receiving the document the social worker would contact the Guardian and notify them of the situation and take steps to see about going to court to rescind the guardianship. Under section Discharge planning Resident #10's careplan stated The Resident will remain as a LTC resident at the facility throughout next review and is dated 3/27/17. No changes were made on revisions dated 7/23/18 or 2/18/18. The facility Administrator was notified at the end of day on 5/11/18 at 5:45 PM. No further information was provided.	F 657		
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 staff interview, clinical record review, and facility documentation review, the facility staff failed to follow the professional standards of practice for medication and diet administration for 1 Resident (Resident #102) in a survey sample of 41 residents. For Resident #102 the facility staff failed to provide a therapeutic diet, fingerstick blood sugars, and insulin, per physician's orders.	F 658	F658 Resident #102 has received diet and medication administration meeting professional standard. Director of Nursing/Designee has conducted Quality Review of current facility residents to ensure medication and diet administration is performed per professional standard. Follow up based on findings. Director of Nursing/Designee provided	6/19/18

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The facility staff stated the facility utilized "Lippincott" as their professional nursing standard.

The findings included:

Resident #102 was admitted to the facility on 1-28-15. Diagnoses included; Neoplasm of tongue, chronic post traumatic stress disorder, schizophrenia, depression anxiety, dysphagia, diabetes, and Parkinson's disease.

Resident #102's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an assessment reference date (ARD) of 4-19-18. The Resident was coded with a Brief Interview of Mental Status score of 8 indicating moderate cognitive impairment and required supervision and set up assistance only for activities of daily living.

On 5-8-18 at 12:15 p.m., the main dining room in the front of the facility was observed during lunch. Resident #102 was observed sitting across from the only other Resident at the table, who was a female, and both were eating.

Resident #102 had nectar thickened milk, whole sliced turkey breast, turkey stuffing, applesauce, cooked whole yellow squash slices, a slice of white bread, and a bowl of bean soup. The Resident consumed 100% of the soup, and applesauce, and left 2 pieces of squash, one half of the bread slice, a spoonful of the stuffing, and one half slice of the 2 slices of turkey breast he received. The other Resident at the table consumed 100% of her meal. Resident #102 had a tray card under his plate, and it was reviewed after he was finished and exited the dining room.

F 658

re-education to Licensed Nurses regarding medication administration standards/regulations. Director of Nursing/Designee has provided re-education to Nursing Staff (Licensed Nurses and Certified Nursing Assistants) regarding diet administration per standards/regulations.
Director of Nursing/Designee to conduct Quality Improvement Monitoring of diet and medication administration per professional standard 5x/week x 2 weeks, weekly x 2 weeks, monthly x 2 months, then quarterly and prn. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.

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The tray card specified the diet order and stated "3 OZ (ounces) ground roast turkey".

On 5-8-18 the Resident's physician's orders were reviewed and revealed a diet order for "Consistent carbohydrate, mechanical soft diet texture with nectar thickened liquids."

The Resident's weight document was reviewed and revealed no significant weight loss.

During the lunch observation surveyors were approached by the Administrator and she was shown the half slice of whole turkey Breast left on the tray, and she stated "That's not right." The other Resident was still sitting at the table with her finished tray in front of her.

Review of Resident #102's MAR (medication administration record) revealed no evidence that the following insulin order was administered on 5-3-18, and 5-5-18, at 6:30 a.m.. There were no nursing notes on these days to describe why the insulin was omitted.

1. Humalog solution 100 units per milliliter, inject as per sliding scale:
If FSBS (finger stick blood sugar) 200 - 249 give 2 units.
If FSBS 250 - 300 give 4 units.
If FSBS 301 - 349 give 6 units.
If FSBS 350 - 400 give 8 units.

Further review of Resident #102's MAR record revealed no evidence that the following FSBS order was administered on 5-3-18, and 5-5-18, at 6:30 a.m.,, and there were no nursing notes on these days to describe why the FSBS was omitted.

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F 658	Continued From page 45	F 658		

On 5-3-18 at 6:00 p.m.,, the Resident's blood sugar was 314, and on 5-8-18 at 6:30 a.m.,, the Residents blood sugar was 327. There were no nursing notes on these days to describe why the doctor was not notified of the high blood sugars per the order below.

2. Accucheck (FSBS) finger stick blood sugar 2 times per day related to diabetes notify MD (doctor) if blood sugar is less than 60 or greater than 300. Ordered on 8-30-17 and was a current order.

There was a second order for FSBS written exactly as the order above, with the exception of the indications to call the doctor. That order read notify MD (doctor) if blood sugar is less than 60 or greater than 400. That order was dated 8-31-17, and was a current order. None of the nursing staff had questioned these conflicting orders since August of 2017 (8 + months) and clarified the orders.

Valid physician's orders were evident for the insulin and FSBS in question.

Review of the facility's policy entitled "Insulin Administration" included:

"Check the MAR for order 3 times", and "Document in medical record". MAR (medication administration record). according to policy."

The Corporate RN (registered Nurse consultant) stated on 5-10-18 at 4:00 p.m., the expectation was for the staff to document medications when they are administered, on the eMAR (electronic MAR).

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F 658	Continued From page 46 Guidance for nursing standards for the administration of medication is provided by "Fundamentals of Nursing, 7th Edition, Potter-Perry, p. 705: Professional standards, such as the American Nurses Association's Nursing : Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. Medications and treatments are given in accordance with physician's orders. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication 2. The right dose 3. The right client 4. The right route 5. The right time 6. The right documentation." At the end of day meeting on 5-10-18, and 5-11-18 the incorrect diet, and lack of insulin and FSBS administration for Resident #102 was discussed with the Administrator, corporate RN, and Director of Nursing. The Administrator stated she had spoken with the kitchen staff about the issue, and they stated the medication administration error was "it is, what it is". No further information was provided.	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 677		6/19/18

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F 677	Continued From page 47 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and in the course of a complaint investigation, the facility staff failed to provide ADL care for four residents (Residents #64, 58, 99, and 4) in a survey sample of 41 residents. 1. For Resident # 64, the facility staff failed to provide (Activities of Daily Living) ADL care for Bathing consistently. 2. For Resident # 58, the facility staff failed to provide (Activities of Daily Living) ADL care for Bathing consistently. 3. Resident #99 had 12 baths or showers documented for March, 6 in April and none for May, 2018. 4. Resident #4 had 6 bed baths in the month of April. Her fingernails were long with dark debris under the nails. Findings included: 1. For Resident # 64, the facility staff failed to provide (Activities of Daily Living) ADL care for Bathing consistently. Resident #64 was admitted to the facility on 4/13/2016 with the diagnoses of, but not limited to, Schizoaffective Disorder, Bipolar Type, Diabetes, Hypertension, Chronic Kidney Disease, Stage 3, Polyarthritis, Gastroesophageal Reflux Disease, Bipolar Disorder, current episode Manic severe with Psychotic Features, and Adult Failure	F 677	F677 Resident□s #64, 58, 99, and 4 have received consistent ADL care (bathing/shower/nail care). Documentation corroborates care received/refused. Director of Nursing/Designee has conducted a Quality Review of current facility residents for receipt of ADL care, i.e.; bathing/shower/nail care and documented as applicable. Follow up based on findings. Director of Nursing provided Nursing Staff (Licensed Nurses and Certified Nursing Assistants) re-education regarding providing and documenting ADL Care. Director of Nursing/Designee to conduct Quality Improvement Monitoring of residents provided consistent ADL care 5x/week x 2 weeks, weekly x 2 weeks, then monthly and prn. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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F 677	Continued From page 48	F 677		

to Thrive.

The most recent Minimum Data Set (MDS) was a Significant Change Assessment with an Assessment Reference Date (ARD) of 3/15/2018. The MDS coded Resident # 64 with a BIMS (Brief Interview for Mental Status) score of 3/15 indicating severe cognitive impairment; Resident # 64 was coded as requiring limited to total assistance of one staff member for Activities of Daily Living except required supervision and set up only for eating; Resident # 64 was coded as always continent of bowel and an indwelling catheter for bladder.

Review of the clinical record was conducted.

During the initial tour of the facility on 5/8/2018 at 12:25 p.m., a very pungent odor of urine was observed in Resident # 64's room. The odor appeared to be more prevalent near the bed where Resident # 64 lived.

On 5/8/2018 at 4:00 p.m., Resident # 64 was observed to be lying in bed. There was a strong odor of urine noted on Resident # 64.

On 5/9/2018 at 10 a.m., review of the clinical record was conducted.

Review of the Activities of Daily Living Shower records revealed no documentation of showers or bed bath for several days. Review of the April 2018 - May 2018 ADL-Bathing record revealed documentation of only one shower and 10 bed baths during those weeks. A shower was performed on 4/23/18 and no documentation of any type of bath activity again until 5/5/2018 when a bed bath was performed.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF WILLIAMSBURG, LLC	1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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During the end of day debriefing on 5/10/2017 at 12:10 PM, the facility Administrator, Director of Nursing and Corporate Consultant (Admin D) were informed of the findings.

No further information was provided.

2. For Resident # 58, the facility staff failed to provide (Activities of Daily Living) ADL care for Bathing consistently.

Resident # 58 was admitted to the facility on 2/21/2017 with diagnoses of but not limited to Hypertension, Schizophrenia, Intellectual Disability, Insomnia, Osteoporosis, Urinary Tract Infection, Iron Deficiency, fracture of Right Acetabulum, constipation, and edema.

Resident # 58's most recent Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 3/20/2018 coded Resident #58 as having a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. The Minimum Data Set coded Resident #58 as requiring minimal to limited assistance of one staff member for Activities of Daily Living (ADLs) care including requiring minimal assistance of one staff person for Hygiene and limited assistance of one staff member for Bathing. The resident was coded as always continent of bowel and occasionally incontinent of bladder.

On 5/9/2018 at 10:00 a.m., an interview was conducted with Resident # 58 who stated she did not receive the help she need for bathing. Resident # 58 stated she needed help with

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washing her legs, feet,and back. Resident # 58 stated she told the staff several times that she wanted a shower on Mondays, Wednesdays and Fridays.

Review of the clinical record was conducted on 5/9/2018 at 4:00 p.m.

Review of the Shower Schedule for the unit and room where Resident # 58 resided showed Resident # 58 was scheduled to have showers on Tuesdays and Fridays on 7-3 shift.

An interview was conducted with the Administrator who stated showers were performed according to the schedules posted at the nurses station. The Administrator stated that sometimes showers were done at different times from the schedule. A copy of the shower records from September 2017- March 2018 for Resident # 58 were requested and received.

Review of the "ADL-Bathing" records dated September 2017-March 2018 revealed documentation under ADL-Bathing that Resident # 58 "prefers Monday, Wednesday and Friday between 8 a.m. and 11 a.m." The review revealed baths or showers were not performed on Monday, Wednesdays and Fridays as requested by Resident # 58.

Review of the care plan revealed documentation of the Focus area: "The resident has impaired ADL function related to decreased mobility..." The Goal was listed as "Resident will continue to participated in the ADL tasks with no more than the limited assist of one daily throughout next review date." The interventions included "Bathing: Assist the resident with bathing.

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Encourage the resident to attempt washing face, washing hands, drying upper body etc.) [etcetera]. Assist as needed."

On 5/10/2018 at 3:15 p.m., an interview was conducted with the Director of Nursing (DON) who stated the nursing staff document baths and showers during their shifts. The DON stated the times on the ADL-Bathing record denote the time the staff documented the shower but did not reflect the time the shower or bath actually occurred. The DON stated the staff members were expected to document as soon after the bathing activity as possible.

During the end of day debriefing on 5/10/2018, the facility Administrator, Director of Nursing and Corporate Consultant were informed of the findings.

No further information was provided.

COMPLAINT Deficiency

3. Resident #99 had 12 baths or showers documented for March, 6 in April and none for May, 2018.

Resident #99 was admitted to the facility on 4/14/17 with diagnoses which included, but not limited to, quadriplegia at C-5 to C-7, depression and anxiety.

Resident #99's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 4/20/18. Resident #99 was coded with a Brief Interview of Mental Status score of "15 out of a

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possible 15 indicating no cognitive impairment. Resident #99 required total assistance of one to two members for bed mobility and bathing and toileting.

On 5/8/18 at 2:15 PM, Resident #99 was observed in his bed, looking at his computer screen. The resident was able to hold the stylus to use the computer. Resident #99 complained he was not getting his showers and that he preferred his showers during the day. He stated, "If they miss your shower day, they will offer showers at 2:00 to 4:00 AM."

Review of the care plan (no date) revealed: "The resident has impaired ADL (activities of daily living- such as bathing) functioning related to quadriplegia. Under bathing the care plan read: "Provide the resident with assistance to bathe daily and as needed." The care plan did not address refusal of showers.

Review of the shower records revealed that Resident #99 received 12 baths/showers in March (5 during the evening shift), 7 in April (three showers are documented on each shift for 4/24/18 to 4/25/18) and none were documented for May up until 5/10/18.

On 5/10/18 at approximately 11:45 AM, the Administrator was notified of the above findings. She stated, "No, he has gotten more than that. He refuses."

Review of nursing notes revealed one occasion (4-18-18) where the resident refused his shower. The resident stated, "prefer to take shower tomorrow during the day." Review of the shower records revealed the resident had a bed bath on

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4/20/18.

4. Resident #4 had 6 bed baths in the month of April. Her fingernails were long with dark debris under the nails.

Resident #4 was admitted to the facility on 2/20/15 with diagnoses which included, but not limited to, diabetes, congestive heart failure and mood disorder.

Review of the care plan dated 2/27/18 and read: "The resident has an ADL Self Care Deficit related to resident is a double above the knee amputee. Intervention included: Provide resident with a sponge bath when a shower can not be tolerated."

Resident #4's most recent Minimum Data Set (MDS) assessment was an annual assessment with an Assessment Reference Date (ARD) of 2/3/18. Resident #4 was coded with a Brief Interview of Mental Status score of "10 out of a possible 15 indicating moderate cognitive impairment. Resident #4 required extensive to total assistance of one to two staff members for bed mobility and bathing and toileting.

On 5/9/18 11:30 AM: Resident #4 was observed in bed. The resident has on a hospital gown, stated, "I like to stay in bed." Finger nails were observed to be long with dark debris under the nails. Resident #4 was asked if she got showers and stated, "I don't know when my last shower was." Her room mate stated, "(name of resident) , you had a shower last Wednesday or Thursday."

On 5/10/18 8:25 AM: Resident #4 observed in

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F 677	Continued From page 54 bed asleep. Hospital gown is on. 05/11/18 10:25 AM: Resident #4 nails were observed to still long with dark debris. Asked LPN (licensed practical nurse) , to view her nails. The LPN stated, "Oh, yes, they need to be cut and soaked." She went to state that this is to be done with the resident's bath/shower. Review of the shower records for April revealed only 6 bed baths as being given. None were documented for May.	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, facility document review, and in the course of a complaint investigation, the facility failed to provide care and services to promote the highest practicable well being for 2 Residents (Residents #5, and #109) in a survey sample of 41 residents. 1. For Resident #5, hospice services for a return to bed for rest periods was not provided by facility staff. 2. For Resident #109, a care planned dry erase	F 684	F684 Resident's #5 is receiving care and services to promote the highest practicable well being. Resident #109 no longer resides in facility. Director of Nursing/designee conducted a Quality Review of current facility residents to ensure care and services provided to promote the highest practicable well being. Follow up based on findings. Executive Director/Director of Nursing/Designee provided re-education to facility staff regarding care and services	6/19/18

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F 684	Continued From page 55 board was not provided to the Resident for communication of needs. The findings included; 1. Resident #5 was admitted to the facility on 4-20-16. Diagnoses included; Hospice, heart disease, chronic respiratory failure, peripheral vascular disease, chronic kidney failure, anxiety, dementia with behavioral disturbance, angina, atrial fibrillation, chronic gout, history of falling, and hypertension. Resident #5's most recent MDS (minimum data set) with an ARD (assessment reference date) of 2-3-18 was coded as an annual assessment. Resident #5 was coded with a Brief Interview for Mental Status (BIMS) score off "99" indicating unable to complete. The Resident was also coded as needing extensive to total assistance of one staff member to perform her activities of daily living, with the exception of eating. For eating the Resident required supervision assistance by staff. Resident #5 was incontinent of bowel and bladder. Resident #5 had no range of motion limitations and her primary mode of mobility was her wheelchair. Resident #5 was coded for no behaviors and no wandering. The Resident was severely cognitively impaired. Initial surveyor observations for this Resident began on 5-8-18 at 12:30 p.m., during initial tour of the building, and continued until 4:30 p.m. The Resident was observed in her room sitting slumped over to her right side in her wheel chair, drooling slightly, with her back to her bed and facing the door. There was a black hair net laying in the seat of the wheel chair partially under the Resident's left buttock. The Resident's bed was	F 684	provided to promote the highest practicable well being. Executive Director/Director of Nursing/Designee to conduct Quality Improvement Monitoring of residents for care and services provided to promote the highest practicable well being 5x/week x 2 weeks, weekly x 2 weeks, then monthly and prn. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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located by the window, with the head of the bed against one wall and the foot facing the other wall. The window in the room was located to the left side of the bed and the entrance of the room to the right of the bed, if the bed were viewed from the foot.

The room mates bed was turned in the opposite direction to Resident #5's bed, as the head of the bed faced the room entrance, and the foot of the bed faced the window. The foot of the room mates bed was so close to Resident #5's bed side, that Resident #5 could not sit beside her bed in her wheel chair with the curtain drawn for privacy. Resident #5 sat directly beside the foot of the room mates bed, with the room mate laying in her own bed, staring at Resident #5, and able to be viewed by all visitors passing in the hallway. Resident #5 was afforded no privacy while sleeping for this 4 hour period, and received no incontinence care nor was she repositioned during this time as her position never changed, and the hairnet remained in place undisturbed.

A second series of observations was conducted by surveyors on 5-9-18 resuming at 9:00 a.m., and continuing until 1:00 p.m.. The Resident was again found in her room slumped over to her right side sleeping in her wheel chair in exactly the same location in the room as the day before, and the room mate was in exactly the same position as the day before, staring at Resident #5. Resident #5 had food particles on the front of the blue sweat suit she wore, which appeared to be dry bread crumbs, or cracker crumbs, and oatmeal, or some tan creamy substance. During these observations the food particles remained on the Resident and were never brushed off. On both days during the observations the room mate

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F 684	Continued From page 57 was found to be alert, smiling, non-verbal, however, nodded yes and no appropriately to questioning. Both days of observations resulted in Resident #5 not receiving incontinence care or repositioning for a 4 hour observed time frame. On 5-10-18 during the end of day debriefing, the Administrator, and Director of Nursing (DON), stated that the expectation for Resident's ADL, repositioning, and incontinence care provision by staff should occur at least every two hours, and more often as needed. The Administrator, DON, and Corporate RN (Registered Nurse) stated staffing had been an ongoing problem, and agency staffing companies had been engaged to provide staff when numbers were insufficient. The Resident's Clinical record was reviewed and revealed a care plan which directed interventions for incontinence care which included the following; 1. Assist with toileting and incontinence care frequently each shift. 2. Keep skin clean and dry. 3. Follow facility policy/protocols for the prevention/treatment of skin breakdown. 4. Check resident frequently and assist with toileting as needed. 5. Provide peri care after each incontinent episode. 6. Check for incontinence, wash rinse and dry soiled areas. 7. Assist the resident to transfer from bed to wheel chair in the morning after ADL care. Assist with transfers from wheel chair to bed for rest periods and sleep daily as needed. Resident	F 684		

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F 684	Continued From page 58 requires weight bearing assistance of 1-2 staff for transfers. It is notable to mention that this Resident was a hospice Resident, and the Resident was allowed to sleep in a wheel chair for 4 hours on two consecutive days. The Care plan was not implemented during survey observations, as the Resident was not transferred back to bed for rest periods. The administrator, DON, and corporate consultant were informed of the failure of the staff to provide sufficient staffing to provide needed care and services to Resident #5 on 5-10-18 at 4:00 p.m., at the end of day debrief. They were further notified that Resident #5 did not receive services to meet the Resident's hospice care rest period needs. No further information was provided by the facility. 2. Resident #109 was originally admitted to the facility on 6-17-14, and recently readmitted on 4-17-18. The Resident's diagnoses included, but were not limited to; Cataracts, dysphagia, bipolar disorder, severe depression, anemia, stroke, chronic viral hepatitis, and human immuno-deficiency virus. Resident #109's most recent Minimum Data Set (MDS) assessment was a significant change assessment with an Assessment Reference Date (ARD) of 5-2-18. Resident #109 was coded with a Brief Interview of Mental Status score of severe cognitive impairment. Resident #109 required total assistance of one to two staff members for bed mobility and dressing and toileting. The Resident was incontinent of bowel & bladder.	F 684		

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F 684 — Continued From page 59 — F 684

On 5-10-18 at 2:05 p.m., Resident #109 was observed in her room in bed. The Resident was awake, and alert. The Resident did not respond to questioning, and a staff member in the hallway stated that the Resident could not hear. A sign was observed over the head of the bed tacked to the wall which said "use dry erase board to communicate." The Activity Director (Employee E) entered the room, and was asked if she could find the dry erase board. Employee E searched all of the room, and the Resident's belongings, and stated it is not here, I will go to rehab and get one." A few minutes later Employee E returned with a dry erase board.

Review of the clinical care plan revealed an intervention for "communication" - "Resident is non-verbal and has a history of moderate hearing loss - does not wear a hearing aid. Resident has dry erase board to aide with communications she is able. Also an intervention for, "hearing impairment: gestures, place near speaker, written instructions."

On 5-10-18 at 4:00 p.m. at the end of day debrief, the Administrator and Director of Nursing were informed of the lack of the dry erase board for Resident #109, and they stated she should have had one. The facility provided no further information.

F 686 SS=D — Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) — F 686 — 6/19/18

§483.25(b) Skin Integrity
§483.25(b)(1) Pressure ulcers.
Based on the comprehensive assessment of a resident, the facility must ensure that-

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F 686	Continued From page 60 (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, resident and staff interview, facility documentation and clinical record review, and in the course of a complaint investigation, the facility failed to for one resident (Resident #1) in a survey sample of 41 residents, to provide care and services of a stage 2 pressure wound. Resident #1 was observed during wound care in which the nurse used an incontinence pad to drag the resident across the mattress. The findings included: Resident #1 was admitted to the facility on 2/25/16 with diagnoses which included, but not limited to, Multiple Sclerosis, seizure disorder and paranoid schizophrenia. Resident #1's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 4/29/18. Resident #1 was coded with a Brief Interview of Mental Status score of "15 out of a possible 15 indicating no cognitive impairment. Resident #1 required total assistance of one to two staff members for bed mobility and dressing	F 686	F686 Resident #1 is receiving care and services including bed mobility to prevent/heal pressure ulcer. LPN (H) was re-educated on care and services provided to prevent/heal pressure ulcers. Director of Nursing/Designee conducted Quality Review of current residents for provision of care and services to prevent/heal pressure ulcer. Follow up based on findings. Director of Nursing/Designee provided re-education to Licensed Nurses regarding care and services provided to prevent/heal pressure ulcers. Director of Nursing/Designee to conduct Quality Improvement Monitoring of provision of care and services to prevent/heal pressure ulcers 5x/week x 2 weeks, 2x/week x 2weeks, weekly x 2weeks, then monthly and prn. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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F 686	Continued From page 61 and toileting. On 5/11/18 at 9:25 AM: Resident # 1's wound care was observed to open area on posterior (back part) right thigh. Resident was in the supine (face up) position. LPN (licensed practical nurse) H performed the procedure. LPN (H) used the resident's incontinence pad to bring the resident to the middle of the bed, dragging the resident across the mattress. The area was cleaned with normal saline. Toenails were noted to be very long. The resident stated, "I need to have them done." The Corporate RN (registered nurse) (Amin D) was asked to describe the wound bed as LPN (H) was uncomfortable describing the wound. RN stated, "There is 90 % slough with pink tissue surrounding, I would stage it as an unable to stage wound." The LPN was asked about using the incontinence pad to reposition the resident and LPN (H) stated, "It would cause shearing." She also stated that the resident was able to assist with repositioning. Review of the care plan with a target date of 7/22/18 included the resident has a potential for impaired skin integrity revealed to impaired mobility. One intervention dated 2/3/16 included: "Handle and position to reduce friction." On 5/11/18 at approximately 1: 30 PM, the Administrator and DON (director of nursing) were notified of above findings.	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	F 689		6/19/18

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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 689	Continued From page 62 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 and facility documentation, the facility staff failed to ensure an environment free from accident hazards for one of three units. The medication cart was left unlocked and unsupervised for 28 minutes. The findings included: 05/10/18 from 8:30 AM to 8:58 AM: The Medication cart was observed to be open during this time frame. Two residents wheeled by the cart in their wheelchairs. During the initial observation, the cart was unattended with no staff in sight. Several staff members, including the unit manager, and another medication nurse at the nurse's station was observed to be in sight of the opened cart during this time. 05/10/18 at 09:00 AM: The DON (director of nursing) was asked to come to unit. The DON stated, "This should absolutely not happen, the cart is to be locked at all times." 5/11/18 at 11:45 AM: The Administrator and DON were notified of the above findings. The DON was asked for a policy and procedure for locking the medication cart; a policy was presented, but it did not contain any information about locking the cart.	F 689	F689 Medication cart observed locked and supervised as per standard. Director of Nursing/Designee conducted a Quality Review of medication carts for locked/supervised per standard. Follow up based on findings. Director of Nursing/Designee provided re-education to Licensed Nurses regarding medication carts locked/supervised per standard. Director of Nursing/Designee to conduct Quality Improvement Monitoring of Medication carts locked/supervised per standard 5x/week x 2weeks, weekly x 2weeks, then monthly and prn. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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F 690	Continued From page 63	F 690		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	F 690		6/19/18

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F 690	Continued From page 64 Based on observation, staff interview, facility documentation and clinical record review, the facility staff failed to, for one resident (Resident #1) in a survey sample of 41 residents, to ensure appropriate and adequate treatment for a UTI (urinary tract infection). Resident #1 received only 3 of 5 physician ordered IM (intramuscular) antibiotic treatment. The findings included: Resident #1 was admitted to the facility on 2/25/16 with diagnoses which included, but not limited to, Multiple Sclerosis, seizure disorder and paranoid schizophrenia. Resident #1's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 4/29/18. Resident #1 was coded with a Brief Interview of Mental Status score of "15 out of a possible 15 indicating no cognitive impairment. Resident #1 required total assistance of one to two staff members for bed mobility and dressing and toileting. On 5/9/18 at 8:45 AM, Resident 31 was in bed. She stated, "I have not been changed yet." She also stated she had a "diaper rash." Clinical record review revealed on 3/5/18 a urinalysis with a culture and sensitivity showed the resident had greater than 100,000 cc (colony count) of Proteus (UTI causing organism). The physician ordered Ceftriaxone (an antibiotic) one gram intramuscularly in the afternoon for 5 days. Give Benadryl (antihistamine) 30 minutes prior to injection. The MAR (medication administration	F 690	F690 Resident #1 has been reviewed and is receiving appropriate treatment and services to restore/maintain bladder function. (No current orders for antibiotics related to diagnosis of UTI noted). Director of Nursing/Designee conducted Quality Review of residents for completion of antibiotic therapy as ordered for residents with diagnosis on UTI (Urinary Tract Infection) to restore/maintain bladder function. Director of Nursing/Designee provided re-education to Licensed Nurses regarding completion of antibiotic therapy as ordered for treatment of UTI/maintenance/restoration of bladder function. Director of Nursing/Designee to conduct Quality Improvement Monitoring of residents with diagnosis of UTI for completion of antibiotic therapy, maintenance/restoration of bladder function. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule to be modified based on findings.	

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F 690	Continued From page 65 record) showed the resident had a current order for Benadryl 25 mg (milligrams) as needed every 4 hours. Continued clinical record review revealed the resident only had three of the five IM doses documented on the MAR. In addition, there was no documentation that the Benadryl was given. This was a Saturday and a Sunday. On 5/10/18 at approximately 4:30 PM, the DON (director of nursing) was asked to provide information regarding the missing doses of the antibiotic. On 5/11/18 at 3:30 PM, the DON stated, "I have no documentation the medication was given." She stated she had a call out to the nurse. No further information was provided.	F 690		
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, resident and staff interview, facility and clinical record documentation, the facility staff failed to, for one resident, Resident #99, in a survey sample of 41 residents, to provide respiratory care and	F 695	F695 Resident #99 has been reviewed by physician and respiratory therapy and is currently receiving respiratory care and services per standard to maintain the	6/19/18

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F 695		F 695		

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services to maintain the highest practicable wellbeing.

Resident #99 had to call his spouse to get emergency respiratory care on 1/1/18. The resident was assessed by a Respiratory Therapist (RT) on 4/4/18 for "inability to bring up mucous." The RT recommended an Acapella which is unavailable to the resident.

The findings included:

Resident #99 was admitted to the facility on 4/14/17 with diagnoses which included, but not limited to, quadriplegia at C-5 to C-7, depression and anxiety.

Resident #99's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 4/20/18. Resident #99 was coded with a Brief Interview of Mental Status score of "15" out of a possible 15 indicating no cognitive impairment. Resident #99 required total assistance of one to two members for bed mobility and bathing and toileting.

On 5/8/18 at 2:15 PM, Resident #99 was observed in his bed, looking at his computer screen. The resident was able to hold the stylus to use the computer. During the resident interview, the resident stated that he has difficulty coughing up mucus. The resident went on to state that he had to call his wife to call 911 for him because the staff would not. He went on to state that the "nurses don't know what they are doing."

Review of the nurse's notes on 1/1/18 revealed the following note: "Complained of having

highest practicable well being.
Director of Nursing/Designee conducted a Quality Review of residents receiving respiratory care and services to attain and maintain the highest practicable well being. Follow up based on findings.
Respiratory Therapist/Director of Nursing provided Licensed Nurses re-education regarding provision of respiratory therapy care and services to attain and maintain the highest practicable well being.
Director of Nursing/Designee to conduct Quality Improvement Monitoring of residents receiving respiratory therapy services to attain/maintain the highest practicable well being 5x/week x 2 weeks, weekly x 2 weeks, then monthly and prn. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.

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difficulty breathing and having mucus in his throat and can't get out. O2 (oxygen) sats (saturation) a little low at 88%. No issues breathing or talking." There was no documentation of any interventions such as administration of oxygen, chest physiotherapy (Chest physiotherapy (CPT) a broad term for treatments using clapping or percussion techniques to help remove mucus from breathing passages. This can be done by nursing or RT.

Review of the Emergency Room (ER) records for the date of 1/1/18 revealed the resident had "mucus plugging of bronchi." The assessment by the physician read: "Patient well known to me. Cervical spine fracture from motor vehicle accident resulting in quadriplegia. He frequently has difficulty clearing chest secretions and requires chest physical therapy." Patient reports feeling much improved after cough induction performed by RT." The report goes on to say that a second cough induction was performed by RT.

On arrival to the ER at 9:28 AM, the resident's oxygen saturation was 81 %. Potter and Perry, Fundamentals of Nursing, 7th edition, page 975 reads: "Normal range (oxygen saturation) is 95-99%."

Review of the care plan (no date) revealed: "The resident has a potential for an ineffective breathing pattern related to intervals of mucous." Interventions included: "Arrange ADL's (activities of daily living) to allow adequate rest, Keep call bell in easy reach, Medication as per physician order, Monitor lung sounds as ordered, and suction as ordered." The care plan also included this entry: "Resident has intervals of falsely accusing staff of not providing care or

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F 695	Continued From page 68	F 695		

assessments when he alleges he is dying or needs ER care when assessment does not indicate emergency. Also accuses staff of not caring when he believes he is dying." One of the interventions for this issue is: "Assess behaviors for underlying cause."

Further review of the clinical record revealed a RT assessment of the resident done on 4/4/18 at 4:20 AM, which read: "RT came and did a (sic) evaluation on patient. Sat (oxygen saturation) 98, HR (pulse) 71, RR (respiratory rate) 18. Breath sounds clear. Patient says he can not cough up mucus. I recommend that he use a Acapella once a day and Mucinex (thins secretions) every 6 hours and Physical Therapy."

Positive Expiratory Pressure (PEP) therapy is used to mobilize secretions. PEP devices have been found to give independence to patients with chronic respiratory diseases as the therapy can be done when convenient for the patient and without the need for an assistant.

Smiths Medical describes the use of an "Acapella Positive Expiratory Pressure (PEP) therapy is used to mobilize secretions. PEP devices have been found to give independence to patients with chronic respiratory diseases as the therapy can be done when convenient for the patient and without the need for an assistant.

Acapella® combines the benefits of both PEP therapy and airway vibrations to mobilize pulmonary secretions and can be used in virtually any position allowing patients to move freely and sit, stand or recline."

On 5/9/18 at approximately at 10:00 AM, LPN

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F 695	Continued From page 69 (licensed practical nurse) H was interviewed about the resident. LPN (H) stated, "He is needy, and will get angry and complain." She went on to state that the resident has a lot of mucus and he wants staff to mash on his stomach (done to strengthen cough) and she told him "I can't do that." She did state that the resident will call the police. LPN (H) was asked about his oxygen saturations and she stated, "Usually good, 96%." She was asked what should happen if oxygen saturations were 88%. LPN (H) sated, "I would give oxygen." On 5/10/18 at 12:30 PM, the DON (director of nursing) stated: "The Acapella is here, we are waiting for RT to train staff. The RT was ill last week."	F 695		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:	F 725		6/19/18

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(i) Except when waived under paragraph (e) of this section, licensed nurses; and
(ii) Other nursing personnel, including but not limited to nurse aides.

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on resident and staff interview and facility documentation and in the course of complaint investigations, the facility staff failed to maintain sufficient staffing to provide for the residents highest practicable well being.

1. Multiple complaints were made by the residents regarding inadequate staffing. These complaints were from individual interviews, residents in the Resident Council meeting and through a complaint investigation.

2. For Resident #5, the facility provided insufficient staff to perform needed re-positioning & incontinence care.

The findings included:

Resident #99 was admitted to the facility on 4/14/17 with diagnoses which included, but not limited to, quadriplegia at C-5 to C-7, depression and anxiety.

Resident #99's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 4/20/18. Resident #99 was coded with a Brief Interview of Mental Status score of "15 out of a

F 725

F725
Resident Council Meeting held, staffing reviewed, council agreeable that sufficient staff is currently being provided. Resident #5s re-positioning and incontinence care needs have been reviewed; staffing adjusted based on resident need/acuity to attain/maintain the highest practicable well being.
Executive Director/Director of Nursing/staff coordinator conducted Quality Review of resident needs/acuity/sufficient staff to attain/maintain the highest practicable well being. Resident interviews conducted to determine satisfaction with staff provided. Follow up based on findings.
Executive Director provided re-education to Director of Nursing, nursing leadership team and staffing coordinator regarding sufficient staff/resident needs/acuity to attain/maintain the highest practicable well being.
Executive Director/Director of Nursing to conduct Quality Improvement Monitoring of resident needs/acuity/staff to attain/maintain the highest practicable well being daily x 2 weeks, 5x/week x 2 weeks,

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possible 15 indicating no cognitive impairment. Resident #99 required total assistance of one to two members for bed mobility and bathing and toileting.

On 5/8/18 at 2:15 PM, Resident #99 was observed in his bed, looking at his computer screen. The resident was able to hold the stylus to use the computer. Resident #99 complained he was not getting his showers and that he preferred his showers during the day. He stated, "If they miss your shower day, they will offer showers at 2:00 to 4:00 AM." Review of the shower records revealed the resident only had 12 baths/showers in March (5 during the evening shift), 7 in April (three showers are documented on each shift for 4/24/18 to 4/25/18) and none were documented for May up until 5/10/18. The resident also stated he was not getting his meals consistently, especially on the weekend.

Resident #1 was admitted to the facility on 2/25/16 with diagnoses which included, but not limited to, Multiple Sclerosis, seizure disorder and paranoid schizophrenia.

Resident #1's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 4/29/18. Resident #1 was coded with a Brief Interview of Mental Status score of "15 out of a possible 15 indicating no cognitive impairment. Resident #1 required total assistance of one to two staff members for bed mobility and dressing and toileting. A complaint had been called to the OLC (office of licensure and certification) regarding inadequate staffing on 2/10/18.

The as worked staffing schedule was reviewed

Provider's plan of correction (F 725, continued):

weekly x 2weeks, then monthly and prn. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.

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for the weekend of 2/10/18 (Saturday). According to the CNA (certified nursing assistant) scheduler the following ratio's of staff to resident are as followed:

7-3 (nurses) total of 9 nurses and 11 CNA's with 2 Restorative CNA's.
3-11 (nurses) total of 6 nurses and 11 CNA's
11-7 (nurses) total of 4 nurses and 8 CNA's

For the time period of 2/10/18, the actual as worked staff to resident ratio was as followed:

7-3 (nurses) total of 5 (including the DON) nurses and 8 CNA's including *2 light duty staff
3-11 (nurses) total of 3 nurses and 10 CNA's
11-7 (nurses) total of 6 nurses and 9 CNA's
Census was at 125

* The Administrator described light duty as, "If they have the doctor's paperwork" usually has a limit as to their duties.

Resident #15 was admitted to the facility on 10/4/17 with diagnoses which included, but not limited to, Bipolar disorder, anxiety and diabetes.

Resident #15's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 2/12/18. Resident #15 was coded with a Brief Interview of Mental Status score of "15 out of a possible 15 indicating no cognitive impairment. Resident #15 required standby assistance of one staff member for bed mobility and dressing and toileting.

On 5/9/18 at 2:40 PM, an interview was conducted with Resident #15. He stated,

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"Sometimes on weekends I don't get cleaned up or get the linens changed."

Review of the prior two weeks as worked schedule revealed the following staffing issues:

4/25/18 (Wednesday) Census 121
7-3 Five nurses (down 4)
4/28/18 (Saturday) Census 121
7-3 Five nurses (down 4) Eight CNA's plus one NA (nurse aide, not certified) Down 5
3-11 Five nurses including the DON and six CNA's (down 5)
11-7 Four nurses (down 2) and five CNA's (down 3)
4/26/18 (Sunday) Census 121
7-3 Four nurses including the DON (down 4) Eight CNA's including 1 restorative (down 4)
3-11 Five nurses (down 1) and 9 CNA's (down 2)

On 5/9/18 at 11:09 AM, the Resident Council meeting was held. The majority of the residents attending either complained about the staffing or agreed when other residents complained.

On 5/11/18 at approximately 4:30 PM, the Administrator and DON (director of nursing) were notified of above findings.

Time clock entries were reviewed for the building, and it was noted that on Saturday 3-10-18 there were only 3 LPNs (Licensed Practical Nurses) in the building during the 7:00 a.m. to 3:00 p.m. (8 hours) day shift. One LPN was there for the entire shift. A second LPN worked from 7:00 a.m., to 10:00 a.m. (3 hours), and the third LPN

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F 725	Continued From page 74 worked for only (one hour) on this shift, which was from 2:00 p.m., to 3:00 p.m. In a 130 bed facility, during 2 meals, medications administration, treatments, bathing, and activities. On 3-10-18 evening shift from 3:00 p.m. to 11:00 p.m., there were 2 LPNs on staff who worked the entire shift. There were 2 other LPNs who worked both from 7:00 p.m. to 11:00 p.m.(4 hours each during the second half of the shift), leaving the first half of the shift with only 2 nurses in a 130 bed facility during a meal and evening hours. During the group council interview Residents who attended complained, and stated this insufficient staffing happened often, but most often on the weekends, and it was very difficult to get call bells answered, to get bathed or toileted during these times. COMPLAINT DEFICIENCY	F 725		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.	F 727		6/19/18

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This REQUIREMENT is not met as evidenced by:

Based on staff interview, facility documentation review, and in the course of a complaint investigation, the facility failed to ensure the DON (director of nursing) was not used as a charge nurse in this 130 bed facility.

The DON functioned as a charge nurse on 2/10/18, 4/28/18 and 4/29/18.

The findings included:

The facility staffing was reviewed for the prior two weeks of survey and also on 2/10/18 as a result of multiple complaints of inadequate staffing. Review of the as worked schedule revealed that the DON had worked on at least three occasions (two in the last 2-3 weeks). Further review of the schedule for 2/10/18 revealed that for the 3-11 shift, five nurses were required for the units. Only three were scheduled. Two of the nurses were from agency. Census was 125 residents. On 4/28/18 for 3-11 shift, five nurses were scheduled. Two called out. The DON worked on the unit to cover. On 4/29/18 on the 7-3 shift, three nurses called out. The DON worked to cover the unit.

On 5/11/18 at approximately 2:30 PM, an interview was conducted with the staffing scheduler (CNA-certified nursing assistant). She stated, "I did not know the DON could not be used on the schedule." The DON also stated she was unaware of this.

On 5/11/18 at 3:45 PM, an interview with the facility Administrator was conducted. She stated that staffing had been a "struggle." She stated the facility had done a wage comparison last year

F 727

F727
Director of Nursing (DON) is not currently being utilized as a charge nurse.
Executive Director and nursing leadership team conducted a Quality Review of nursing schedule for the last 30 days to determine RN charge nurse scheduling needs. Follow up based on findings.
Regional Director of Clinical Services/Regional Vice President of Operations provided re-education to Executive Director and Director of Nursing regarding RN charge nurse/DON regulation/standard.
Executive Director/Director of Nursing to conduct Quality improvement Monitoring of nursing schedule for RN charge nurse daily x 2 weeks, weekly x 2 weeks, then monthly and prn. Findings to be reviewed at monthly QAPI Committee Meeting.
Monitoring schedule modified based on findings.

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F 727	Continued From page 76 and that staff received a raise. She also stated a sign up bonus and referral bonus was added. The Administrator was notified of the above findings.	F 727		
F 728 SS=D	Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through	F 728		6/19/18

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F 728	Continued From page 77 satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on employee record review and staff interview, the facility employed an individual as a nurse aide for more than 4 months without confirming competency through completion of a training and competency evaluation program. Employee #16 was employed as a nursing assistant on 2/28/2017. This employee did not pass the competency examination to be a Certified Nursing Assistant (CNA) until 11/22/17. The findings include: During the survey a review of employee #16 personal file was conducted. The review showed employee 16 was hired as a nurse aide on 2/28/2017. The review showed employee #16 did not become a CNA until 11/22/2017 At the end of the day conference on 5/10/2018, the employee record was returned to the Administrator, with a note listing which employee documentation was not found in the record. On 5/11/2018 at 10:10 am, the Administrator returned the employee record to the surveyor and stated "if we found it, it is on the front of the file". The original CNA license verification with an effective date of 11/22/17 remained in the employee file, with no additional documentation provided. The Administrator also stated "we found some more missing documentation, and have already done a plan of correction".	F 728	F728 Employee #16□s competencies are current. Executive Director/Human Resources Director/Designee have conducted a Quality Review of current CNA employee files for competencies complete/current per standard/regulation. Follow up based on findings. Regional Director of Clinical Services provided re-education for Executive Director/Human Resources Director/Director of Nursing regarding employee competencies (CNA) current per standard/regulation. Executive Director/Human Resources Director/Designee to conduct Quality Improvement Monitoring of CNA files for competencies complete/current per standard/regulation weekly x 2 weeks, then monthly and prn. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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F 728	Continued From page 78 No further information was provided prior to exit.	F 728		
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. This REQUIREMENT is not met as evidenced by: Based on interview facility documentation and clinical record review the facility failed for 1 resident (Resident #10) in a survey sample of 41 residents to provide medically related Social Services. For Resident #10 the Social Worker failed to follow up with the Guardian Ad Litem about a psychiatric evaluation dated 3/9/18, in which the Resident was deemed able to make her own decisions. The findings included Resident # 10 a 79 year old female was admitted to the facility on 3/4/17. She was admitted from the hospital post stroke and in need of nursing services. At that time and currently she had a Guardian Ad Litem for medical and financial decision making. On 5/8/18 at 1:00 pm during an interview, Resident #10 stated that she wanted to be closer to her family. She stated she had a family member in [name of nearby city] and wanted to be close so they could visit. She also stated she was trying to get discharged and understood that	F 745	F745 Guardian for resident #10 has been informed of psychiatric evaluation completed on 3/9/18. Social Services Director/Designee conducted a Quality Review of current residents receiving psychiatric services for responsible party notification of services. Follow up based on findings. Executive Director provided Social services Department re-education regarding notification of responsible party when psychiatric services are provided. Social Services Director/Designee to conduct Quality Improvement Monitoring of residents receiving psychiatric services for responsible party notification weekly x2, then monthly and prn. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	6/19/18

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she was admitted after her stroke and couldn't communicate well but now she is better and didn't understand why she couldn't make her own decisions.

Review of document provided by the Director of Nursing (DON) revealed that Resident #10 had Psychiatric evaluation on 3/9/18. The evaluation stated that the reason for evaluation was Request for Capacity evaluation for the resident to make treatment decisions, financial decisions and possible rescinding of the guardianship.

The psychiatrist stated in the evaluation report that Resident #10 is deemed to have capacity to make informed treatment decisions. She is deemed to have the capacity to make decisions regarding her medical care, financial affairs decisions regarding disposition and will not need a surrogate decision maker to assist with such decisions. Please consider rescinding Guardianship.

An interview with Social Worker revealed that the Social Worker had no knowledge of the evaluation done on 3/09/18. When asked the expectation of action once receiving this evaluation she stated the expectation was that upon receiving the document the social worker would contact the Guardian and notify them of the situation and take steps to see about going to court to rescind the guardianship.

Social Worker called the guardian on Speakerphone with survey team present informed guardian of evaluation and stated they would fax a copy to the Guardian. The Guardian stated that Resident #10 has a care plan coming up this week and it would be addressed.

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F 745	Continued From page 80 The facility Administrator was notified at the end of day on 5/11/18 at 5:45 PM. No further information was provided.	F 745		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 755		6/19/18

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F 755	Continued From page 81 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed to ensure medication were available for administration for 3 residents (Resident #30, 471, and #72) of 41 residents in the survey sample. 1. For Resident #30, aspirin and Sucralfate Suspension were unavailable for administration. 2. For Resident #471, facility staff failed to ensure medications were available for administration on 3 consecutive occasions. 3. For Resident # 72, the facility staff failed to provide medications as ordered by the physician. The medications were listed as medication unavailable. The findings included: 1. For Resident #30, aspirin and Sucralfate Suspension were unavailable for administration. Resident #30, a 66 year old, was admitted to the facility on 11/24/17. Diagnoses included chronic obstructive pulmonary disease, reflux, heart disease, pain, depression, seizures, and dysphagia. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 2/27/18. Resident #30 was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment and required limited assistance with activities of daily living.	F 755	F755 Resident□s #30, 471 and 72□s medications have been reconciled and are currently available in medication carts. Director of Nursing/Designee conducted a Quality Review of current resident medication orders/medications available to ensure medications stocked/available for use. Follow up based on findings. Director o Nursing/Designee provided re-education for Licensed Nurses on ensuring medications ordered/available for administration per physician orders. Director of Nursing/Designee to conduct Quality Improvement Monitoring of resident medication orders/ medications stocked ensuring available for administering as ordered weekly X2 then montly. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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The medication pour and pass observation was conducted with Licensed Practical Nurse C (LPN C) on 5/9/18 at 9:27 a.m. LPN C prepared medications for Resident #30. Prior to entering Resident #30's room, LPN C stated that she did not prepare the aspirin or the carafate syrup because it was not available for administration.

Resident #30 had the following physician orders:
1. Aspirin 81 milligram give 1 tablet 1 time per day for heart disease. Order date 11/25/17.
2. Sucralfate Suspension 10 milliliter by mouth four times per day. Order date 11/25/17.

Resident #30's May 2018 Medication Administration Record (MAR) was reviewed. On 5/9/18, the Aspirin was signed with LPN C's initials and the number "9" entered into the signature box. According to the "chart code" the number 9 indicated "Other/ See Nurse Notes". The corresponding nurse note was reviewed. The Aspirin was documented as unavailable in the nurse note.

On 5/9/18, the Sucralfate Suspension was signed with LPN C's initials and the number "9" entered into the signature box. According to the "chart code" the number 9 indicated "Other/ See Nurse Notes". The corresponding nurse note was reviewed. The Sucralfate Suspension was documented as unavailable in the nurse note.

The Facility staff was notified of the medication issues.

2. For Resident #471, facility staff failed to ensure medications were available for administration on

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3 consecutive occasions.

Resident #471 a 60 year old female was admitted to the facility on 5/4/18 with diagnoses of but not limited to Major depressive disorder, Anxiety disorder, End stage renal disease requiring dialysis.

Interview with Resident on 5/10/18 and she stated she was unhappy with the care because she did not get most of her medications on the weekend. She stated they just started giving them all to her on 5/10/18.

Review of the clinical record was conducted on 5/10/2018

Review of the May 2018 Medication Administration Record (MAR) revealed missing documentation of administration of the following medications:

Klonopin 0.5 (mg) milligrams
5/6/2018 at 9:00 AM
5/7/2018 at 9:00 AM
5/7/2018 at 5:00 PM

Nurses Notes dated 5/6/18 stated Awaiting pharmacy will administer when received
Nurses Notes dated 5/6/18 stated On order
Nurses Notes dated 3/7/2018 stated On order

Oxycodone 5 mg Give 1 tablet every 4 hours as needed for pain
5/5/2018 at 6:01 AM
Nurses Note stated awaiting med from pharmacy

Oxycodone HCL 10 mg tablet 1 every 12 hrs for Severe Pain.

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5/6/2018 at 9:00 PM
5/7/2018 at 9:00 AM
Nurses Notes dated 5/6/2018 stated On order
Nurses Notes dated 5/7/2018 stated On order

Midodrine HCL 5 mg tablet give 3 tablets by mouth three times per day for End Stage Renal Disease
5/5/2018 at 9:00 AM

Nurses Notes dated 5/5/18 Awaiting pharmacy will administer once received.

Review of the Stat Box contents revealed the list of medications available included medications listed as not administered because the medication was unavailable .

Oxycodone HCL 5mg

On 5/11/2018 at 2 PM, an interview was conducted with the Director of Nursing (DON) who stated medications should be administered as ordered by the physician. She also stated the nurses were supposed to get the medications from the STAT box if the Resident did not have any more and notify pharmacy and the physician or nurse practitioner to see if there is a substitution they want to order until the med arrives from the pharmacy.

During the end of day debriefing, the facility Administrator, and Corporate Consultant (Admin A and Admin D) were informed of the findings.

No further information provided.

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3. For Resident # 72, the facility staff failed to provide medications as ordered by the physician. The medications were listed as medication unavailable.

Resident #72 was admitted to the facility on 7/11/2017 with the diagnoses of, but not limited to, Major Depressive Disorder, Alzheimer's Disease, Psychosis,Bronchiectasis, Hepatitis A, Chronic Atrial Fibrillation, Gastroesophageal Reflux Disease, and fusion of the spine.

Resident # 72's most recent Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date (ARD) of 4/1/2018. The MDS coded Resident # 72 with a cognitive status of severely impaired; Resident # 72 was coded as independent for Activities of Daily Living except required supervision for hygiene, bathing and dressing; Resident # 72 was coded as always continent of bowel and frequently incontinent of bladder.

On 5/9/2018, review of the clinical record was conducted.

Review of the Progress Notes revealed documentation that medications were not available from the Pharmacy during April 30, 2018 and May 2, 2018.

On 4/30/2018 at 2:52 p.m., eMar (electronic Medication Administration Record) Medication Administration Note: Awaiting arrival from pharmacy

On 4/30/2018 at 10:02 p.m., eMar (electronic Medication Administration Record) Medication Administration Note: Awaiting delivery

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On 5/1/2018 at 6:05 a.m., eMar (electronic Medication Administration Record) Medication Administration Note: Awaiting arrival from pharmacy

On 5/1/2018 at 2:29 p.m., eMar (electronic Medication Administration Record) Medication Administration Note: on order.

On 5/1/2018 at 9:15 p.m., eMar (electronic Medication Administration Record) Medication Administration Note: on order.

On 5/2/2018 at 5:22 p.m., eMar (electronic Medication Administration Record) Medication Administration Note: medication unavailable from pharmacy, no script noted. Dr [-----] aware will administer upon arrival from pharmacy.

Review of the Physicians Orders revealed an order for ABH (Ativan 1 milligrams (mg)/Benadryl 25 milligrams/Haldol 1 milligram) 1 mg/25 mg/1 mg % gel apply to inner wrist topically every morning and bedtime for anxiety. Apply topically as directed every 12 hours.

On 5/10/2018 at 3:25 p.m., an interview was conducted with the Director of Nursing (DON) who stated the nursing staff documented a medication was not available. The DON stated Resident # 72 "often refused the medication and it was not available when the nurse need to administer it." The DON stated the medication that was unavailable was the ABH gel.

The DON stated medications should be available for administration as ordered by the physician. The DON stated the Pharmacy routinely delivered

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medications twice a day at the facility. The DON stated the expectation was that medications should be delivered by the pharmacy during the next delivery after a new order and should be available at the time of scheduled for administration if an existing order. The DON stated she would check the Pharmacy deliver logs to determine when the medication was administered to the facility.

During the end of day debriefing on 5/11/2018, the Facility Administrator, Director of Nursing and Corporate Consultant were informed of the findings. The Director of Nursing stated the Pharmacy should ensure medications are available for administration as ordered by the physician.

No further information was provided.

F 756 SS=E — Drug Regimen Review, Report Irregular, Act On — F 756 — 6/19/18

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

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F 756	Continued From page 88 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, 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 documentation review and clinical record review, the facility staff failed to respond to recommendations written by the Consultant Pharmacist during Monthly Medication Reviews for 8 residents (Residents # 68, # 95, # 27, # 58, # 64, # 72, # 37, and # 1) in a survey sample of 41 residents. 1. For Resident # 68, the facility staff failed to respond to the Pharmacy Consultant recommendations identified on Monthly Medication Reviews. 2. For Resident # 95, the facility staff failed to respond to the Pharmacy Consultant recommendations identified on Monthly	F 756	F756 Consultant Pharmacist recommendations have been addressed for resident□s # 68, 95, 27, 58, 64, 72, 37, and 1. Director of Nursing/Designee to conduct Quality Review of pharmacist recommendations for timely response. Consultant Pharmacist to validate review results. Follow up based on findings. Director of Nursing provided re-education to Licensed Nurses regarding pharmacy recommendation follow up. Director of Nursing/Designee to conduct Quality Improvement Monitoring of pharmacy recommendations for timely response monthly x 3 months, quarterly,	

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F 756	Continued From page 89 Medication Reviews. 3. For Resident # 27, the facility staff failed to respond to the Pharmacy Consultant recommendations identified on Monthly Medication Reviews. 4. For Resident # 58, the facility staff failed to respond to the Pharmacy Consultant recommendations identified on Monthly Medication Reviews. 5. For Resident # 64, the facility staff failed to respond to the Pharmacy Consultant recommendations identified on Monthly Medication Reviews. 6. For Resident # 72, the facility staff failed to respond to the Pharmacy Consultant recommendations identified on Monthly Medication Reviews. 7. For Resident # 37, the facility staff failed to respond to the Pharmacy Consultant recommendations identified on Monthly Medication Reviews. 8. Review of the clinical record revealed that MMR (monthly medication review) were not acted upon for Resident #1. Findings included: 1. For Resident # 68, the facility staff failed to respond to the Pharmacy Consultant recommendations identified on Monthly Medication Reviews. Resident #68 was admitted to the facility on	F 756	then prn. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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F 756	Continued From page 90 4/13/2016 with the diagnoses of, but not limited to, Schizoaffective Disorder, Bipolar Type, Diabetes, Hypertension, Chronic Kidney Disease, Stage 3, Polyarthritis, Gastroesophageal Reflux Disease, Bipolar Disorder , current episode Manic severe with Psychotic Features, and Adult Failure to Thrive. The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 3/31/2018. The MDS coded Resident # 68 with a cognitive status of moderately impaired; Resident # 68 was coded as independent for Activities of Daily Living except required set up only for eating and supervision for bathing; Resident # 68 was coded as always continent of bowel and occasionally incontinent of bladder. Review of the Clinical record revealed no Medication Regimen Review in the clinical record after 3/29/2018. On 5/11/2018 at 2:11 PM, an interview was conducted with the Pharmacy Consultant, Administrator and Director of Nursing. The Pharmacy Consultant (Admin H) stated she started working with the facility in January 2018 and did perform monthly medication reviews. Admin H stated she did not sign the yellow Medical Regimen Review forms located in each resident's records monthly. Admin H stated she did perform the reviews and submitted a copy of the recommendations to the facility each month. Admin H presented copies of Consultation Report forms with Pharmacy Recommendations that were dated on the dates the reviews were completed. Admin H stated the Consultation Report forms were given to the Director of	F 756		

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F 756	Continued From page 91 Nursing each month. Review of the Consultation Reports dated 4/29/18 showed documentation of comment: "REPEATED RECOMMENDATION from 3/29/18: Please respond promptly to assure facility compliance with Federal regulations." REPEATED RECOMMENDATION from 2/22/18: Please respond promptly to assure facility compliance with Federal regulations." [ ] has not had an assessment of renal function within the past six months. No labs seen since 2016. Recommendation: Please consider monitoring serum creatinine on the next convenient lab day and every 6 months thereafter so that appropriate staging can be assigned from the Glomerular Filtration Rate (GFR) and appropriate dosing adjustments can be made based upon estimated creatinine clearance (CrCl). Rationale for Recommendation: It is [ ]'s standard of practice to request a creatinine evaluation every six months due to the higher risk of the population we serve based on recommendations from Kidney Disease: Improving Global Outcomes Work Group 2012 Clinical Practice Guideline for the Evaluation and Management of Chronic Kidney Disease." Review of the clinical record revealed no documentation of the Physician's response to the recommendations. Review of the labs revealed no evidence of labs drawn as recommended. Review of documentation of Consultation Reports dated 2/22/18 and 3/29/18 revealed the same	F 756		

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recommendations listed as above on 4/29/18.

Review of the clinical record revealed no documentation that the Physician or facility staff acted upon the recommendations listed.

2. For Resident # 95, the facility staff failed to respond to the Pharmacy Consultant recommendations identified on Monthly Medication Reviews.

Resident # 95 was admitted to the facility on 3/19/2012 and readmitted on 11/9/2016 with the diagnoses of, but not limited to, Diabetes, Hypertension, Anxiety, Gastroesophageal Reflux Disease, Bipolar Disorder, Alzheimer's Disease and Lipidemia.

The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 4/12/2018. The MDS coded Resident # 95 with a BIMS (Brief Interview for Mental Status) score of 9 indicating moderate impairment; Resident # 95 was coded as requiring supervision and set up assistance for Activities of Daily Living. Resident # 95 was coded as always continent of bowel and occasionally incontinent of bladder.

Review of the clinical record revealed no documentation of a Monthly Medication Review (MRR) since 3/29/2018.

On 5/11/2018 at 2:11 PM, an interview was conducted with the Pharmacy Consultant, Administrator and Director of Nursing. The Pharmacy Consultant (Admin H) stated she started working with the facility in January 2018

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and did perform monthly medication reviews. Admin H stated she did not sign the yellow Medical Regimen Review forms located in each resident's records monthly. Admin H stated she did perform the reviews and submitted a copy of the recommendations to the facility each month. Admin H presented copies of Consultation Report forms with Pharmacy Recommendations that were dated on the dates the reviews were completed. Admin H stated the Consultation Report forms were given to the Director of Nursing each month.

Review of the Consultation Report dated 4/30/2018 stated under Comment:

"REPEATED RECOMMENDATION from 3/29/2018: Please respond promptly to assure facility compliance with Federal regulations.

REPEATED RECOMMENDATION from 2/22/2018: Please respond promptly to assure facility compliance with Federal regulations.

REPEATED RECOMMENDATION from 1/8/2018: Please respond promptly to assure facility compliance with Federal regulations.

REPEATED RECOMMENDATION from 12/4/2017: Please respond promptly to assure facility compliance with Federal regulations.

REPEATED RECOMMENDATION from 11/6/2017: Please respond promptly to assure facility compliance with Federal regulations.

REPEATED RECOMMENDATION from 10/4/2017: Please respond promptly to assure facility compliance with Federal regulations.

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REPEATED RECOMMENDATION from 9/6/2017: Please respond promptly to assure facility compliance with Federal regulations.

REPEATED RECOMMENDATION from 8/4/2017: Please respond promptly to assure facility compliance with Federal regulations.

[ ] has orders for labs to be drawn, but at the time of this review they were not available in the resident record. The missing lab values include:
7/24/17 Mg (Magnesium)
Also, on 10/6/17, recommendations were accepted to do A1c and CMP, but those are not on file.

Recommendation: Unless otherwise indicated, please follow up with th lab and have results forwarded to the facility."

Review of the clinical record revealed no documentation that the Physician or facility staff acted upon the recommendations listed.

3. For Resident # 27, the facility failed to respond to the Pharmacy Consultant recommendations identified on Monthly Medication Reviews.

Resident # 27 was admitted to the facility on 9/27/2013 with the diagnoses of, but not limited to, Diabetes, Hypertension, Polyosteoarthritis, General Anxiety Disorder.

The most recent Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date (ARD) of 2/26/2018. The MDS

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coded Resident # 27 with a BIMS (Brief Interview for Mental Status) of 14/15 indicating no cognitive impairment; Resident # 27 was coded as requiring total assistance of one staff person for Activities of Daily Living.

On 5/9/18 at 4 p.m., Resident # 27's clinical record was reviewed. Review of the Clinical record revealed no Medication Regimen Review after 3/29/2018.

On 5/11/2018 at 2:11 PM, an interview was conducted with the Pharmacy Consultant, Administrator and Director of Nursing. The Pharmacy Consultant (Admin H) stated she started working with the facility in January 2018 and did perform monthly medication reviews. Admin H stated she did not sign the yellow Medical Regimen Review forms located in each resident's records monthly. Admin H stated she did perform the reviews and submitted a copy of the recommendations to the facility each month. Admin H presented copies of Consultation Report forms with Pharmacy Recommendations that were dated on the dates the reviews were completed. Admin H stated the Consultation Report forms were given to the Director of Nursing each month.

Review of the Consultation Report dated 4/30/2018 stated under Comments:

"REPEATED RECOMMENDATION from 3/29/2018: Please respond promptly to assure facility compliance with Federal regulations."

[ ] PRN (as needed) order(s) below have not been used within the precious 90 days.

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1. Guaifenesin liquid
2. Tylenol # 3 (pain levels have all been recorded as zero with the exception of once)

Recommendation: Please consider discontinuing due to lack of use."

Review of documentation of Consultation Report dated 3/29/18 revealed the same recommendations listed as above on 4/30/18.

Review of the clinical record revealed no documentation that the Physician or facility staff acted upon the recommendations listed.

4. For Resident # 58, the facility failed to respond to the Pharmacy Consultant recommendations identified on Monthly Medication Reviews.

Resident # 58 was admitted to the facility on 2/21/2017 with diagnoses of but not limited to Hypertension, Schizophrenia, Intellectual Disability, Insomnia, Osteoporosis, Urinary Tract Infection, Iron Deficiency, fracture of Right Acetabulum, constipation, and edema.

Resident # 58's most recent Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 3/20/2018 coded Resident #58 as having a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. The Minimum Data Set coded Resident #58 as requiring minimal to limited assistance of one staff member for Activities of Daily Living (ADLs) care including requiring minimal assistance of one staff person for Hygiene and limited assistance of one staff member for Bathing. The resident was coded as

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always continent of bowel and occasionally incontinent of bladder.

Review of the clinical record was conducted. Review of the Monthly Medication Review (MRR) form revealed no MRR since 1/29/18.

On 5/11/2018 at 2:11 PM, an interview was conducted with the Pharmacy Consultant, Administrator and Director of Nursing. The Pharmacy Consultant (Admin H) stated she started working with the facility in January 2018 and did perform monthly medication reviews. Admin H stated she did not sign the yellow Medical Regimen Review forms located in each resident's records monthly. Admin H stated she did perform the reviews and submitted a copy of the recommendations to the facility each month. Admin H presented copies of Consultation Report forms with Pharmacy Recommendations that were dated on the dates the reviews were completed. Admin H stated the Consultation Report forms were given to the Director of Nursing each month.

Review of the Consultation Report dated 4/30/2018 stated under Comment:
"REPEATED RECOMMENDATION from 3/29/2018: Please respond promptly to assure facility compliance with Federal regulations.

REPEATED RECOMMENDATION from 2/22/2018: Please respond promptly to assure facility compliance with Federal regulations."

REPEATED RECOMMENDATION from 1/7/2018: Please respond promptly to assure facility compliance with Federal regulations.

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REPEATED RECOMMENDATION from 12/5/2017: Please respond promptly to assure facility compliance with Federal regulations.

[ ] receives quetiapine a medication which may cause involuntary movements including tardive dyskinesia (TD), but an AIMS or DISCUS assessment is not documented in the resident record within the previous 6 months.
Recommendation:
Please consider monitoring for involuntary movements by using one of the available scales (DISCUS, AIMS, etc.) now and then at least every six months thereafter (or per facility protocol). It is recommended that monitoring frequency increase during dosage changes. If symptoms appear, it is recommended that a risk/benefit assessment be completed.

Rationale for Recommendation: Early detection of TD-like symptoms is one of the best opportunities to avoid irreversible tardive dyskinesia. There are several involuntary movement scales (DISCUS, AIMS, etc) utilized to monitor for onset of TD."

Review of documentation of Consultation Reports dated 2/22/18 and 3/29/18 revealed the same recommendations listed as above on 4/30/18.

Review of the clinical record revealed no documentation that the Physician or facility staff acted upon the recommendations listed.

5. For Resident # 64, the facility failed to respond to the Pharmacy Consultant recommendations identified on Monthly Medication Reviews.

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Resident #64 was admitted to the facility on 4/13/2016 with the diagnoses of, but not limited to, Schizoaffective Disorder, Bipolar Type, Diabetes, Hypertension, Chronic Kidney Disease, Stage 3, Polyarthritis, Gastroesophageal Reflux Disease, Bipolar Disorder, current episode Manic severe with Psychotic Features, and Adult Failure to Thrive.

The most recent Minimum Data Set (MDS) was a Significant Change Assessment with an Assessment Reference Date (ARD) of 3/15/2018. The MDS coded Resident # 64 with a BIMS (Brief Interview for Mental Status) score of 3/15 indicating severe cognitive impairment; Resident # 64 was coded as requiring limited to total assistance of one staff member for Activities of Daily Living except required supervision and set up only for eating; Resident # 64 was coded as always continent of bowel and an indwelling catheter for bladder.

Review of the clinical record was conducted. Review of the Medication Regimen Reviews (MRR) revealed no signature for MRR since 3/29/2018.

On 5/11/2018 at 2:11 PM, an interview was conducted with the Pharmacy Consultant, Administrator and Director of Nursing. The Pharmacy Consultant (Admin H) stated she started working with the facility in January 2018 and did perform monthly medication reviews. Admin H stated she did not sign the yellow Medical Regimen Review forms located in each resident's records monthly. Admin H stated she did perform the reviews and submitted a copy of the recommendations to the facility each month.

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Admin H presented copies of Consultation Report forms with Pharmacy Recommendations that were dated on the dates the reviews were completed. Admin H stated the Consultation Report forms were given to the Director of Nursing each month.

Review of the Consultation Report dated 4/30/2018 stated:
"REPEATED RECOMMENDATION from 3/29/2018: Please respond promptly to assure facility compliance with Federal regulations."

REPEATED RECOMMENDATION from 2/22/2018: Please respond promptly to assure facility compliance with Federal regulations."

"REPEATED RECOMMENDATION from 1/7/2018: Please respond promptly to assure facility compliance with Federal regulations."

[ ] has not had a CBC (Complete Blood Count) nor CMP (Comprehensive Metabolic Profile in the past 6 months.

Recommendation: Please consider monitoring CBC and CMP on the next convenient lab day and every 6 months thereafter."

Review of documentation of Consultation Reports dated 2/22/18 and 3/29/18 revealed the same recommendations listed as above on 4/30/18.

Review of the clinical record revealed no documentation that the Physician or facility staff acted upon the recommendations listed.

6. For Resident # 72, the facility failed to

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respond to the Pharmacy Consultant recommendations identified on Monthly Medication Reviews.

Resident #72 was admitted to the facility on 7/11/2017 with the diagnoses of, but not limited to, Major Depressive Disorder, Alzheimer's Disease, Psychosis,Bronchiectasis, Hepatitis A, Chronic Atrial Fibrillation, Gastroesoaphaeal Reflux Disease, and fusion of the spine.

The most recent Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date (ARD) of 4/1/2018. The MDS coded Resident # 72 with a cognitive status of severely impaired; Resident # 72 was coded as independent for Activities of Daily Living except required supervision for hygiene, bathing and dressing; Resident # 72 was coded as always continent of bowel and frequently incontinent of bladder.

Review of the clinical record was conducted. Review of the Medication Regimen Reviews (MRR) revealed no signature for MRR since 3/29/2018.

On 5/11/2018 at 2:11 PM, an interview was conducted with the Pharmacy Consultant, Administrator and Director of Nursing. The Pharmacy Consultant (Admin H) stated she started working with the facility in January 2018 and did perform monthly medication reviews. Admin H stated she did not sign the yellow Medical Regimen Review forms located in each resident's records monthly. Admin H stated she did perform the reviews and submitted a copy of the recommendations to the facility each month. Admin H presented copies of Consultation Report

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forms with Pharmacy Recommendations that were dated on the dates the reviews were completed. Admin H stated the Consultation Report forms were given to the Director of Nursing each month.

Review of the Consultation Report dated 4/29/2018 stated:

"REPEATED RECOMMENDATION from 3/29/2018: Please respond promptly to assure facility compliance with Federal regulations."

[ ] has not had an assessment of renal function within the past six months.

Recommendation: Please consider monitoring serum creatinine on the next convenient lab day and every 6 months thereafter so that appropriate staging can be assigned from the Glomerular Filtration Rate (GFR) and appropriate dosing adjustments can be made based upon estimated creatinine clearance (CrCl).
Rationale for Recommendation: It is [ ]'s standard of practice to request a creatinine evaluation every six months due to the higher risk of the population we serve based on recommendations from Kidney Disease: Improving Global Outcomes Work Group 2012 Clinical Practice Guideline for the Evaluation and Management of Chronic Kidney Disease."

Review of documentation of Consultation Reports dated 3/29/18 revealed the same recommendations listed as above on 4/29/18.

Review of the clinical record revealed no documentation that the Physician or facility staff acted upon the recommendations listed.

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7. For Resident # 37, the facility failed to respond to the Pharmacy Consultant recommendations identified on Monthly Medication Reviews.

Resident # 37 was admitted to the facility on 4/10/2014 with diagnoses of but not limited to Paranoid Schizophrenia, Cerebral Infarction, Major Depressive Disorder, Hemiplegia, Chronic Embolism, General Anxiety Disorder, Contracture to left ankle and left foot. and Gastroesophageal Reflux Disease

Resident # 37's most recent Minimum Data Set (an assessment protocol) was coded as a Quarterly Assessment with an Assessment Reference Date of 3/1 /2018. Resident # 37 was coded as having a BIMS (Brief Interview for Mental Status) score of 14/15 indicating no cognitive impairment. The Minimum Data Set coded Resident # 37 as requiring extensive to total assistance of one to two staff members for Activities of Daily Living (ADLs) care except requiring Supervision and set up for eating. The resident was coded as always incontinent of bowel and bladder.

Review of the clinical record was conducted. Review of the Medication Regimen Reviews (MRR) revealed no signature for MRR since 1/7/2018.

On 5/11/2018 at 2:11 PM, an interview was conducted with the Pharmacy Consultant, Administrator and Director of Nursing. The Pharmacy Consultant (Admin H) stated she started working with the facility in January 2018 and did perform monthly medication reviews.

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F 756	Continued From page 104 Admin H stated she did not sign the yellow Medical Regimen Review forms located in each resident's records monthly. Admin H stated she did perform the reviews and submitted a copy of the recommendations to the facility each month. Admin H presented copies of Consultation Report forms with Pharmacy Recommendations that were dated on the dates the reviews were completed. Admin H stated the Consultation Report forms were given to the Director of Nursing each month. Review of the Consultation Report dated 4/30/2018 stated under Comment: "REPEATED RECOMMENDATION from 3/29/2018: Please respond promptly to assure facility compliance with Federal regulations. REPEATED RECOMMENDATION from 2/22/2018: Please respond promptly to assure facility compliance with Federal regulations." REPEATED RECOMMENDATION from 1/7/2018: Please respond promptly to assure facility compliance with Federal regulations. REPEATED RECOMMENDATION from 12/5/2017: Please respond promptly to assure facility compliance with Federal regulations. [ ] receives Olanzapine, a medication which may cause involuntary movements including tardive dyskinesia (TD), but an AIMS or DISCUS assessment is not documented in the resident record within the previous 6 months. Recommendation: Please consider monitoring for involuntary movements by using one of the available scales	F 756		

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(DISCUS, AIMS, etc.) now and then at least every six months thereafter (or per facility protocol). It is recommended that monitoring frequency increase during dosage changes. If symptoms appear, it is recommended that a risk/benefit assessment be completed.

Rationale for Recommendation: Early detection of TD-like symptoms is one of the best opportunities to avoid irreversible tardive dyskinesia. There are several involuntary movement scales (DISCUS, AIMS, etc) utilized to monitor for onset of TD."

Review of documentation of Consultation Reports dated 2/22/18 and 3/29/18 revealed the same recommendations listed as above on 4/30/18. Review of the clinical record revealed no documentation that the Physician or facility staff acted upon the recommendations listed.

8. Review of the clinical record revealed that MMR (monthly medication review) were not acted upon for Resident #1.

Resident #1 was admitted to the facility on 2/25/16 with diagnoses which included, but not limited to, Multiple Sclerosis, seizure disorder and paranoid schizophrenia.

Resident #1's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 4/29/18. Resident #1 was coded with a Brief Interview of Mental Status score of "15 out of a possible 15 indicating no cognitive impairment. Resident #1 required total assistance of one to

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F 756	Continued From page 106 two staff members for bed mobility and dressing and toileting. Review of the monthly medication review for March, 2018, indicated that the "resident's prn (as needed) Benadryl orders had not been used in the last 60 days. Please consider discontinuing due to lack of use." There was no physician or DON (director of nursing) signatures to document these recommendations had been reviewed. The following month (April) recommendations were the same as the previous month. On 5/11/2018 at 2:11 PM, an interview was conducted with the Pharmacy Consultant, Administrator and Director of Nursing. The Pharmacy Consultant (Admin H) stated she started working with the facility in January 2018 and did perform monthly medication reviews. Admin H stated she did not sign the yellow Medical Regimen Review forms located in each resident's records monthly. Admin H stated she did perform the reviews and submitted a copy of the recommendations to the facility each month. The DON (director of nursing and Administrator were present during the interview.	F 756		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to ensure four residents	F 760	F760 Resident□s # 108, 2, 10, and 102 have been assessed by physician post receipt	6/19/18

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F 760	Continued From page 107 (Resident #108, 2, 10, and #102) were free from significant medication errors. 1. For Resident #108, expired Humulin R Insulin was administered on four occasions in May 2018. 2. For Resident # 2, expired Latanoprost (glaucoma eye drops) was administered on seven occasions in May 2018. 3. For Resident # 10, the facility staff failed to ensure medications were available for administration as ordered by the physician. 4. For Resident #102 the facility staff failed to provide fingerstick blood sugars, and insulin, per physician's orders. The findings included: 1. For Resident #108, expired Humulin R Insulin was administered on four occasions in May 2018. Resident #108, a 67 year old, was admitted to the facility on 4/24/17. Diagnoses included seizures, diabetes, anemia, kidney failure, depression, anxiety, and schizoaffective disorder. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 4/24/18. She was coded with a Brief Interview of Mental Status score of 15 indicting no cognitive impairment and required limited assistance with activities of daily living. Resident #108 had a physician order dated 4/26/17 for Humulin R insulin. The insulin was to be administered on a sliding scale basis The bottle of Humulin R on the medication cart	F 760	of expired medication. No adverse effects noted. Director of Nursing/Designee conducted Quality Review of Medication Stock to ensure medications are within current date. Consultant Pharmacist to validate results of review. Follow up based on findings. Director of Nursing/Designee provided re-education to Licensed Nurses regarding medication administration/medication expiration. Director of Nursing/ Designee validated Licensed Nurse Competency via med pass observation. Director of Nursing/Designee to conduct Quality Improvement Monitoring of medication stock ensuring within current date 5x/week x 2weeks, weekly x 2weeks, then monthly and prn. Findings to be reviewed at monthly QAPI Committee Meeting. Follow up based on findings.	

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was dated 3/20/18. Included on the bottle was a label with the direction to discard the bottle 28 days after it was opened. The bottle should have been discarded on 4/17/18.

According to Resident #108's May 2018 Medication Administration Record, the Humulin R was administered on 5/4/18, twice on 5/6/18, 5/7/18, and 5/8/18.

On 5/8/18 at 3:00 p.m., Licensed Practical Nurse G was asked if there was another bottle of Humulin R on the cart for Resident #108. He stated that no replacement bottle was on the cart. He also stated that Resident #108 doesn't use the Humulin R much because her blood sugars do not run that high.

2. For Resident # 2, expired Latanoprost (glaucoma eye drops) was administered on seven occasions in May 2018.

Resident #2, a 66 year old, was admitted to the facility on 9/15/17. Diagnoses included convulsions, osteoporosis, bipolar, anxiety, dementia, schizophrenia, hyperlipidemia, hypertension, glaucoma, and major depression.

The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 1/31/18. She was coded with a Brief Interview of Mental Status score of 6 indicting severe cognitive impairment and required limited assistance with activities of daily living.

Resident #2 had a physician order dated 9/15/16 for Latanoprost 0.0005% solution, 1 drop in left

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eye at bedtime for glaucoma.

The bottle of Latanoprost on the medication cart was dated 2/27/18. Included on the bottle was a label with the direction to discard the bottle 42 days after it was opened. The bottle should have been discarded on 4/11/18.

According to Resident #2's May 2018 Medication Administration Record, the Latanoprost was administered daily from 5/1/18- 5/7/18.

On 5/8/18 at 3:00 p.m., Licensed Practical Nurse G was asked if there was another bottle of Latanoprost on the cart for Resident #2. He stated that no replacement bottle was on the cart. He also stated that Resident #2 often refused the medication.

During the review of the medications on the medication cart, the Corporate Nurse (Admin D) was asked to observe the expired medications. She agreed that they should have been discarded.

All of the issues with expired medications were reviewed with the Administrator on 5/9/18 at 7:55 a.m. The Administrator stated that after the survey team identified issues with expired medications, all medications were checked by facility administration on the evening of 5/8/18.

3. For Resident # 10, the facility staff failed to ensure medications were available for administration as ordered by the physician.

Resident # 10 a 79 year old female was admitted to the facility on 3/4/17 with diagnoses that included but not limited to Epilepsy. A review of

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Resident #10's clinical record showed an physician order for Keppra 500 milligrams (mg) twice a day.

According to nurses notes Resident #10 was not given two doses. The notes read:

On 5/9/18 at 7:27 PM waiting for med from pharmacy.

On 5/10/18 @ 3:19 PM pharmacy stated the med was being "STAT" and the NP (nurse practitioner) was notified. The NP stated to wait for pharmacy to bring it there and there was nothing to be given in place of it because what is needed is suspension form.

An interview was conducted with LPN D. LPN D stated, "I did not give the med because we are out of it and there is none in the stat box. I did let the NP know and she didn't give me any new orders."

Review conducted on 5/10/18 of the Stat Box contents showed that Keppra was not stocked in the stat box.

The administration was made aware at end of day meeting on 5/10/18. No further information was provided.

4. For Resident #102 the facility staff failed to provide fingerstick blood sugars, and insulin, per physician's orders.

Resident #102 was admitted to the facility on 1-28-15. Diagnoses included; Neoplasm of tongue, chronic post traumatic stress disorder,

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schizophrenia, depression anxiety, dysphagia, diabetes, and Parkinson's disease.

Resident #102's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an assessment reference date (ARD) of 4-19-18. The Resident was coded with a Brief Interview of Mental Status score of 8 indicating moderate cognitive impairment and required supervision and set up assistance only for activities of daily living.

Review of Resident #102's MAR (medication administration record) revealed no evidence that the following insulin order was administered on 5-3-18, and 5-5-18, at 6:30 a.m.. There were no nursing notes on these days to describe why the insulin was omitted.

1. Humalog solution 100 units per milliliter, inject as per sliding scale:
If FSBS 200 - 249 give 2 units.
If FSBS 250 - 300 give 4 units.
If FSBS 301 - 349 give 6 units.
If FSBS 350 - 400 give 8 units.

Further review of Resident #102's MAR record revealed no evidence that the following FSBS order was administered on 5-3-18, and 5-5-18, at 6:30 a.m, and there were no nursing notes on these days to describe why the FSBS was omitted.

On 5-3-18 at 6:00 p.m, the Resident's blood sugar was 314, and on 5-8-18 at 6:30 a.m, the Residents blood sugar was 327. There were no nursing notes on these days to describe why the doctor was not notified of the high blood sugars per the order below.

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2. Accucheck (FSBS) finger stick blood sugar 2 times per day related to diabetes notify MD (doctor) if blood sugar is less than 60 or greater than 300. Ordered on 8-30-17 and was a current order.

There was a second order for FSBS written exactly as the order above, with the exception of the indications to call the doctor. That order read notify MD (doctor) if blood sugar is less than 60 or greater than 400. That order was dated 8-31-17, and was a current order. None of the nursing staff had questioned these conflicting orders since August of 2017 (8 + months) and clarified the orders.

Valid physician's orders were evident for the insulin and FSBS in question.

Review of the facility's policy entitled "Insulin Administration" included:

"Check the MAR for order 3 times", and "Document in medical record". MAR (medication administration record). according to policy."

The Corporate RN (registered Nurse consultant) stated on 5-10-18 at 4:00 p.m., the expectation was for the staff to document medications when they are administered, on the eMAR (electronic MAR).

At the end of day meeting on 5-10-18, and 5-11-18 the lack of insulin and FSBS administration for Resident #102 was discussed with the Administrator, corporate RN, and Director of Nursing. The Administrator stated the medication administration error was "it is, what it

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F 760	Continued From page 113 is". No further information was provided.	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed to ensure expired medications were not available for administration for three residents (Resident #108, #2, and #117) and failed to ensure a multidose vial of Tuberculin was not available for administration on 1 of 3 units.	F 761	F761 Resident□s #108, 2, and 117 medications are currently available and within current date. Tuberculin multidose vial is stocked and available for use on 3/3 units. Director of Nursing/Designee conducted Quality Review of medication stock to	6/19/18

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F 761	Continued From page 114 1. For Resident #108, an expired vial of Humulin R Insulin was available for use on the medication cart. 2. For Resident # 2, an expired bottle of Latanoprost (glaucoma eye drops) was available for use on the medication cart. 3. For Resident #117, two expired Novolog Flexpens (insulin) were available for use on the medication cart. 4. An expired vial of Tuberculin was available for use on the Freedom Unit. The findings included: 1. For Resident #108, an expired vial of Humulin R insulin was available for use on the medication cart. Resident #108, a 67 year old, was admitted to the facility on 4/24/17. Diagnoses included seizures, diabetes, anemia, kidney failure, depression, anxiety, and schizoaffective disorder. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 4/24/18. She was coded with a Brief Interview of Mental Status score of 15 indicting no cognitive impairment and required limited assistance with activities of daily living. Resident #108 had a physician order dated 4/26/17 for Humulin R insulin. The insulin was to be administered on a sliding scale basis. The bottle of Humulin R on the medication cart was dated 3/20/18. Included on the bottle was a label with the direction to discard the bottle 28 days after it was opened. The bottle should have been discarded on 4/17/18.	F 761	ensure medications available for administration and within current date. Follow up based on findings. Director of Nursing/Designee provided re-education for Licensed Nurses regarding medication storage/administration standard/regulation. Director of Nursing/Designee to conduct Quality Improvement Monitoring of medication stock ensuring within current date and available for administration 5x/week x 2 weeks, weekly x 2 weeks, monthly x 2 months then quarterly and prn. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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Continued From page 115

According to Resident #108's May 2018 Medication Administration Record, the Humulin R was administered on 5/4/18, twice on 5/6/18, 5/7/18, and 5/8/18.

On 5/8/18 at 3:00 p.m., Licensed Practical Nurse G was asked if there was another bottle of Humulin R on the cart for Resident #108. He stated that no replacement bottle was on the cart. He also stated that Resident #108 doesn't use the Humulin R much because her blood sugars do not run that high.

2. For Resident # 2, an expired bottle of Latanoprost (glaucoma eye drops) was available for use on the medication cart.

Resident #2, a 66 year old, was admitted to the facility on 9/15/17. Diagnoses included convulsions, osteoporosis, bipolar, anxiety, dementia, schizophrenia, hyperlipidemia, hypertension, glaucoma, and major depression.

The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 1/31/18. She was coded with a Brief Interview of Mental Status score of 6 indicting severe cognitive impairment and required limited assistance with activities of daily living.

Resident #2 had a physician order dated 9/15/16 for Latanoprost 0.0005% solution, 1 drop in left eye at bedtime for glaucoma.

The bottle of Latanoprost on the medication cart was dated 2/27/18. Included on the bottle was a

F 761 Continued From page 116 F 761

label with the direction to discard the bottle 42 days after it was opened. The bottle should have been discarded on 4/11/18.

According to Resident #2's May 2018 Medication Administration Record, the Latanoprost was administered daily from 5/1/18- 5/7/18.

On 5/8/18 at 3:00 p.m., Licensed Practical Nurse G was asked if there was another bottle of Latanoprost on the cart for Resident #2. He stated that no replacement bottle was on the cart. He also stated that Resident #2 often refused the medication.

3. For Resident #117, two expired Novolog Flexpens (insulin) were available for use on the medication cart.

Resident #117, a 53 year old, was admitted to the facility on 3/31/18. Diagnoses included insomnia, asthma, breast cancer, dysphagia, and diabetes.

The most recent Minimum Data Set assessment was an annual assessment with an assessment reference date of 4/27/18. She was coded with a Brief Interview of Mental Status score of 15 indicting no cognitive impairment and required extensive assistance with activities of daily living.

Resident #117 had a physician order date 4/10/18 for Insulin Aspart Solution (Novolog Flexpen) inject per sliding scale.

Three Novolog flex pens were available for use on the medication cart for Resident #117. The pens were dated as opened on 4/2/18, 4/5/18 and 4/13/18. There were to be discarded in 28 days

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after use. Only pen dated 4/13/18 was still within the 28 day usage period.

According to Resident #117's May 2018 Medication Administration Record, a Novolog flexpen was used on 14 times to administer insulin between 5/1/18- 5/7/18. It is unclear which pen was used to administer the insulin.

On 5/8/18 at 3:00 p.m., Licensed Practical Nurse G stated that the Novolog flexpen was a current order for Resident #117.

During the review of the medication on the medication cart, the Corporate Nurse was asked to observe the expired medications. She agreed that they should have been discarded.

4. An expired vial of Tuberculin was available for use on the Freedom Unit.

On 5/8/18 at 1:35 p.m., the medication room on the Freedom Unit was observed with Licensed Practical Nurse E. A bottle of Tuberculin dated 3/15/18 was available for use. When asked what the expiration of an opened bottle of Tuberculin was, Licensed Practical Nurse E stated "I think it is 30 days." The tuberculin was not discarded at the time of observation. It was put back into the refrigerator for use.

All of the issues with expired medications were reviewed with the Administrator on 5/9/18 at 7:55 a.m. The Administrator stated that after the survey team identified issues with expired medications, all medications were checked by facility administration on the evening of 5/8/18.

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F 803	Continued From page 118	F 803		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview and clinical record review, the facility staff failed to ensure one resident, Resident # 15 in a survey sample of 41 residents, to meet the resident's nutritional needs. Resident #15 complained he was not getting double portions for meals as he has requested.	F 803	F 803 Resident #15 re-evaluated by Registered Dietician/Dietary Manager, current meals provided meet resident□s nutritional needs. Registered Dietician/Designee conducted a Quality Review of current residents to ensure meals meet resident□s nutritional	6/19/18

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F 803	Continued From page 119 The findings included: Resident #15 was admitted to the facility on 10/4/17 with diagnoses which included, but not limited to, Bipolar disorder, anxiety and diabetes. Resident #15's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 2/12/18. Resident #15 was coded with a Brief Interview of Mental Status score of "15 out of a possible 15 indicating no cognitive impairment. Resident #15 required standby assistance of one staff member for bed mobility and dressing and toileting. On 5/8/18 at approximately 11:30 AM, Resident #15 was observed in his room, lying in bed. The resident stated, "The food is not good and I am supposed to get double portions, but it's not enough." 5/9/18 at 2:40 PM: Resident complained at this time and on tour the day before of not getting enough to eat. He is 84 inches in height and currently weighs 461.8 pounds. Has had a 9.4 % weight gain since admission. Has asked for double portions, stated he is not receiving double portions. Stated he is "starving" every morning. 05/10/18 at 12:41 PM: Resident # 15 observed in room, had finished his lunch tray, was unable to verify the amount of food on the plate. Resident informed will check at breakfast. A clinical record review on 05/11/18 at 9:00 AM showed Resident #15 is to get double portions. Received egg omelet, one strip of bacon, one	F 803	needs. Follow up based on findings. Registered Dietician provided re-education to Dietary Staff regarding preparation of meals as ordered to meet resident needs. Director of Nursing provided re-education to Nursing Staff regarding providing resident meals as recommended to meet resident□s nutritional needs. Director of Nursing/Registered Dietician/Designee to conduct Quality Improvement Monitoring of resident meal provided to ensure meeting nutritional needs weekly x 2 weeks, monthly x 2 months, then quarterly and prn. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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F 803	Continued From page 120 piece of toast, oatmeal and juice. Resident #15 was not satisfied with the meal or the portions. On 5/11/18 at approximately 11:45 AM, the Administrator and DON (director of nursing) were notified of above findings.	F 803		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to provide a physician ordered therapeutic diet for 1 resident (Resident #102) of the 41 residents in the survey sample. Resident #102 was served a regular diet tray on 5-8-18 at lunch time in the dining room, when a mechanical soft diet was ordered. The findings included: Resident #102 was admitted to the facility on 1-28-15. Diagnoses included; Neoplasm of tongue, chronic post traumatic stress disorder, schizophrenia, depression anxiety, dysphagia, diabetes, and Parkinson's disease.	F 808	F808 Resident #1 currently receives physician ordered therapeutic diet. Director of Nursing/Designee conducted Quality Review of current residents during meal time to ensure receiving physician ordered therapeutic diet. Follow up based on findings. Director of Nursing/Designee provided re-education to Nursing Staff/Dinning Room staff regarding ensuring residents receive physician ordered therapeutic diet. Director of Nursing/Designee to conduct Quality Improvement Monitoring of resident�s meals ensuring receipt of physician ordered therapeutic diet 5x/week x 2 weeks, weekly x 4 weeks, monthly and prn. Findings to be reviewed	6/19/18

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F 808	Continued From page 121	F 808		

Resident #102's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an assessment reference date (ARD) of 4-19-18. The Resident was coded with a Brief Interview of Mental Status score of 8 indicating moderate cognitive impairment and required supervision and set up assistance only for activities of daily living.

On 5-8-18 at 12:15 p.m. The main dining room in the front of the facility was observed during lunch. Resident #102 was observed sitting across from the only other Resident at the table, who was a female, and both were eating. Resident #102 had nectar thickened milk, whole sliced turkey breast, turkey stuffing, applesauce, cooked whole yellow squash slices, a slice of white bread, and a bowl of bean soup. The Resident consumed 100% of the soup, and applesauce, and left 2 pieces of squash, one half of the bread slice, a spoonful of the stuffing, and one half slice of the 2 slices of turkey breast he received. The other Resident at the table consumed 100% of her meal. Resident #102 had a tray card under his plate, and it was reviewed after he was finished and exited the dining room. The tray card specified the diet order and stated "3 OZ (ounces) ground roast turkey".

On 5-8-18 the Resident's physician's orders were reviewed and revealed a diet order for "Consistent carbohydrate, mechanical soft diet texture with nectar thickened liquids."

The Resident's weight document was reviewed and revealed no significant weight loss.

During the lunch observation surveyors were approached by the Administrator and she was

Provider's plan of correction (F 808):

at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.

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F 808	Continued From page 122 shown the half slice of whole turkey Breast left on the tray, and she stated "That's not right." The other Resident was still sitting at the table with her finished tray in front of her. At the end of day meeting on 5-10-18, the incorrect diet for Resident #102 was discussed with the Administrator and Director of Nursing. The Administrator stated she had spoken with the kitchen staff about the issue. No further information was provided.	F 808		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §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 the facility staff failed to store food in accordance with professional standards for food service safety.	F 812	F812 Two ice machine drainage pipes were repaired to enable air gap in accordance	6/19/18

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F 812	Continued From page 123 The drainage pipe on the kitchen ice machine was inserted directly into the pipe connected to the floor drain. An air gap was not in place to prevent contamination from the back flow of water. The findings included: The ice machine in the main kitchen was observed on 5/8/18 at 12:15 p.m. The Dietary Manager was present during the observation. It appeared that the drainage pipe went into the wall. An air gap was not visible. On 5/9/18 at 8:00 a.m., the kitchen ice machine was observed in the presence of the Administrator and Assistant Maintenance staff (Employee A). After clearing the area so that the back of the ice machine was visible, the drainage pipe from the ice machine was observed to be inserted into a black rubber funnel that was fitted onto a drainage pipe in the wall. There was no air gap in place. Both the Administrator and Employee A agreed that the kitchen ice machine drainage pipe was inserted into the black rubber funnel that was connected to the pipe leading to the floor drain. Employee E stated that he understood the issue. No further information was provided.	F 812	with professional standards for food service safety. Executive Director/Designee conducted Quality Review of kitchen equipment to ensure meet professional standard for food service safety. Follow up based on findings. There is no other ice machine in the facility. Eexecutive Director, Maintenance Director /Maintenance Staff and Dietary Manager re-education regarding kitchen equipment in accordance with professional standards for food service safety. Maintenance Director to conduct Quality Improvement monitoring of kitchen equipment ensuring in accordance with professional standards for food service safety monthly and prn. Findings to be reported at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is	F 842		6/19/18

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F 842	Continued From page 124	F 842		

resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

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

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

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

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F 842	Continued From page 125 §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for 13 residents (Residents # 68, # 95, # 27, # 58, # 64, # 72, # 37, #112, #100, #40, #119, #18, and #81) in a survey sample of 41 residents. 1. For Resident # 68, the facility staff failed to ensure the Monthly Medication Reviews forms was signed monthly. There was no signature after 3/29/2018. 2. For Resident # 95, the facility staff failed to ensure the Monthly Medication Reviews forms was signed monthly. There was no signature after 3/29/2018.	F 842	F842 Pharmacy Report received validating review of residents #68, 95, 27, 58, 64, 72, 37, 112, 100, 40, 18, and 81. Resident #119 was discharged to ALF as planed. Pharmacist completed focus visit updating Monthly Medication Review forms for residents #68, 95, 27, 58, 64, 72, 37, 112,100, 40, 18, and 81. Director of Nursing/Designee conducted Quality Review of current resident records for accurate up to date Monthly Medication Review forms. Follow up based on findings. Regional Director of Clinical Services/Executive Director provided	

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F 842	Continued From page 126 3. For Resident # 27, the facility staff failed to ensure the Monthly Medication Reviews forms was signed monthly. There was no signature after 3/29/2018. 4. For Resident # 58, the facility staff failed to ensure the Monthly Medication Reviews forms was signed monthly. There was no signature after 1/7/2018. 5. For Resident # 64, the facility staff failed to ensure the Monthly Medication Reviews forms was signed monthly. There was no signature after 3/29/2018. 6. For Resident # 72, the facility staff failed to ensure the Monthly Medication Reviews forms was signed monthly. There was no signature after 3/29/2018. 7. For Resident # 37, the facility staff failed to ensure the Monthly Medication Reviews forms was signed monthly. There was no signature after 1/7/2018. 8. For Residents #112, #100, #40, #119, #18, and #81, facility staff failed to maintain an accurate record of Medication Regimen Reviews. Findings included: 1. For Resident # 68, the facility staff failed to ensure the Monthly Medication Reviews forms was signed monthly. There was no signature after 3/29/2018.	F 842	re-education to Director of Nursing and Consultant Pharmacist regarding signing Monthly Medication Review form in resident record and standard/regulation for accurate medical record. Director of Nursing/Designee to conduct Quality Review of resident records for complete/accurate Monthly Medication Review forms post consultant pharmacist visit monthly x 3 months, then quarterly and prn. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.	

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Resident #68 was admitted to the facility on 4/13/2016 with the diagnoses of, but not limited to, Schizoaffective Disorder, Bipolar Type, Diabetes, Hypertension, Chronic Kidney Disease, Stage 3, Polyarthritis, Gastroesophageal Reflux Disease, Bipolar Disorder , current episode Manic severe with Psychotic Features, and Adult Failure to Thrive.

The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 3/31/2018. The MDS coded Resident # 68 with a cognitive status of moderately impaired; Resident # 68 was coded as independent for Activities of Daily Living except required set up only for eating and supervision for bathing; Resident # 68 was coded as always continent of bowel and occasionally incontinent of bladder.

On 5/11/2018 at 2:11 PM, an interview was conducted with the Pharmacy Consultant, Administrator and Director of Nursing. The Pharmacy Consultant (Admin H) stated she started working with the facility in January 2018 and did perform monthly medication reviews. Admin H stated she did not sign the yellow Medical Regimen Review forms located in each resident's records monthly. Admin H stated she did perform the reviews and submitted a copy of the recommendations to the facility each month. Admin H presented copies of Consultation Report forms with Pharmacy Recommendations that were dated on the dates the reviews were completed. Admin H stated the Consultation Report forms were given to the Director of Nursing each month.

The Pharmacy Consultant and Director of

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Nursing presented copies of Monthly Medication Review forms signed for Resident # 68 and dated 5/11/2018 as a "late entry" along with the date the review was actually done.

The Pharmacy Consultant stated she would sign the Medication Regimen Review forms monthly in the future. The Administrator stated the clinical record should be accurate.

During the end of day debriefing on 5/11/2018, the Administrator, Director of Nursing and Corporate Consultant were informed of the findings.

No further information was provided.

2. For Resident # 95, the facility staff failed to ensure the Monthly Medication Reviews forms was signed monthly. There was no signature after 3/29/2018.

Resident # 95 was admitted to the facility on 3/19/2012 and readmitted on 11/9/2016 with the diagnoses of, but not limited to, Diabetes, Hypertension, Anxiety, Gastroesophageal Reflux Disease, Bipolar Disorder, Alzheimer's Disease and Lipidemia.

The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 4/12/2018. The MDS coded Resident # 95 with a BIMS (Brief Interview for Mental Status) score of 9 indicating moderate impairment; Resident # 95 was coded as requiring supervision for Activities of Daily Living. Resident # 95 was coded as always continent of bowel and occasionally incontinent of bladder.

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F 842	Continued From page 129 Review of the clinical record revealed no documentation of a Monthly Medication Review (MRR) since 3/29/2018. On 5/11/2018 at 2:11 PM, an interview was conducted with the Pharmacy Consultant, Administrator and Director of Nursing. The Pharmacy Consultant (Admin H) stated she started working with the facility in January 2018 and did perform monthly medication reviews. Admin H stated she did not sign the yellow Medical Regimen Review forms located in each resident's records monthly. Admin H stated she did perform the reviews and submitted a copy of the recommendations to the facility each month. Admin H presented copies of Consultation Report forms with Pharmacy Recommendations that were dated on the dates the reviews were completed. Admin H stated the Consultation Report forms were given to the Director of Nursing each month. The Pharmacy Consultant and Director of Nursing presented copies of Monthly Medication Review forms signed for Resident # 95 and dated 5/11/2018 as a "late entry" along with the date the review was actually done. The Pharmacy Consultant stated she would sign the Medication Regimen Review forms monthly in the future. The Administrator stated the clinical record should be accurate. During the end of day debriefing on 5/11/2018, the Administrator, Director of Nursing and Corporate Consultant were informed of the findings.	F 842		

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No further information was provided.

3. For Resident # 27, the facility staff failed to ensure the Monthly Medication Reviews forms was signed monthly. There was no signature after 3/29/2018.

Resident # 27 was admitted to the facility on 9/27/2013 with the diagnoses of, but not limited to, Diabetes, Hypertension, Polyosteoarthritis, General Anxiety Disorder

The most recent Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date (ARD) of 2/26/2018. The MDS coded Resident # 27 with a BIMS (Brief Interview for Mental Status) of 14/15 indicating no cognitive impairment; Resident # 27 was coded as requiring total assistance of one staff person for Activities of Daily Living.

Review of the clinical record revealed no documentation of a Monthly Medication Review (MRR) since 3/29/2018.

On 5/11/2018 at 2:11 PM, an interview was conducted with the Pharmacy Consultant, Administrator and Director of Nursing. The Pharmacy Consultant (Admin H) stated she started working with the facility in January 2018 and did perform monthly medication reviews. Admin H stated she did not sign the yellow Medical Regimen Review forms located in each resident's records monthly. Admin H stated she did perform the reviews and submitted a copy of the recommendations to the facility each month. Admin H presented copies of Consultation Report forms with Pharmacy Recommendations that

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were dated on the dates the reviews were completed. Admin H stated the Consultation Report forms were given to the Director of Nursing each month.

The Pharmacy Consultant and Director of Nursing presented copies of Monthly Medication Review forms signed for Resident # 27 and dated 5/11/2018 as a "late entry" along with the date the review was actually done.

The Pharmacy Consultant stated she would sign the Medication Regimen Review forms monthly in the future. The Administrator stated the clinical record should be accurate.
During the end of day debriefing on 5/11/2018, the Administrator, Director of Nursing and Corporate Consultant were informed of the findings.

No further information was provided.

4. For Resident # 58, the facility staff failed to ensure the Monthly Medication Reviews forms was signed monthly. There was no signature after 1/7/2018.

Resident # 58 was admitted to the facility on 2/21/2017 with diagnoses of but not limited to Hypertension, Schizophrenia, Intellectual Disability, Insomnia, Osteoporosis, Urinary Tract Infection, Iron Deficiency, fracture of Right Acetabulum, constipation, and edema.

Resident # 58's most recent Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 3/20/2018 coded Resident #58 as having a BIMS (Brief Interview for Mental

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Status) score of 15 indicating no cognitive impairment. The Minimum Data Set coded Resident #58 as requiring minimal to limited assistance of one staff member for Activities of Daily Living (ADLs) care including requiring minimal assistance of one staff person for Hygiene and limited assistance of one staff member for Bathing. The resident was coded as always continent of bowel and occasionally incontinent of bladder.

Review of the clinical record revealed no documentation of a Monthly Medication Review (MRR) since 1/7/2018.

On 5/11/2018 at 2:11 PM, an interview was conducted with the Pharmacy Consultant, Administrator and Director of Nursing. The Pharmacy Consultant (Admin H) stated she started working with the facility in January 2018 and did perform monthly medication reviews. Admin H stated she did not sign the yellow Medical Regimen Review forms located in each resident's records monthly. Admin H stated she did perform the reviews and submitted a copy of the recommendations to the facility each month. Admin H presented copies of Consultation Report forms with Pharmacy Recommendations that were dated on the dates the reviews were completed. Admin H stated the Consultation Report forms were given to the Director of Nursing each month.

The Pharmacy Consultant and Director of Nursing presented copies of Monthly Medication Review forms signed for Resident #58 and dated 5/11/2018 as a "late entry" along with the date the review was actually done.

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The Pharmacy Consultant stated she would sign the Medication Regimen Review forms monthly in the future. The Administrator stated the clinical record should be accurate.

During the end of day debriefing on 5/11/2018, the Administrator, Director of Nursing and Corporate Consultant were informed of the findings.

No further information was provided.

5. For Resident # 64, the facility staff failed to ensure the Monthly Medication Reviews forms was signed monthly. There was no signature after 3/29/2018.

Resident #64 was admitted to the facility on 4/13/2016 with the diagnoses of, but not limited to, Schizoaffective Disorder, Bipolar Type, Diabetes, Hypertension, Chronic Kidney Disease, Stage 3, Polyarthritis, Gastroesophageal Reflux Disease, Bipolar Disorder, current episode Manic severe with Psychotic Features, and Adult Failure to Thrive.

The most recent Minimum Data Set (MDS) was a Significant Change Assessment with an Assessment Reference Date (ARD) of 3/15/2018. The MDS coded Resident # 64 with a BIMS (Brief Interview for Mental Status) score of 3/15 indicating severe cognitive impairment; Resident # 64 was coded as requiring limited to total assistance of one staff member for Activities of Daily Living except required supervision and set up only for eating; Resident # 64 was coded as always continent of bowel and an indwelling catheter for bladder.

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Review of the clinical record was conducted. Review of the Medication Regimen Reviews (MRR) revealed no signature for MRR since 3/29/2018.

On 5/11/2018 at 2:11 PM, an interview was conducted with the Pharmacy Consultant, Administrator and Director of Nursing. The Pharmacy Consultant (Admin H) stated she started working with the facility in January 2018 and did perform monthly medication reviews. Admin H stated she did not sign the yellow Medical Regimen Review forms located in each resident's records monthly. Admin H stated she did perform the reviews and submitted a copy of the recommendations to the facility each month. Admin H presented copies of Consultation Report forms with Pharmacy Recommendations that were dated on the dates the reviews were completed. Admin H stated the Consultation Report forms were given to the Director of Nursing each month.

The Pharmacy Consultant and Director of Nursing presented copies of Monthly Medication Review forms signed for Resident # 64 and dated 5/11/2018 as a "late entry" along with the date the review was actually done.

The Pharmacy Consultant stated she would sign the Medication Regimen Review forms monthly in the future. The Administrator stated the clinical record should be accurate.

During the end of day debriefing on 5/11/2018, the Administrator, Director of Nursing and Corporate Consultant were informed of the findings.

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No further information was provided.

6. For Resident # 72, the facility staff failed to ensure the Monthly Medication Reviews forms was signed monthly. There was no signature after 3/29/2018.

Resident #72 was admitted to the facility on 7/11/2017 with the diagnoses of, but not limited to, Major Depressive Disorder, Alzheimer's Disease, Psychosis,Bronchiectasis, Hepatitis A, Chronic Atrial Fibrillation, Gastroesophageal Reflux Disease, and fusion of the spine.

The most recent Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date (ARD) of 4/1/2018. The MDS coded Resident # 72 with a cognitive status of severely impaired; Resident # 72 was coded as independent for Activities of Daily Living except required supervision for hygiene, bathing and dressing; Resident # 72 was coded as always continent of bowel and frequently incontinent of bladder.

Review of the clinical record was conducted. Review of the Medication Regimen Reviews (MRR) revealed no signature for MRR since 3/29/2018.

On 5/11/2018 at 2:11 PM, an interview was conducted with the Pharmacy Consultant, Administrator and Director of Nursing. The Pharmacy Consultant (Admin H) stated she started working with the facility in January 2018 and did perform monthly medication reviews. Admin H stated she did not sign the yellow

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Medical Regimen Review forms located in each resident's records monthly. Admin H stated she did perform the reviews and submitted a copy of the recommendations to the facility each month. Admin H presented copies of Consultation Report forms with Pharmacy Recommendations that were dated on the dates the reviews were completed. Admin H stated the Consultation Report forms were given to the Director of Nursing each month.

The Pharmacy Consultant and Director of Nursing presented copies of Monthly Medication Review forms signed for Resident # 72 and dated 5/11/2018 as a "late entry" along with the date the review was actually done.

The Pharmacy Consultant stated she would sign the Medication Regimen Review forms monthly in the future. The Administrator stated the clinical record should be accurate.

During the end of day debriefing on 5/11/2018, the Administrator, Director of Nursing and Corporate Consultant were informed of the findings.

No further information was provided.

7. For Resident # 37, the facility staff failed to ensure the Monthly Medication Reviews forms was signed monthly. There was no signature after 1/7/2018.

Resident # 37 was admitted to the facility on 4/10/2014 with diagnoses of but not limited to Paranoid Schizophrenia, Cerebral Infarction, Major Depressive Disorder, Hemiplegia, Chronic

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Embolism, General Anxiety Disorder, Contracture to left ankle and left foot. and Gastroesophageal Reflux Disease

Resident # 37's most recent Minimum Data Set (an assessment protocol) was coded as a Quarterly Assessment with an Assessment Reference Date of 3/1 /2018. Resident # 37 was coded as having a BIMS (Brief Interview for Mental Status) score of 14/15 indicating no cognitive impairment. The Minimum Data Set coded Resident # 37 as requiring extensive to total assistance of one to two staff members for Activities of Daily Living (ADLs) care except requiring Supervision and set up for eating. The resident was coded as always incontinent of bowel and bladder.

Review of the clinical record was conducted. Review of the Medication Regimen Reviews (MRR) revealed no signature for MRR since 1/7/2018.

On 5/11/2018 at 2:11 PM, an interview was conducted with the Pharmacy Consultant, Administrator and Director of Nursing. The Pharmacy Consultant (Admin H) stated she started working with the facility in January 2018 and did perform monthly medication reviews. Admin H stated she did not sign the yellow Medical Regimen Review forms located in each resident's records monthly. Admin H stated she did perform the reviews and submitted a copy of the recommendations to the facility each month. Admin H presented copies of Consultation Report forms with Pharmacy Recommendations that were dated on the dates the reviews were completed. Admin H stated the Consultation Report forms were given to the Director of

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Nursing each month.

The Pharmacy Consultant and Director of Nursing presented copies of Monthly Medication Review forms signed for Resident # 37 and dated 5/11/2018 as a "late entry" along with the date the review was actually done.

The Pharmacy Consultant stated she would sign the Medication Regimen Review forms monthly in the future. The Administrator stated the clinical record should be accurate.

During the end of day debriefing on 5/11/2018, the Administrator, Director of Nursing and Corporate Consultant were informed of the findings.

No further information was provided.

8. Resident #112, an 84-year-old, was admitted on 5/18/16. His most recent Minimum Data Set (MDS) Assessment was a Significant Change Assessment with an Assessment Reference Date (ARD) of 5/1/18. The Brief Interview for Mental Status scored him at 15, indicating no impairment. Resident #112's diagnoses included Peripheral Vascular Disease, Cellulitis of the Left Lower Extremity, Edema, Diabetes Mellitus II, Hypertension, Gastro-Esophageal Reflux Disease, Congestive Heart Failure, Atrial Fibrillation, Benign Prostatic Hyperplasia, Hyperkalemia, Chronic Kidney Disease Stage 3, and Dysphagia. Resident #112 required total assistance of 1 staff member for Bed Mobility, Transfers, and Bathing; Extensive assistance of 1 staff member for Dressing, Toileting, and Hygiene; and setup and supervision for eating.

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On 5/9/18, resident records were reviewed. It was noted that Medication Regimen Reviews (MRRs) were documented in the Hard Chart, on a document titled "MEDICATION REGIMEN REVIEW". The document was divided into sections, with an area for documentation, a signature, and a date in each section. Records reviewed uniformly lacked signatures dated after March of 2018. No Medication Regimen Review data was available to surveyors in the Electronic Medical Record. Copies of the MRR sheets were obtained by surveyors.

On 5/11/18 at approximately 2:15p.m., an interview was conducted with EMPLOYEE F, the Pharmacist in charge of conducting Medication Regimen Reviews. The Director of Nursing (DON) also attended. EMPLOYEE F stated that she was new to the position, and not aware of the need to sign the monthly signature sheets. She stated that when she conducted monthly MRRs, she sent her recommendations to the Director of Nursing via email. The DON confirmed that she had a binder with the MRRs in her office. The DON stated that they were "behind" in getting the MRRs reviewed by the Physicians, that "I started in March and they haven't been completed since August."

The Administrator stated that EMPLOYEE F had come in to provide late-entry signatures on the MRR sheets for those that did not have signatures for April. The MRR sheets when reviewed on 5/11/18 contained a new signature dated 4/30/18 with "late entry 5/11/18" next to it. No further information was provided.

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9. Resident #100, a 63-year-old, was admitted on 1/7/18. Her most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 4/16/18. The Brief Interview for Mental Status (BIMS) scored her a 15, indicating no impairment. Her diagnoses included Diabetes Mellitus II, Chronic Obstructive Pulmonary Disease, Hypertension, Congestive Heart Failure, Chronic Kidney Disease Stage 3, Hyperlipidemia, Gastro-Esophageal Reflux Disease, Anemia, Peripheral Vascular Disease, Pneumonia, Gout, Urinary Tract Infection, and Osteomyelitis. Resident #100 required extensive assistance of 1 staff member for Bed Mobility, Ambulation, Dressing, and Toileting; as well as setup and supervision for eating.

On 5/9/18, resident records were reviewed. It was noted that Medication Regimen Reviews (MRRs) were documented in the Hard Chart, on a document titled "MEDICATION REGIMEN REVIEW". The document was divided into sections, with an area for documentation, a signature, and a date in each section. Records reviewed uniformly lacked signatures dated after March of 2018. No Medication Regimen Review data was available to surveyors in the Electronic Medical Record. Copies of the MRR sheets were obtained by surveyors.

On 5/11/18 at approximately 2:15p.m., an interview was conducted with EMPLOYEE F, the Pharmacist in charge of conducting Medication Regimen Reviews. The Director of Nursing (DON) also attended. EMPLOYEE F stated that she was new to the position, and not aware of the need to sign the monthly signature sheets. She stated that when she conducted monthly MRRs,

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she sent her recommendations to the Director of Nursing via email. The DON confirmed that she had a binder with the MRRs in her office. The DON stated that they were "behind" in getting the MRRs reviewed by the Physicians, that "I started in March and they haven't been completed since August."

The Administrator stated that EMPLOYEE F had come in to provide late-entry signatures on the MRR sheets for those that did not have signatures for April. The MRR sheets when reviewed on 5/11/18 contained a new signature dated 4/30/18 with "late entry 5/11/18" next to it. No further information was provided.

10. Resident #40, a 61-year-old, was admitted on 6/10/14. Her most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 3/3/18. The Brief Interview for Mental Status (BIMS) scored her at 15, indicating no impairment. Resident #40's diagnoses included Diabetes Mellitus II, Hypertension, Gastro-Esophageal Reflux Disease, Morbid Obesity, Osteoarthritis, and Schizophrenia. Resident #40 was independent in her ADLs.

On 5/9/18, resident records were reviewed. It was noted that Medication Regimen Reviews (MRRs) were documented in the Hard Chart, on a document titled "MEDICATION REGIMEN REVIEW". The document was divided into sections, with an area for documentation, a signature, and a date in each section. Records reviewed uniformly lacked signatures dated after March of 2018. No Medication Regimen Review data was available to surveyors in the Electronic

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Medical Record. Copies of the MRR sheets were obtained by surveyors.

On 5/11/18 at approximately 2:15p.m., an interview was conducted with EMPLOYEE F, the Pharmacist in charge of conducting Medication Regimen Reviews. The Director of Nursing (DON) also attended. EMPLOYEE F stated that she was new to the position, and not aware of the need to sign the monthly signature sheets. She stated that when she conducted monthly MRRs, she sent her recommendations to the Director of Nursing via email. The DON confirmed that she had a binder with the MRRs in her office. The DON stated that they were "behind" in getting the MRRs reviewed by the Physicians, that "I started in March and they haven't been completed since August."

The Administrator stated that EMPLOYEE F had come in to provide late-entry signatures on the MRR sheets for those that did not have signatures for April. The MRR sheets when reviewed on 5/11/18 contained a new signature dated 4/30/18 with "late entry 5/11/18" next to it. No further information was provided.

11. Resident #119, a 64-year-old, was admitted on 4/1/18. Her diagnoses included Left Hip Arthroplasty, Bipolar Disorder, Anxiety, Schizoaffective Disorder, Gastro-Esophageal Reflux Disease, Major Depressive Disorder with psychotic symptoms, Hyperlipidemia, Hypertension, and Urinary Tract Infection. Her most recent Minimum Data Set (MDS) Assessment was a Change of Therapy Assessment with an Assessment Reference Date (ARD) of 5/6/18. The Brief Interview for Mental Status scored her a 15, indicating no impairment.

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Resident #119 required extensive assistance of one staff member for bed mobility, transfers, and toileting; and setup assistance for eating.
On 5/9/18, resident records were reviewed. It was noted that Medication Regimen Reviews (MRRs) were documented in the Hard Chart, on a document titled "MEDICATION REGIMEN REVIEW". The document was divided into sections, with an area for documentation, a signature, and a date in each section. Records reviewed uniformly lacked signatures dated after March of 2018. No Medication Regimen Review data was available to surveyors in the Electronic Medical Record. Copies of the MRR sheets were obtained by surveyors.

On 5/11/18 at approximately 2:15p.m., an interview was conducted with EMPLOYEE F, the Pharmacist in charge of conducting Medication Regimen Reviews. The Director of Nursing (DON) also attended. EMPLOYEE F stated that she was new to the position, and not aware of the need to sign the monthly signature sheets. She stated that when she conducted monthly MRRs, she sent her recommendations to the Director of Nursing via email. The DON confirmed that she had a binder with the MRRs in her office. The DON stated that they were "behind" in getting the MRRs reviewed by the Physicians, that "I started in March and they haven't been completed since August."

The Administrator stated that EMPLOYEE F had come in to provide late-entry signatures on the MRR sheets for those that did not have signatures for April. The MRR sheets when reviewed on 5/11/18 contained a new signature dated 4/30/18 with "late entry 5/11/18" next to it. No further information was provided.

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12. Resident #18, an 81-year-old, was admitted on 2/2/17. Her diagnoses included Chronic Obstructive Pulmonary Disease, generalized anxiety, Polyneuropathy, Dementia without behaviors, Major Depressive Disorder, Hypertension, Gastro-Esophageal Reflux Disease, Chronic Pain, and Abdominal Aortic Aneurysm. Her most recent Minimum Data Set (MDS) assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 2/14/18. The Brief Interview for Mental Status scored Resident #18 as a 15, indicating no impairment. Resident #18 required setup assistance of one staff member for eating and was independent in other ADLs.
On 5/9/18, resident records were reviewed. It was noted that Medication Regimen Reviews (MRRs) were documented in the Hard Chart, on a document titled "MEDICATION REGIMEN REVIEW". The document was divided into sections, with an area for documentation, a signature, and a date in each section. Records reviewed uniformly lacked signatures dated after March of 2018. No Medication Regimen Review data was available to surveyors in the Electronic Medical Record. Copies of the MRR sheets were obtained by surveyors.

On 5/11/18 at approximately 2:15p.m., an interview was conducted with EMPLOYEE F, the Pharmacist in charge of conducting Medication Regimen Reviews. The Director of Nursing (DON) also attended. EMPLOYEE F stated that she was new to the position, and not aware of the need to sign the monthly signature sheets. She stated that when she conducted monthly MRRs, she sent her recommendations to the Director of

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Nursing via email. The DON confirmed that she had a binder with the MRRs in her office. The DON stated that they were "behind" in getting the MRRs reviewed by the Physicians, that "I started in March and they haven't been completed since August."

The Administrator stated that EMPLOYEE F had come in to provide late-entry signatures on the MRR sheets for those that did not have signatures for April. The MRR sheets when reviewed on 5/11/18 contained a new signature dated 4/30/18 with "late entry 5/11/18" next to it. No further information was provided.

13. Resident #81, a 60-year-old, was admitted on 8/13/07. Her diagnoses included Carcinoma in situ, hypertension, Diabetes Mellitus II, Hypothyroidism, Hyperlipidemia, Major Depressive Disorder, Chronic Kidney Disease, Anxiety, Vitamin D Deficiency, and Obesity. Resident #81's most recent Minimum Data Set (MDS) assessment was an Annual Assessment with an Assessment Reference Date (ARD) of 4/5/18. The Brief Interview for Mental Status scored Resident #81 as a 15, indicating no impairment. Resident #81 required supervision and setup assistance of one staff member for Transfers, Ambulation, Dressing, Hygiene, and Toileting, and required setup only for Eating.
On 5/9/18, resident records were reviewed. It was noted that Medication Regimen Reviews (MRRs) were documented in the Hard Chart, on a document titled "MEDICATION REGIMEN REVIEW". The document was divided into sections, with an area for documentation, a signature, and a date in each section. Records reviewed uniformly lacked signatures dated after

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March of 2018. No Medication Regimen Review data was available to surveyors in the Electronic Medical Record. Copies of the MRR sheets were obtained by surveyors.

On 5/11/18 at approximately 2:15p.m., an interview was conducted with EMPLOYEE F, the Pharmacist in charge of conducting Medication Regimen Reviews. The Director of Nursing (DON) also attended. EMPLOYEE F stated that she was new to the position, and not aware of the need to sign the monthly signature sheets. She stated that when she conducted monthly MRRs, she sent her recommendations to the Director of Nursing via email. The DON confirmed that she had a binder with the MRRs in her office. The DON stated that they were "behind" in getting the MRRs reviewed by the Physicians, that "I started in March and they haven't been completed since August."

The Administrator stated that EMPLOYEE F had come in to provide late-entry signatures on the MRR sheets for those that did not have signatures for April. The MRR sheets when reviewed on 5/11/18 contained a new signature dated 4/30/18 with "late entry 5/11/18" next to it. No further information was provided.

14. For Resident # 22 the facility failed to have accurate monthly pharmacy review by licensed pharmacist.

Resident #22 a 65 year old male was admitted to the facility on 06/29/05 with a diagnosis of but not limited to above knee amputation of right leg, amputation of right arm between elbow and shoulder, hemiparesis right side, lack of

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F 842	Continued From page 147 coordination, abnormal posture, with tracheostomy and G-tube (feeding tube). Resident is non verbal due to tracheostomy On 5/10/18 @ 2:00 PM while reviewing resident clinical record it was noted that the pharmacy review sheet had not been signed after January 2018. On 5/11/2018 at 2:11 PM, an interview was conducted with the Pharmacy Consultant, Administrator and Director of Nursing. The Pharmacy Consultant (Admin H) stated she started working with the facility in January 2018 and did perform monthly medication reviews. Admin H stated she did not sign the yellow Medical Regimen Review forms located in each resident's records monthly. Admin H stated she did perform the reviews and submitted a copy of the recommendations to the facility each month. No further information was provided	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		6/19/18

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a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

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

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F 880	Continued From page 149 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility staff failed to ensure an air gap was in place on 2 of 2 ice machines and failed to ensure for 1 resident (Resident #95) of 41 residents in the survey sample that proper infection control practices were used when cleaning the glucometer. 1. The drainage pipe on both ice machines was inserted directly into the pipe connected to the floor drain. An air gap was not in place to prevent contamination from the back flow of water. 2. Resident #95's glucometer was cleaned with an alcohol wipe instead of the MicroKill bleach wipes indicated by the manufacturer. The findings included: 1. The drainage pipe on both ice machines was inserted directly into the pipe connected to the floor drain. An air gap was not in place to prevent contamination from the back flow of water.	F 880	F880 Two ice machine drainage pipes were repaired to enable air gap in accordance with professional standards for food service safety/infection control standard/regulation. Resident #95□s glucometer was re-cleaned per manufacturer recommendation. There is no other ice machine in the facility . Director of Nursing/Designee conducted Quality Review of glucometer cleaning to ensure completed per manufacturer recommendation. Follow up based on findings. Executive Director provided Maintenance Director/maintenance staff and Dietary Manager re-education regarding ice machine drainage pipes in accordance with professional standards for food service safety. Director of Nursing/Designee provided Licensed Nurses re-education regarding glucometer cleaning per manufacturer recommendation, competency verified via	

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The ice machine in the main kitchen was observed on 5/8/18 at 12:15 p.m. The Dietary Manager was present during the observation. It appeared that the drainage pipe went into the wall. An air gap was not visible.

The ice machine outside of the main kitchen was observed on 5/8/18 at 12:30 p.m. The Dietary Manager was present during the observation. When asked who used the ice machine, the Dietary Manager stated the nurses used the ice for the hydration cart.

The ice machine did not have an air gap. The machine's drainage pipe was inserted directly into another pipe that went into the floor drain.

On 5/9/18 at 8:00 a.m., the air gap to both machines was observed in the presence of the Administrator and Assistant Maintenance staff (Employee A). Both the Administrator and Employee A agreed that the nursing ice machine drainage pipe was inserted into the pipe that connected to the floor drain.

The kitchen ice machine was also observed with the Administrator and Employee A. After clearing the area so that the back of the ice machine was visible, the drainage pipe from the ice machine was observed to be inserted into a black rubber funnel that was fitted onto a drainage pipe in the wall. There was no air gap in place. Both the Administrator and Employee A agreed that the kitchen ice machine drainage pipe was inserted into the black rubber funnel that was connected to the pipe leading to the floor drain.

Employee A stated that he understood the issue with the air gap.

F 880

demonstration.
Maintenance Director to conduct Quality Improvement monitoring of ice machines draingage pipes ensuring in accordance with professional standards for food service safety monthly and prn. Director of Nursing/Designee to conduct random Quality Improvement Monitoring of glucometer cleaning practice to ensure per manufacturer recommendation weekly x 2 weeks, monthly x 2 months, then quarterly and prn. Findings to be reported at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings.

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No further information was provided.

2. Resident #95's glucometer was cleaned with an alcohol wipe instead of the MicroKill bleach wipes indicated by the manufacturer.

Resident #95, an 89 year old, was admitted to the facility on 11/9/16. Diagnoses included insomnia, dysphagia, depression, and diabetes.

The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 4/12/18. Resident #95 was coded with a Brief Interview of Mental Status score of 9 indicating moderate cognitive impairment and required limited assistance with activities of daily living.

Resident #95 had a physician order dated 9/30/16 for blood sugar checks two times per day. Residents requiring blood sugar checks each had their own glucometer.

On 5/9/18 at 8:22 a.m., a medication pour and pass observation was conducted with Licensed Practical Nurse A (LPN A). During the observation, LPN A cleaned Resident #95's glucometer with an alcohol prep pad. She stated that she used the alcohol pad because she did not have any bleach wipes on her cart.

After checking Resident #95's blood sugar, LPN A cleaned the glucometer with another alcohol prep pad.

On 5/9/18 at 9:30 a.m., the Administrator was asked to provide the manufacturer's instructions

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for the glucometer. She was also asked to identify the type of cleaning product that was supposed to be used to clean the glucometer.

The Administrator provided a copy of the "Glucometer Competency Skills Checklist", pointed to bullet 13 where it read that "disinfectant wipes" were used. The Administrator was asked to provide the specific name and example of the cleaning product to be used.

On 5/9/18 at 10:17 a.m., the Director of Nursing (DON) provided the user's guide for the glucometer. Page 46 of the user guide read "The following products have been approved for the cleaning and disinfecting (glucometer name)". Included on the list was "Medline Micro-Kill Bleach Germicidal Bleach Wipes". This was the cleaning product provided by the DON as the product to be used by the nursing staff. When asked how long the cleaning product needed to contact the glucometer, the DON stated 30 seconds.

It was reviewed with the DON that LPN A did not use the correct product to clean the glucometer.

F 917 SS=D	Resident Room Bed/Furniture/Closet CFR(s): 483.10(i)(4), 483.90(e)(2)(3)	F 917		6/19/18

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv)

§483.90(e)(2) -The facility must provide each resident with--
(i) A separate bed of proper size and height for the safety and convenience of the resident;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	C 05/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF WILLIAMSBURG, LLC	1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185

(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 917	Continued From page 153 (ii) A clean, comfortable mattress; (iii) Bedding, appropriate to the weather and climate; and (iv) Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident. §483.90(e)(3) CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (e)(1) (i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations (i) Are in accordance with the special needs of the residents; and (ii) Will not adversely affect residents' health and safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, the facility staff failed to provide functional furniture for one resident (Resident # 27) in a survey sample of 41 residents. For Resident # 27, the 3 drawer nightstand/dresser with clothing was broken with all three drawers off track. Findings included: Resident # 27 was admitted to the facility on 9/27/2013 with the diagnoses of, but not limited to, Diabetes, Hypertension, Polyosteoarthritis, General Anxiety Disorder The most recent Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date (ARD) of 2/26/2018. The MDS	F 917	F917 1. Resident #27 provided a functional 3 door nightstand/dresser. Maintenance Director/maintenance staff conducted Quality Review of resident 3 drawer nightstand/dressers are functional. Follow up based on findings. Executive Director completed re-education with current facility staff regarding resident furniture functional and reporting identified furniture utilizing maintenance request. Executive Director/Designee to conducted Quality Improvement Monitoring of resident 3 drawer nightstand/dresser for function utilizing Mock Survey Rounds process 5x/week x 2 weeks, weekly x 2 weeks, then monthly and prn. Findings to be reviewed at monthly QAPI Committee	

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F 917	Continued From page 154	F 917		

coded Resident # 27 with a BIMS (Brief Interview for Mental Status) of 14/15 indicating no cognitive impairment; Resident # 27 was coded as requiring total assistance of one staff person for Activities of Daily Living.

On initial tour of the facility on 5/8/2018, a wooden three drawer nightstand/dresser was observed in Resident # 27's room. All three drawers on the nightstand were off track and the left lower corner was broken and separating. The drawers were difficult to open.

An interview was conducted with the Administrator who stated she would have the Maintenance Director fix the nightstand/dresser.

On 5/10/18 at 4 p.m., observed the nightstand/dresser in Resident # 27's was repaired. All three drawers were on track and opened easily. The left corner was connected together.

Meeting. Monitoring schedule modified based on findings.