STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	VA0218	A. BUILOING _____ B. WING _____	03/30/2018

NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
EVERGREEN HEALTH AND REHAB	380 MILLWOOD AVENUE WINCHESTER, VA 22601

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETE OATE
F 000	Initial Comments	F 000		

An unannounced biennial State Licensure Inspection was conducted 3/27/18 through 3/30/18. Corrections are required for compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow.

The census in this 176 certified bed facility was 138 at the time of the survey. The survey sample consisted of 28 current resident reviews (Residents # 236, 235, 234, 132, 90, 133, 89, 97, 74, 55, 83, 3, 61, 114, 130, 99, 69, 17, 37, 105, 38, 95, 384, 73, 66, 57, 47 and 98) and three closed record reviews (Residents # 334, 135 and 134).

F 001 Non Compliance

F 001

The facility was out of compliance with the following state licensure requirements:

This RULE: is not met as evidenced by:
12VAC5-371- 370.A cross references to F584 — Please see corrective action under F584

12VAC5-371-220.D cross references to F677 — Please see corrective action under F677

12VAC5-371-250.G cross references to F641 — Please see corrective action under F641

There is no state regulation related to F 845 - completion of the PASARR.

12 VAC 5 - 371 - 220 B cross references to F 684. — Please see corrective action under F645

12 VAC 5 - 371 - 300 A cross references to F 755. — Please see corrective action under F684

12 VAC 5 - 371 - 220 A, B cross references to F 758 — Please see corrective action under F755

12 VAC 5 - 371 - 320 A, B cross references to F — Please see corrective action under F758

Please see corrective action under F791

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0218	A. BUILDING _____ B. WING _____	03/30/2018

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F 001	Continued From Page 1	F 001		
	791			
	12 VAC 5 - 371 - 360 B cross references to F 842		Please see corrective action under F842	
	12 VAC 5 - 371 - 360 E cross references to F 842		Please see corrective action under F842	
	12VAC5-371-180. Infection Control. Cross reference to F880		Please see corrective action under F880	
	12VAC5-371-220. Nursing Services. Cross reference to F622, F624, F625, F658, F695, and F756		Please see corrective action under F622, F624, F625, F658, F695, F756	
	12VAC5-371-240. Physician Services. Cross reference to F623		Please see corrective action under F623	
	12VAC5-371-250. Resident Assessment and Care Planning. Cross reference to F641		Please see corrective action under F641	
	12VAC5-371-270. Social Services. Cross reference to F645 and F745		Please see corrective action under F645 and F745	
	12VAC5-371-300. Pharmaceutical Services. Cross reference to F756		Please see corrective action under F756	
	12VAC5-371-340. Dietary and Food Service Program. Cross reference to F812		Please see corrective action under F812	
	12VAC5-371-180. Infection Control cross reference to F880		Please see corrective action under F880	
	12VAC-371-220. Nursing Services cross reference to F580		Please see corrective action under F580	
	12VAC-371-140. Policies and Procedures cross references to F623, F689		Please see corrective action under FF623, F689	
	12VAC-371-250. Resident Assessment and Care Planning cross references to F657.		Please see corrective action under F657	

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 3/28/17 through 3/30/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
E 001 SS=C	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to establish and maintain a complete	E 001	E001 1. The facility has an emergency preparedness plan in place. The plan will be revised to include any missing elements so that it meets the requirements of the regulations. 2. Current facility residents have the potential to be affected by the alleged deficient practice. 3. The emergency preparedness plan will be revised to include missing elements so that it is a comprehensive plan that meets the requirements of the regulations. The Safety Chairman will be educated on updating and revising the emergency preparedness plan to include any new and/or revised requirements to the regulations. Facility staff will be educated on the updated emergency plan. 4. The Administrator/designee will be responsible for updating the emergency plan as needed. The emergency preparedness program will be monitored by the QA Committee on a quarterly basis for any changes/additions that need to be made. 5. Completion Date: May 11, 2018	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ramona J. Runyatt	Administrator	4/23/2018

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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E 001	Continued From page 1 emergency preparedness plan. The facility staff failed to establish and maintain a comprehensive emergency preparedness program that meets the requirements of these regulations. The findings include: On 3/28/18 at 3:47 p.m., the facility's emergency preparedness plan was reviewed with ASM (administrative staff member) # 1 (the administrator), ASM #2 (the director of nursing) and OSM (other staff member) #1 (the dietary manager). Review of the facility's emergency preparedness plan failed to evidence a comprehensive plan that meets the requirements of these regulations. ASM #1, ASM #2 and ASM #3 were made aware of this concern. No further information was presented prior to exit.	E 001		
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) [The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.] * [For hospitals at §482.15 and CAHs at §485.625(a):] The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this	E 004	E004 1. The facility has an emergency preparedness plan in place. The plan will be revised to include any missing elements so that it meets the requirements of the regulations. 2. Current facility residents have the potential to be affected by the alleged deficient practice. 3. The facility emergency preparedness plan, once revised, will be evaluated and updated on a quarterly, or as needed basis, and reviewed for compliance at least annually. The Safety Chairman will be educated on updating and revising the emergency preparedness plan to include any new and/or revised requirements to the regulations. Facility staff will be educated on the updated emergency plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 004 Continued From page 2

section, utilizing an all-hazards approach.

The emergency preparedness program must include, but not be limited to, the following elements:]
(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least annually.

* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least annually.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document review it was determined that the facility staff failed to maintain a complete emergency preparedness plan.

The facility staff failed to develop and maintain a complete emergency preparedness plan.

The findings include:

On 3/28/18 at 3:47 p.m., the facility's emergency preparedness plan was reviewed with ASM (administrative staff member) # 1 (the administrator), ASM #2 (the director of nursing) and OSM (other staff member) #1 (the dietary manager). Review of the facility's emergency preparedness plan failed to evidence a complete plan that contained all the required elements. ASM #1, ASM #2 and ASM #3 were made aware of this concern.

No further information was obtained prior to exit.

E 004 4. The Administrator/designee will be responsible for updating the emergency plan as needed. The emergency preparedness program will be monitored by the QA Committee on a quarterly basis for any changes/additions that need to be made. The QA Committee will review the complete plan on an annual basis.

5. Completion Date: May 11, 2018

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E 006 SS=C	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to develop an emergency preparedness plan based on and including a facility-based and community-based risk assessment, utilizing an all-hazards approach.	E 006	E006 1. The facility has an emergency preparedness plan in place. The plan will be revised to include any missing elements so that it meets the requirements of the regulations. 2. Current facility residents have the potential to be affected by the alleged deficient practice. 3. The emergency preparedness plan will be updated to include a facility-based and community-based risk assessment that utilizes an all-hazards approach. The Safety Chairman will be educated on updating and revising the emergency preparedness plan to include any new and/or revised requirements to the regulations. Facility staff will be educated on the updated emergency plan. 4. The Administrator/designee will be responsible for updating the emergency plan as needed. The emergency preparedness program will be monitored by the QA Committee on a quarterly basis for any changes/additions that need to be made. 5. Completion Date: May 11, 2018	

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E 006	Continued From page 4 The facility staff failed to complete a facility-based and community-based risk assessment. The findings include: On 3/28/18 at 3:47 p.m., the facility's emergency preparedness plan was reviewed with ASM (administrative staff member) # 1 (the administrator), ASM #2 (the director of nursing) and OSM (other staff member) #1 (the dietary manager). Review of the facility's emergency preparedness plan failed to evidence a facility-based and community-based risk assessment, utilizing an all-hazards approach. ASM #1, ASM #2 and ASM #3 were made aware of this concern. No further information was obtained prior to exit.	E 006		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced	E 007	E007 1. The facility has an emergency preparedness plan in place. The plan will be revised to include any missing elements so that it meets the requirements of the regulations. 2. Current facility residents have the potential to be affected by the alleged deficient practice. 3. The emergency preparedness plan will be updated to address our at-risk population by most to least vulnerable. Strategies for ensuring their safety and well-being will be outlined in the plan. The Safety Chairman will be educated on updating and revising the emergency preparedness plan to include any new and/or revised requirements to the regulations. Facility staff will be educated on the updated emergency plan.	

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E 007	Continued From page 5 by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop the emergency preparedness plan that included the facility's patient population that would be at risk and strategies that the facility put in place to address the needs of at-risk or vulnerable patients. The findings include: On 3/28/18 at 3:47 p.m., the facility's emergency preparedness plan was reviewed with ASM (administrative staff member) # 1 (the administrator), ASM #2 (the director of nursing) and OSM (other staff member) #1 (the dietary manager). Review of the facility's emergency preparedness plan failed to evidence the emergency preparedness plan included the facility's patient population that would be at risk and strategies that the facility put in place to address the needs of at-risk or vulnerable patients. ASM #1, ASM #2 and ASM #3 were made aware of this concern. No further information was obtained prior to exit.	E 007	4. The Administrator/designee will be responsible for updating the emergency plan as needed. The emergency preparedness program will be monitored by the QA Committee on a quarterly basis for any changes/additions that need to be made. 5. Completion Date: May 11, 2018	
E 013 SS=C	Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of	E 013	E013 1. The facility has an emergency preparedness plan in place. The plan will be revised to include any missing elements so that it meets the requirements of the regulations. 2. Current facility residents have the potential to be affected by the alleged deficient practice.	

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E 013	Continued From page 6 this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document	E 013	3. The emergency preparedness plan will be updated to include written policies and procedures based on the facility and community based risk assessment and communication plan that addresses the areas of potential hazards. The Safety Chairman will be educated on updating and revising the emergency preparedness plan to include any new and/or revised requirements to the regulations. Facility staff will be educated on the updated emergency plan. 4. The Administrator/designee will be responsible for updating the emergency plan as needed. The emergency preparedness program will be monitored by the QA Committee on a quarterly basis for any changes/additions that need to be made. 5. Completion Date: May 11, 2018	

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E 013	Continued From page 7 review it was determined that the facility staff failed to have a complete emergency preparedness plan. Facility staff failed to provide documentation that the policies and procedures were developed based on the facility-and-community based risk assessment and communication plan, utilizing an all-hazards approach. The findings include: On 3/28/18 at 3:47 p.m., the facility's emergency preparedness plan was reviewed with ASM (administrative staff member) # 1 (the administrator), ASM #2 (the director of nursing) and OSM (other staff member) #1 (the dietary manager). Review of the facility's emergency preparedness plan failed to evidence documentation that the policies and procedures were developed based on a facility- based and community-based risk assessment and utilizing an all-hazards approach.. ASM #1, ASM #2 and ASM #3 were made aware of this concern. No further information was obtained prior to exit.	E 013		
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must	E 015	E015 1. The facility has an emergency preparedness plan in place. The plan will be revised to include any missing elements so that it meets the requirements of the regulations. 2. Current facility residents have the potential to be affected by the alleged deficient practice.	

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E 015	Continued From page 8	E 015		

address the following:

(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:
(i) Food, water, medical and pharmaceutical supplies
(ii) Alternate sources of energy to maintain the following:
(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(B) Emergency lighting.
(C) Fire detection, extinguishing, and alarm systems.
(D) Sewage and waste disposal.

*[For Inpatient Hospice at §418.113(b)(6)(iii):]
Policies and procedures.
(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:
(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:
(A) Food, water, medical, and pharmaceutical supplies.
(B) Alternate sources of energy to maintain the following:
(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(2) Emergency lighting.
(3) Fire detection, extinguishing, and alarm systems.
(C) Sewage and waste disposal.

3. The emergency preparedness plan will be updated to include written policies and procedures for the provision of emergency resources to include food, water, sewage, and waste disposal. The Safety Chairman will be educated on updating and revising the emergency preparedness plan to include any new and/or revised requirements to the regulations. Facility staff will be educated on the updated emergency plan.

4. The Administrator/designee will be responsible for updating the emergency plan as needed. The emergency preparedness program will be monitored by the QA Committee on a quarterly basis for any changes/additions that need to be made.

5. Completion Date: May 11, 2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495142	A. BUILDING _____ B. WING _____	C 03/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN HEALTH AND REHAB	380 MILLWOOD AVENUE WINCHESTER, VA 22601

(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
E 015	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures for the provision of subsistence needs including but not limited to food, water, sewage and waste disposal. The findings include: On 3/28/18 at 3:47 p.m., the facility's emergency preparedness plan was reviewed with ASM (administrative staff member) # 1 (the administrator), ASM #2 (the director of nursing) and OSM (other staff member) #1 (the dietary manager). Review of the facility's emergency preparedness plan failed to evidence documentation of policies and procedures for the provision of subsistence needs including but not limited to food, water, sewage and waste disposal. ASM #1, ASM #2 and ASM #3 were made aware of this concern. No further information was obtained prior to exit.	E 015		
E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be	E 018	E018 1. The facility has an emergency preparedness plan in place. The plan will be revised to include any missing elements so that it meets the requirements of the regulations. 2. Current facility residents have the potential to be affected by the alleged deficient practice.	

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E 018	Continued From page 10 reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.	E 018	3. The emergency preparedness plan will be updated to include written policies and procedures of how staff and residents will be tracked as to location should evacuation due to an emergency be necessary. The Safety Chairman will be educated on updating and revising the emergency preparedness plan to include any new and/or revised requirements to the regulations. Facility staff will be educated on the updated emergency plan. 4. The Administrator/designee will be responsible for updating the emergency plan as needed. The emergency preparedness program will be monitored by the QA Committee on a quarterly basis for any changes/additions that need to be made. 5. Completion Date: May 11, 2018	

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E 018	Continued From page 11	E 018		

*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

*[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.

*[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan.

The facility staff failed to develop policies and procedures to include a tracking system for patients and staff.

The findings include:

On 3/28/18 at 3:47 p.m., the facility's emergency preparedness plan was reviewed with ASM (administrative staff member) # 1 (the administrator), ASM #2 (the director of nursing) and OSM (other staff member) #1 (the dietary

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E 018	Continued From page 12 manager). Review of the facility's emergency preparedness plan failed to evidence policies and procedures to include a tracking system for patients and staff. ASM #1, ASM #2 and ASM #3 were made aware of this concern. No further information was obtained prior to exit.	E 018		
E 022 SS=C	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document	E 022	E022 1. The facility has an emergency preparedness plan in place. The plan will be revised to include any missing elements so that it meets the requirements of the regulations. 2. Current facility residents have the potential to be affected by the alleged deficient practice. 3. The emergency preparedness plan will be updated to include policies and procedures that address the facility's ability to shelter in place for patients, staff and volunteers should the need arise. Sheltering in place will be dependent on the facility risk assessment and the hazard encountered. The Safety Chairman will be educated on updating and revising the emergency preparedness plan to include any new and/or revised requirements to the regulations. Facility staff will be educated on the updated emergency plan. 4. The Administrator/designee will be responsible for updating the emergency plan as needed. The emergency preparedness program will be monitored by the QA Committee on a quarterly basis for any changes/additions that need to be made. 5. Completion Date: May 11, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 022	Continued From page 13 review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures of how the facility will provide a means to shelter in place for patients, staff and volunteers who remain in the facility and how those policies and procedures are aligned with a facility risk assessment. The findings include: On 3/28/18 at 3:47 p.m., the facility's emergency preparedness plan was reviewed with ASM (administrative staff member) # 1 (the administrator), ASM #2 (the director of nursing) and OSM (other staff member) #1 (the dietary manager). Review of the facility's emergency preparedness plan failed to evidence documentation of policies and procedures of how the facility will provide a means to shelter in place for patients, staff and volunteers who remain in the facility and how those policies and procedures are aligned with a facility risk assessment. ASM #1, ASM #2 and ASM #3 were made aware of this concern. No further information was obtained prior to exit.	E 022		
E 023 SS=C	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of	E 023	E023 1. The facility has an emergency preparedness plan in place. The plan will be revised to include any missing elements so that it meets the requirements of the regulations. 2. Current facility residents have the potential to be affected by the alleged deficient practice.	

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E 023	Continued From page 14 this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures of how the facility preserves patient information, protects confidentiality of patient	E 023	3. The emergency preparedness plan will be updated to more accurately reflect the facility's policies and procedures regarding the preservation and protection of patient information and medical records. The Safety Chairman will be educated on updating and revising the emergency preparedness plan to include any new and/or revised requirements to the regulations. Facility staff will be educated on the updated emergency plan. 4. The Administrator/designee will be responsible for updating the emergency plan as needed. The emergency preparedness program will be monitored by the QA Committee on a quarterly basis for any changes/additions that need to be made. 5. Completion Date: May 11, 2018	

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E 023	Continued From page 15 information, and secures and maintains availability of records. The findings include: On 3/28/18 at 3:47 p.m., the facility's emergency preparedness plan was reviewed with ASM (administrative staff member) # 1 (the administrator), ASM #2 (the director of nursing) and OSM (other staff member) #1 (the dietary manager). Review of the facility's emergency preparedness plan failed to evidence documentation of policies and procedures of how the facility preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. ASM #1, ASM #2 and ASM #3 were made aware of this concern. No further information was obtained prior to exit.	E 023		
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated	E 024	E024 1. The facility has an emergency preparedness plan in place. The plan will be revised to include any missing elements so that it meets the requirements of the regulations. 2. Current facility residents have the potential to be affected by the alleged deficient practice. 3. The emergency preparedness plan will be updated to include the policy and procedure for the use of volunteers, if needed, in the event of an emergency. The Safety Chairman will be educated on updating and revising the emergency preparedness plan to include any new and/or revised requirements to the regulations. Facility staff will be educated on the updated emergency plan. 4. The Administrator/designee will be responsible for updating the emergency plan as needed. The emergency preparedness program will be monitored by the QA Committee on a quarterly basis for any changes/additions that need to be made. 5. Completion Date: May 11, 2018	

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E 024	Continued From page 16 health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures for the use of volunteers in the emergency plan. The findings include: On 3/28/18 at 3:47 p.m., the facility's emergency preparedness plan was reviewed with ASM (administrative staff member) # 1 (the administrator), ASM #2 (the director of nursing) and OSM (other staff member) #1 (the dietary manager). Review of the facility's emergency preparedness plan failed to evidence documentation of policies and procedures for the use of volunteers in the emergency plan. ASM #1, ASM #2 and ASM #3 were made aware of this concern. No further information was obtained prior to exit.	E 024		
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must	E 026	E026 1. The facility has an emergency preparedness plan in place. The plan will be revised to include any missing elements so that it meets the requirements of the regulations. 2. Current facility residents have the potential to be affected by the alleged deficient practice.	

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E 026	Continued From page 17 develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at alternate care sites under an 1135 waiver. The findings include: On 3/28/18 at 3:47 p.m., the facility's emergency preparedness plan was reviewed with ASM	E 026	3. The emergency preparedness plan will be updated to include facility policies and procedures for the provision of care and treatment of patients if they have to be moved to an alternate care site if so mandated by emergency management officials. The Safety Chairman will be educated on updating and revising the emergency preparedness plan to include any new and/or revised requirements to the regulations. Facility staff will be educated on the updated emergency plan. 4. The Administrator/designee will be responsible for updating the emergency plan as needed. The emergency preparedness program will be monitored by the QA Committee on a quarterly basis for any changes/additions that need to be made. 5. Completion Date: May 11, 2018	

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E 026	Continued From page 18 (administrative staff member) # 1 (the administrator), ASM #2 (the director of nursing) and OSM (other staff member) #1 (the dietary manager). Review of the facility's emergency preparedness plan failed to evidence documentation of policies and procedures in the emergency plan that describe the facility's role in providing care and treatment at alternate care sites under an 1135 waiver. ASM #1, ASM #2 and ASM #3 were made aware of this concern. No further information was obtained prior to exit.	E 026		
E 033 SS=C	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4).	E 033	E033 1. The facility has an emergency preparedness plan in place. The plan will be revised to include any missing elements so that it meets the requirements of the regulations. 2. Current facility residents have the potential to be affected by the alleged deficient practice. 3. The emergency preparedness plan will be updated to include documentation that the communication plan includes a method for sharing information and medical documentation for facility patients with other healthcare providers and policy on how the facility will communicate patient condition and location. The Safety Chairman will be educated on updating and revising the emergency preparedness plan to include any new and/or revised requirements to the regulations. Facility staff will be educated on the updated emergency plan. 4. The Administrator/designee will be responsible for updating the emergency plan as needed. The emergency preparedness program will be monitored by the QA Committee on a quarterly basis for any changes/additions that need to be made. 5. Completion Date: May 11, 2018	

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E 033	Continued From page 19	E 033		

*[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative.

*[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan.

The facility staff failed to provide evidence of documentation that the communication plan included a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity of care by reviewing the communication plan and documentation that the facility has developed policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients by reviewing the communication plan.

The findings include:

On 3/28/18 at 3:47 p.m., the facility's emergency preparedness plan was reviewed with ASM (administrative staff member) # 1 (the

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E 033	Continued From page 20 administrator), ASM #2 (the director of nursing) and OSM (other staff member) #1 (the dietary manager). Review of the facility's emergency preparedness plan failed to evidence documentation that the communication plan included a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health providers to maintain the continuity of care by reviewing the communication plan and documentation that the facility has developed policies and procedures that address the means the facility will use to release patient information to include the general condition and location of patients by reviewing the communication plan. ASM #1, ASM #2 and ASM #3 were made aware of this concern. No further information was obtained prior to exit.	E 033		
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency	E 035	E035 1. The facility has an emergency preparedness plan in place. The plan will be revised to include any missing elements so that it meets the requirements of the regulations. 2. Current facility residents have the potential to be affected by the alleged deficient practice. 3. The emergency preparedness plan will be updated to include documentation that the communication plan includes a method for sharing information from the emergency with patients and their families or representatives. The Safety Chairman will be educated on updating and revising the emergency preparedness plan to include any new and/or revised requirements to the regulations. Facility staff will be educated on the updated emergency plan.	

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E 035	Continued From page 21 preparedness plan. The facility staff failed to provide evidence of documentation that the communication plan includes a method for sharing information from the emergency plan with residents or clients and their families or representatives. The findings include: On 3/28/18 at 3:47 p.m., the facility's emergency preparedness plan was reviewed with ASM (administrative staff member) # 1 (the administrator), ASM #2 (the director of nursing) and OSM (other staff member) #1 (the dietary manager). Review of the facility's emergency preparedness plan failed to evidence documentation that the communication plan includes a method for sharing information from the emergency with residents or clients and their families or representatives. ASM #1, ASM #2 and ASM #3 were made aware of this concern. No further information was obtained prior to exit.	E 035	4. The Administrator/designee will be responsible for updating the emergency plan as needed. The emergency preparedness program will be monitored by the QA Committee on a quarterly basis for any changes/additions that need to be made. 5. Completion Date: May 11, 2018	
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.	E 036	E036 1. The facility has an emergency preparedness plan in place. The plan will be revised to include any missing elements so that it meets the requirements of the regulations. 2. Current facility residents have the potential to be affected by the alleged deficient practice. 3. The emergency preparedness plan will be updated to include a written training and testing program that meets the requirements of the regulation. The Safety Chairman will be educated on updating and revising the emergency preparedness plan to include any new and/or revised requirements to the regulations. Facility staff will be educated on the updated emergency plan.	

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E 036	Continued From page 22 *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation that the facility has a written training and testing program that meets the requirements of the regulation. The findings include:	E 036	4. The Administrator/designee will be responsible for updating the emergency plan as needed. The emergency preparedness program will be monitored by the QA Committee on a quarterly basis for any changes/additions that need to be made. 5. Completion Date: May 11, 2018	

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E 036	Continued From page 23 On 3/28/18 at 3:47 p.m., the facility's emergency preparedness plan was reviewed with ASM (administrative staff member) # 1 (the administrator), ASM #2 (the director of nursing) and OSM (other staff member) #1 (the dietary manager). Review of the facility's emergency preparedness plan failed to evidence documentation that the facility has a written training and testing program that meets the requirements of the regulation. ASM #1, ASM #2 and ASM #3 were made aware of this concern. No further information was obtained prior to exit.	E 036		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their	E 037	E037 1. The facility has an emergency preparedness plan in place. The plan will be revised to include any missing elements so that it meets the requirements of the regulations. 2. Current facility residents have the potential to be affected by the alleged deficient practice. 3. The emergency preparedness plan will be updated to include initial emergency preparedness training and annual emergency preparedness training for volunteers with the provision of documenting such training. The Safety Chairman will be educated on updating and revising the emergency preparedness plan to include any new and/or revised requirements to the regulations. Facility staff will be educated on the updated emergency plan. 4. The Administrator/designee will be responsible for updating the emergency plan as needed. The emergency preparedness program will be monitored by the QA Committee on a quarterly basis for any changes/additions that need to be made. 5. Completion Date: May 11, 2018	

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E 037	Continued From page 24 expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training.	E 037		

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*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness

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policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan.

The facility staff failed to provide evidence of documentation of the facility's initial emergency preparedness training and annual emergency preparedness training offerings for volunteers and documentation that facility volunteers have

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E 037	Continued From page 27 received initial & annual emergency preparedness training. The findings include: On 3/28/18 at 3:47 p.m., the facility's emergency preparedness plan was reviewed with ASM (administrative staff member) # 1 (the administrator), ASM #2 (the director of nursing) and OSM (other staff member) #1 (the dietary manager). Review of the facility's emergency preparedness plan failed to evidence documentation of the facility's initial emergency preparedness training and annual emergency preparedness training offerings for volunteers and documentation that facility volunteers have received initial & annual emergency preparedness training. ASM #1, ASM #2 and ASM #3 were made aware of this concern. No further information was obtained prior to exit.	E 037		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/27/18 through 3/30/18. One complaint was investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 176 certified bed facility was 138 at the time of the survey. The survey sample consisted of 28 current resident reviews (Residents # 236, 235, 234, 132, 90, 133, 89, 97, 74, 55, 83, 3, 61, 114, 130, 99, 69, 17, 37, 105, 38, 95, 384, 73, 66, 57, 47 and 98) and three closed record reviews (Residents # 334, 135 and	F 000		

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	134).			
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F 580	F580	

§483.10(g)(14) Notification of Changes.
(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically

1. Corrective action has been accomplished for the alleged deficient practice in regards to resident #130, resident has discharged from the facility.
2. Current facility residents have the potential to be affected by the alleged deficient practice. 100% audit will be completed of NP/MD notification of all significant weight loss residents starting February 1, 2018 til April 13, 2018. 100% Audit of new admissions will then continue weekly x 4 weeks, then monthly x 2 months.
3. Measures put into place to assure alleged deficient practice does not recur include: Nursing staff will be reeducated on notification to NP/MD for significant weight loss.
4. The Director of Nursing and/or designee will analyze/review for patterns/trends and report in the Quality Assurance committee meeting quarterly for a minimum of six months to evaluate the effectiveness of the plan and will adjust the plan as the committee may recommend, based on outcomes/trends identified from date.
5. Completion Date: May 11, 2018

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update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to notify the physician (or nurse practitioner) of a resident's change in condition for one of 31 residents in the survey sample, Resident #130.

The facility staff failed to notify Resident #130's physician/nurse practitioner of significant weight loss in February 2018 and March 2018.

The findings include:

Resident #130 was admitted to the facility on 1/11/18 and readmitted on 2/2/18. Resident #130's diagnoses included but were not limited to pneumonia, diabetes and urinary tract infection. Resident #130's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/9/18, coded the resident as cognitively intact. Section K documented Resident #130 presented with a weight loss of five percent or more in the last month or ten percent or more in the last six

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months.

Review of Resident #130's clinical record revealed the following weights:
1/23/18- 204 pounds
2/2/18- 188.5 pounds
2/10/18- 183.5 pounds
2/22/18- 175.5 pounds
3/10/18- 173 pounds
3/13/18- 178 pounds

A note signed by the registered dietician on 2/10/18 documented, "Resident is 188.5% of IBW (ideal body weight) for ht (height), which denotes obesity; BMI (body mass index) 36.8. Resident has lost 15.5lb (pounds)/7.6% of wt (weight) x (times) 10 days since being in the hospital. Received Lasix (1) during hospital stay, which is likely the cause of her wt (weight) loss. Po (By mouth) intakes typically 75-100%, but sometimes only eats 25% of a meal. Labs (labratory tests) and meds (medications) reviewed. Skin intact. P (Plan): 1. Continue current diet regimen. 2. Monitor wts and labs as available..."

A note signed by the registered dietician on 3/17/18 documented, "Resident is 178% of IBW for ht (height), which denotes obesity; BMI 34.8. Resident has lost 10.5lb/5.6% of wt x 1 month since readmission. Wt loss during hospital stay noted as well. Had received Lasix during hospital stay, however Po (by mouth) intakes continues to be 75-100%, but sometimes eats less. Labs and meds reviewed. Skin intact. Will continue to monitor wts. May need nutrition supplement if wt continues to fall. P (Plan): 1. Continue current diet regimen. 2. Monitor wts and labs as available..."

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Further review of Resident #130's clinical record (including nurses' notes, physician notes and nurse practitioner notes) failed to reveal Resident #130's physician (or the nurse practitioner) was made aware of the above weight loss.

Resident #130's comprehensive care plan initiated on 1/11/18 failed to document information regarding physician notification of weight loss.

On 3/29/18 at 1:15 p.m., an interview was conducted with ASM (administrative staff member) #5 (the nurse practitioner). ASM #5 was asked if she was supposed to be notified when a resident presents with a significant weight loss. ASM #5 stated the staff normally notifies her regarding a significant weight loss to see if she wants to prescribe an appetite stimulant but the staff takes it upon themselves to initiate supplements. ASM #5 was asked if she had been made aware of Resident #130's weight loss in February and March. ASM #5 stated she had not.

On 3/29/18 at 2:17 p.m., an interview was conducted with LPN (licensed practical nurse) #6. LPN #6 was asked who should be notified when a resident presents with a significant weight loss. LPN #6 stated the nurse practitioner and dietary department should be notified. When asked why the nurse practitioner should be notified, LPN #6 stated because the resident may need more supplements and there may be other "issues" going on.

On 3/29/18 at 5:48 pm., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

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F 580	Continued From page 32 The facility document titled, "WEIGHT VARIANCE CLINICAL MANAGEMENT PROTOCOL" documented, "3. The physician, the dietary supervisor, and consulting dietitian will be notified when any of the following occurs: a. Weight variance of 5% or greater in any one month b. Weight variance of 7.5% or greater over any three month period c. Weight variance of 10% or greater over any six month period..." No further information was presented prior to exit. (1) "Furosemide (Lasix) is used alone or in combination with other medications to treat high blood pressure. Furosemide is used to treat edema (fluid retention; excess fluid held in body tissues) caused by various medical problems, including heart, kidney, and liver disease. Furosemide is in a class of medications called diuretics ('water pills'). It works by causing the kidneys to get rid of unneeded water and salt from the body into the urine." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682858.html	F 580		
F 584 SS=E	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	F 584	F584 1. Corrective action has been accomplished for the alleged deficient practice in regards to residents #38 and #95 by cleaning and organizing patient's belongings as they requested. For residents #105 and #47, the rooms were cleaned and sanitized by the facility staff and housekeeping. 2. Current facility residents have the potential to be affected by the alleged deficient practice. 100% audit of resident rooms was completed assuring rooms were clean, organized, and home-like.	

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F 584	Continued From page 33 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. §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, resident interview, staff interview and facility document review it was determined, the facility staff failed to maintain a clean, comfortable, homelike environment for four of 31 residents in the survey sample, Residents #38, #95, #105 and #47.	F 584	3. Measures put into place to assure alleged deficient practice does not recur include: Unit managers will audit 20 residents rooms per week x 4 weeks, then 50 rooms per month x 2 months to validate rooms are clean, organized, and home-like. Nursing staff and housekeeping will be reeducated in regards to cleaning policy and providing a home-like environment. 4. The Director of Nursing and/or designee will analyze/review for patterns/trends and report in the Quality Assurance committee meeting quarterly for a minimum of six months to evaluate the effectiveness of the plan and will adjust the plan as the committee may recommend, based on outcomes/trends identified from date. 5. Completion Date: May 11, 2018	

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1. The facility staff failed to assist Resident #38 and #95 in cleaning and organizing their room as requested.

2. The facility staff failed to ensure a clean environment in Resident #105's bathroom.

3. The facility staff failed to ensure a clean environment in Resident #47's bathroom.

The findings include:

1. Resident #38 was admitted to the facility on 2/18/17 with diagnoses that included but were not limited to: anemia, high blood pressure, poor circulation in the legs, diabetes and elevated cholesterol. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 11/13/17 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring the assistance of two staff for all activities of daily living except for eating which the resident could perform after the tray was prepared.

Resident #95 was admitted to the facility on 2/17/16 and readmitted on 3/3/18 with diagnoses that included but were not limited to: intestinal bleeding, schizophrenia, heart failure and diabetes. The most recent complete MDS, a quarterly assessment, with an ARD of 2/23/18 coded the resident as having scored a 15 out of 15 on the BIMS indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring supervision for

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activities of daily living.

Resident #38 and Resident #95 shared the same room in the facility.

An observation was made on 3/27/18 at 2:30 p.m. of the residents' room. In the left corner of the room, a gray bin had clothes and bed pads stacked on top. There were two opened plastic bags with bed pads lying on the floor next to the bin. There was an item grabber on the floor halfway under a chair. On the right side of the room, there were two books and some cards lying on the floor next to the dresser. There were clothes lying on the floor next to the bed and there was a blouse lying over the oxygen concentrator.

An interview was conducted on 3/29/18 at 2:50 p.m. with Resident #38 and #95. The residents stated that they had asked staff to assist them in cleaning up and organizing their room but they do not get assistance. Resident #38 stated, "I asked them to hang up my coat last Friday and the housekeeper finally did it today." (Six days later). Resident #38 stated, "I've asked them to move the bin next to my bed so I can organize my things, I can't get to anything by myself." When asked what staff say when they request assistance, Resident #38 stated, "'We don't have time'." Resident #95 stated, "I asked for another dresser, which would really help." Resident #95 stated, "They haven't changed my bed in over a week. It's supposed to be changed after every shower." When asked if she had requested her sheets to be changed, Resident #95 stated, "They say they will but they don't come back." Resident #95 stated, "They always say this is home. Does this look like home? They won't let

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me hang a calendar. I'd like to have a calendar." The walls in the residents' room was bare of any decoration. Resident #38 stated, "That reacher (on the floor) is mine but I can't pick it up. How can I use it?"

An observation was conducted on 3/29/18 at 3:30 p.m. Resident #38 and #95's room with LPN (licensed practical nurse) #6. When asked what the facility was to the residents, LPN #6 stated, "Home." When asked how the resident's room looked, LPN #6 stated, "It doesn't look like home. The cluttered things should be hung up." When asked who was to assist residents in keeping their room clean, LPN #6 stated, "We are." When asked if it was acceptable to have opened plastic bags of bed pads on the floor, LPN #6 stated, "They're getting dirty. The floors are the dirtiest place."

An interview was conducted on 3/29/18 at 4:15 p.m. with ASM (administrative staff member) #2, the director of nursing. When asked what the facility was to the residents, ASM #2 stated, "Their home." When asked if residents requested help to clean up their room would they get assistance, ASM #2 stated, "Yes." When asked if opened plastic bags containing bed pads were to be on the floor, ASM #2 stated, "No." When asked why, ASM #2 stated, "Because the risk of it getting infected." When asked about residents hanging things on the walls, ASM #2 stated, "We're asking them not to. It's okay if our staff put it up." When informed of Resident #95 wanting a calendar hung up, ASM #2 did not have a response. ASM #2 was made aware of the findings at that time.

On 3/29/18 at 6:00 p.m. ASM #1, the

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administrator, ASM #2, the director of nursing and ASM #7, the owner were made aware of the findings. ASM #1 stated, "I knew they had asked for help getting the room cleaned up."

An interview was conducted on 3/30/18 at 9:05 a.m. with CNA (certified nursing assistance) #4. When asked if opened plastic bags of bed pads could be left on the floor, CNA #4 stated, "Oh no, they can't be on the floor. We put them in the closet or on the wheelchair. They can become cross contaminated with whatever's on the floor. When asked what staff do, if residents ask to have their room cleaned and organized, CNA #4 stated, "We are to help them." When asked about Resident #38's request to have the room cleaned and organized, CNA #4 stated, "I'm not her aide but she is stuck in that bed until we can get her up. I know how she likes her things."

No further information was provided prior to exit.

2. The facility staff failed to clean a brown substance on the toilet seat for Resident #105.

Resident #105 was admitted to the facility on 4/23/10 and readmitted on 6/17/13 with diagnoses that included but were not limited to: anemia, diabetes, high blood pressure, difficulty speaking and depression. The most recent MDS, a quarterly assessment, with an ARD of 3/5/18 coded the resident as having scored 15 out of 15 on the BIMS (breif interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring one-person assistance for all activities of daily living.

An observation was made on 3/27/18 at 2:46 p.m.

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of Resident #105's bathroom. The toilet seat was raised and there was a brown substance smeared across the lower part of the seat. There was a raised toilet seat on the toilet. There was brown substance on the front of the seat and down the inside of the seat.

An observation was made on 3/27/18 at 4:05 p.m. of Resident #105's bathroom. The toilet seat was raised and there was a brown substance smeared across the lower part of the seat. There was a raised toilet seat on the toilet. There was brown substance on the front of the seat and down the inside of the seat.

An observation was made on 3/28/18 at 7:55 a.m. of Resident #105's bathroom. The toilet seat was raised and there was a brown substance smeared across the lower part of the seat. There was a raised toilet seat on the toilet. There was brown substance on the front of the seat and down the inside of the seat.

An observation was made on 3/28/18 at 8:05 a.m. of Resident #105's bathroom, with OSM (other staff member) #6, the housekeeper. OSM #6 stated, "Oh that needs to be cleaned up. I'll take care of it." When asked how often bathrooms are cleaned, OSM #6 stated, "Everyday and as needed." When asked how she was made aware that a toilet needed to be cleaned, OSM #6 stated, "The staff should call us or if we see it when we make our rounds."

On 3/29/18 at 6:00 p.m. ASM #1, the administrator, ASM #2, the director of nursing and ASM #7, the owner were made aware of the findings.

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An interview was conducted on 3/30/18 at 9:02 a.m. with CNA (certified nursing assistant) #4, the resident's aide. When asked what staff did if the resident's bathroom needed cleaning; CNA #4 stated, "If they're on the wing I'll go up to the housekeeper and let them know. They can't do bodily fluids and I'll clean it up and they sanitize it." When asked what staff would do if the resident's toilet seat was soiled, CNA #4 stated, "I clean it up and use Sani wipes. If I am here I make a point to check my residents' rooms." When informed of the observations in Resident #105's bathroom, CNA #4 stated, "Not all CNAs will clean them up." When asked why staff cleaned the toilets, CNA #4 stated, "Because it can carry diseases. It's very important for us to clean them up so they're not stinking. They need to be clean for the resident and family members as well.

Review of the facility's policy titled, "DAILY WORK ROUTINE - LIGHT HOUSEKEEPER" documented, "705am (7:05 a.m.) AM Walkthrough identify and fix; spills, odors, debris, fill lower paper and soap supplies resident rooms, bathrooms, nursing areas. 2:00 PM Lunch Walkthrough identify and fix; spills, odors, debris, low supplies resident rooms, bathrooms, nursing areas pull trash from all nursing areas."

No further information was provided prior to exit.
3. The facility staff failed to ensure a clean environment in Resident #47's bathroom.

Resident #47 was admitted to the facility on 3/23/16 with diagnoses that included but were not limited to anxiety disorder, Alzheimer's disease, unspecified dementia without behavioral disturbance, high blood pressure, muscle

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weakness, and major depressive disorder. Resident #47's most recent MDS (minimum data set) assessment was annual assessment with an ARD (assessment reference date) of 1/1/18. Resident #47 was coded as severely cognitively impaired in the ability to make daily decision scoring 03 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #47 was coded as requiring extensive assistance from two or more persons with most ADLS (activities of daily living).

On 3/27/18 at 4:12 p.m., observation of Resident #47's bathroom was conducted. A brown substance resembling feces was observed dried to the bathroom floor.

On 3/28/18 at 7:30 a.m., observation of Resident #47's bathroom was conducted. The brown substance remained on the floor.

On 3/28/18 at 7:42 a.m., an interview was conducted with CNA (certified nursing assistant) #5. When asked how often CNA's round on their residents, CNA #5 stated she was not sure because she was not technically a CNA. CNA #5 stated she passes out water, snacks etc. CNA #5 stated that when CNAs first get onto the unit they should be checking their residents and the rooms. CNA #5 stated checking the rooms included the bathrooms. CNA #5 stated she will also check the rooms for cleanliness. When asked if she had been in Resident #47's room that morning, CNA #5 stated that she had. When asked if she had checked Resident #47's bathroom, CNA #5 stated she had not. CNA #5 accompanied this writer to Resident #47's bathroom. When CNA #5 was asked what she saw on the bathroom floor, CNA #5 confirmed

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there was a brown substance on the floor but could not identify what it was. CNA #5 stated, "She uses a lift to go to the bathroom, so there is no reason why that is on the floor." When asked if she was implying the brown substance was feces, CNA #5 stated, "It better not be."

On 3/28/18 at 7:46 a.m., an interview was conducted with LPN (licensed practical nurse) #1, Resident #47's nurse. When asked when she first starts her rounding in the morning, LPN #1 stated that first she will get report, and then do rounds, looking at residents and rooms. When asked who was responsible for checking the resident's bathrooms for cleanliness, LPN #1 stated, "We are all responsible." LPN #1 accompanied this writer to Resident #47's bathroom. LPN #1 confirmed that there was a brown substance on the floor. LPN #1 could not identify what the substance was. LPN #1 stated that she had not yet been in Resident #47's room. LPN #1 stated she was not sure how often housekeeping rounded on the unit. LPN #1 stated, "It depends."

On 3/30/18 at 8:18 a.m., further interview was conducted with LPN #1. When asked who cleaned the brown substance off the floor of Resident #47's bathroom, LPN #1 stated she did, and then told housekeeping to sanitize behind her. When asked if Resident #47's bathroom was a clean environment, LPN #1 stated, "No I don't consider that a clean environment."

On 3/30/18 at 8:30 a.m., an interview was conducted with OSM (other staff member) #9, the Director of Housekeeping. When asked the housekeeping schedule, OSM #9 stated that her staff will do rounds in the morning until breakfast

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F 584	Continued From page 42 trays come onto the floor. During breakfast, her staff will clean offices and the lobby. OSM #9 stated when the trays are off the floor; her staff will go back to cleaning the rooms. What asked what cleaning entailed, OSM #9 stated her staff will sweep, and mop both the floors, including the bathrooms, dust and collect trash. OSM #9 stated her staff will make several rounds throughout the day and check the rooms for trash, things on the floor. etc. OSM #9 stated her staff leave at 3 p.m. When asked if nursing staff will call/alert them if there is feces or anything like that on the bathroom floor, OSM #9 stated typically nursing staff clean up any bodily fluids and then housekeeping will come behind them and sanitize. OSM #9 stated they have to be alerted in order for them to know which room to sanitize. OSM #9 stated she has a floor tech that is present after 3:00 p.m. that can sanitize rooms. OSM #9 stated her staff were not made aware of the brown substance in Resident #47's bathroom. OSM #9 stated there was no communication to her department. On 3/29/18 at 5:47 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) and ASM #7, the facility owner were made aware of the above concerns.	F 584		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs	F 622	F622 1. Corrective action has been accomplished for the alleged deficient practice in regards to residents #3, 74, and 97. The NP has documented late entries for the residents noted related to the reason for the transfer and the reason their care was not manageable in this facility.	

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F 622	Continued From page 43 cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this	F 622	2. Current facility residents have the potential to be affected by the alleged deficient practice. Moving forward, the NP on call or covering for the facility will give a verbal order, if appropriate, then remotely write a note on the resident. A 100% audit of resident transferred to the hospital will be completed starting on 3/1/18 and ending on 3/31/18, then 100% weekly and reported at risk meeting x 3 months. 3. Measures put into place to assure alleged deficient practice does not recur include: Medical Director will in-service NP's on procedure. 4. The Director of Nursing and/or designee will analyze/review for patterns/trends and report in the Quality Assurance committee meeting quarterly for a minimum of six months to evaluate the effectiveness of the plan and will adjust the plan as the committee may recommend, based on outcomes/trends identified from date. 5. Completion Date: May 11, 2018.	

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

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Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide evidence of physician documentation in the clinical record when three of 31 residents in the survey sample; Residents #3, #74, and #97, were transferred to the hospital.

1. Resident #3 was transferred and admitted to the hospital on 3/17/18. The clinical record, failed to evidence any documented physician notes regarding the reason for the transfer, and rationale for how the facility was not able to manage the resident's condition.

2. Resident #74 was transferred and admitted to the hospital on 3/22/18, 12/24/17, and 12/8/17. The clinical record, failed to evidence any documented physician notes regarding the reason for the transfer, and rationale for how the facility was not able to manage the resident's condition.

3. Resident #97 was transferred to hospital for on 2/2/18 and 2/28/18. The facility staff failed ensure the physician documented in the clinical record to justify the reason for the transfers and why the facility was not able to manage the resident's condition.

The findings include:

1. Resident #3 was transferred and admitted to the hospital on 3/17/18. The clinical record, failed to evidence any documented physician notes regarding the reason for the transfer, and rationale for how the facility was not able to manage the resident's condition.

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Resident #3 was admitted to the facility on 9/10/16 with the diagnoses of but not limited to atrial fibrillation, morbid obesity, chronic kidney disease, systemic inflammatory response syndrome, bladder obstruction, chronic ischemic heart disease, schizophrenia, Parkinson's disease, diabetes, high blood pressure, and bipolar disorder. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/14/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting, and hygiene; was independent for eating; and as incontinent of bowel and as having an indwelling catheter for bladder.

A review of the clinical record revealed the following nurse's note dated 3/17/18:

- 8:08: "Resident rolled self out into nursing station c/o (complains of) all over body pain. Resident stated that Tylenol [1] does not help and that there is nothing that the staff can do for him. Resident continues to blame "Trump" for all over pain and discomfort stating, "he is trying to hurt me, he uses his black box to hurt my head and groin." Resident's BP (blood pressure) was 158/102, P (pulse) 80 reg (regular) T (temperature) 98.1, R (Respirations) 22. Pain of 10/10 (ten out of ten on a zero to ten scale) all throughout. Pupils were not equal, Left [sic] greater than Right [sic], both do constrict with light but Right [sic] more than Left [sic]. (ASM #8) (Administrative Staff Member, the Nurse Practitioner) contacted at 1938 (7:38PM) and agreed to send resident out for further eval

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(evaluation). Wife contacted at 1941 (7:41PM). 911 contacted 2000 (8:00PM). Arrived at 2005 (8:05PM) and just left with resident. Will contact (hospital) for update in a few hours."

Further review of the clinical record failed to reveal a note by the facility physician regarding the reason for the transfer and rationale for why the resident's condition could not be managed at the facility.

On 3/29/18 at 1:35 p.m., in an interview with ASM #5 (a Nurse Practitioner), regarding transfers to the hospital, she stated that if she is in the building, she will see the resident and write a note. If it is after hours, she is at home, and the facility calls her, she will not write a note because she did not see the resident. ASM #5 stated that she "probably should make quick note about it."

A review of the facility policy "Policy and Procedures Regarding Physician Services" failed to reveal any criteria for the physician to write a note describing why a resident was transferred to the hospital and why the resident's condition could not be managed at the facility.

On 3/29/18 at 6:05PM at the end of day meeting, the Administrator, ASM (Administrative Staff Member) #1 , Director of Nursing (ASM #2), and the facility owner (ASM #7) were made aware of the findings. No further information was provided by the end of the survey.

[1] Tylenol is used to treat mild to moderate pain. Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html

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2. Resident #74 was transferred and admitted to the hospital on 3/22/18, 12/24/17, and 12/8/17. The clinical record, failed to evidence any documented physician notes regarding the reason for the transfer, and rationale for how the facility was not able to manage the resident's condition.

Resident #74 was admitted to the facility on 8/26/13 with the diagnoses of but not limited to stroke, intestinal disease, depression, metabolic encephalopathy, dementia, schizoaffective disorder, dysphagia, gastrostomy feeding tube, cataracts, presbyopia, Parkinson's disease, schizophrenia, bipolar disorder, angina, diabetes, high blood pressure, hypothyroidism, and chronic obstructive pulmonary disease. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/16/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for transfers, dressing, and hygiene; extensive care for eating; and as incontinent of bowel and bladder.

A review of the clinical record revealed the following nurse's note dated 3/22/18:

- 3:00PM: "Resident is Lethargic BP (blood pressure) 138/68 P (pulse) 86, 97.9 (temperature), R (respirations) 18, O2 (oxygen) @ (at) 83% BP [sic] 282. New Order (ASM #5) (Administrative Staff Member, a Nurse Practitioner) apply O2@2L (oxygen at 2 liters) via mask. V.O. (verbal order) (ASM #5) send to ER (emergency room) for evaluation for Hypoxia.

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(Name of daughter) notified @ 1455 (2:55PM) arrived at facility @ 1505 (3:05PM) report given to daughter. 911 notified @ 1505 and arrived at 1515 (3:15PM). Report given to EMT (emergency medical technician). Daughter went with daughter [sic- mother] to (hospital). Report called to ER (emergency room) @1530 (3:30PM) talked to (daughter). Daughter agreed to bed hold witnessed by two nurses."

Further review of the clinical record failed to reveal a note by the facility physician regarding the reason for the transfer and a rationale for why the resident's condition could not be managed at the facility.

A review of the clinical record revealed the following nurse's notes dated 12/24/17:

- 4:00PM: Thus nurse went in to visit resident upon arrival onto shift. Family was present and was asking questions about residents behaviors for the past couple of days. Advised that this nurse had just come on but had resident yesterday and things seemed fine. Advised she didn't really want to talk but seemed her normal self. Daughter then asked about the cookie swallow that was done and wanted to know how it went. Advised that this nurse did not realize she had one done but wouldn't be surprised if it went well. Family agreed and then stated that they feel she would pass as they have recently brought in mashed potatoes and gravy. Family aware that resident is listed as NPO (nothing by mouth) but admitted to feeding it to her and stating that she did well. NP (nurse practitioner) and assigned nurse made aware of families [sic] comments."

- 4:04PM: Temp 100.3 tympanic pulse 72 R

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(respirations) 22. Nonlabored. BS (bowel sounds) positive. Lungs clear, Resident was yelling out and hitting this nurse with her right hand when I was assessing her lungs. Resident denies pain or discomfort. Asked three times if she didn't feel well. Daughter here and is concerned about the left side of her neck which appear red and slightly swollen. Warm to touch. NP telephoned."

- 4:22PM: (ASM #5) telephoned (hospital) back. (wasn't on call) but ordered Rocephin [1] 1 gm (gram) IM (intramuscular) now and if daughter wants her mom to go to hospital later on order is given.

- 6:13PM: Informed daughter that NP stated if she wants her mom to go to the hospital then she can go. Daughter gave consent for her to go. 911 (nine one one) telephoned. Necessary paperwork prepared. Resident is alert and verbalizing at this time with gentle coaxing by granddaughter at bedside. Resident answers simple questions appropriately. HOB (Head of bed) elevated. EMTs arrived, all paperwork given to EMTS. Resident somewhat non compliant with letting EMTS take her vitals going to hit them, but EMTs were successful after several attempts. Transported safely out of Facility x2 EMTS and daughter and granddaughter following to hospital..

- 10:17PM: (Hospital) telephoned on update of resident. Admitted to step down with diagnosis of parotitis. (salivary gland).

Further review of the clinical record failed to reveal a note by the facility physician regarding the reason for the transfer and rationale for why

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the resident's condition could not be managed at the facility.

A review of the clinical record revealed the following nurse's notes dated 12/8/17:

- 3:05PM: V.O. (verbal order) (ASM #8) (Administrative Staff Member, a Nurse Practitioner) to send resident to (hospital) for evaluation due to vomiting and nausea x2 days. Staff reported no vomiting or nausea this shift. VSS (vital signs stable). Afebrile at this time. Daughter aware of transfer to ER. 911 notified @ (at) 1504 (3:04PM) and arrived to facility @ 1510 (3:10PM). Resident A&Ox2 (alert and oriented to two spheres).

- 3:19PM: (Hospital) notified 2 [sic] 1520 (3:20PM) resident in route to ER for evaluation. Report given to (hospital staff).

- 11:55PM: Spoke with (hospital) with nurse. Resident admitted to room (room number) with DX (diagnosis) of Colonic Mass. Notified (ASM #8) with this information."

Further review of the clinical record failed to reveal a note by the facility physician regarding the reason for the transfer and why the resident's condition could not be managed at the facility.

On 3/29/18 at 1:35 p.m., in an interview with ASM #5 (a Nurse Practitioner), regarding transfers to the hospital, she stated that if she is in the building, she will see the resident and write a note. If it is after hours, she is at home, and the facility calls her, she will not write a note because she did not see the resident. ASM #5 stated that she "probably should make quick note about it."

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A review of the facility policy "Policy and Procedures Regarding Physician Services" failed to reveal any criteria for the physician to write a note describing why a resident was transferred to the hospital and why the resident's condition could not be managed at the facility.

On 3/29/18 at 6:05PM at the end of day meeting, the Administrator ASM (Administrative Staff Member) #1, Director of Nursing (ASM #2), and the facility owner (ASM #7) were made aware of the findings. No further information was provided by the end of the survey.

[1] Rocephin is an antibiotic.
Information obtained from https://medlineplus.gov/druginfo/meds/a685032.html

3. Resident #97 was transferred to hospital for on 2/2/18 and 2/28/18. The facility staff failed ensure the physician documented in the clinical record to justify the reason for the transfers and why the facility was not able to manage the resident's condition.

Resident # 97 was admitted to the facility on 11/19/17, with a most recent readmission on 3/15/18 with diagnoses that included but were not limited to: bladder infections, hypotension (too low blood pressure), malnutrition, depression, difficulty sleeping, asthma, and has a colostomy. The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 2/27/18, coded the resident as scoring a 15 on the BIMS

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(brief interview for mental status) score, indicating she was capable of making her daily decisions. The resident was coded as requiring limited to extensive assistance for her activities of daily living (ADL).

The clinical record revealed a nurse's note dated, 2/2/18 at 11:07 a.m. that documented in part, "Resident c/o (complained of) dizzy feeling this am (morning) bp (blood pressure) obtained noted to be 64/40. NP (nurse practitioner) aware new order noted for Midodrine (used to elevate blood pressure) (1), 5 mg (milligrams) now and then qd (every day). Also ordered 1 liter of d5 (dextrose 5%) 1/2 (half strength) normal saline. Medication administered and IV (intravenous) placed to left arm. IV to start (sic) to infuse resident c/o left sided chest pain with pressure. B/P 76/50 at this time. Resident denied sob (shortness of breath) but stated she hadn't had this pain before and wanted to go to hospital. NP aware of new concerns. New order noted to send to er (emergency room) 911 (emergency medical services) called and daughter (name of daughter) aware. 911 left arrived assessed and left around 11 am. (Daughter's name) is aware of bed hold but will call later after she knows what the plan is for her mother."

Review of the clinical record did not reveal a note by the physician or the nurse practitioner of her seeing the resident on 2/2/18 or a note related to why the resident was transferred to the hospital and how the facility could not meet the resident's needs.

The clinical record documented a nurse's note dated, 2/28/18 at 10:13 a.m. "At Approximately 10:00 a.m. (Resident #97)'s CNA (certified

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nursing assistant) notified this nurse that (Resident #97) 'Yelling for a nurse and crying.' This nurse immediately assessed (Resident #97) and noted that she was pale and clammy with SOB (shortness of breath) at rest. Blood pressure was 56/48. (Resident #97)'s legs were immediately elevated and NP (nurse practitioner) notified. NP assessed (Resident #97) and order this nurse to send to ED (emergency department) 911 for eval (evaluation) and tx (treatment) due to symptomatic hypotension. BP was taken by second nurse and was noted to be 70/42. At approximately 10:10 AM, rescue squad arrived and noted her blood pressure to be 72/42 with continued symptoms. (Resident #97) was unable to keep eyes open but was responding verbally and answering questions accordingly/appropriately. VS (vital signs) at time of transfer to ED were as follows: 97.5 (temperature), 75 (pulse) 18 Respirations), 72/42 (blood pressure) 95% RA (95% oxygen saturation on room air). (Resident #97)'s husband notified per resident request."

Review of the clinical record failed to evidence a note by the nurse practitioner who assessed the resident on 2/28/18 and the decision to transfer the resident to the hospital.

An interview was conducted with administrative staff member (ASM) #5, the nurse practitioner, on 3/29/18 at 1:20 p.m. When asked if she writes a note when a resident is transferred to the hospital, ASM #5 stated, "If I am in building, yes I do. If it's after hours, I usually don't. (ASM #6) the medical director and I spoke yesterday and that it would be a good idea to write a note as to why they went out, whoever gets the call."

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F 622	Continued From page 55 The administrator, ASM #1, director of nursing ASM #2, and ASM #7, the owner were made aware of the above findings on 3/29/18 at 6:10 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011219/?report=details	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623	F623 1. Corrective action has been accomplished for the alleged deficient practice in regards to residents #66, 57, 73, 130, 3, 74, 95, 99, and 97. These residents have returned to the facility. 2. Current facility residents have the potential to be affected by the alleged deficient practice. Social Service worker will do a 100% audit of transferred residents starting on 4/1/18 to 4/15/18 r/t the transfer/discharge notification sheet, assuring the resident or the resident's representative is given the information, then will be done daily x 3 months. 3. Measures put into place to assure alleged deficient practice does not recur include: Social Service workers will be reeducated to notify the resident or resident's representative of transfer and reason for transfer from this facility. 4. The Director of Nursing and/or designee will analyze/review for patterns/trends and report in the Quality Assurance committee meeting quarterly for a minimum of six months to evaluate the effectiveness of the plan and will adjust the plan as the committee may recommend, based on outcomes/trends identified from date. 5. Completion Date: May 11, 2018.	

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EVERGREEN HEALTH AND REHAB	380 MILLWOOD AVENUE WINCHESTER, VA 22601

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before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with

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developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on staff interview, and clinical record review, it was determined that the facility staff failed to provide the required written notifications at the time of a facility initiated transfer for 9 of 31 residents in the survey sample, Resident #66, #57, #73, #130, #3, #74, #95, #99 and #97.

1. Resident #66 was discharged to the hospital

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on 2/27/18. The facility staff failed to provide written notification of the facility initiated discharge to the resident's representative.

2. Resident #57 was discharged to the hospital on 1/16/18. The facility staff failed to provide written notification of the facility initiated discharge to the resident's representative.

3. Resident #73 was discharged to the hospital on 1/15/18. The facility staff failed to provide written notification of the facility initiated discharge to the resident's representative.

4. Resident #130 discharged to the hospital on 1/26/18. The facility staff failed to provide written notification of the facility initiated discharge to the resident's representative.

5. Resident #3 was transferred and admitted to the hospital on 3/17/18. The facility did not provide written notification to the responsible party regarding the reason for the transfer.

6. Resident #74 was transferred and admitted to the hospital on 3/22/18, 12/24/17, and 12/8/17. The facility did not provide written notification to the responsible party regarding the reason for the transfer.

7. The facility staff failed to provide a written notification to Resident #95 or the resident's representative for a facility initiated emergency room transfer on 2/28/18.

8. The facility staff failed to provide a written notification to Resident #99's representative for a facility initiated emergency room transfer on 2/5/18.

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9. The facility staff failed to provide written documentation that Resident 97 or the resident's representative were notified in writing when she was transferred to the hospital on 2/2/18 and 2/28/18.

The findings include:

1. Resident #66 was admitted to the facility on 4/19/17 and readmitted on 2/11/18 with diagnoses that included but were not limited to unspecified dementia without behavioral disturbance, heart failure, gout, major depressive disorder, high blood pressure and atrial fibrillation. Resident #66's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 2/13/18. Resident #66 was coded as severely cognitively impaired in the ability to make daily decisions scoring 03 out of 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #66's clinical record reveled that she went to the hospital on 2/27/18. The following note was documented, "0450 (4:50 a.m.) resident sitting in chair in common area. resident (sic) leaning forward to pick something up. staff (sic) directed resident to sit back and started going to resident. resident (continued) to lean forward and fell face first onto floor. this (sic) nurse and CNA (certified nursing assistant) (Name of CNA) to resident. resident (sic) alert and able to speak clearly. follow (sic) instructions and answers questions appropriately. PERRLA (Pupils Equal, Round, Reactive to light), and accommodation). denied (sic) headache/nausea/dizziness. resident (sic) wearing glasses on face at time of fall, residents

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glasses had slid up onto forehead during fall. large (sic) laceration noted to forehead. copious (sic) amounts of blood noted. ROM (range of motion) performed with minimal difficulty. resident (sic) denied that need for PRN (as needed) Tylenol (1). resident (sic) refusing to lay in current position. sitting (sic) up on floor. gauze (sic) and kling (sic) wrap applied to forehead. (Name of NP (nurse practitioner)) notified of above information. order (sic) obtained to send to (Name of ED (emergency department)) for eval (evaluation) and treat. resident (sic) husband and son both RP (responsible party) to be contacted. messages (sic) left."

Further review of the nursing notes revealed the RP was notified of the transfer. There was no evidence that the responsible party was notified in writing of the reason for transfer to the hospital.

On 3/29/18 at 2:17 p.m., an interview was conducted with LPN (licensed practical nurse) #6. When asked how she notifies the family of a resident transfer to the emergency room or hospital, LPN #6 stated the family is always notified verbally. LPN #6 stated the nurses do not provide written notification to the responsible party documenting the reason for transfer.

On 3/29/18 at 5:47 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) and ASM #7, the facility owner were made aware of the above concerns. A policy could not be provided regarding the above concern. No further information was presented prior to exit.

(1) Tylenol Tablet 325 mg (Acetaminophen) treats minor aches and pains and also reduces fever.

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This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008785/?report=details.

2. Resident #57 was discharged to the hospital on 1/16/18. The facility staff failed to provide written notification of the facility initiated discharge to the resident's representative.

Resident #57 was admitted to the facility on 5/24/14 and readmitted on 1/22/18 with diagnoses that included but were not limited to Dementia with behavioral disturbance, muscle weakness, Alzheimer's disease and mood disorder. Resident #57's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/8/18. Resident #57 was coded as being severely impaired in cognitive function scoring 06 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #57's clinical record revealed that he went out to the the hospital on 1/16/18. The following note was documented: "1/15/18 at 2:56 p.m., Resident was leaning to the left in his wheelchair with rapid respirations noted. Prior to this being noted resident ate well for breakfast and was then wheeling himself up and down the hallway and wandering like his normal behavior. BP (blood pressure 130/80, P (pulse) 98, R (Respirations)-26, o2 (sic) (oxygen saturation) 91 % (percent) temp (temperature) 98.9. NP (nurse practitioner) assessed resident and requested we call his daughter to see if she would like us to treat him here or continue to monitor him she was updated on new orders given by NP for 1 time

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dose of Lasix (1) 20 mg (milligrams) p.o. (by mouth) for BIL (bilateral) LE (lower extremity) edema, chest x-ray to be completed today, scheduled duonebs (2) BID (two times a day) x 7 days...daughter (name of daughter) came to visit after and was updated the chest xray had been completed at 2:30 p.m. and we were waiting results. She stated he appears stable at this time and if any changes noted with resident to call her at any time during the night..."

A nursing note dated 1/16/18 documented the following: "Res. (Resident) due to go out to Neurology apt (appointment). NP seen res (resident) and asked that res. apt (appointment) be canceled due to res being very lethargic and leaning to left side. Res. was repositioned x 2 and res unable to stay up right. Res. c/o (complained) pain routine (sic) pain meds (medications) given earlier. Notified Neurology Dept. (department) to cancel appt. (sic) Spoke to dtr (daughter) about rethinking sending res to hosp (hospital) for eval (evaluation). dtr. stated it would be ok to send him out..."

Further review of the clinical record revealed that Resident #57 arrived back to the facility on 1/22/18 with a primary diagnosis of a UTI (urinary tract infection).

There was no evidence that the responsible party was notified in writing of the reason for transfer to the hospital.

On 3/29/18 at 2:17 p.m., an interview was conducted with LPN (licensed practical nurse) #6. When asked how she notifies the family of a resident transfer to the emergency room or hospital, LPN #6 stated the family is always

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notified verbally. LPN #6 stated the nurses do not provide written notification to the responsible party documenting the reason for transfer.

On 3/29/18 at 5:47 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) and ASM #7, the facility owner were made aware of the above concerns. No further information was presented prior to exit.

(1) Lasix used to decrease edema (excess fluid) in patients with heart failure, liver impairment or kidney disease. This information was obtained from Davis's Drug Guide for Nurses, 11th edition, p. 587.

(2) Duonebs (ipratropium/albuterol) bronchodilator used to open up the lungs. This information was obtained from https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010776/?report=details

3. Resident #73 was discharged to the hospital on 1/15/18. The facility staff failed to provide written notification of the facility initiated discharge to the resident's representative.

Resident #73 was admitted to the facility on 12/12/16 and readmitted on 1/21/18 with diagnoses that included but were not limited to muscle weakness, dementia with behavioral disturbance, major depressive disorder, and high blood pressure. Resident #73's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/15/18. Resident #73 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam.

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Review of Resident #73's nursing notes revealed the following note dated 1/15/18 that documented the following: "This nurse was entering room and observed Resident to be sitting on the floor with her back against the bathroom door. Resident was crying and her right leg was drawn up. Resident stated she could not move her leg. Staff stayed with Resident. VS (vital signs): 98.1 (temperature) 92 (pulse) 30-respirations, 158/82 (blood pressure), 02 (oxygen) 100 percent RA (room air). Resident was not moved. This nurse called 911. EMS (emergency staff) x 2 transported Resident to (Name of Medical Center) via stretcher at 18:15 (6:15) p.m. (Name of NP) and (Name of POA) notified. On-call nurse also notified."

Further Review of Resident #73's clinical record revealed that she arrived back to the facility on 1/22/18 with diagnoses of fracture to her right femur.

There was no evidence that the responsible party was notified in writing of the reason for transfer to the hospital.

On 3/29/18 at 2:17 p.m., an interview was conducted with LPN (licensed practical nurse) #6. When asked how she notifies the family of a resident transfer to the emergency room or hospital, LPN #6 stated the family is always notified verbally. LPN #6 stated the nurses do not provide written notification to the responsible party documenting the reason for transfer.

On 3/29/18 at 5:47 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) and ASM #7, the facility

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owner were made aware of the above concerns. No further information was presented prior to exit.

4. Resident #130 discharged to the hospital on 1/26/18. The facility staff failed to provide written notification of the facility initiated discharge to the resident's representative.

Resident #130 was admitted to the facility on 1/11/18 and readmitted on 2/2/18. Resident #130's diagnoses included but were not limited to pneumonia, diabetes and urinary tract infection. Resident #130's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/9/18, coded the resident as cognitively intact.

Review of Resident #130's clinical record revealed a nurse's note dated 1/26/18 that documented, "Resident noted to be lethargic unable to wake up. VS (Vital Signs) - 97.3 (temperature) - 67 (pulse) - 20 (respirations) - 90/50 (blood pressure) - 92% (oxygen saturation) with 3L (liters) o2 (oxygen). bs (blood sugar) 236 did not eat lunch. NP (Nurse Practitioner) aware of change in condition. New order to send to ER (Emergency Room) via 911. Son (name) aware and notified of bed hold voiced if gets admitted he would not like bed hold."

Resident #130 was admitted to the hospital on 1/26/18 and returned to the facility on 2/2/18.

Further review of Resident #130's clinical record failed to reveal the resident's representative was made aware of the reason for the discharge in writing.

On 3/29/18 at 2:17 p.m., an interview was

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conducted with LPN (licensed practical nurse) #6 regarding the nurses' role when a resident is sent to the hospital. LPN #6 was asked how the resident's family is notified of transfers to the hospital. LPN #6 stated, "By phone." When asked if any written notification is provided to the resident's representative, LPN #6 stated, "No."

On 3/29/18 at 2:59 p.m., an interview was conducted with OSM (other staff member) #3 (social worker). OSM #3 was asked if she provides written notification to the resident representative when a resident is sent to the hospital. OSM #3 stated, "I do not."

On 3/29/18 at 5:48 pm., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

On 3/30/18 at 12:30 p.m., ASM #2 stated the facility did not have a policy regarding transfers and discharges.

No further information was presented prior to exit.

5. Resident #3 was transferred and admitted to the hospital on 3/17/18. The facility did not provide written notification to the responsible party regarding the reason for the transfer.

Resident #3 was admitted to the facility on 9/10/16 with the diagnoses of but not limited to atrial fibrillation, morbid obesity, chronic kidney disease, systemic inflammatory response syndrome, bladder obstruction, chronic ischemic heart disease, schizophrenia, Parkinson's disease, diabetes, high blood pressure, and bipolar disorder. The most recent MDS

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(Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/14/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident required total care for bathing; extensive care for transfers, dressing, toileting, and hygiene; was independent for eating; and was incontinent of bowel and had an indwelling catheter for bladder.

A review of the clinical record revealed the following nurse's note dated 3/17/18:

- 8:08: "Resident rolled self out into nursing station c/o (complains of) all over body pain. Resident stated that Tylenol [1] does not help and that there is nothing that the staff can do for him. Resident continues to blame "Trump" for all over pain and discomfort stating, "he is trying to hurt me, he uses his black box to hurt my head and groin." Resident's BP (blood pressure) was 158/102, P (pulse) 80 reg (regular) T (temperature) 98.1, R (Respirations) 22. Pain of 10/10 (ten out of ten on a zero to ten scale) all throughout. Pupils were not equal, Left [sic] greater than Right [sic], both do constrict with light but Right [sic] more than Left [sic]. (ASM #8) (Administrative Staff Member, a nurse practitioner) contacted at 1938 (7:38PM) and agreed to send resident out for further eval (evaluation). Wife contacted at 1941 (7:41PM). 911 contacted 2000 (8:00PM). Arrived at 2005 (8:05PM) and just left with resident. Will contact (hospital) for update in a few hours."

Further review of the clinical record failed to reveal any evidence that the responsible party was notified of the reasons for the hospitalization in writing.

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EVERGREEN HEALTH AND REHAB	380 MILLWOOD AVENUE WINCHESTER, VA 22601

(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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On 3/29/18 at 2:27 p.m., in an interview with LPN #6 (Licensed Practical Nurse), when asked about the process staff follow for sending a resident to the hospital, she stated, check the vital signs, call the doctor or nurse practitioner, get an order, complete the paperwork, chart on it, notify the family, and call 911. She stated the family is notified verbally by phone. When asked if the facility provides any written notification to family, she stated, "No. I don't believe that the facility provides any written notification."

On 3/29/18 at 6:05 p.m., at the end of day meeting, the Administrator, ASM (Administrative Staff Member) #1, Director of Nursing (ASM #2), and the facility owner (ASM #7) were made aware of the findings. A policy regarding written notifications was requested. No further information was provided by the end of the survey.

[1] Tylenol is used to treat mild to moderate pain. Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html

6. Resident #74 was transferred and admitted to the hospital on 3/22/18, 12/24/17, and 12/8/17. The facility did not provide written notification to the responsible party regarding the reason for the transfer.

Resident #74 was admitted to the facility on 8/26/13 with the diagnoses of but not limited to stroke, intestinal disease, depression, metabolic

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encephalopathy, dementia, schizoaffective disorder, dysphagia, gastrostomy feeding tube, cataracts, presbyopia, Parkinson's disease, schizophrenia, bipolar disorder, angina, diabetes, high blood pressure, hypothyroidism, and chronic obstructive pulmonary disease. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/16/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident required total care for transfers, dressing, and hygiene; extensive care for eating; and was incontinent of bowel and bladder.

A review of the clinical record revealed the following nurse's note dated 3/22/18:

- 3:00PM: "Resident is Lethargic BP (blood pressure) 138/68 P (pulse) 86, 97.9 (temperature), R (respirations) 18, O2 (oxygen) @ (at) 83% BP [sic] 282. New Order (ASM #5) (Administrative Staff Member, a Nurse Practitioner) apply O2@2L (oxygen at 2 liters) via mask. V.O. (verbal order) (ASM #5) send to ER (emergency room) for evaluation for Hypoxia. (Name of daughter) notified @ 1455 (2:55PM) arrived at facility @ 1505 (3:05PM) report given to daughter. 911 notified @ 1505 and arrived at 1515 (3:15PM). Report given to EMT (emergency medical technician). Daughter went with daughter [sic- mother] to (hospital). Report called to ER (emergency room) @1530 (3:30PM) talked to (daughter). Daughter agreed to bed hold witnessed by two nurses."

Further review of the clinical record failed to reveal any evidence that the responsible party was notified of the reasons for the hospitalization

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in writing.

A review of the clinical record revealed the following nurse's notes dated 12/24/17:

- 4:00PM: Thus, nurse went in to visit resident upon arrival onto shift. Family was present and was asking questions about residents behaviors for the past couple of days. Advised that this nurse had just come on but had resident yesterday and things seemed fine. Advised she didn't really want to talk but seemed her normal self. Daughter then asked about the cookie swallow that was done and wanted to know how it went. Advised that this nurse did not realize she had one done but wouldn't be surprised if it went well. Family agreed and then stated that they feel she would pass as they have recently brought in mashed potatoes and gravy. Family aware that resident is listed as NPO (nothing by mouth) but admitted to feeding it to her and stating that she did well. NP (nurse practitioner) and assigned nurse made aware of families [sic] comments."

- 4:04PM: Temp 100.3 tympanic pulse 72 R (respirations) 22. Nonlabored. BS (bowel sounds) positive. Lungs clear, Resident was yelling out and hitting this nurse with her right hand when I was assessing her lungs. Resident denies pain or discomfort. Asked three times if she didn't feel well. Daughter here and is concerned about the left side of her neck which appear red and slightly swollen. Warm to touch. NP telephoned."

- 4:22PM: (ASM #5) telephoned (hospital) back. (wasn't on call) but ordered Rocephin [1] 1 gm (gram) IM (intramuscular) now and if daughter wants her mom to go to hospital later on order is

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given.

- 6:13PM: Informed daughter that NP stated if she wants her mom to go to the hospital then she can go. Daughter gave consent for her to go. 911 (nine one one) telephoned. Necessary paperwork prepared. Resident is alert and verbalizing at this time with gentle coaxing by granddaughter at bedside. Resident answers simple questions appropriately. HOB (Head of bed) elevated. EMTs arrived, all paperwork given to EMTS. Resident somewhat non compliant with letting EMTS take her vitals going to hit them, but EMTs were successful after several attempts. Transported safely out of Facility x2 EMTS and daughter and granddaughter following to hospital.

- 10:17PM: (Hospital) telephoned on update of resident. Admitted to step down with diagnosis of parotitis. (salivary gland).

Further review of the clinical record failed to reveal any evidence that the responsible party was notified of the reasons for the hospitalization in writing.

A review of the clinical record revealed the following nurse's notes dated 12/8/17:

- 3:05PM: V.O. (verbal order) (ASM #8) (Administrative Staff Member, a Nurse Practitioner) to send resident to (hospital) for evaluation due to vomiting and nausea x2 days. Staff reported no vomiting or nausea this shift. VSS (vital signs stable). Afebrile at this time. Daughter aware of transfer to ER. 911 notified @ (at) 1504 (3:04PM) and arrived to facility @ 1510 (3:10PM). Resident A&Ox2 (alert and oriented to two spheres).

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- 3:19PM: (Hospital) notified 2 [sic] 1520 (3:20PM) resident in route to ER for evaluation. Report given to (hospital staff).

- 11:55PM: Spoke with (hospital) with nurse. Resident admitted to room (room number) with DX (diagnosis) of Colonic Mass. Notified (ASM #8) with this information."

Further review of the clinical record failed to reveal any evidence that the responsible party was notified of the reasons for the hospitalization in writing.

On 3/29/18 at 2:27 p.m., in an interview with LPN #6 (Licensed Practical Nurse), when asked the process for sending a resident to the hospital, she stated, check the vital signs, call the doctor or nurse practitioner, get an order, complete the paperwork, chart on it, notify the family, and call 911. She stated the family is notified verbally by phone. When asked if the facility provides any written notification to family, she stated, "No. I don't believe that the facility provides any written notification."

On 3/29/18 at 6:05 p.m., at the end of day meeting, the Administrator, ASM (Administrative Staff Member) #1, Director of Nursing (ASM #2), and the facility owner (ASM #7) were made aware of the findings. A policy regarding written notifications was requested. No further information was provided by the end of the survey.

[1] Rocephin is an antibiotic. Information obtained from https://medlineplus.gov/druginfo/meds/a685032.h

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tml
7. The facility staff failed to provide a written notification to Resident #95 or the resident's representative for a facility initiated emergency room transfer on 2/28/18.

Resident #95 was admitted to the facility on 2/17/16 and readmitted on 3/3/18 with diagnoses that included but were not limited to: intestinal bleeding, schizophrenia, heart failure and diabetes.

The most recent complete MDS, a quarterly assessment, with an ARD of 2/23/18 coded the resident as having scored 15 out of 15 on the BIMS (breif interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring supervision for activities of daily living.

Review of the nurse's notes dated 2/28/18 documented that the resident's hemoglobin (1) was four.

Review of the nurse practitioner's note dated 2/28/18 documented that the resident was to be sent to the hospital for treatment of the hemoglobin.

Further review of the clinical record did not evidence documentation that the resident or the resident's representative were notified in writing of the emergency room transfer.

On 3/29/18 at 6:00 p.m. ASM #1, the administrator, ASM #2, the director of nursing and ASM #7, the facility owner were made aware of the findings.

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No further information was provided prior to exit.

1 Hemoglobin -- Hemoglobin (Hb) is the protein contained in red blood cells that is responsible for delivery of oxygen to the tissues. This information was obtained from: https://www.ncbi.nlm.nih.gov/books/NBK259/

8. The facility staff failed to provide a written notification to Resident #99's representative for a facility initiated emergency room transfer on 2/5/18.

Resident #99 was admitted to the facility on 6/9/17 and readmitted on 2/26/18 with diagnoses that included but were not limited to: heart failure, pneumonia, anemia, depression and cognitive communication deficit.

The most recent MDS, a significant change assessment, with an ARD of 3/5/18 coded the resident as 99 on the BIMS (breif interview for mental status) indicating the resident was not able to complete the exam. The resident was coded as understanding others and being understood and having intact short and long term memory. The resident was coded as requiring assistance for all activities of daily living.

Review of the nurse's notes dated 2/5/18 documented that the resident complained of shortness of breath. The resident's oxygen saturation (1) was 88% to 92% on 3 liters of oxygen.

Review of the nurse practitioner's note dated 2/5/18 documented that due to the resident's low oxygen saturation and pneumonia the resident

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was to be sent to the emergency room for further treatment.

On 3/29/18 at 2:17 p.m., in an interview with LPN #6 (Licensed Practical Nurse), when asked about the process staff follow for sending a resident to the hospital, LPN #6 stated, check the vital signs, call the doctor or nurse practitioner, get an order, complete the paperwork, chart on it, notify the family, and call 911. She stated the family is notified verbally by phone. When asked if the facility provides any written notification to family, LPN #6 stated, "No. I don't believe that the facility provides any written notification."

On 3/29/18 at 6:00 p.m. ASM #1, the administrator, ASM #2, the director of nursing and ASM #7, the facility owner were made aware of the findings.

No further information was provided prior to exit.

1. Oxygen Saturation --patients with hypoxemia (blood oxygen saturation <90%) are usually hospitalized, although validated criteria (eg, the Pneumonia Severity Index [PSI]) suggest outpatient treatment is safe. This information was obtained at: https://www.ncbi.nlm.nih.gov/pubmed/21217179

9. The facility staff failed to provide written documentation that Resident 97 or the resident's representative were notified in writing when she was transferred to the hospital on 2/2/18 and 2/28/18.

Resident # 97 was admitted to the facility on 11/19/17, with a most recent readmission on 3/15/18 with diagnoses that included but were not

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limited to: bladder infections, hypotension (too low blood pressure), malnutrition, depression, difficulty sleeping, asthma, and has a colostomy.

The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 2/27/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating she was capable of making her daily decisions.

The clinical record revealed a nurse's note dated, 2/2/18 at 11:07 a.m. documented in part, "Resident c/o (complained of) dizzy feeling this am (morning) bp (blood pressure) obtained noted to be 64/40. NP (nurse practitioner) aware new order noted for Midodrine (used to elevate blood pressure) (1), 5 mg (milligrams) now and then qd (every day). Also ordered 1 liter of d5 (dextrose 5%) 1/2 (half strength) normal saline). Medication administered and IV (intravenous) placed to left arm. IV to start (sic) to infuse resident c/o left sided chest pain with pressure. B/P 76/50 at this time. Resident denied sob (shortness of breath) but stated she hadn't had this pain before and wanted to go to hospital. NP aware of new concerns. New order noted to send to er (emergency room) 911 (emergency medical services) called and daughter (name of daughter) aware. 911 left arrived assessed and left around 11 am. (Daughter's name) is aware of bed hold but will call later after she knows what the plan is for her mother."

Review of the clinical record did not reveal documentation that the resident or their representative were provided written documentation as to why the resident was being transferred to the hospital.

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The clinical record documented a nurse's note dated, 2/28/18 at 10:13 a.m. "At Approximately 10:00 a.m. (Resident #97)'s CNA (certified nursing assistant) notified this nurse that (Resident #97) 'Yelling for a nurse and crying.' This nurse immediately assessed (Resident #97) and noted that she was pale and clammy with SOB (shortness of breath) at rest. Blood pressure was 56/48. (Resident #97)'s legs were immediately elevated and NP (nurse practitioner) notified. NP assessed (Resident #97) and order this nurse to send to ED (emergency department) 911 for eval (evaluation) and tx (treatment) due to symptomatic hypotension. BP was taken by second nurse and was noted to be 70/42. At approximately 10:10 AM, rescue squad arrived and noted her blood pressure to be 72/42 with continued symptoms. (Resident #97) was unable to keep eyes open but was responding verbally and answering questions accordingly/appropriately. VS (vital signs) at time of transfer to ED were as follows: 97.5 (temperature), 75 (pulse) 18 Respirations), 72/42 (blood pressure) 95% RA (95% oxygen saturation on room air). (Resident #97)'s husband notified per resident request."

Review of the clinical record did not reveal documentation that the resident or their representative were provided written documentation as to why the resident was being transferred to the hospital.

An interview was conducted with LPN (licensed practical nurse) #6 on 3/29/18 at 2:25 p.m. When asked about the nurse's responsibility when a resident is sent to the hospital, LPN #6 stated, "I get vital signs, call the doctor or nurse practitioner

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F 623	Continued From page 78 to get the order, fill in the paperwork, call the family and call 911." When asked how she notifies the family, LPN #6 stated, "Verbally by phone." When asked if she provides any written notification to the family, LPN #6 stated, "I don't believe that the facility does that with written notification." When asked if any, nursing plays any part in the bed hold policy, LPN #6 stated, "We ask if they want the bed hold and the amount (cost) of the hold. We have either an acceptance or declination of the bed hold. Two nurses verify and sign the bed hold paper." When asked if this is done for every resident sent to the hospital, LPN #6 stated, "If they are admitted." When asked if the family or resident is given any written documents, LPN #6 stated, "No, once we get the bed hold signed it goes to the front office." The administrator, director of nursing and ASM #7, the owner were made aware of the above findings on 3/29/18 at 6:10 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011219/?	F 623		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can	F 624	F624 1. Corrective action has been accomplished for the alleged deficient practice in regards to residents #3 and 74. The residents have since returned to the facility.	

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understand.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, it was determined that the facility staff failed to orient, prepare, and document the same, a resident for transfer to the hospital for two of 31 residents in the survey sample; Residents #3, and #74.

1. The facility staff failed to document that Resident #3 was properly oriented and prepared for a hospital transfer that occurred on 3/17/18.

2. The facility staff failed to document that Resident #74 was properly oriented and prepared for a hospital transfer that occurred on 3/22/18, 12/24/17, and 12/8/17.

The findings include:

1. The facility staff failed to document that Resident #3 was properly oriented and prepared for a hospital transfer that occurred on 3/17/18.

Resident #3 was admitted to the facility on 9/10/16 with the diagnoses of but not limited to atrial fibrillation, morbid obesity, chronic kidney disease, systemic inflammatory response syndrome, bladder obstruction, chronic ischemic heart disease, schizophrenia, Parkinson's disease, diabetes, high blood pressure, and bipolar disorder. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/14/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident required total care for

2. Current facility residents have the potential to be affected by the alleged deficient practice. The quality assurance nurse will do a 100% audit of residents transferred to the hospital since 4/1/18 r/t documentation stating the resident's nurse has explained to the resident or resident's representative the reasoning the resident is being transferred to the hospital, orienting and preparing him or her for the transfer.
3. Measures put into place to assure alleged deficient practice does not recur include: Nurses and Social Service will be reeducated on proper documentation when transferring a resident.
4. The Director of Nursing and/or designee will analyze/review for patterns/trends and report in the Quality Assurance committee meeting quarterly for a minimum of six months to evaluate the effectiveness of the plan and will adjust the plan as the committee may recommend, based on outcomes/trends identified from date.
5. Completion Date: May 11, 2018.

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bathing; extensive care for transfers, dressing, toileting, and hygiene; was independent for eating; and was incontinent of bowel and had an indwelling catheter for bladder.

A review of the clinical record revealed the following nurse's note dated 3/17/18:

- 8:08: "Resident rolled self out into nursing station c/o (complains of) all over body pain. Resident stated that Tylenol [1] does not help and that there is nothing that the staff can do for him. Resident continues to blame "Trump" for all over pain and discomfort stating, "he is trying to hurt me, he uses his black box to hurt my head and groin." Resident's BP (blood pressure) was 158/102, P (pulse) 80 reg (regular) T (temperature) 98.1, R (Respirations) 22. Pain of 10/10 (ten out of ten on a zero to ten scale) all throughout. Pupils were not equal, Left [sic] greater than Right [sic], both do constrict with light but Right [sic] more than Left [sic]. (ASM #8) (Administrative Staff Member, a nurse practitioner) contacted at 1938 (7:38PM) and agreed to send resident out for further eval (evaluation). Wife contacted at 1941 (7:41PM). 911 contacted 2000 (8:00PM). Arrived at 2005 (8:05PM) and just left with resident. Will contact (hospital) for update in a few hours."

There was no documentation in the clinical record that the resident was prepared and oriented for transfer.

On 3/29/18 at 2:27p.m., in an interview with LPN #6 (Licensed Practical Nurse), when asked about preparing and orienting residents for transfer to the hospital, she stated if they are alert, tell them they are going to the hospital, let them know what

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is going on, and document the resident's understanding in nurses notes.

On 3/29/18 at 6:05 p.m., at the end of day meeting, the Administrator, ASM (Administrative Staff Member) #1, Director of Nursing (ASM #2), and the facility owner (ASM #7) were made aware of the findings. A policy regarding written notifications was requested. No further information was provided by the end of the survey.

[1] Tylenol is used to treat mild to moderate pain. Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html

2. The facility staff failed to document that Resident #74 was properly oriented and prepared for a hospital transfer that occurred on 3/22/18, 12/24/17, and 12/8/17.

Resident #74 was admitted to the facility on 8/26/13 with the diagnoses of but not limited to stroke, intestinal disease, depression, metabolic encephalopathy, dementia, schizoaffective disorder, dysphagia, gastrostomy feeding tube, cataracts, presbyopia, Parkinson's disease, schizophrenia, bipolar disorder, angina, diabetes, high blood pressure, hypothyroidism, and chronic obstructive pulmonary disease. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/16/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident required total care for transfers, dressing, and hygiene; extensive care for eating; and was incontinent of

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bowel and bladder.

A review of the clinical record revealed the following nurse's note dated 3/22/18:

- 3:00PM: "Resident is Lethargic BP (blood pressure) 138/68 P (pulse) 86, 97.9 (temperature), R (respirations) 18, O2 (oxygen) @ (at) 83% BP [sic] 282. New Order (ASM #5) (Administrative Staff Member, a Nurse Practitioner) apply O2@2L (oxygen at 2 liters) via mask. V.O. (verbal order) (ASM #5) send to ER (emergency room) for evaluation for Hypoxia. (Name of daughter) notified @ 1455 (2:55PM) arrived at facility @ 1505 (3:05PM) report given to daughter. 911 notified @ 1505 and arrived at 1515 (3:15PM). Report given to EMT (emergency medical technician). Daughter went with daughter [sic- mother] to (hospital). Report called to ER (emergency room) @1530 (3:30PM) talked to (daughter). Daughter agreed to bed hold witnessed by two nurses."

Further review of the clinical record failed to reveal any documentation that the resident was prepared and oriented for transfer.

A review of the clinical record revealed the following nurse's notes dated 12/24/17:

- 4:00PM: Thus, nurse went in to visit resident upon arrival onto shift. Family was present and was asking questions about residents behaviors for the past couple of days. Advised that this nurse had just come on but had resident yesterday and things seemed fine. Advised she didn't really want to talk but seemed her normal self. Daughter then asked about the cookie swallow th at was done and wanted to know how it

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went. Advised that this nurse did not realize she had one done but wouldn't be surprised if it went well. Family agreed and then stated that they feel she would pass as they have recently brought in mashed potatoes and gravy. Family aware that resident is listed as NPO (nothing by mouth) but admitted to feeding it to her and stating that she did well. NP (nurse practitioner) and assigned nurse made aware of families [sic] comments."

- 4:04PM: Temp 100.3 tympanic pulse 72 R (respirations) 22. Nonlabored. BS (bowel sounds) positive. Lungs clear, Resident was yelling out and hitting this nurse with her right hand when I was assessing her lungs. Resident denies pain or discomfort. Asked three times if she didn't feel well. Daughter here and is concerned about the left side of her neck which appear red and slightly swollen. Warm to touch. NP telephoned."

- 4:22PM: (ASM #5) telephoned (hospital) back. (wasn't on call) but ordered Rocephin [1] 1 gm (gram) IM (intramuscular) now and if daughter wants her mom to go to hospital later on order is given.

- 6:13PM: Informed daughter that NP stated if she wants her mom to go to the hospital then she can go. Daughter gave consent for her to go. 911 (nine one one) telephoned. Necessary paperwork prepared. Resident is alert and verbalizing at this time with gentle coaxing by granddaughter at bedside. Resident answers simple questions appropriately. HOB (Head of bed) elevated. EMTs arrived, all paperwork given to EMTS. Resident somewhat non compliant with letting EMTS take her vitals going to hit them, but EMTs were successful after several attempts.

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Transported safely out of Facility x2 EMTS and daughter and granddaughter following to hospital.

- 10:17PM: (Hospital) telephoned on update of resident. Admitted to step down with diagnosis of parotitis. (salivary gland).

There was no documentation in the clinical record that the resident was prepared and oriented for transfer.
A review of the clinical record revealed the following nurse's notes dated 12/8/17:

- 3:05PM: V.O. (verbal order) (ASM #8) (Administrative Staff Member, a Nurse Practitioner) to send resident to (hospital) for evaluation due to vomiting and nausea x2 days. Staff reported no vomiting or nausea this shift. VSS (vital signs stable). Afebrile at this time. Daughter aware of transfer to ER. 911 notified @ (at) 1504 (3:04PM) and arrived to facility @ 1510 (3:10PM). Resident A&Ox2 (alert and oriented to two spheres).

- 3:19PM: (Hospital) notified 2 [sic] 1520 (3:20PM) resident in route to ER for evaluation. Report given to (hospital staff).

- 11:55PM: Spoke with (hospital) with nurse. Resident admitted to room (room number) with DX (diagnosis) of Colonic Mass. Notified (ASM #8) with this information."

There was no documentation in the clinical record that the resident was prepared and oriented for transfer.

On 3/29/18 at 2:27p.m., in an interview with LPN #6 (Licensed Practical Nurse), when asked about

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F 624	Continued From page 85 preparing and orienting residents for transfer to the hospital, she stated if they are alert, tell them they are going to the hospital, let them know what is going on, and document the resident's understanding in nurses notes. On 3/29/18 at 6:05 p.m., at the end of day meeting, the Administrator, ASM (Administrative Staff Member) #1, Director of Nursing (ASM #2), and the facility owner (ASM #7) were made aware of the findings. A policy regarding written notifications was requested. No further information was provided by the end of the survey. [1] Rocephin is an antibiotic. Information obtained from https://medlineplus.gov/druginfo/meds/a685032.html	F 624		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding	F 625	F625 1. Corrective action has been accomplished for the alleged deficient practice in regards to residents #130, #73, #57, #74, #97, and #95: Staff has been reeducated on the bed hold policy. 100% audit of residents currently in the hospital will be completed assuring a bed hold has been completed and if not it will be offered 2. Current facility residents have the potential to be affected by the alleged deficient practice. Auditing of transferred pts regarding the bed hold policy will be done daily during morning meeting and documented on report sheet. 3. Measures put into place to assure alleged deficient practice does not recur include: Reeducation will be given to nurses to follow the bed hold policy.	

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F 625	Continued From page 86 bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide a written bed hold notice for a facility initiated transfer for six of 31 residents in the survey sample, Residents #130, #73, #57, #74, #97 and #95. 1. The facility staff failed to provide Resident #130 or the resident's representative written notification of the bed hold policy when the resident was discharged to the hospital on 1/26/18. 2. The facility staff failed to provide Resident #73 or the resident's representative a written bed hold notice for a facility-initiated transfer on 1/15/18. 3. The facility staff failed to provide Resident #57 or the resident's representative a written bed hold notice for a facility-initiated transfer on 1/16/18. 4. The facility staff failed to evidence that Resident #74's resident representative was provide a written bed hold policy/notification,	F 625	4. The Director of Nursing and/or designee will analyze/review for patterns/trends and report in the Quality Assurance committee meeting quarterly for a minimum of six months to evaluate the effectiveness of the plan and will adjust the plan as the committee may recommend, based on outcomes/trends identified from date. 5. Completion Date: May 11, 2018	

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within 24 hours of a transfer and admission to the hospital on 12/24/17 and 12/8/17.

5. The facility staff failed to provide written bed hold notice for a facility initiated transfer for Resident #97.

6. The facility staff failed to give Resident #95 or the resident's representative a written bed hold notice for the 2/28/18 hospital admission.

The findings include:

1. The facility staff failed to provide Resident #130 or the resident's representative written notification of the bed hold policy when the resident was discharged to the hospital on 1/26/18.

Resident #130 was admitted to the facility on 1/11/18 and readmitted on 2/2/18. Resident #130's diagnoses included but were not limited to pneumonia, diabetes and urinary tract infection. Resident #130's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/9/18, coded the resident as cognitively intact.

Review of Resident #130's clinical record revealed a nurse's note dated 1/26/18 that documented, "Resident noted to be lethargic unable to wake up. VS (Vital Signs) - 97.3 (temperature) - 67 (pulse) - 20 (respirations) - 90/50 (blood pressure) - 92% (oxygen saturation) with 3L (liters) o2 (oxygen). bs (blood sugar) 236 did not eat lunch. NP (Nurse Practitioner) aware of change in condition. New order to send to ER (Emergency Room) via 911. Son (name) aware and notified of bed hold voiced if gets admitted he

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would not like bed hold."

Further review of Resident #130's clinical record revealed a notice of bed hold policy dated 1/26/18 that documented, "(Name of Resident #130) has been sent to the hospital today. If the resident is on Medicaid and is admitted to the hospital, Virginia Medicaid does not pay to hold the resident's bed. Whatever the resident's payment source, unless the nursing home is paid to reserve the bed while the resident is in the hospital, the nursing home may move someone else into the resident's room. However, even if the nursing home is not paid to hold the bed, the resident may have the right to return as soon as a bed is available in a semi-private room in this nursing home as long as the resident still needs the services provided by this nursing home..." A handwritten "X" was documented beside, "No, I do not wish to hold the resident's bed." The handwritten word, "Decline" was written. The handwritten words, "Son- (First name)" was written on the Responsible Party/Legal Representative signature line and the form was signed by a nurse. Although the nurse's note documented Resident #130's representative was notified of the bed hold policy, the clinical record failed to reveal the written bed hold document was provided to the representative.

Resident #130 was admitted to the hospital on 1/26/18 and returned to the facility on 2/2/18.

On 3/29/18 at 2:17 p.m., an interview was conducted with LPN (licensed practical nurse) #6 regarding the nurses' role in providing bed hold notification. LPN #6 stated, "We have to ask if they want the bed hold; tell them how much a day and do a decline or acceptance and give to the

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front office." LPN #6 stated if the bed hold notice is provided over the phone then two nurses verify the telephone notification and sign the bed hold policy. When asked if written documentation is offered and/or provided to resident representatives, LPN #6 stated, "If they are there they can sign, but I think the front office has them sign."

On 3/29/18 at 2:43 p.m., an interview was conducted with OSM (other staff member) #2 (the business office manager) regarding the bed hold policy process. OSM #2 stated staff should explain the bed hold policy and provide the bed hold form to a resident when he/she is going out the hospital so the resident knows what is going on and can sign the form. OSM #2 stated nurses should follow up with a resident's power of attorney or next of kin and explain the policy if the resident does not want to sign the bed hold form. When asked if the resident representative is provided written notice of the bed hold policy when the resident is sent to the hospital, OSM #2 stated the policy is provided and contracts are signed when a resident is first admitted to the facility. OSM #2 stated the business office has the resident representative come to the facility and sign the bed hold notice if the representative wishes to hold the bed but the business office does not provide written notification or has the representative sign the form if the representative does not wish to hold the bed.

On 3/29/18 at 5:48 pm., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility document titled, "Policy & Procedure

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Relating to Facility bed Hold Practices" documented, "Policy- The resident and responsible party/legal representative will be notified of the facility's bed hold practices when the resident is transferred to the hospital and remains in the hospital. Procedure- The resident/responsible party will be notified in writing of the facility's bed hold policy at the time of admission. Thereafter, prior to the resident being transferred to the hospital the Notice of Bed Hold Policy will be explained to the resident and the resident will acknowledge receipt of the information by signing the notice. In the event the resident is unwilling/unable to acknowledge receipt of the notice, the nurse will document this on the notice and proceed with notifying the responsible party/legal representative. The responsible party will be notified as soon as possible, but at least within 24 hours of the time the resident transfers to the hospital. The responsible party/legal representative will have Notice of Bed Hold Policy explained by the nurse. If the responsible party/legal representative cannot come in within 24 hours to sign for receipt of the notice, then their verbal understanding of the policy will be documented on the form by the nurse and a copy of the notice will be mailed to the responsible party/legal representative. Completed notices will be retained in the resident's Business Office file."

No further information was presented prior to exit.
2. The facility staff failed to provide Resident #73 or the resident's representative a written bed hold notice for a facility-initiated transfer on 1/15/18.

Resident #73 was admitted to the facility on 12/12/16 and readmitted on 1/21/18 with diagnoses that included but were not limited to

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muscle weakness, dementia with behavioral disturbance, major depressive disorder, and high blood pressure. Resident #73's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/15/18. Resident #73 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #73's nursing notes revealed the following note dated 1/15/18 that documented the following: "This nurse was entering room and observed Resident to be sitting on the floor with her back against the bathroom door. Resident was crying and her right leg was drawn up. Resident stated she could not move her leg. Staff stayed with Resident. VS (vital signs): 98.1 (temperature) 92 (pulse) 30-respirations, 158/82 (blood pressure), 02 (oxygen) 100 percent RA (room air). Resident was not moved. This nurse called 911. EMS (emergency staff) x 2 transported Resident to (Name of Medical Center) via stretcher at 18:15 (6:15) p.m. (Name of NP) and (Name of POA [power of attorney]) notified. On-call nurse also notified."

There was no evidence in the clinical record that Resident #73 was provided a written bed hold notice for her facility- initiated transfer to the hospital.

On 3/29/18 at 2:17 p.m., an interview was conducted with LPN (licensed practical nurse) #6. When asked if she provided written bed hold notification to the responsible party, LPN #6 stated, "No, I don't. Not written notification. We have to ask them if they want the bed held verbally. We either document a decline or

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acceptance." LPN #6 stated that two nurses will verify over the phone with the responsible party and sign the bed hold policy. LPN #6 stated that it is supposed to be done with every resident transfer.

On 3/29/18 at 2:43 p.m., an interview was conducted with OSM (other staff member) #2 (the business office manager) regarding the bed hold policy process. OSM #2 stated staff should explain the bed hold policy and provide the bed hold form to a resident when he/she is going out the hospital so the resident knows what is going on and can sign the form. OSM #2 stated nurses should follow up with a resident's power of attorney or next of kin and explain the policy if the resident does not want to sign the bed hold form. When asked if the resident representative is provided written notice of the bed hold policy when the resident is sent to the hospital, OSM #2 stated the policy is provided and contracts are signed when a resident is first admitted to the facility. OSM #2 stated the business office has the resident representative come to the facility and sign the bed hold notice if the representative wishes to hold the bed but the business office does not provide written notification or has the representative sign the form if the representative does not wish to hold the bed.

A bed hold notice could not be provided for Resident #73.

On 3/29/18 at 5:47 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) and ASM #7, the facility owner were made aware of the above concerns.

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3. The facility staff failed to provide Resident #57 or the resident's representative a written bed hold notice for a facility-initiated transfer on 1/16/18.

Resident #57 was admitted to the facility on 5/24/14 and readmitted on 1/22/18 with diagnoses that included but were not limited to Dementia with behavioral disturbance, muscle weakness, Alzheimer's disease and mood disorder. Resident #57's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/8/18. Resident #57 was coded as being severely impaired in cognitive function scoring 06 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #57's clinical record revealed that he went out to the hospital on 1/16/18. The following note was documented: "1/15/18 at 2:56 p.m., Resident was leaning to the left in his wheelchair with rapid respirations noted. Prior to this being noted resident ate well for breakfast and was then wheeling himself up and down the hallway and wandering like his normal behavior. BP (blood pressure 130/80, P (pulse) 98, R (Respirations)-26, o2 (sic) (oxygen saturation) 91 % (percent) temp (temperature) 98.9. NP (nurse practitioner) assessed resident and requested we call his daughter to see if she would like us to treat him here or continue to monitor him she was updated on new orders given by NP for 1 time dose of Lasix (1) 20 mg (milligrams) p.o. (by mouth) for BIL (bilateral) LE (lower extremity) edema, chest x-ray to be completed today, scheduled duonebs (2) BID (two times a day x 7 days...daughter (name of daughter) came to visit after and was updated the chest xray had been completed at 2:30 p.m. and we were waiting

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results. She stated he appears stable at this time and if any changes noted with resident to call her at any time during the night..."

A nursing note dated 1/16/18 documented the following: "Res. (Resident) due to go out to Neurology apt (appointment). NP seen res and asked that res. apt be canceled due to res being very lethargic and leaning to left side. Res. was repositioned x 2 and res unable to stay up right. Res. c/o (complained) pain routine (sic) pain meds (medications) given earlier. Notified Neurology Dept. (department) to cancel appt. (sic) Spoke to dtr (daughter) about rethinking sending res to hosp (hospital) for eval (evaluation). dtr. stated it would be ok to send him out..."

Further review of the clinical record revealed that Resident #57 arrived back to the facility on 1/22/18 with a primary diagnosis of a UTI (urinary tract infection).

There was no evidence in the clinical record that Resident #57's responsible party was provided a written bed hold notice for his facility- initiated transfer to the hospital.

On 3/29/18 at 2:17 p.m., an interview was conducted with LPN (licensed practical nurse) #6. When asked if she provided written bed hold notification to the responsible party, LPN #6 stated, "No, I don't. Not written notification. We have to ask them if they want the bed held verbally. We either document a decline or acceptance." LPN #6 stated that two nurses will verify over the phone with the responsible party and sign the bed hold policy. LPN #6 stated that it is supposed to be done with every resident

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transfer.

On 3/29/18 at 2:43 p.m., an interview was conducted with OSM (other staff member) #2 (the business office manager) regarding the bed hold policy process. OSM #2 stated staff should explain the bed hold policy and provide the bed hold form to a resident when he/she is going out the hospital so the resident knows what is going on and can sign the form. OSM #2 stated nurses should follow up with a resident's power of attorney or next of kin and explain the policy if the resident does not want to sign the bed hold form. When asked if the resident representative is provided written notice of the bed hold policy when the resident is sent to the hospital, OSM #2 stated the policy is provided and contracts are signed when a resident is first admitted to the facility. OSM #2 stated the business office has the resident representative come to the facility and sign the bed hold notice if the representative wishes to hold the bed but the business office does not provide written notification or has the representative sign the form if the representative does not wish to hold the bed.

A bed hold notice could not be provided for Resident #73.

On 3/29/18 at 5:47 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) and ASM #7, the facility owner were made aware of the above concerns.

4. The facility staff failed to evidence that Resident #74's resident representative was provide a written bed hold policy/notification, within 24 hours of a transfer and admission to the hospital on 12/24/17 and 12/8/17.

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Resident #74 was admitted to the facility on 8/26/13 with the diagnoses of but not limited to stroke, intestinal disease, depression, metabolic encephalopathy, dementia, schizoaffective disorder, dysphagia, gastrostomy feeding tube, cataracts, presbyopia, Parkinson's disease, schizophrenia, bipolar disorder, angina, diabetes, high blood pressure, hypothyroidism, and chronic obstructive pulmonary disease. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/16/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident required total care for transfers, dressing, and hygiene; extensive care for eating; and was incontinent of bowel and bladder.

A review of the clinical record revealed the following nurse's note dated 3/22/18:

- 3:00PM: "Resident is Lethargic BP (blood pressure) 138/68 P (pulse) 86, 97.9 (temperature), R (respirations) 18, O2 (oxygen) @ (at) 83% BP [sic] 282. New Order (ASM #5) (Administrative Staff Member, a Nurse Practitioner) apply O2@2L (oxygen at 2 liters) via mask. V.O. (verbal order) (ASM #5) send to ER (emergency room) for evaluation for Hypoxia. (Name of daughter) notified @ 1455 (2:55PM) arrived at facility @ 1505 (3:05PM) report given to daughter. 911 notified @ 1505 and arrived at 1515 (3:15PM). Report given to EMT (emergency medical technician). Daughter went with daughter [sic- mother] to (hospital). Report called to ER (emergency room) @1530 (3:30PM) talked to (daughter). Daughter agreed to bed hold witnessed by two nurses."

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There was no evidence in the clinical record that the resident representative was provided with a written bed hold policy.

A review of the clinical record revealed the following nurse's notes dated 12/24/17:

- 4:00PM: Thus, nurse went in to visit resident upon arrival onto shift. Family was present and was asking questions about residents behaviors for the past couple of days. Advised that this nurse had just come on but had resident yesterday and things seemed fine. Advised she didn't really want to talk but seemed her normal self. Daughter then asked about the cookie swallow that was done and wanted to know how it went. Advised that this nurse did not realize she had one done but wouldn't be surprised if it went well. Family agreed and then stated that they feel she would pass as they have recently brought in mashed potatoes and gravy. Family aware that resident is listed as NPO (nothing by mouth) but admitted to feeding it to her and stating that she did well. NP (nurse practitioner) and assigned nurse made aware of families [sic] comments."

- 4:04PM: Temp 100.3 tympanic pulse 72 R (respirations) 22. Nonlabored. BS (bowel sounds) positive. Lungs clear, Resident was yelling out and hitting this nurse with her right hand when I was assessing her lungs. Resident denies pain or discomfort. Asked three times if she didn't feel well. Daughter here and is concerned about the left side of her neck which appear red and slightly swollen. Warm to touch. NP telephoned."

- 4:22PM: (ASM #5) telephoned (hospital) back.

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(wasn't on call) but ordered Rocephin [1] 1 gm (gram) IM (intramuscular) now and if daughter wants her mom to go to hospital later on order is given.

- 6:13PM: Informed daughter that NP stated if she wants her mom to go to the hospital then she can go. Daughter gave consent for her to go. 911 (nine one one) telephoned. Necessary paperwork prepared. Resident is alert and verbalizing at this time with gentle coaxing by granddaughter at bedside. Resident answers simple questions appropriately. HOB (Head of bed) elevated. EMTs arrived, all paperwork given to EMTS. Resident somewhat non compliant with letting EMTS take her vitals going to hit them, but EMTs were successful after several attempts. Transported safely out of Facility x2 EMTS and daughter and granddaughter following to hospital.

- 10:17PM: (Hospital) telephoned on update of resident. Admitted to step down with diagnosis of parotitis. (Salivary gland).

There was no evidence in the clinical record that the resident representative was provided with a written bed hold policy.

A review of the clinical record revealed the following nurse's notes dated 12/8/17:

- 3:05PM: V.O. (verbal order) (ASM #8) (Administrative Staff Member, a Nurse Practitioner) to send resident to (hospital) for evaluation due to vomiting and nausea x2 days. Staff reported no vomiting or nausea this shift. VSS (vital signs stable). Afebrile at this time. Daughter aware of transfer to ER. 911 notified @

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(at) 1504 (3:04PM) and arrived to facility @ 1510 (3:10PM). Resident A&Ox2 (alert and oriented to two spheres).

- 3:19PM: (Hospital) notified 2 [sic] 1520 (3:20PM) resident in route to ER for evaluation. Report given to (hospital staff).

- 11:55PM: Spoke with (hospital) with nurse. Resident admitted to room (room number) with DX (diagnosis) of Colonic Mass. Notified (ASM #8) with this information."

There was no evidence in the clinical record that the resident representative was provided with a written bed hold policy.

On 3/29/18 at 2:27PM in an interview with LPN #6 (Licensed Practical Nurse), when asked about providing a written bed hold policy, she stated the staff asks them if they want the bed hold, how much a day, and do a decline or an acceptance. LPN #6 stated if it is over the phone, two nurses hear it and sign declined or accepted and sign bed hold policy. When asked if any written documentation of bed hold provided, LPN #6 stated she thinks the front office gives it to them. She didn't know what happens after that.

On 3/29/18 at 2:43PM, in an interview with OSM #2 (Other Staff Member, the business office manager), she stated that a bed hold policy is given when a resident is going out to the hospital. The staff should be talking to them and showing them the bed hold sheet so they can sign it themselves so they know what is going on. OSM #2 stated if they don't want to sign it, nursing follows up with responsible party regarding a bed

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hold, have them sign the sheet and bring it to the business office. OSM #2 stated they are supposed to provide one each time they go out to the hospital and she gets the signed papers. When asked if the family is being provided written notice of bed hold notice, OSM #2 stated that nursing probably isn't giving a copy on each transfer. If they don't want a bed hold, they are probably not getting a copy.

On 3/29/18 at 6:05 p.m., at the end of day meeting, the Administrator, ASM (Administrative Staff Member) #1, Director of Nursing (ASM #2), and the facility owner (ASM #7) were made aware of the findings. A policy regarding written notifications was requested. No further information was provided by the end of the survey.

[1] Rocephin is an antibiotic. Information obtained from https://medlineplus.gov/druginfo/meds/a685032.html

5. The facility staff failed to provide written bed hold notice for a facility initiated transfer for Resident #97.

Resident # 97 was admitted to the facility on 11/19/17, with a most recent readmission on 3/15/18 with diagnoses that included but were not limited to: bladder infections, hypotension (too low blood pressure), malnutrition, depression, difficulty sleeping, asthma, and has a colostomy.

The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment,

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with an assessment reference date of 2/27/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating she was capable of making her daily decisions.

The clinical record revealed a nurse's note dated, 2/2/18 at 11:07 a.m. documented in part, "Resident c/o (complained of) dizzy feeling this am (morning) bp (blood pressure) obtained noted to be 64/40. NP (nurse practitioner) aware new order noted for Midodrine (used to elevate blood pressure) (1), 5 mg (milligrams) now and then qd (every day). Also ordered 1 liter of d5 (dextrose 5%) 1/2 (half strength) normal saline). Medication administered and IV (intravenous) placed to left arm. IV to start (sic) to infuse resident c/o left sided chest pain with pressure. B/P 76/50 at this time. Resident denied sob (shortness of breath) but stated she hadn't had this pain before and wanted to go to hospital. NP aware of new concerns. New order noted to send to er (emergency room) 911 (emergency medical services) called and daughter (name of daughter) aware. 911 left arrived assessed and left around 11 am. (Daughter's name) is aware of bed hold but will call later after she knows what the plan is for her mother."

Review of the clinical record failed to evidence a copy of a written bed hold notice for the facility initiated transfer to the hospital on 2/2/18.

The clinical record documented a nurse's note dated, 2/28/18 at 10:13 a.m. "At Approximately 10:00 a.m. (Resident #97)'s CNA (certified nursing assistant) notified this nurse that (Resident #97) 'Yelling for a nurse and crying.' This nurse immediately assessed (Resident #97) and noted that she was pale and clammy with

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SOB (shortness of breath) at rest. Blood pressure was 56/48. (Resident #97)'s legs were immediately elevated and NP (nurse practitioner) notified. NP assessed (Resident #97) and order this nurse to send to ED (emergency department) 911 for eval (evaluation) and tx (treatment) due to symptomatic hypotension. BP was taken by second nurse and was noted to be 70/42. At approximately 10:10 AM, rescue squad arrived and noted her blood pressure to be 72/42 with continued symptoms. (Resident #97) was unable to keep eyes open but was responding verbally and answering questions accordingly/appropriately. VS (vital signs) at time of transfer to ED were as follows: 97.5 (temperature), 75 (pulse) 18 Respirations), 72/42 (blood pressure) 95% RA (95% oxygen saturation on room air). (Resident #97)'s husband notified per resident request."

Review of the clinical record failed to evidence a copy of a written bed hold notice for the facility initiated transfer to the hospital on 2/2/18.

An interview was conducted with LPN (licensed practical nurse) #6 on 3/29/18 at 2:25 p.m. When asked about the nurse's responsibility when a resident is sent to the hospital, LPN #6 stated, "I get vital signs, call the doctor or nurse practitioner to get the order, fill in the paperwork, call the family and call 911." When asked how she notifies the family, LPN #6 stated, "Verbally by phone." When asked if she provides any written notification to the family, LPN #6 stated, "I don't believe that the facility does that with written notification." When asked if any, nursing plays any part in the bed hold policy, LPN #6 stated, "We ask if they want the bed hold and the amount (cost) of the hold. We have either an acceptance

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or declination of the bed hold. Two nurses verify and sign the bed hold paper." When asked if this is done for every resident sent to the hospital, LPN #6 stated, "If they are admitted." When asked if the family or resident is given any written documents, LPN #6 stated, "No, once we get the bed hold signed it goes to the front office."

An interview was conducted with other staff member (OSM) #2, the business office manager, on 3/29/18 at 2:42 p.m. When asked her role in issuing a bed hold, OSM #2 stated, "Our bed hold policy is that a patient going out to the hospital. We should be talking to them and give them the sheet, if they are capable of signing it. If they go out and come back, they don't need one. The nursing staff follows up with the POA (power of attorney) or next of kin on going out and letting them know the policy for bed hold that is once they are admitted." When asked if this is done each time a resident goes to the hospital, OSM #2 stated, "Yes." When asked if the resident and or responsible party are given the written copy of the bed hold paper, OSM 2 stated, "We ask them to come in and sign. If we have an unsigned bed hold paper, and they want to hold the bed, when it is paid we make every attempt to get it signed." When asked if they are being given the written copy each time a resident goes out to the hospital, OSM #2 stated, "They are not being provided a copy from the facility. If the family is not here, then they are not getting a copy."

The administrator, director of nursing and ASM #7, the owner were made aware of the above findings on 3/29/18 at 6:10 p.m.

No further information was provided prior to exit.

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(1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011219/?report=details

6. The facility staff failed to give Resident #95 or the resident's representative a written bed hold notice for the 2/28/18 hospital admission.

Resident #95 was admitted to the facility on 2/17/16 and readmitted on 3/3/18 with diagnoses that included but were not limited to: intestinal bleeding, schizophrenia, heart failure and diabetes.

The most recent complete MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 2/23/18 coded the resident as having a 15 out of 15 on the BIMS (breif interview for mental status) exam indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring supervision for activities of daily living.

On 3/29/18 at 2:17 p.m., an interview was conducted with LPN (licensed practical nurse) #6 regarding the nurses' role in providing bed hold notification. LPN #6 stated, "We have to ask if they want the bed hold; tell them how much a day and do a decline or acceptance and give to the front office." LPN #6 stated if the bed hold notice is provided over the phone then two nurses verify the telephone notification and sign the bed hold policy. When asked if written documentation is offered and/or provided to resident representatives, LPN #6 stated, "If they are there they can sign but I think the front office has them sign."

On 3/29/18 at 2:43 p.m., an interview was

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F 625	Continued From page 105 conducted with OSM (other staff member) #2 (the business office manager) regarding the bed hold policy process. OSM #2 stated staff should explain the bed hold policy and provide the bed hold form to a resident when he/she is going out the hospital so the resident knows what is going on and can sign the form. OSM #2 stated nurses should follow up with a resident's power of attorney or next of kin and explain the policy if the resident does not want to sign the bed hold form. When asked if the resident representative is provided written notice of the bed hold policy when the resident is sent to the hospital, OSM #2 stated the policy is provided and contracts are signed when a resident is first admitted to the facility. OSM #2 stated the business office has the resident representative come to the facility and sign the bed hold notice if the representative wishes to hold the bed but the business office does not provide written notification or has the representative sign the form if the representative does not wish to hold the bed. On 3/29/18 at 6:00 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #7, the facility owner were made aware of the findings. No further information was obtained prior to exit.	F 625		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record	F 641	F641 1. It is the policy of this facility to code all resident MDS assessments correctly per the current RAI manual utilizing the information provided in the resident EMR as well as direct observation and interview with resident. Corrective action has been accomplished for the alleged deficient practice in regards to accurate documentation for restraint use for Residents # 105, 95, 37, 69, 99, 90, 89, 130, 132, 133, 47, 66, 57, 3, 74, 114, 87, 83 and 55 for MDS assessments with ARD dates	

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F 641	Continued From page 106 review, it was determined the facility staff failed to maintain an accurate minimum data set (MDS) assessment for nineteen of 31 residents in the survey sample, Residents #105, #95, #37, #69, #99, #90, #89, #130, #132, #133, #47, #66, #57, #3, #74, #114, #87, #83 and #55 1. The facility staff failed to code Resident #105's quarterly (minimum data set) MDS assessment, with an ARD (assessment reference date) of 3/5/18, accurately for the use of a restraint and an external urinary catheter. 2. The facility staff failed to code Resident #95's quarterly MDS assessment, with an ARD of 2/23/18, accurately for the use of a restraint. 3. The facility staff failed to code Resident #37's quarterly MDS (minimum data set) assessment, with an ARD of 1/22/18, accurately for the use of a restraint and an accurate dental assessment. 4. The facility staff failed to code Resident #69's quarterly MDS (minimum data set) assessment, with an ARD of 2/14/18, accurately for the use of a restraint. 5. The facility staff failed to code Resident #99's significant change MDS (minimum data set) assessment, with an ARD of 3/5/18, accurately for the use of a restraint. 6. The facility staff failed to code Resident #90's MDS assessment, a quarterly assessment, with an assessment reference date of 2/22/18, accurately for the use of a restraint. 7. The facility staff failed to code Resident #89's quarterly MDS assessment, with an assessment	F 641	provided. Corrective action has been accomplished for the alleged deficient practice in regards to accurate documentation of external catheter present for ARD date provided for resident # 105. Corrective action has been accomplished for alleged deficient practice in regards to accurate documentation of dental assessment for ARD date provided for resident # 37. 2. Current facility residents have the potential to be affected by the alleged deficient practice. An audit of resident MDS assessments for the first quarter of 2018 will be conducted to identify incorrect coding of Sections "P", "H", and "L". Corrections will be made as necessary. 3. Measures put into place to assure alleged deficient practice does not recur include MDS Coordinators have been re-educated and have reviewed the current RAI Manual regarding the definition of restraint use and correct practices, bladder and dental issues. 4. The Director of Nursing and/or designee will review 5 MDS records weekly for 3 months to evaluate the correct coding of Sections "P", "H", and "L". Any non-compliance discovered will be discussed at weekly Risk Management meeting and an action plan developed. Ongoing issues of non-compliance will be discussed at quarterly Quality Assurance meetings and an action plan will be adjusted as the committee may recommend based on outcomes identified. 5. Completion Date: May 11, 2018.	

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reference date of 2/22/18, accurately for the use of a restraint.

8. The facility staff coded Resident #130 inaccurately as having a physical restraint on a quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 3/9/18.

9. The facility staff inaccurately coded Resident #132 as having a physical restraint on a significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 3/15/18.

10. The facility staff inaccurately coded Resident #133 as having a physical restraint on an admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 3/15/18.

11. The facility staff coded the Resident #47's annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 1/1/18 in accurately for the use of restraints when in fact the resident did not have restraints.

12. The facility staff coded Resident #66's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 2/13/18, in accurately for the use of restraints, when in fact the resident did not have restraints.

13. The facility staff coded Resident #57's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 2/8/18, inaccurately for the use of a restraint, when in fact the resident did not have restraints.

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14. The facility staff coded Resident #3's quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 3/14/18, inaccurately for the use of restraints, when in fact the resident did not have restraints.

15. The facility staff coded Resident #74's quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 2/16/18, inaccurately for the use of restraints, when in fact the resident did not have restraints.

16. The facility staff coded Resident #114's quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/6/18, inaccurately for the use of restraints, when in fact the resident did not have restraints.

17. The facility staff coded Resident #87's quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 3/12/18, inaccurately for the use of restraints, when in fact the resident did not have restraints.

18. The facility staff coded Resident #83's MDS assessment correctly for the use of restraints, when in fact the resident did not have restraints.

19. The facility staff coded Resident #55's quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 2/7/18, inaccurately for the use of restraints, when in fact the resident did not have restraints.

The findings include:

1. Resident #105 was admitted to the facility on 4/23/10 and readmitted on 6/17/13 with diagnoses that included but were not limited to:

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anemia, diabetes, high blood pressure, difficulty speaking and depression.

The most recent MDS, a quarterly assessment, with an ARD (assessment reference date) of 3/5/18 coded the resident as having a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring one person assistance for all activities of daily living. The resident was coded as having an external urinary catheter. In Section P -- Restraints and Alarms the following was documented, "Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body." The resident was coded as using the bed rail daily.

Review of the physician's March 2018 orders documented, "1/2 side rails to aide in position and or safety every shift Start Date 9/27/2018." There was no documentation regarding an external urinary catheter.

Review of the March 2018 treatment administration record (TAR) documented, "1/2 side rails to aide in position and or safety every shift Start Date 9/27/2018." It was documented the side rails were in place each shift." There was no documentation regarding an external urinary catheter.

Review of the care plan did not evidence documentation regarding the side rails or an external urinary catheter.

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Review of the side rail and entrapment risk evaluation dated 8/29/17 documented, "B. Resident Evaluation. 1. The resident/resident representative has requested use of the side rails. Yes (was marked). 2. The resident is physically able to use the side rails for bed positioning or transfer independently or with assistance. Yes (was marked). 3. The resident is able to recognize safety hazards when using the side rails. Yes (was marked)."

Observations were made of Resident #105 throughout the survey. There was no external catheter seen. The resident was always in the wheelchair and the side rails were lowered.

An interview was conducted on 3/28/18 at 4:30 p.m. with LPN (licensed practical nurse) #6, the resident's nurse. When asked if the resident had an external catheter, LPN #6 stated, "No. He uses the urinal or goes to the bathroom."

An interview was conducted on 3/29/18 at 12:48 p.m. with RN (registered nurse) #1, the MDS coordinator. When asked who completed section P of the MDS quarterly assessment, with an ARD (assessment reference date) of 3/5/18, RN #1 stated she did. When asked why the resident triggered for a physical restraint, RN #1 stated, "The first question under section P is for side rails, the majority of our residents have half side rails it triggers for a restraint." When asked what policy or manual she used to complete section P, RN #1 stated, "The RAI (resident assessment instrument)." RN #1 was asked to bring a copy of the RAI for section P to the surveyors. When RN #1 returned she stated, "I just talked to (name of director of nursing). She said if the use of the bed rails meets the definition of a physical restrain

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then we count them as a restraint but if they don't meet those requirements we don't code it as a restraint." When asked if the resident's side rails were considered a restraint, RN #1 stated, "No." When asked if the MDS was coded correctly, RN #1 stated, "No."

On 3/29/18 at 6:00 p.m. ASM #1, the administrator, ASM #2, the director of nursing and ASM #7, the facility owner were made aware of the findings.

An interview was conducted on 3/30/18 at 9:05 a.m. with CNA (certified nursing assistant) #4, the resident's aide. When asked if the resident had an external catheter, CNA #4 stated, "Never."

An interview was conducted on 3/30/18 at 1:30 p.m. with RN #1. When asked to review the 3/5/18 MDS for the external catheter, RN #1 stated, "That's my mistake. He doesn't have an external catheter."

No further information was provided prior to exit.

2. The facility staff failed to code Resident #95's quarterly MDS assessment, with an ARD of 2/23/18, accurately for the use of a restraint.

Resident #95 was admitted to the facility on 2/17/16 and readmitted on 3/3/18 with diagnoses that included but were not limited to: intestinal bleeding, schizophrenia, heart failure and diabetes.

The most recent complete MDS, a quarterly assessment, with an ARD of 2/23/18 coded the resident as having scored 15 out of 15 on the BIMS indicating the resident was cognitively intact

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to make daily decisions. The resident was coded as requiring supervision for activities of daily living. In Section P -- Restraints and Alarms the following was documented, "Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body." The resident was coded as using the bed rails daily.

Review of the March 2018 physician's orders documented, "use of bilateral rails for positioning and safety every shift for House prot...(protocol) Start Date 3/5/2018."

Review of the March 2018 TAR did not evidence documentation regarding the side rails.

Review of the care plan did not evidence documentation regarding the use of the side rails.

Review of the side rail and entrapment risk evaluation dated 3/3/18 documented, "B. Resident Evaluation. 1. The resident/resident representative has requested use of the side rails. Yes (was marked). 2. The resident is physically able to use the side rails for bed positioning or transfer independently or with assistance. Yes (was marked). 3. The resident is able to recognize safety hazards when using the side rails. Yes (was marked)."

An interview was conducted on 3/29/18 at 12:48 p.m. with RN (registered nurse) #1, the MDS coordinator. When asked who completed section P of Resident #95's quarterly MDS assessment, with an ARD of 2/23/18, RN #1 stated she did. When asked why the resident triggered for a

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physical restraint, RN #1 stated, "The first question under section P is for side rails, the majority of our residents have half side rails it triggers for a restraint." When asked what policy or manual she used to complete section P, RN #1 stated, "The RAI (resident assessment instrument)." RN #1 was asked to bring a copy of the RAI for section P to the surveyors. When RN #1 returned she stated, "I just talked to (name of director of nursing). She said if the use of the bed rails meets the definition of a physical restrain then we count them as a restraint but if they don't meet those requirements we don't code it as a restraint." When asked if the resident's side rails were considered a restraint, RN #1 stated, "No." When asked if the MDS was coded correctly, RN #1 stated, "No."

On 3/29/18 at 6:00 p.m. ASM #1, the administrator, ASM #2, the director of nursing and ASM #7 the facility owner were made aware of the findings.

3. The facility staff failed to accurately code Resident #37's quarterly MDS (minimum data set) assessment, with an ARD of 1/22/18 for the use of a restraint and an accurate dental assessment.

Resident #37 was admitted to the facility on 1/17/17 and readmitted on 12/11/17 with diagnoses that included but were not limited to: heart failure, shortness of breath, diabetes, stroke and kidney disease.

The most recent MDS, a quarterly assessment, with an ARD of 1/22/18 coded the resident as having scored 15 out of 15 on the BIMS, indicating the resident was cognitively intact to

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make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could perform after the tray was prepared. In section L -- Oral/Dental status, the resident was coded as having no dental issues. In Section P -- Restraints and Alarms the following was documented, "Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body." The resident was coded as using the bed rails daily."

Review of the nursing assessment dated 10/31/17 did not evidence documentation regarding the resident's dental issues.

An interview was conducted on 3/27/18 at 3:23 p.m. with Resident #37. When asked about the use of the side rails, Resident #37 stated, "I use them all the time. They make it easier for me to move around in the bed by myself." During the interview, the resident stated that she had asked for dentures because she has many missing teeth and her gums hurt sometimes when she eats, but was told it would be out of pocket and she couldn't afford them. When asked when she had requested the dentures, Resident #37 stated, "A couple weeks ago."

Review of the March 2018 physician's orders documented, "1/2 side rails x2 to assist in turning and positioning, and transfer to/from bed, and with stabilization while sitting on the side of the bed QS (every shift). Start Date 11/28/2017." There was no evidence of an order for the resident to be seen by the dentist.

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Review of the March 2018 TAR documented, "1/2 side rails x2 to assist in turning and positioning, and transfer to/from bed, and with stabilization while sitting on the side of the bed QS (every shift). Start Date 11/28/2017."

Review of the care plan did not evidence documentation regarding the side rails.

Review of the care plan initiated on 3/23/18 documented "Focus. The resident is a smoker. Interventions/Tasks. Monitor oral hygiene."

Review of the side rail and entrapment risk evaluation dated 11/28/17 documented, "B. Resident Evaluation. 1. The resident/resident representative has requested use of the side rails. Yes (was marked). 2. The resident is physically able to use the side rails for bed positioning or transfer independently or with assistance. Yes (was marked). 3. The resident is able to recognize safety hazards when using the side rails. Yes (was marked)."

Review of the nursing and social services notes for March 2018 did not evidence documentation regarding the resident's request for dentures and or to be seen by a dentist.

An interview was conducted on 3/29/18 at 12:48 p.m. with RN (registered nurse) #1, the MDS coordinator. When asked who completed section P Resident #37's quarterly MDS (minimum data set) assessment, with an ARD of 1/22/18, RN #1 stated she did. When asked why the resident triggered for a physical restraint, RN #1 stated, "The first question under section P is for side rails, the majority of our residents have half side

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rails it triggers for a restraint." When asked what policy or manual she used to complete Section P, RN #1 stated, "The RAI (resident assessment instrument)." RN #1 was asked to bring a copy of the RAI for section P to the surveyors. When RN #1 returned she stated, "I just talked to (name of director of nursing). She said if the use of the bed rails meets the definition of a physical restrain then we count them as a restraint but if they don't meet those requirements we don't code it as a restraint." When asked if the resident's side rails were considered a restraint, RN #1 stated, "No." When asked if the MDS was coded correctly, RN #1 stated, "No."

On 3/29/18 at 6:00 p.m. ASM #1, the administrator, ASM #2, the director of nursing and ASM #7 the facility owner were made aware of the findings.

An interview was conducted on 3/30/18 at 11:31 a.m. with RN (registered nurse) #1, the MDS coordinator. When asked who completed Section L of the MDS, RN #1 stated, "I do" When asked how the residents were assessed, RN #1 stated, "The first thing I look at is the nursing admission note and the admission assessment form. When I do my initial interview with the resident, I talk about their teeth. I ask them if they have their own teeth or if they have dentures. If they're having any issues with their teeth or gums or if their dentures are not fitting properly. I do an assessment of my own." When asked to review Section L of the resident's MDS assessment in which the resident was coded as having no dental issues, RN #1 stated, "I don't really have an answer for you on how that happened." When asked if the resident should have been coded as having dental issues, RN #1 stated, "Absolutely it

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should have been coded."

4. The facility staff failed to code Resident #69's quarterly MDS (minimum data set) assessment, with an ARD of 2/14/18, accurately for the use of a restraint.

Resident #69 was admitted to the facility on 7/8/16 and readmitted on 8/25/17 with diagnoses that included but were not limited to: heart failure, diabetes, dementia, hypertension and difficulty sleeping.

The most recent MDS, a quarterly assessment, with an ARD of 2/14/18 coded the resident as scoring 15 out of 15 on the BIMS. The resident was coded as needing assistance from staff for all activities of daily living. In Section P -- Restraints and Alarms the following was documented, "Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body." The resident was coded as using the bed rails daily.

Review of the March 2018 physician orders documented, "1/2 side rails to aide in positioning and or safety every shift Start Date 09/26/2016."

Review of the March 2018 TAR documented, "1/2 side rails to aide in positioning and or safety every shift Start Date 09/26/2016."

Review of the care plan did not evidence documentation regarding the side rails.

An interview was conducted on 3/29/18 at 12:48

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p.m. with RN (registered nurse) #1, the MDS coordinator. When asked who completed section P of the MDS, RN #1 stated she did. When asked why the resident triggered for a physical restraint, RN #1 stated, "The first question under section P is for side rails, the majority of our residents have half side rails it triggers for a restraint." When asked what policy or manual she used to complete Section P, RN #1 stated, "The RAI (resident assessment instrument)." RN #1 was asked to bring a copy of the RAI for section P to the surveyors. When RN #1 returned she stated, "I just talked to (name of director of nursing). She said if the use of the bedrails meets the definition of a physical restrain then we count them as a restraint but if they don't meet those requirements we don't code it as a restraint." When asked if the resident's side rails were considered a restraint, RN #1 stated, "No." When asked if the MDS was coded correctly, RN #1 stated, "No."

On 3/29/18 at 6:00 p.m. ASM #1, the administrator, ASM #2, the director of nursing and ASM #7 the facility owner were made aware of the findings.

5. The facility staff failed to code Resident #99's significant change MDS (minimum data set) assessment, with an ARD of 3/5/18, accurately for the use of a restraint.

Resident #99 was admitted to the facility on 6/9/17 and readmitted on 2/26/18 with diagnoses that included but were not limited to: heart failure, pneumonia, anemia, depression and cognitive communication deficit.

The most recent MDS, a significant change assessment, with an ARD of 3/5/18 coded the

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resident as 99 on the BIMS indicating the resident was not able to complete the exam. The resident was coded as understanding others and being understood and having intact short and long term memory. The resident was coded as requiring assistance for all activities of daily living. In Section P -- Restraints and Alarms documented, "Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body." The resident was coded as using the bed rails daily.

Review of the March 2018 physician's orders documented, "1/2 side rails to assist in turning and repositioning every shift Start Date 2/26/2018."

Review of the March 2018 TAR documented, "1/2 side rails to assist in turning and repositioning every shift Start Date 2/26/2018."

Review of the care plan did not evidence documentation regarding the use of the side rails.

An interview was conducted on 3/29/18 at 12:48 p.m. with RN (registered nurse) #1, the MDS coordinator. When asked who completed section P of Resident #69's quarterly MDS (minimum data set) assessment, with an ARD of 2/14/18, RN #1 stated she did. When asked why the resident triggered for a physical restraint, RN #1 stated, "The first question under section P is for side rails, the majority of our residents have half side rails it triggers for a restraint." When asked what policy or manual she used to complete Section P, RN #1 stated, "The RAI (resident

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assessment instrument)." RN #1 was asked to bring a copy of the RAI for section P to the surveyors. When RN #1 returned she stated, "I just talked to (name of director of nursing). She said if the use of the bed rails meets the definition of a physical restrain then we count them as a restraint but if they don't meet those requirements we don't code it as a restraint." When asked if the resident's side rails were considered a restraint, RN #1 stated, "No." When asked if the MDS was coded correctly, RN #1 stated, "No."

On 3/29/18 at 6:00 p.m. ASM #1, the administrator, ASM #2, the director of nursing and ASM #7 the facility owner were made aware of the findings.

No further information was provided prior to exit.
6. The facility staff failed to code Resident #90's MDS assessment, a quarterly assessment, with an assessment reference date of 2/22/18, accurately for the use of a restraint.

Resident #90 was admitted to the facility on 5/2/12 with diagnoses that included but were not limited to: Huntington's chorea (abnormal hereditary condition characterized by progressive involuntary rapid, jerky motions and mental deterioration, leading to dementia) (1), muscle weakness, schizophrenia (any of a group of mental disorders characterized by gross distortions of reality, withdrawal from social contacts, and disturbances of thought, language, perception and emotional response.) (2), and dysphagia (a condition in which swallowing is difficult or painful due to obstruction of the esophagus or muscular abnormalities of the esophagus). (3)

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The most recent MDS assessment, a quarterly assessment, with an assessment reference date of 2/22/18, coded the resident as scoring a two on the BIMS (brief interview for mental status) score indicating the resident is severely impaired to make cognitive daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living. In Section P - Restraints and Alarms, the resident was coded as using bed rails daily. The instructions under P0100 Physical Restraints: Physical restraints are any manual method of physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body."

The "Side Rail & Entrapment Risk Evaluation" dated 2/16/18, documented in part the following:
"1. The resident/resident representative has requested use of the side rails. - Yes was documented.
2. The resident is physically able to use the side rails for bed positioning or transfers independently or with assistance - Yes was documented.
3. The resident is able to recognize safety hazard when using the side rails - Yes was documented.
4. The resident does not demonstrate behaviors that would place resident at risk for injury and/or entrapment - Yes was documented.
5. The resident has difficulty with balance or poor trunk control when in bed or transferring to/from bed - Yes was documented.
6. The resident does not have a history of 'climbing' over or around rails - Yes was documented.
7. The resident does not have an injury from use

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of side rails - Yes was documented.
8. The resident is able (cognitively and functionally) to use the call bed to call for assistance - Yes was documented.
9. The use of a side rail will optimize resident independence in bed mobility and transfer - Yes was documented.
10. The use of the side rail during care provide by staff will optimize resident safety and security - Yes was documented.
11. The resident is using an alternation air pressure mattress or overlay mattress - No was documented.
12. The resident has uncontrolled body movements - No was documented.
13. The resident has periods of confusions or unsafe behaviors that may place resident at risk - No was documented.
14. The bed inspection has been completed and demonstrated that the bed is safe functionally and railed and mattress do not create a risk for entrapment or restraint - Yes was documented.
15. Resident/resident representative has signed consent if side rails are being used.
16. Physician order is complete for use of side rails - Yes was documented."
This form was signed and dated by the nurse completing it on 2/27/18.

The physician orders dated, 8/7/17 documented, "Padded side rails QS (every shift)."

The comprehensive care plan dated, 9/8/17, documented in part, "Focus: Potential for impaired skin integrity." The "Interventions" documented in part, "Resident has 1/2 side rails, padded to aid in turning and positioning."

An interview was conducted with RN (registered

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nurse) #1, the MDS coordinator, on 3/29/18 at 12:44 p.m. When asked why the resident was coded for restraints, RN #1 stated, "The first question is related to bedrails. Most have one half side rails in place for positioning. So the first question is do they use side rails, and how often." RN #1 then went to get the RAI (resident assessment instrument) manual. She returned at approximately 1:00 p.m. and stated, "I spoke with the DON (director of nursing), she (the DON) said if the use of the bed rails meets the definition of a physical restraint then we code them as a restraint. But if they don't meet the requirement then we don't code it as a restraint." When asked the definition of a restraint, RN #1 stated, "any manual method or physical or mechanical device, material or equipment attached or adjacent tot eh resident's body that he individual cannot remove easily and which restricts freedom of movement or normal access to one body. This is as per the RAI manual." RN #1 further stated, "We are apparently need to reevaluate all of this." RN #1 was asked if 90 meet the definition for a restraint, RN #1 stated, "I was playing safe. Not everyone was evaluated to see if they met the definition of a restraint." When asked if side rail assessments are done with each MDS, RN #1 stated, "Yes but not by me. The nurse's do them."

On 3/29/18 at 4:09 a.m., RN #1 returned and stated, "I evaluated the list of residents that was given to me to see if they met the criteria for a restraint. They do not. None of them meets the criteria for a restraint.

The administrator, ASM (administrative staff member) #1, the director of nursing, ASM #2 and ASM #7, the owner were made aware of the above findings on 3/29/18 at 6:10 p.m.

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No further information was provided prior to exit.

(1) Barron's Dictionary for Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 246.
(2) Barron's Dictionary for Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 522.
(3) Barron's Dictionary for Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 178.

7. The facility staff failed to code Resident #89's quarterly MDS assessment, with an assessment reference date of 2/22/18, accurately for the use of a restraint.

Resident #89 was admitted to the facility on 5/4/14 with a recent readmission of 3/18/18, with diagnoses that included but were not limited to: left shoulder pain, urinary tract infection, fracture of her leg, diabetes, depression, high blood pressure, stroke, and psychosis (major mental disorder in which the person is usually detached from reality and has impaired perceptions, thinking, responses and interpersonal relationships) (1).

The most recent MDS, a quarterly assessment, with an assessment reference date of 2/22/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for most of her activities of daily living. In Section P - Restraints and Alarms, the

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resident was coded as using bed rails daily.

The most recent "Side Rail & Entrapment Risk Evaluation" dated, 12/15/17 and signed by the nurse on 12/20/17, documented the following:
"The "Side Rail & Entrapment Risk Evaluation" dated 2/16/18, documented in part the following:
"1. The resident/resident representative has requested use of the side rails. - Yes was documented.
2. The resident is physically able to use the side rails for bed positioning or transfers independently or with assistance - Yes was documented.
3. The resident is able to recognize safety hazard when using the side rails - Yes was documented.
4. The resident does not demonstrate behaviors that would place resident at risk for injury and/or entrapment - Yes was documented.
5. The resident has difficulty with balance or poor trunk control when in bed or transferring to/from bed - Yes was documented.
6. The resident does not have a history of 'climbing' over or around rails - Yes was documented.
7. The resident does not have an injury from use of side rails - Yes was documented.
8. The resident is able (cognitively and functionally) to use the call bed to call for assistance - Yes was documented.
9. The use of a side rail will optimize resident independence in bed mobility and transfer - Yes was documented.
10. The use of the side rail during care provide by staff will optimize resident safety and security - Yes was documented.
11. The resident is using an alternation air pressure mattress or overlay mattress - No was documented.

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12. The resident has uncontrolled body movements - No was documented.
13. The resident has periods of confusions or unsafe behaviors that may place resident at risk - No was documented.
14. The bed inspection has been completed and demonstrated that the bed is safe functionally and railed and mattress do not create a risk for entrapment or restraint - Yes was documented.
15. Resident/resident representative has signed consent if side rails are being used.
16. Physician order is complete for use of side rails - Yes was documented."

The physician order dated 5/26/18 documented, "1/2 (half) side rails to aid in bed mobility every shift."

The comprehensive care plan dated, 5/26/17, documented in part, "Focus: Potential for impaired skin integrity." The "Interventions" documented in part, "Resident has 1/2 side rails to aid in turning and positioning."

On 3/29/18 at 4:09 a.m., RN #1 returned and stated, "I evaluated the list of residents (Resident #89 was on the list) that was given to me to see if they met the criteria for a restraint. They do not. None of them meets the criteria for a restraint.

The administrator, ASM (administrative staff member) #1, the director of nursing, ASM #2 and ASM #7, the owner were made aware of the above findings on 3/29/18 at 6:10 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary for Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and

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Chapman, page 483.

8. The facility staff coded Resident #130 inaccurately as having a physical restraint on a quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 3/9/18.

Resident #130 was admitted to the facility on 1/11/18 and readmitted on 2/2/18. Resident #130's diagnoses included but were not limited to pneumonia, diabetes and urinary tract infection. Resident #130's most recent MDS, a quarterly assessment with an ARD of 3/9/18, coded the resident as cognitively intact. Section G documented Resident #130 as requiring extensive assistance of one staff with bed mobility. Section P0100 Physical Restraints documented, "Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body." A bed rail was coded as a restraint used daily for Resident #130.

Review of Resident #130's clinical record revealed a physician's order dated 2/2/18 for one-half side rails to assist in turning and positioning. A side rail and entrapment risk evaluation dated 2/2/18 documented, "The use of a side rail will optimize resident independence in bed mobility and transfer..."

On 3/29/18 at 12:48 p.m., an interview was conducted with RN (registered nurse) #1 (the MDS Coordinator) regarding physical restraint coding on the MDS assessment. RN #1 stated, "The first question under (section) p is bed

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railings. I would say a great majority of our residents have bedrails in place for turning and positioning. Side rails trigger as restraints. RN #1 was asked to obtain the CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) manual. RN #1 left the room and returned a few moments later. RN #1 stated she just spoke to the director of nursing who said if the use of bedrails meets the definition of a physical restraint then the MDS staff has to code a restraint but if the use of bedrails does not meet the definition then the MDS staff should not code a restraint. RN #1 was asked the definition of a restraint. RN #1 stated, "Any manual method or physical or mechanical device material or equipment attached or adjacent to the resident's body that the individual cannot remove easily and which restricts freedom of movement or normal access to one's body." RN #1 stated this definition was obtained from the RAI manual. When asked if this definition applies to every resident who uses side rails, RN #1 stated, "Apparently we are going to need to reevaluate all of this. Every resident that was coded (for a physical restraint) was not evaluated to see if it met the true definition of a restraint." RN #1 was provided a list of resident names (including Resident #130) and asked to evaluate whether those residents' use of side rails should be coded as physical restraints.

On 3/29/18 at 4:07 p.m., RN #1 stated she evaluated the list of residents to see if the use of side rails for those residents met the criteria for restraints. RN #1 stated the use of side rails for all of those residents did not meet the criteria for a physical restraint.

On 3/29/18 at 5:48 pm., ASM (administrative staff

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member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

9. The facility staff coded Resident #132 inaccurately as having a physical restraint on a significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 3/15/18.

Resident #132 was admitted to the facility on 2/6/18 and readmitted on 3/8/18. Resident #132's diagnoses included but were not limited to acute respiratory failure, stroke and muscle weakness. Resident #132's most recent MDS, a significant change in status assessment with an ARD of 3/15/18, coded the resident's cognition as severely impaired. Section G documented Resident #132 as requiring extensive assistance of two or more staff with bed mobility. Section P0100 Physical Restraints documented, "Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body." A bed rail was coded as a restraint used daily for Resident #132.

Review of Resident #132's clinical record revealed a physician's order dated 3/8/18 for one-half side rails to both sides of the bed to assist the resident in turning and positioning. A side rail and entrapment risk evaluation dated 3/8/18 documented, "The use of a side rail will optimize resident independence in bed mobility and transfer..."

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On 3/29/18 at 12:48 p.m., an interview was conducted with RN (registered nurse) #1 (the MDS Coordinator) regarding physical restraint coding on the MDS assessment. RN #1 was provided a list of resident names (including Resident #132) and asked to evaluate whether those residents' use of side rails should be coded as physical restraints.

On 3/29/18 at 4:07 p.m., RN #1 stated she evaluated the list of residents to see if the use of side rails for those residents met the criteria for restraints. RN #1 stated the use of side rails for all of those residents did not meet the criteria for a physical restraint.

On 3/29/18 at 5:48 pm., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

10. The facility staff coded Resident #133 inaccurately as having a physical restraint on an admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 3/15/18.

Resident #133 was admitted to the facility on 3/8/18. Resident #133's diagnoses included but were not limited to heart failure, high blood pressure and chronic kidney disease. Resident #133's most recent MDS, an admission assessment with an ARD (assessment reference date) of 3/15/18, coded the resident's cognition as moderately impaired. Section G documented Resident #133 as requiring extensive assistance

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of two or more staff with bed mobility. Section P0100 Physical Restraints documented, "Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body." A bed rail was coded as a restraint used daily for Resident #133.

Review of Resident #133's clinical record revealed a physician's order dated 3/8/18 for one-half side rails to assist the resident in turning and positioning. A side rail and entrapment risk evaluation dated 3/8/18 documented, "The use of a side rail will optimize resident independence in bed mobility and transfer..."

On 3/29/18 at 12:48 p.m., an interview was conducted with RN (registered nurse) #1 (the MDS Coordinator) regarding physical restraint coding on the MDS assessment. RN #1 was provided a list of resident names (including Resident #133), and asked to evaluate whether those residents' use of side rails should be coded as physical restraints.

On 3/29/18 at 4:07 p.m., RN #1 stated she evaluated the list of residents to see if the use of side rails for those residents met the criteria for restraints. RN #1 stated the use of side rails for all of those residents did not meet the criteria for a physical restraint.

On 3/29/18 at 5:48 pm., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

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No further information was presented prior to exit.

11. The facility staff coded the Resident #47's annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 1/1/18 in accurately for the use of restraints when in fact the resident did not have restraints.

Resident #47 was admitted to the facility on 3/23/16 with diagnoses that included but were not limited to anxiety disorder, Alzheimer's disease, unspecified dementia without behavioral disturbance, high blood pressure, muscle weakness, and major depressive disorder. Resident #47's most recent MDS (minimum data set) assessment was annual assessment with an ARD (assessment reference date) of 1/1/18. Resident #47 was coded as severely cognitively impaired in the ability to make daily decisions scoring 03 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Section P (restraints and alarms) coded Resident #47 has having bed rail restraints used on a daily basis.

Review of Resident #47's most current POS (physician order summary) documented the following order: "1/2 side rails for turning and positioning every shift."

Review of Resident #47's side rail assessment dated 12/18/17 documented the side rails as not being a restraint.

On 3/29/18 at 12:45 p.m., an interview was conducted with RN (registered nurse) #1, the MDS nurse. RN #1 stated that the great majority of residents in the building had 1/2 side rails. RN #1 stated that all side rails were considered a restraint and therefore documented as such on

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the MDS assessment. RN #1 was asked to provide that information from the RAI (Resident Assessment Instrument) manual.

On 3/29/18 at approximately 1:00 p.m., RN #1 stated that she had just spoken to the DON (Director of Nursing). RN #1 stated that if the bed rails met the definition of a restraint, then the bed rails would be coded as a restraint on the MDS. RN #1 stated that if they don't meet the requirement of a restraint, then the MDS should code them as a restraint. When asked the definition of a physical restraint, RN #1 stated that a restraint was "any manual method or physical or mechanical device material or equipment attached or adjacent to the resident's body that the individual cannot remove easily and which restricts freedom of movement or normal access to one's body." RN #1 was reading this definition straight from the RAI manual. RN #1 stated, "Apparently we are going to re-evaluate all of this." RN #1 stated that the nurses did the side rail assessments for residents with side rails.

On 3/29/18 at 5:47 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) and ASM #7, the facility owner were made aware of the above concerns.

12. The facility staff coded Resident #66's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 2/13/18, inaccurately for the use of restraints, when in fact the resident did not have restraints.

Resident #66 was admitted to the facility on 4/19/17 and readmitted on 2/11/18 with diagnoses

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that included but were not limited to unspecified dementia without behavioral disturbance, heart failure, gout, major depressive disorder, high blood pressure and atrial fibrillation. Resident #66's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 2/13/18. Resident #66 was coded as severely cognitively impaired in the ability to make daily decisions scoring 03 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #66 was coded as requiring extensive assistance from one staff member with most ADLs (activities of daily living). Section P (restraints and alarms) coded Resident #66 has having bed rail restraints used on a daily basis.

Review of Resident #66's most current POS (physician order summary) documented the following order: "1/2 side rails for turning and positioning every shift."

Review of Resident #66's side rail assessment dated 2/11/17 documented the side rails as not being a restraint.

On 3/29/18 at 12:45 p.m., an interview was conducted with RN (registered nurse) #1, the MDS nurse. RN #1 stated that the great majority of residents in the building had 1/2 side rails. RN #1 stated that all side rails were considered a restraint and therefore documented as such on the MDS. RN #1 was asked to provide that information from the RAI (Resident Assessment Instrument) manual.

On 3/29/18 at approximately 1:00 p.m., RN #1 stated that she had just spoken to the DON (Director of Nursing). RN #1 stated that if the bed

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rails met the definition of a restraint, then the bed rails would be coded as a restraint on the MDS. RN #1 stated that if they don't meet the requirement of a restraint, then the MDS should code them as a restraint. When asked the definition of a physical restraint, RN #1 stated that a restraint was "any manual method or physical or mechanical device material or equipment attached or adjacent to the resident's body that the individual cannot remove easily and which restricts freedom of movement or normal access to one's body." RN #1 was reading this definition straight from the RAI manual. RN #1 stated, "Apparently we are going to re-evaluate all of this." RN #1 stated that the nurses did the side rail assessments for residents with side rails.

On 3/29/18 at 5:47 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) and ASM #7, the facility owner were made aware of the above concerns.

13. The facility staff coded Resident #57's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 2/8/18, inaccurately for the use of a restraint, when in fact the resident did not have restraints.

Resident #57 was admitted to the facility on 5/24/14 and readmitted on 1/22/18 with diagnoses that included but were not limited to Dementia with behavioral disturbance, muscle weakness, Alzheimer's disease and mood disorder. Resident #57's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/8/18. Resident #57 was coded as being severely impaired in cognitive function

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scoring 06 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #57 was coded as requiring extensive assistance from two staff members with most ADLS (activities of daily living). Section P (restraints and alarms) coded Resident #57 has having bed rail restraints used on a daily basis.

Review of Resident #57's most current POS (physician order summary) documented the following order: "1/2 side rails for turning and positioning every shift."

Review of Resident #57's side rail assessment dated 2/11/17 documented the side rails as not being a restraint.

On 3/29/18 at 12:45 p.m., an interview was conducted with RN (registered nurse) #1, the MDS nurse. RN #1 stated that the great majority of residents in the building had 1/2 side rails. RN #1 stated that all side rails were considered a restraint and therefore documented as such on the MDS. RN #1 was asked to provide that information from the RAI (Resident Assessment Instrument) manual.

On 3/29/18 at approximately 1:00 p.m., RN #1 stated that she had just spoken to the DON (Director of Nursing). RN #1 stated that if the bed rails met the definition of a restraint, then the bed rails would be coded as a restraint on the MDS. RN #1 stated that if they don't meet the requirement of a restraint, then the MDS should code them as a restraint. When asked the definition of a physical restraint, RN #1 stated that a restraint was "any manual method or physical or mechanical device material or equipment attached or adjacent to the resident's body that

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the individual cannot remove easily and which restricts freedom of movement or normal access to one's body." RN #1 was reading this definition straight from the RAI manual. RN #1 stated, "Apparently we are going to re-evaluate all of this." RN #1 stated that the nurses did the side rail assessments for residents with side rails.

On 3/29/18 at 5:47 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) and ASM #7, the facility owner were made aware of the above concerns.

14. The facility staff coded Resident #3's quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 3/14/18, inaccurately for the use of restraints, when in fact the resident did not have restraints.

Resident #3 was admitted to the facility on 9/10/16 with the diagnoses of but not limited to atrial fibrillation, morbid obesity, chronic kidney disease, systemic inflammatory response syndrome, bladder obstruction, chronic ischemic heart disease, schizophrenia, Parkinson's disease, diabetes, high blood pressure, and bipolar disorder.

The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/14/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident required total care for bathing; extensive care for transfers, dressing, toileting, and hygiene; was independent for eating; and was incontinent of bowel and had an indwelling catheter for bladder. Section P "Restraints and Alarms" documented, "Physical restraints are any manual method or physical or

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mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body." The coding options were "0. Not used, 1. Used less than daily, 2. Used daily." Next to "Bed rail", the resident was coded "2" for "Used daily." No other restraint devices were coded.

A review of the clinical record revealed a physician's order dated 3/21/18 for "1/2 side rails to assist times 2 with bed mobility." There was no evidence the side rails were ordered to be a restraint.

A review of the care plan failed to reveal any evidence of the resident requiring restraints.

Observations made on 3/17/18 at 3:29 p.m., 3/28/18 at 8:13 a.m., 3/29/18 at 8:16 a.m., revealed the resident in bed asleep, and half-length side rails up.

On 3/29/18 at 12:46 p.m., in an interview with RN #1 (Registered Nurse, the MDS nurse) she stated, "a great majority of residents have 1/2 side rails for turning and positioning, which triggers it for a restraint. At this time, she left the room to obtain her RAI manual (Resident Assessment Instrument).

On 3/29/18 at 1:00 p.m., RN #1 returned and stated she had spoken with the Director of Nursing (DON). RN #1 stated the DON stated that if the use of bed rails meets the definition of a physical restraint then we have to count them as a restraint, but if they don't meet the definition

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then we should not code them as a restraint. She stated the definition of a restraint is "Any manual method or physical or mechanical device material or equipment attached or adjacent to the resident's body that the individual cannot remove easily and which restricts freedom of movement or normal access to one's body." RN #1 then stated, "Apparently we are going to need to reevaluate all of this." When asked if, when coding this, did she evaluate the residents to see if they met this definition for a restraint. She stated, "I was playing it safe, every resident was not evaluated to see if they met the definition of a restraint. If resident wants it, it would not be considered a restraint."

On 3/29/18 at 4:09 p.m., RN #1 returned and stated she had evaluated all the residents on the list (including Resident #3) to see if they met criteria for side rails as a restraint. RN #1 stated that none of them meets the criteria for a restraint; therefore, none of them should have been coded as having a restraint.

On 3/29/18 at 6:05 p.m., at the end of day meeting, the Administrator, ASM (Administrative Staff Member) #1, Director of Nursing (ASM #2), and the facility owner (ASM #7) were made aware of the findings. No further information was provided by the end of the survey.

15. The facility staff coded Resident #74's quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 2/16/18, inaccurately for the use of restraints, when in fact the resident did not have restraints.

Resident #74 was admitted to the facility on

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8/26/13 with the diagnoses of but not limited to stroke, intestinal disease, depression, metabolic encephalopathy, dementia, schizoaffective disorder, dysphagia, gastrostomy feeding tube, cataracts, presbyopia, Parkinson's disease, schizophrenia, bipolar disorder, angina, diabetes, high blood pressure, hypothyroidism, and chronic obstructive pulmonary disease.

The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/16/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident required total care for transfers, dressing, and hygiene; extensive care for eating; and was incontinent of bowel and bladder. Section P "Restraints and Alarms" documented, "Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body." The coding options were "0. Not used, 1. Used less than daily, 2. Used daily." Next to "Bed rail", the resident was coded "2" for "Used daily." No other restraint devices were coded.

A review of the clinical record revealed a physician's order dated 3/24/18 for "1/2 side rails to aid in independent bed mobility." There was no evidence the side rails were ordered to be a restraint.

A review of the care plan failed to reveal any evidence of the resident requiring restraints.

Observations made on 3/17/18 at 3:29 p.m., 3/28/18 at 8:13 a.m., and 3/29/18 at 8:16 a.m.,

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revealed the resident in bed asleep, half-length side rails up.

On 3/29/18 at 12:46 p.m., in an interview with RN #1 (Registered Nurse, the MDS nurse) she stated, "a great majority of residents have 1/2 side rails for turning and positioning, which triggers it for a restraint. At this time, she left the room to obtain her RAI manual (Resident Assessment Instrument).

On 3/29/18 at 1:00 p.m., RN #1 returned and stated she had spoken with the Director of Nursing (DON). RN #1 stated the DON stated that if the use of bed rails meets the definition of a physical restraint then we have to count them as a restraint, but if they don't meet the definition then we should not code them as a restraint. She stated the definition of a restraint is "Any manual method or physical or mechanical device material or equipment attached or adjacent to the resident's body that the individual cannot remove easily and which restricts freedom of movement or normal access to one's body." RN #1 then stated, "Apparently we are going to need to reevaluate all of this." When asked if, when coding this, did she evaluate the residents to see if they met this definition for a restraint. She stated, "I was playing it safe, every resident was not evaluated to see if they met the definition of a restraint. If resident wants it, it would not be considered a restraint."

On 3/29/18 at 4:09 p.m., RN #1 returned and stated she had evaluated all the residents on the list (including Resident #3) to see if they met criteria for side rails as a restraint. RN #1 stated that none of them meets the criteria for a restraint; therefore, none of them should have

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been coded as having a restraint.

On 3/29/18 at 6:05 p.m., at the end of day meeting, the Administrator, ASM (Administrative Staff Member) #1, Director of Nursing (ASM #2), and the facility owner (ASM #7) were made aware of the findings. No further information was provided by the end of the survey.

16. The facility staff coded Resident #114's quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/6/18, inaccurately for the use of restraints, when in fact the resident did not have restraints.

Resident #114 was admitted to the facility on 4/7/17 with the diagnoses of but not limited to deep vein thrombosis, ankle fracture, aspiration pneumonia, shortness of breath, edema, insomnia, dementia, schizophrenia, depression, anxiety disorder, high blood pressure, emphysema, chronic obstructive pulmonary disease, osteoarthritis, fibromyalgia, and chronic kidney disease.

The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/6/18. The resident was coded as being severely impaired in ability to make daily life decisions. The resident required total care for bathing; extensive care for hygiene, dressing, and transfers; limited assistance for toileting; independent for eating; and was continent of bowel and bladder. Section P "Restraints and Alarms" documented, "Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that

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	495142	A. BUILDING _____ B. WING _____	C 03/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN HEALTH AND REHAB	380 MILLWOOD AVENUE WINCHESTER, VA 22601

(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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the individual cannot remove easily which restricts freedom of movement or normal access to one's body." The coding options were "0. Not used, 1. Used less than daily, 2. Used daily." Next to "Bed rail", the resident was coded "2" for "Used daily." No other restraint devices were coded.

A review of the clinical record revealed a physician's order dated 6//3/17 for "1/2 side rails x2 to assist with t/p (turning and positioning)." There was no evidence the side rails were ordered to be a restraint.

A review of the care plan failed to reveal any evidence of the resident requiring restraints.

Observations made on 3/17/18 at 3:28 p.m., revealed the resident to be out of the room; 3/28/18 at 9:15 a.m., revealed the resident up in her wheelchair watching television and on 3/29/18 at 8:16 a.m., revealed the resident in bed asleep, with half-length side rails up.

On 3/29/18 at 12:46 p.m., in an interview with RN #1 (Registered Nurse, the MDS nurse) she stated, "a great majority of residents have 1/2 side rails for turning and positioning, which triggers it for a restraint. At this time, she left the room to obtain her RAI manual (Resident Assessment Instrument).

On 3/29/18 at 1:00 p.m., RN #1 returned and stated she had spoken with the Director of Nursing (DON). RN #1 stated the DON stated that if the use of bed rails meets the definition of a physical restraint then we have to count them as a restraint, but if they don't meet the definition then we should not code them as a restraint. She

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stated the definition of a restraint is "Any manual method or physical or mechanical device material or equipment attached or adjacent to the resident's body that the individual cannot remove easily and which restricts freedom of movement or normal access to one's body." RN #1 then stated, "Apparently we are going to need to reevaluate all of this." When asked if, when coding this, did she evaluate the residents to see if they met this definition for a restraint. She stated, "I was playing it safe, every resident was not evaluated to see if they met the definition of a restraint. If resident wants it, it would not be considered a restraint."

On 3/29/18 at 4:09 p.m., RN #1 returned and stated she had evaluated all the residents on the list (including Resident #3) to see if they met criteria for side rails as a restraint. RN #1 stated that none of them meets the criteria for a restraint; therefore, none of them should have been coded as having a restraint.

On 3/29/18 at 6:05 p.m., at the end of day meeting, the Administrator, ASM (Administrative Staff Member) #1, Director of Nursing (ASM #2), and the facility owner (ASM #7) were made aware of the findings. No further information was provided by the end of the survey.

17. The facility staff coded Resident #87's quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 3/12/18, inaccurately for the use of restraints, when in fact the resident did not have restraints.

Resident #87 was admitted to the facility on 8/16/17 with the diagnoses of but not limited to

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pneumonia, osteoporosis, bronchitis, hypothyroidism, diabetes, morbid obesity, depression, Parkinson's disease, epilepsy, high blood pressure, ischemic heart disease, pulmonary embolism, stroke, peripheral vascular disease, chronic obstructive pulmonary disease, respiratory failure, spinal stenosis, fibromyalgia, shortness of breath, dysphagia, and ataxia.

The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/12/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident required total care for bathing; extensive assistance for transfers, dressing, toileting, and hygiene; independent for eating; and was incontinent of bowel and bladder. Section P "Restraints and Alarms" documented, "Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body." The coding options were "0. Not used, 1. Used less than daily, 2. Used daily." Next to "Bed rail", the resident was coded "2" for "Used daily." No other restraint devices were coded.

A review of the clinical record revealed a physician's order dated 12/14/17 for "1/2 side rails to aid in independent bed mobility." There was no evidence the side rails were ordered to be a restraint.

A review of the care plan failed to reveal any evidence of the resident requiring restraints.

Observations made on 3/17/18 at 3:17 p.m.,

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3/28/18 at 8:29 a.m., and 3/29/18 at 8:12 a.m., revealed the resident to be in bed asleep, half-length side rails up.

On 3/29/18 at 12:46 p.m., in an interview with RN #1 (Registered Nurse, the MDS nurse) she stated, "a great majority of residents have 1/2 side rails for turning and positioning, which triggers it for a restraint. At this time, she left the room to obtain her RAI manual (Resident Assessment Instrument).

On 3/29/18 at 1:00 p.m., RN #1 returned and stated she had spoken with the Director of Nursing (DON). RN #1 stated the DON stated that if the use of bed rails meets the definition of a physical restraint then we have to count them as a restraint, but if they don't meet the definition then we should not code them as a restraint. She stated the definition of a restraint is "Any manual method or physical or mechanical device material or equipment attached or adjacent to the resident's body that the individual cannot remove easily and which restricts freedom of movement or normal access to one's body." RN #1 then stated, "Apparently we are going to need to reevaluate all of this." When asked if, when coding this, did she evaluate the residents to see if they met this definition for a restraint. She stated, "I was playing it safe, every resident was not evaluated to see if they met the definition of a restraint. If resident wants it, it would not be considered a restraint."

On 3/29/18 at 4:09 p.m., RN #1 returned and stated she had evaluated all the residents on the list (including Resident #3) to see if they met criteria for side rails as a restraint. RN #1 stated that none of them meets the criteria for a

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restraint; therefore, none of them should have been coded as having a restraint.

On 3/29/18 at 6:05 p.m., at the end of day meeting, the Administrator, ASM (Administrative Staff Member) #1, Director of Nursing (ASM #2), and the facility owner (ASM #7) were made aware of the findings. No further information was provided by the end of the survey.

18. The facility staff coded Resident #83's MDS assessment correctly for the use of restraints, when in fact the resident did not have restraints.

Resident #83 was admitted to the facility on 4/11/17 with the diagnoses of but not limited to acute kidney failure, aspiration pneumonia, respiratory failure with hypoxia, dysphagia, chronic obstructive pulmonary disease, depression, and shortness of breath.

The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/19/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident required total care for bathing; extensive care for transfers, dressing, toileting, and hygiene; independent for eating; and was incontinent of bowel and bladder. Section P "Restraints and Alarms" documented, "Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body." The coding options were "0. Not used, 1. Used less than daily, 2. Used daily." Next to "Bed rail", the resident was coded

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"2" for "Used daily." No other restraint devices were coded.

A review of the clinical record revealed a physician's order dated 12/14/17 for "1/2 side rails to aid in independent bed mobility." There was noevidence the side rails were ordered to be a restraint.

A review of the care plan failed to reveal any evidence of the resident requiring restraints.

Observations made on 3/17/18 at 3:20PM, and 3/28/18 at 8:58AM revealed the resident to be in bed, half-length side rails up.

On 3/29/18 at 12:46 p.m., in an interview with RN #1 (Registered Nurse, the MDS nurse) she stated, "a great majority of residents have 1/2 side rails for turning and positioning, which triggers it for a restraint. At this time, she left the room to obtain her RAI manual (Resident Assessment Instrument).

On 3/29/18 at 1:00 p.m., RN #1 returned and stated she had spoken with the Director of Nursing (DON). RN #1 stated the DON stated that if the use of bed rails meets the definition of a physical restraint then we have to count them as a restraint, but if they don't meet the definition then we should not code them as a restraint. She stated the definition of a restraint is "Any manual method or physical or mechanical device material or equipment attached or adjacent to the resident's body that the individual cannot remove easily and which restricts freedom of movement or normal access to one's body." RN #1 then stated, "Apparently we are going to need to reevaluate all of this." When asked if, when

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coding this, did she evaluate the residents to see if they met this definition for a restraint. She stated, "I was playing it safe, every resident was not evaluated to see if they met the definition of a restraint. If resident wants it, it would not be considered a restraint."

On 3/29/18 at 4:09 p.m., RN #1 returned and stated she had evaluated all the residents on the list (including Resident #3) to see if they met criteria for side rails as a restraint. RN #1 stated that none of them meets the criteria for a restraint; therefore, none of them should have been coded as having a restraint.

On 3/29/18 at 6:05 p.m., at the end of day meeting, the Administrator, ASM (Administrative Staff Member) #1, Director of Nursing (ASM #2), and the facility owner (ASM #7) were made aware of the findings. No further information was provided by the end of the survey.

19. The facility staff coded Resident #55's quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 2/7/18, inaccurately for the use of restraints, when in fact the resident did not have restraints.

Resident #55 was admitted to the facility on 10/25/04 with the diagnoses of but not limited to Parkinson's disease, benign prostatic hyperplasia, diabetes, dementia, psychosis, depression, mood disorder, anxiety disorder, pseudobulbar affect, high blood pressure, and dysphagia.

The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment

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Reference Date) of 2/7/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident required extensive care for bathing, hygiene, toileting, dressing, and transfers; supervision for eating; and was incontinent of bowel and bladder. Section P "Restraints and Alarms" documented, "Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body." The coding options were "0. Not used, 1. Used less than daily, 2. Used daily." Next to "Bed rail", the resident was coded "2" for "Used daily." No other restraint devices were coded.

A review of the clinical record revealed a physician's order dated 12/14/17 for "1/2 side rails to aid in independent bed mobility." There was no evidence the side rails were ordered to be a restraint.

A review of the care plan failed to reveal any evidence of the resident requiring restraints.

Observations made on 3/17/18 at 3:16PM, 3/28/18 at 9:12AM, and 3/29/18 at 8:14AM revealed the resident to be in bed asleep, half-length side rails up.

A review of the above MDS,

On 3/29/18 at 12:46 p.m., in an interview with RN #1 (Registered Nurse, the MDS nurse) she stated, "a great majority of residents have 1/2 side rails for turning and positioning, which triggers it for a restraint. At this time, she left the

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room to obtain her RAI manual (Resident Assessment Instrument).

On 3/29/18 at 1:00 p.m., RN #1 returned and stated she had spoken with the Director of Nursing (DON). RN #1 stated the DON stated that if the use of bed rails meets the definition of a physical restraint then we have to count them as a restraint, but if they don't meet the definition then we should not code them as a restraint. She stated the definition of a restraint is "Any manual method or physical or mechanical device material or equipment attached or adjacent to the resident's body that the individual cannot remove easily and which restricts freedom of movement or normal access to one's body." RN #1 then stated, "Apparently we are going to need to reevaluate all of this." When asked if, when coding this, did she evaluate the residents to see if they met this definition for a restraint. She stated, "I was playing it safe, every resident was not evaluated to see if they met the definition of a restraint. If resident wants it, it would not be considered a restraint."

On 3/29/18 at 4:09 p.m., RN #1 returned and stated she had evaluated all the residents on the list (including Resident #3) to see if they met criteria for side rails as a restraint. RN #1 stated that none of them meets the criteria for a restraint; therefore, none of them should have been coded as having a restraint.

On 3/29/18 at 6:05 p.m., at the end of day meeting, the Administrator, ASM (Administrative Staff Member) #1, Director of Nursing (ASM #2), and the facility owner (ASM #7) were made aware of the findings. No further information was provided by the end of the survey.

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F 645 SS=E	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §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	F 645	F645 1. PASARR's have been completed for Residents #89, #90, #74, #114, #55, and #98. 2. Current facility residents have the potential to be affected by the alleged deficient practice. 100% audit will be completed to ensure residents have had a Preadmission Screening and Resident Review (PASARR). The screening will be done for those residents identified as not having one. 3. Measures put into place to assure alleged deficient practice does not recur include: Admissions and Social Service staff will be reeducated on PASARR and ensuring the resident has one at the time of admission. 4. The Director of Nursing and/or designee will analyze/review for patterns/trends and report in the Quality Assurance committee meeting quarterly for a minimum of six months to evaluate the effectiveness of the plan and will adjust the plan as the committee may recommend, based on outcomes/trends identified from date. 5. Completion Date: May 11, 2018	

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being admitted to the nursing facility, was 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 staff interview and clinical record review, it was determined the facility staff failed to complete a Preadmission Screening and Resident Review (PASARR) for six of 31 residents in the survey sample, Residents #89, #90, #74, #114, #55 and #98.

1. The facility staff failed to complete a Level I PASARR for Resident # 89, to ensure each resident in a nursing facility, is screened for a

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mental disorder (MD) or intellectual disability (ID) prior to admission, and that individuals are evaluated, and receive care and services in the most integrated setting appropriate to their needs.

2. The facility staff failed to complete a Level I PASARR for Resident #90, to ensure each resident in a nursing facility, is screened for a mental disorder (MD) or intellectual disability (ID) prior to admission and individuals are evaluated and receive care and services in the most integrated setting appropriate to their needs.

3. The facility staff failed to ensure Resident #74's PASARR was complete to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs.

4. The facility staff failed to ensure Resident #114's PASARR was complete to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs.

5. The facility staff failed to ensure Resident #55's PASARR was complete to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs.

6. The facility staff failed to complete a Level I PASAAR for Resident #98, to ensure each resident in a nursing facility, is screened for a mental disorder (MD) or intellectual disability (ID) prior to admission and that individuals are evaluated and receive care and services in the most integrated setting appropriate to their needs.

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The findings include:

1. The facility staff failed to complete a Level I PASARR for Resident # 89, to ensure each resident in a nursing facility, is screened for a mental disorder (MD) or intellectual disability (ID) prior to admission and that individuals are evaluated and receive care and services in the most integrated setting appropriate to their needs.

Resident #89 was admitted to the facility on 5/4/14 with a recent readmission of 3/18/18, with diagnoses that included but were not limited to: left shoulder pain, urinary tract infection, fracture of her leg, diabetes, depression, high blood pressure, stroke, and psychosis (major mental disorder in which the person is usually detached from reality and has impaired perceptions, thinking, responses and interpersonal relationships). (1)

The most recent MDS, a quarterly assessment, with an assessment reference date of 2/22/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions.

Review of the clinical record failed to evidence a Preadmission Screening and Resident Review was completed.

On 3/29/18 at the end of the day meeting, a request was made for Resident #89's PASARR.

An interview was conducted with other staff member (OSM) #3, the social worker, on 3/30/18

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at 9:28 a.m. When asked if she had any knowledge of the PASARR for the residents, OSM #3 stated, "I explained to the business office manager, I was not told that it was something that I should be doing. It came to our attention yesterday. The other social worker spoke with me this morning about PASARR. To my knowledge, we don't have any of the PASARRs." When asked what the PASARR is, OSM #3 stated, "It's some type of evaluation of that person." When asked what the purpose of the PASARR was, OSM #3 stated she did not know.

An interview was conducted with OSM #4, the other social worker, on 3/30/18 at 9:45 a.m. When asked what a PASARR is, OSM #4 stated, "My understanding is that it starts at the hospital and to determine if a resident has a mental illness or mental disability to make sure they are safe to come to the facility and if they need a psychologist or doctor so we can safely take care of them." When asked the purpose of the PASARR, OSM #4 stated it's so they can come to the facility. If one does not come from the hospital the admission did it in West Virginia, where I worked, but in Virginia it's referred to the social worker to complete." When asked if there is more to the PASARR then being safe to come to the facility, OSM #4 stated, "If they have an issue so we can meet their needs. Level 2 typically get a notice with yes or no. The doctor sometimes has to decide if a resident is going to come here." OSM #4 stated, "Unfortunately it was not communicated to me that social services was to do it." When asked if she was provided with a job description, OSM #4 stated, "Yes, there is one in my file but it's pretty basic."

The Job Description for the Social Worker

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documented in part, "Clinical - 4. Ensure or provide support and education to resident/family members/significant others to assist in their understanding of placement and facility issues in addition to referring them to the appropriate social service agencies when the facility does not provide the needed services."

On 3/30/18 at 10:30 a.m. the director of nursing, ASM (administrative staff member) #2, informed the survey team the facility did not have any policy on PASARR.

The administrator, ASM #1 was made aware of the above findings on 3/30/18 at 12:57 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary for Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 483.

2. The facility staff failed to complete a Level I PASARR for Resident #90, to ensure each resident in a nursing facility, is screened for a mental disorder (MD) or intellectual disability (ID) prior to admission and that individuals are evaluated and receive care and services in the most integrated setting appropriate to their needs.

Resident #90 was admitted to the facility on 5/2/12 with diagnoses that included but were not limited to: Huntington's chorea (abnormal hereditary condition characterized by progressive involuntary rapid, jerky motions and mental deterioration, leading to dementia) (1), muscle weakness, schizophrenia (any of a group of mental disorders characterized by gross distortions of reality, withdrawal from social

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contacts, and disturbances of thought, language, perception and emotional response.) (2), and dysphagia (a condition in which swallowing is difficult or painful due to obstruction of the esophagus or muscular abnormalities of the esophagus.) (3)

The most recent MDS assessment, a quarterly assessment, with an assessment reference date of 2/22/18, coded the resident as scoring a two on the BIMS (brief interview for mental status) score indicating the resident is severely impaired to make cognitive daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living.

Review of the clinical record failed to evidence a Preadmission Screening and Resident Review had been completed for Resident #90.

On 3/29/18 at the end of the day meeting, a request was made for Resident #90's PASARR.

An interview was conducted with other staff member (OSM) #3, the social worker, on 3/30/18 at 9:28 a.m. When asked if she had any knowledge of the PASARR for the residents, OSM #3 stated, "I explained to the business office manager, I was not told that it was something that I should be doing. It came to our attention yesterday. The other social worker spoke with me this morning about PASARR. To my knowledge, we don't have any of the PASARRs." When asked what the PASARR is, OSM #3 stated, "It's some type of evaluation of that person." When asked what the purpose of the PASARR was, OSM #3 stated she did not know.

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An interview was conducted with OSM #4, the other social worker, on 3/30/18 at 9:45 a.m. When asked what a PASARR is, OSM #4 stated, "My understanding is that it starts at the hospital and to determine if a resident has a mental illness or mental disability to make sure they are safe to come to the facility and if they need a psychologist or doctor so we can safely take care of them." When asked the purpose of the PASARR, OSM #4 stated it's so they can come to the facility. If one does not come from the hospital the admission did it in West Virginia, where I worked, but in Virginia it's referred to the social worker to complete." When asked if there is more to the PASARR then being safe to come to the facility, OSM #4 stated, "If they have an issue so we can meet their needs. Level 2 typically get a notice with yes or no. The doctor sometimes has to decide if a resident is going to come here." OSM #4 stated, "Unfortunately it was not communicated to me that social services was to do it." When asked if she was provided with a job description, OSM #4 stated, "Yes, there is one in my file but it's pretty basic."

On 3/30/18 at 10:30 a.m. the director of nursing, ASM (administrative staff member) #2, informed the survey team the facility did not have any policy on PASARR.

The administrator, ASM #1 was made aware of the above findings on 3/30/18 at 12:57 p.m.

No further information was provided prior to exit.

No further information was provided prior to exit.
(1) Barron's Dictionary for Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 246.

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(2) Barron's Dictionary for Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 522.
(3) Barron's Dictionary for Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 178.

3. The facility staff failed to ensure Resident #74's PASARR was complete to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs.

Resident #74 was admitted to the facility on 8/26/13 with the diagnoses of but not limited to stroke, intestinal disease, depression, metabolic encephalopathy, dementia, schizoaffective disorder, dysphagia, gastrostomy feeding tube, cataracts, presbyopia, Parkinson's disease, schizophrenia, bipolar disorder, angina, diabetes, high blood pressure, hypothyroidism, and chronic obstructive pulmonary disease. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/16/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for transfers, dressing, and hygiene; extensive care for eating; and as incontinent of bowel and bladder.

Review of Resident #74's clinical record failed to reveal the resident's PASARR. Resident #74's comprehensive care plan failed to reveal documentation regarding the PASARR.

On 3/29/18 at 6:05 p.m., at the end of day meeting, the Administrator ASM (Administrative Staff Member) #1, Director of Nursing (ASM #2),

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and the facility owner (ASM #7) were made aware of the findings. A request was made for evidence of the PASARR.

On 3/30/18 at 9:33 a.m., in an interview with OSM (Other Staff Member, the social worker) #3, she stated she "was not told it was something that I had to do" (obtaining, performing PASARR's). She further stated that the facility did not have them for Resident #74. When asked what is the purpose of a PASARR, OSM #3 stated, "some type of evaluation. I don't know what the purpose of it is for."

On 3/30/18 at 9:44 a.m., in an interview with OSM #4, another social worker, she stated, that regarding a PASARR, that "It is done at the hospital. They review the chart to make sure the resident doesn't have any mental illness or a mental disability to determine if there is a level 2 screening that needs to be processed by a psychologist, in order to make sure they (the residents) are safe to come to a facility, and are deemed that we can take care of them safely." When asked if a PASARR does not come from the hospital, is the social worker responsible to do one, OSM #4 stated, "That was not communicated to me here." When asked what is the purpose of the PASARR, OSM #4 stated, "To make sure that if there is an issue, that we are able to handle their needs and how we can best meet their needs.

The administrator, ASM #1 was made aware of the above findings on 3/30/18 at 12:57 p.m.

No further information was provided prior to exit.

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4. The facility staff failed to ensure Resident #114's PASARR was complete to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs.

Resident #114 was admitted to the facility on 4/7/17 with the diagnoses of but not limited to deep vein thrombosis, ankle fracture, aspiration pneumonia, shortness of breath, edema, insomnia, dementia, schizophrenia, depression, anxiety disorder, high blood pressure, emphysema, chronic obstructive pulmonary disease, osteoarthritis, fibromyalgia, and chronic kidney disease. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/6/18. The resident was coded as severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for hygiene, dressing, and transfers; limited assistance for toileting; independent for eating; and as continent of bowel and bladder.

Review of Resident #114's clinical record failed to reveal the resident's PASARR. Resident #114's comprehensive care plan failed to reveal documentation regarding the PASARR.

On 3/29/18 at 6:05 p.m, at the end of day meeting, the Administrator, ASM (Administrative Staff Member) #1, Director of Nursing (ASM #2), and the facility owner (ASM #6) were made aware of the findings. A request was made for evidence of the PASARR.

On 3/30/18 at 9:33 a.m., in an interview with OSM (Other Staff Member, the social worker) #3, she

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stated she "was not told it was something that I had to do" (obtaining, performing PASARR's). She further stated that the facility did not have them for Resident #74. When asked what is the purpose of a PASARR, OSM #3 stated, "some type of evaluation. I don't know what the purpose of it is for."

On 3/30/18 at 9:44 a.m., in an interview with OSM #4, another social worker, she stated, that regarding a PASARR, that "It is done at the hospital. They review the chart to make sure the resident doesn't have any mental illness or a mental disability to determine if there is a level 2 screening that needs to be processed by a psychologist, in order to make sure they (the residents) are safe to come to a facility, and are deemed that we can take care of them safely." When asked if a PASARR does not come from the hospital, is the social worker responsible to do one, OSM #4 stated, "That was not communicated to me here." When asked what is the purpose of the PASARR, OSM #4 stated, "To make sure that if there is an issue, that we are able to handle their needs and how we can best meet their needs.

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

5. The facility staff failed to ensure Resident #55's PASARR was complete to ensure the resident was evaluated and receiving care and services in the most integrated setting appropriate for the resident's needs.

Resident #55 was admitted to the facility on 10/25/04 with the diagnoses of but not limited to

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Parkinson's disease, benign prostatic hyperplasia, diabetes, dementia, psychosis, depression, mood disorder, anxiety disorder, pseudobulbar affect, high blood pressure, and dysphagia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/7/18. The resident was coded as being severely cognitively impaired in ability to make daily life decisions. The resident required extensive care for bathing, hygiene, toileting, dressing, and transfers; supervision for eating; and was incontinent of bowel and bladder.

Review of Resident #55's clinical record failed to reveal the resident's PASARR. Resident #55's comprehensive care plan failed to reveal documentation regarding the PASARR.

On 3/29/18 at 6:05 p.m., at the end of day meeting, the Administrator (ASM #1 - Administrative Staff Member), Director of Nursing (ASM #2), and the facility owner (ASM #6) were made aware of the findings. A request was made for evidence of the PASARR.

On 3/30/18 at 9:33 a.m., in an interview with OSM #3 (Other Staff Member, the social worker) she stated that she "was not told it was something that I had to do" (obtaining, performing PASARR's). She further stated that the facility did not have them for Resident #55. When asked what is the purpose of a PASARR, she stated, "some type of evaluation. I don't know what the purpose of it is for."

On 3/30/18 at 9:44 a.m., in an interview with OSM #4, another social worker, she stated, that regarding a PASARR, that "It is done at the

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hospital. They review the chart to make sure the resident doesn't have any mental illness or a mental disability to determine if there is a level 2 screening that needs to be processed by a psychologist, in order to make sure they (the residents) are safe to come to a facility, and are deemed that we can take care of them safely." When asked if one does not come from the hospital, is the social worker responsible to do one, she stated, "That was not communicated to me here." When asked what is the purpose of one, she stated, "To make sure that if there is an issue, that we are able to handle their needs and how we can best meet their needs.

The administrator, ASM #1 was made aware of the above findings on 3/30/18 at 12:57 p.m.

No further information was provided prior to exit.
6. The facility staff failed to complete a Level I PASAAR for Resident #98, to ensure each resident in a nursing facility, is screened for a mental disorder (MD) or intellectual disability (ID) prior to admission and that individuals are evaluated and receive care and services in the most integrated setting appropriate to their needs.

Resident #98 was admitted to the facility on 4/21/15 with diagnoses that included but not limited muscle weakness, diabetes mellitus, chest pain, paranoid schizophrenia, chronic kidney disease, and high blood pressure. Resident #98's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/28/18. Resident #98 was coded as being moderately impaired in cognitive function scoring 10 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #98 was coded as

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requiring extensive assistance from one staff member with most ADLs (activities of daily living).

The most recent comprehensive MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 11/1/18, coded in Section A1500 - Preadmission Screening and Resident Review, the resident as not being currently considered by the state level II PASAAR process to have a serious mental illness and/or intellectual disability or a related condition.

Review of the clinical record failed to evidence a Preadmission Screening and Resident Review was completed for Resident #98.

On 3/30/18 at 9:23 a.m., an interview was conducted with OSM (other staff member) #3, the social worker. OSM #3 stated that she was not aware that social services was responsible for completing the PASAAR. OSM #3 stated it was brought to her attention that she had to complete PASAARS. When asked how long she had been the social worker, OSM #3 stated since April of 2010. OSM #3 asked the purpose of the PASAAR. OSM #3 stated she was not sure of the (of the PASARR) purpose or what it was used for.

On 3/30/18 at 9:32 a.m., an interview was conducted with OSM #4, another social worker who was recently hired at the facility. When asked what a PASAAR was, OSM #4 stated that the PASAAR usually happens at the hospital and they review the resident's chart to see if a resident has a mental illness or disability and then will determine if a level two PASAAR needs to be done. OSM #4 stated that it ensures residents are safe to come to the facility and that the facility can meet the resident's needs. OSM #4 stated

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F 645	Continued From page 167 that no one had communicated to her that social services was to complete the PASAAR if the hospital did not do one. OSM #4 stated that in another state where she had worked previously, another department was responsible for completing PASAARS. OSM #4 could not provide a PASAAR for Resident #98. On 3/29/18 at 5:47 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) and ASM #7, the facility owner were made aware of the above concerns. On 3/30/18 at 10:30 a.m., ASM #2 stated that the facility did not have a PASAAR Policy.	F 645		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services.	F 655	F655 1. Corrective action has been accomplished for the alleged deficient practice in regards to resident # 132 and #235. A care plan has been developed for resident #132 for an indwelling catheter. A care plan has been developed for resident #235 for oxygen use. 2. Current facility residents have the potential to be affected by the alleged deficient practice. 100% audit of admissions since April 1, 2018 will be done to assure an appropriate baseline care plan has been completed. Then every admission will be audited by the Care Plan Coordinator or designee x 3 months to assure compliance. 3. Measures put into place to assure alleged deficient practice does not recur include: Nursing staff will be reeducated on individualized baseline plan of care and its importance.	

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F 655	Continued From page 168 (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to develop a complete baseline care plan for two of 31 residents in the survey sample, Residents #132 and #235. 1. The facility staff failed to develop a baseline care plan for Resident #132's indwelling catheter. 2. The facility staff failed to address the use of oxygen on the baseline care plan for Resident #235.	F 655	4. The Director of Nursing and/or designee will analyze/review for patterns/trends and report in the Quality Assurance committee meeting quarterly for a minimum of six months to evaluate the effectiveness of the plan and will adjust the plan as the committee may recommend, based on outcomes/trends identified from date. 5. Completion Date: May 11, 2018	

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The findings include:

1. The facility staff failed to develop a baseline care plan for Resident #132's indwelling catheter.

Resident #132 was admitted to the facility on 2/6/18 and readmitted on 3/8/18. Resident #132's diagnoses included but were not limited to acute respiratory failure, stroke and muscle weakness. Resident #132's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 3/15/18, coded the resident's cognition as severely impaired. Section H coded the resident as having an indwelling catheter (1).

Review of Resident #132's clinical record revealed a physician's order dated 3/9/18 for a catheter due to a wound.

Resident #132's computerized initial care plan and handwritten baseline care plan summary dated 3/8/18 failed to document information regarding the resident's indwelling catheter.

On 3/29/18 at 7:44 a.m., Resident #132 was observed lying in a low bed. The resident's catheter bag was observed on the floor and on a fall mat lying on the floor.

On 3/30/18 at 8:25 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked the purpose of the initial baseline care plan. LPN #3 stated the handwritten care plan is done on the day of admission and a copy is provided to the resident and family along with a medication list. LPN #3 stated the initial care plan is completed in the computer after the handwritten care plan is

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F 655	Continued From page 170	F 655		

complete. When asked what information should be included on the baseline care plan, LPN #3 stated, "Why they are here, what they are going to need, for example: oxygen therapy, blood sugars, sign and symptoms of infection. It depends on their diagnosis." When asked if an indwelling catheter should be included on the baseline care plan, LPN #3 stated, "Yes." When asked why, LPN #3 stated, "To make sure we are providing care for it." LPN #3 was asked to review Resident #132's initial care plan and baseline care plan summary. LPN #3 confirmed documentation regarding a catheter was not on either form.

On 3/30/18 at 9:54 a.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern. On 3/30/18 at 9:55 a.m., ASM #2 (the director of nursing) was made aware of the above concern.

The facility document titled, "Comprehensive Person-Centered Care Planning" documented, "1. To assure that the resident's immediate care needs are met and maintained, an interim care plan will be developed within 48 hours of the resident's admission. a) The Interdisciplinary Team will review the following to assist in developing the interim care plan: i) Orders obtained at the time of admission. ii) IDT (Interdisciplinary team) initial evaluation and assessment..."

No further information was presented prior to exit.

(1) "You have an indwelling catheter (tube) in your bladder. 'Indwelling' means inside your body. This catheter drains urine from your bladder into a bag outside your body." This information was

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obtained from the website: https://medlineplus.gov/ency/patientinstructions/000140.htm

2. The facility staff failed to address the use of oxygen on the baseline care plan for Resident #235.

Resident #235 was admitted to the facility on 3/22/18 with diagnoses that included but were not limited to: fracture of her leg, Parkinson's disease (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling, and muscle weakness) (1), falls, and chronic obstructive pulmonary disease (COPD) (COPD - a general term for chronic, non-reversible lung disease that is usually a combination of emphysema and chronic bronchitis). (2)

There was no completed MDS (minimum data set) assessment completed at the time of survey.

The "Nursing Admission Assessment" dated, 3/22/18 documented the resident was alert and oriented to time, place and person.

The resident was observed on 3/27/18 at 2:47 p.m. with oxygen in use via nasal cannula (a tube with two prongs that are inserted in the resident's nostrils) connected to an oxygen concentrator that was set at 2 L/min (liters per minute). The resident was observed on 3/29/18 at 8:39 a.m. with her oxygen in use.

Review of the care plan dated, 3/23/18, documented in part, "Focus: The resident has altered respiratory status/difficulty breathing r/t

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(related to) COPD and chronic respiratory failure." The "Interventions" failed to evidence documentation of the administration of oxygen.

Review of the treatment administration record (TAR) documented, "O2 (oxygen) @ (at) 2 L (liters) via n/c (nasal cannula), titrate as needed every shift." The oxygen was documented as being administered every shift since admission on 3/22/18.

An interview was conducted with RN (registered nurse) #1 on 3/29/18 at 1:09 p.m. When asked who develops the care plan, RN #1 stated, "The care plan coordinator develops and revises the care plan."

An interview was conducted with LPN (licensed practical nurse) #5, the care plan coordinator, on 3/29/18 at 3:11 p.m. When asked if oxygen should be on the baseline care plan, LPN #5 stated, "Yes, it should be." When asked the purpose of the care plan, LPN #5 stated, "It's the plan of care for the patient and it has goals and how to obtain them." When asked if it should be accurate, LPN #5 stated, "Yes." When asked who uses the care plan, LPN #5 stated, "The nursing staff, the doctors, and activities."

The administrator, director of nursing and owner of the facility were made aware of the above findings on 3/29/18 at 6:10 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary for Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437.

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F 655	Continued From page 173 (2) Barron's Dictionary for Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights 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	F 656	F656 1. Corrective action has been accomplished for the alleged deficient practice in regards to residents #95, 99, 57, 234, 97 has been reviewed and revised as applicable. The care plan for a fluid restriction has been discontinued for resident #95, a care plan has been developed for #99 for oxygen use, a care plan has been developed for #57 antipsychotic mediation, for #234 a care plan has been developed for heparin use, and #97 a care plan was developed for a psychotropic medication. 2. Current facility residents have the potential to be affected by the alleged deficient practice. 100% audit of care plans has been completed to ensure all areas have been care planned. The Care Plan Coordinator and IDT team will review 10 current residents monthly for 4 weeks, then 15 residents monthly for 3 months to validate the appropriate care plans have been initiated for the resident. Results will be submitted to QAPI quarterly to ensure compliance. 3. Measures put into place to assure alleged deficient practice does not recur include: Reeducation will be given to Care Plan Coordinator to ensure all areas have been care planned. 4. The Director of Nursing and/or designee will analyze/review for patterns/trends and report in the Quality Assurance committee meeting quarterly for a minimum of six months to evaluate the effectiveness of the plan and will adjust the plan as the committee may recommend, based on outcomes/trends identified from date. 5. Completion Date: May 11, 2018	

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whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility policy review and clinical record review, it was determined facility staff failed to develop and implement the comprehensive care plan for five of 31 residents in the survey sample, Residents # 95, 99, 57, 234 and 97.

1. The facility staff care planned that Resident #95 was on a fluid restriction when the resident was not on a fluid restriction.

2. The facility staff failed to develop a comprehensive care plan for oxygen administration for Resident #99.

3. The facility staff failed to develop an anti-psychotic medication care plan for Resident #57.

4. The facility staff failed to develop a comprehensive care plan for the use of heparin for Resident #234.

5. The facility staff failed to develop a comprehensive care plan for the use of psychotropic medications for Resident #97.

The findings include:

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1. Resident #95 was admitted to the facility on 2/17/16 and readmitted on 3/3/18 with diagnoses that included but were not limited to: intestinal bleeding, schizophrenia, heart failure and diabetes.

The most recent complete MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 2/23/18 coded the resident as having scored 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring supervision for activities of daily living.

Review of the care plan initiated on 3/5/18 documented, "The resident has altered cardiovascular status r/t (related to) Hyperlipidemia (1), Hypertension (high blood pressure). Interventions. 1500cc (cubic centimeter) fluid restriction, resident is non-compliant at times."

Review of the March 2018 physician's orders did not evidence documentation regarding an order for fluid restriction.

Review of the March 2018 treatment administration record (TAR) did not evidence documentation regarding a fluid restriction.

An interview was conducted on 3/29/18 at 2:25 p.m. with RN (registered nurse) #3, the resident's nurse. When asked why residents had care plans, RN #3 stated, "Well, we have to have care plans for some basic things first of all and then anything that might be a specific thing to that resident." When asked who used the care plan, RN #3 stated, "Well, I'm assuming we do. I don't

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have much to do with that as far as putting it in or anything." When asked if Resident #95 was on a fluid restriction, RN #3 stated she was not.

On 3/29/18 at 6:00 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #7 the facility owner were made aware of the findings.

An interview was conducted on 3/30/18 at approximately 1:00 p.m. with LPN (licensed practical nurse) #3, the care plan coordinator. When asked who completed the care plans, LPN #3 stated she did but she had just been recently hired. When asked why residents had care plans, LPN #3 stated, to provide the care for the residents. When asked if a resident was care planned for fluid restriction but was not ordered to have a fluid restriction if that was accurate, LPN #3 stated, no.

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

No further information was provided prior to exit.

1. Hyperlipidemia -- Cholesterol is a waxy, fat-like substance that's found in all the cells in your body. Your body needs some cholesterol to make hormones, vitamin D, and substances that help you digest foods. Your body makes all the cholesterol it needs. Cholesterol is also found in foods from animal sources, such as egg yolks, meat, and cheese. If you have too much cholesterol in your blood, it can combine with

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other substances in the blood to form plaque. Plaque sticks to the walls of your arteries. This buildup of plaque is known as atherosclerosis. It can lead to coronary artery disease, where your coronary arteries become narrow or even blocked. This information was obtained from: https://medlineplus.gov/cholesterol.html

2. The facility staff failed to develop a care plan for oxygen administration for Resident #99.

Resident #99 was admitted to the facility on 6/9/17 and readmitted on 2/26/18 with diagnoses that included but were not limited to: heart failure, pneumonia, anemia, depression and cognitive communication deficit.

The most recent MDS, a significant change assessment, with an ARD of 3/5/18 coded the resident as 99 on the BIMS indicating the resident was not able to complete the exam. The resident was coded as as understanding others and being understood and having intact short and long term memory. Resident #99 was coded as requiring assistance for all activities of daily living. The resident was coded as receiving oxygen.

Review of the March 2018 physician orders documented, "O2 (oxygen) @4L (liters) n/c (nasal cannula - soft plastic prongs that fit in the nose to deliver oxygen) may titrate as needed every shift."

Review of the March 2018 TAR documented, "O2 @4L n/c may titrate as needed every shift."

Review of the resident's care plan did not evidence documentation of an oxygen plan of care.

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An interview was conducted on 3/29/18 at 2:25 p.m. with RN (registered nurse) #3, the resident's nurse. When asked why residents had care plans, RN #3 stated, "Well, we have to have care plans for some basic things first of all and then anything that might be a specific thing to that resident." When asked who used the care plan, RN #3 stated, "Well, I'm assuming we do. I don't have much to do with that as far as putting it in or anything." When asked if Resident #99 was on oxygen, RN #3 stated he was. When asked if that would be care planned, RN #3 stated she thought it should be.

On 3/29/18 at 6:00 p.m. ASM #1, the administrator, ASM #2, the director of nursing and ASM #7 the facility owner were made aware of the findings.

An interview was conducted on 3/30/18 at approximately 1:00 p.m. with LPN (licensed practical nurse) #3, the care plan coordinator. When asked who completed the care plans, LPN #3 stated she did but she had just been recently hired. When asked why residents had care plans, LPN #3 stated, to provide the care for the residents. When asked if a care plan would be developed for a resident on oxygen, LPN #3 stated they would.

No further information was provided prior to exit.

3. The facility staff failed to develop an anti-psychotic medication care plan for Resident #57

Resident #57 was admitted to the facility on 5/24/14 and readmitted on 1/22/18 with diagnoses that included but were not limited to

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Dementia with behavioral disturbance, muscle weakness, Alzheimer's disease and mood disorder. Resident #57's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/8/18. Resident #57 was coded as severely impaired in cognitive function scoring 06 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #57 was coded as requiring extensive assistance from two staff members with most ADLS (activities of daily living).

Review of Resident #57's most recent physician order summary revealed that Resident #57 was on Zyprexa (1) 5 mg (milligrams) two times a day related to behavioral disturbance. Resident #57 was readmitted from the hospital with this order on 1/22/18.

Resident #57's psychiatric physician evaluated Resident #57 on 2/2/18 and decided to keep the Zyprexa as is until next visit. The following was documented, "Plan - continue current medications as above. - No medication changes at this time. Would consider decreasing Zyprexa at next visit."

Review of Resident #57's comprehensive care plan dated 1/24/18 failed to evidence an anti-psychotic medication care plan to address the use of Zyprexia.

On 3/29/18 at 3:11 p.m., an interview was conducted with LPN (licensed practical nurse) #5, the care plan coordinator. When asked if it was important that the care plan was accurate, LPN #5 stated that it was. LPN #5 stated that she was responsible for developing care plans. When

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asked if it was important for a resident on an anti-psychotic medication to have a care plan in place, LPN #5 stated that a care plan should be developed. When asked who has access to the care plan, LPN #5 stated that the IDT (interdisciplinary team) uses the care plan. LPN #5 confirmed that there was not an anti-psychotic care plan for Resident #57.

On 3/30/18, LPN #5 presented this writer with an updated care plan for Resident #57. The following was documented: "Focus: The Resident uses Zyprexa... r/t (related to) Behavior and mood disorder. Goal: The resident will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance...cognitive/behavioral impairment through next review date...Administer psychotropic medications as ordered by physician. Monitor for side effects and effectiveness q (every shift). Monitor/Document/report PRN (as needed) any adverse side effects of Psychotropic medications...Monitor/record occurrence of for target behavior symptoms and document per facility protocol."

On 3/29/18 at 5:47 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) and ASM #7, the facility owner were made aware of the above concerns.

(1) Zyprexa is an antipsychotic used to treat nervous, emotional and mental conditions. Can also be used to treat bipolar disorder. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH

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T0011473/?report=details.
4. The facility staff failed to develop a comprehensive care plan for the use of heparin for Resident #234.

Resident #234 was admitted to the facility on 3/13/18 with diagnoses that included but were not limited to: fracture of her left femur, pain and chronic obstructive pulmonary disease (COPD) (COPD - a general term for chronic, non-reversible lung disease that is usually a combination of emphysema and chronic bronchitis). (1)

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 3/20/18, coded the resident as scoring a 14 on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for most of her activities of daily living except eating in which she was independent. In Section N - Medications, Resident #234 was coded as receiving seven days of an anticoagulant during the seven says of the look back period.

The physician order dated, 3/27/18, documented, "Heparin Sodium*, 5000 Units/ML (milliliters); inject 1 ML subcutaneously every 12 hours related to unspecified intracapsular fracture of left femur until 4/3/18."

*Heparin Sodium in an anticoagulant. It is used to decrease the clotting ability of the blood and help prevent harmful clots from forming. (2)

The comprehensive care plan dated, 3/13/18,

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failed to evidence documentation related to the use of an anticoagulant by Resident #234.

The mediation administration record (MAR) documented, "Heparin Sodium 5000 Units/ML; inject 1 ML subcutaneously every 12 hours related to unspecified intracapsular fracture of left femur until 4/3/18." It was documented the resident received her heparin every twelve hours as prescribed.

An interview was conducted with RN (registered nurse) #1 on 3/29/18 at 1:09 p.m. When asked who develops the care plan, RN #1 stated, "The care plan coordinator develops and revises the care plan."

An interview was conducted with LPN (licensed practical nurse) #5, the care plan coordinator, on 3/29/18 at 3:11 p.m. When asked what is your role in the care plans, LPN #5 stated, "I review and revise the care plans." When asked if heparin should be on the care plan, LPN #5 stated, "Yes, it should be." When asked the purpose of the care plan, LPN #5 stated, "It's the plan of care for the patient and it has goals and how to obtain them." When asked if it should be accurate, LPN #5 stated, "Yes." When asked who uses the care plan, LPN #5 stated, "The nursing staff, the doctors, and activities." When asked if the CNAs (certified nursing assistants) have access to the care plan, LPN #5 stated, "They don't have actual access to the care plans."

The administrator, director of nursing and owner of the facility were made aware of the above findings on 3/29/18 at 6:10 p.m.

No further information was provided prior to exit.

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(1) Barron's Dictionary for Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.
(2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010545/?report=details.

5. The facility staff failed to develop o comprehensive care plan for the use of psychotropic medications for Resident #97.

Resident # 97 was admitted to the facility on 11/19/17, with a most recent readmission on 3/15/18 with diagnoses that included but were not limited to: bladder infections, hypotension (too low blood pressure), malnutrition, depression, difficulty sleeping, asthma, and has a colostomy.

The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 2/27/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating she was capable of making her daily decisions. The resident was coded requiring limited to extensive assistance for her activities of daily living. In Section N - Medications, the resident was coded as receiving seven days of an antipsychotic medication during the look back period.

The physician order dated, 3/15/18, documented, "Quetiapine Fumarate * Tablet 100 mg (milligrams); give 1 tablet by mouth at bedtime related to other specified anxiety disorders."

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*Quetiapine Fumarate is an antipsychotic medication used to treat schizophrenia and bipolar disorders. (1)

Review of the comprehensive care plan dated, 3/15/18, failed to evidence a care plan to address the use of an antipsychotic medication for Resident #97.

An interview was conducted with RN (registered nurse) #1 on 3/29/18 at 1:09 p.m. When asked who develops the care plan, RN #1 stated, "The care plan coordinator develops and revises the care plan."

An interview was conducted with LPN (licensed practical nurse) #5, the care plan coordinator, on 3/29/18 at 3:11 p.m. When asked what is your role in the care plans, LPN #5 stated, "I review and revise the care plans." When asked if a resident is receiving an anti-psychotic medication should it be on the care plan, LPN #5 stated, "Yes, it should be." When asked the purpose of the care plan, LPN #5 stated, "It's the plan of care for the patient and it has goals and how to obtain them." When asked if it should be accurate, LPN #5 stated, "Yes." When asked who uses the care plan, LPN #5 stated, "The nursing staff, the doctors, and activities."

The administrator, director of nursing and owner of the facility were made aware of the above findings on 3/29/18 at 6:10 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cf

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F 657 SS=E	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: Based on observation, staff interview, clinical record review, and facility document review, it was determined that facility staff failed to review and revise the comprehensive care plan for five	F 657	F657 1. Corrective action has been accomplished for the alleged deficient practice in regards to residents #66, 98, 47, 384, and 130 has been reviewed and revised as applicable. A comprehensive care plan has been developed for resident #66 for a head laceration secondary to fall. Resident's #66 and #47 have had their fall care plan reviewed and revised. Resident #98's comprehensive care plan has been updated to reflect his use of chewing tobacco. 2. Current facility residents have the potential to be affected by the alleged deficient practice. 100% audit of care plans has been completed to ensure all areas have been care planned. The Care Plan Coordinator and IDT team will review 10 current residents monthly for 4 weeks, then 15 residents monthly for 3 months to validate the appropriate care plans have been initiated for the resident. Results will be submitted to QAPI quarterly to ensure compliance. 3. Measures put into place to assure alleged deficient practice does not recur include: Reeducation will be given to Care Plan Coordinator to ensure all areas have been care planned. 4. The Director of Nursing and/or designee will analyze/review for patterns/trends and report in the Quality Assurance committee meeting quarterly for a minimum of six months to evaluate the effectiveness of the plan and will adjust the plan as the committee may recommend, based on outcomes/trends identified from date. 5. Completion Date: May 11, 2018	

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of 31 residents in the survey sample, Resident # 66, 98, 47, 384, 130.

1 a. The facility staff failed to revise Resident #66's comprehensive care plan after she obtained a head laceration secondary to a fall on 2/27/18.

1b. The facility staff failed to revise Resident #66's comprehensive care plan after a fall on 4/27/17.

2. The facility staff failed to revise Resident #98's comprehensive care plan to reflect that he chews tobacco.

3. The facility staff failed to revise Resident #47's comprehensive care plan after a fall on 5/20/17 and 6/13/17.

4. The facility staff failed to revise Resident #384's comprehensive care plan to reflect a bruise that was obtained on 3/25/18.

5. The facility staff failed to revise Resident #130's care plan to include the resident's refusal of oxygen.

The findings include:

1 a. Resident #66 was admitted to the facility on 4/19/17 and readmitted on 2/11/18 with diagnoses that included but were not limited to unspecified dementia without behavioral disturbance, heart failure, gout, major depressive disorder, high blood pressure and atrial fibrillation. Resident #66's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 2/13/18.

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Resident #66 was coded as severely cognitively impaired in the ability to make daily decisions scoring 03 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #66 was coded as requiring extensive assistance from one staff member with most ADLs (activities of daily living).

On 3/27/18 at 5:15 p.m., an observation was made of Resident #66. Resident #66 was sitting up in the dining room with a bandage to the left side of her forehead.

On 3/28/18 at 7:32 a.m., an observation was made of Resident #66. She was sleeping in bed and her bed was at the lowest position. The bandage was still in place to left side of her forehead.

Review of Resident #66's current POS (physician order summary) revealed a daily treatment order for a head laceration.

Review of Resident #66's clinical record reveled that she went to the hospital on 2/27/18. The following note was documented, "0450 (4:50 a.m.) resident sitting in chair in common area. resident (sic) leaning forward to pick something up. staff (sic) directed resident to sit back and started going to resident. resident (continued) to lean forward and fell face first onto floor. this (sic) nurse and CNA (certified nursing assistant) (Name of CNA) to resident. resident (sic) alert and able to speak clearly. follow (sic) instructions and answers questions appropriately. PERRLA (Pupils Equal, Round, Reactive to light), and accommodation). denied headache/nausea/dizziness. resident (sic) wearing glasses on face at time of fall, residents

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glasses had slid up onto forehead during fall. large (sic) laceration noted to forehead. copious (sic) amounts of blood noted. ROM (range of motion) performed with minimal difficulty. resident (sic) denied that need for PRN (as needed) Tylenol (1). resident (sic) refusing to lay in current position. sitting (sic) up on floor. gauze (sic) and kling (sic) wrap applied to forehead. (Name of NP (nurse practitioner)) notified of above information. order (sic) obtained to send to (Name of ED (emergency department)) for eval (evaluation) and treat. resident (sic) husband and son both RP (responsible party) to be contacted. messages (sic) left."

Further review of Resident #66's clinical record revealed that she returned to the facility on 2/27/18 at 11:00 a.m. The following was documented: "Resident returned via stretcher with paramedics from (Name of hospital) for head injuries from a fall...she has a laceration to left side of forehead measuring 2 cm (centimeters) X (by) 1 cm pen area. Laceration with 6 sutures measuring 3 cms and another laceration under the laceration with the sutures measuring 3 cms. I re-dressed it due to dressing being saturated with bright red blood. New dressing is non-adherent, 4x4's and cling wrap. She has scabbed areas on the right middle finger, area between right thumb and pointer finger...bruising to left wrist, shoulder, elbow and right hip and bruise to center of chest. Abrasion to left cheek and left eye is black..."

Review of Resident #66's fall care plan dated 10/9/17 and updated 2/27/18 revealed the following intervention after her 2/27/18 fall: "Therapy to evaluate for reacher (2/27/18)."

Further review of her current care plan failed to

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evidence her head laceration.

On 3/29/18 at 3:11 p.m., an interview was conducted with LPN (licensed practical nurse) #5, the care plan coordinator, regarding the purpose of the care plan. LPN #5 stated that the purpose of the care plan was to plan the care of the patient, determine goals and how the resident will obtain these goals. When asked if it was important that the care plan was accurate, LPN #5 stated that it was. When asked when the care plan would be updated, LPN #5 stated that the care plan would be updated for any changes in treatment such as new orders, any monitoring etc. When asked if care plans should be updated after falls, LPN #5 stated yes. When asked if a resident obtains a head laceration, if that information should be on the care plan, LPN #5 stated that it should. LPN #5 stated that the floor nurses did not update the care plan that it was just her. LPN #5 stated the quality assurance nurse updates and puts interventions in place after a resident has a fall on the care plan. When asked who has access to the care plan, LPN #5 stated that the IDT (interdisciplinary team) uses the care plan. LPN #5 confirmed that Resident #66's head laceration was not on the care plan.

On 3/29/18 at 5:47 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) and ASM #7, the facility owner were made aware of the above concerns.

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

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

(1) Tylenol Tablet 325 mg (Acetaminophen) treats minor aches and pains and also reduces fever. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008785/?report=details.

1b. The facility staff failed to revise Resident #66's comprehensive care plan after a fall on 4/27/17.

Review of Resident #66's clinical record revealed the following note dated 4/27/17: "Resident yelled out for help and upon entering the room Resident (sic) was sitting on the floor in between the wheelchair legs she (sic) had stool all over (sic) she was able to move all extremities (sic) she was assisted to chair and taken to the shower (sic) she denies having any pain or discomfort (sic) Resident has some indentations on her back from where she was leaning against the wheelchair legs (sic) Resident was showered and now resting quietly in bed."

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Review of Resident #66's fall report dated 4/27/17 failed to evidence the care plan was updated or that a fall prevention intervention was put into place.

Review of Resident #66's comprehensive care plan with resolved items and revisions, failed to evidence her care plan was updated after the 4/27/17 fall.

Further review of Resident #66's clinical record revealed she had a second fall on 2/8/18. Her care plan was updated after that fall and she had no major injuries.

On 3/29/18 at 3:11 p.m., an interview was conducted with LPN (licensed practical nurse) #5, the care plan coordinator, regarding the purpose of the care plan. LPN #5 stated that the purpose of the care plan was to plan the care of the patient, determine goals and how the resident will obtain these goals. When asked if it was important that the care plan was accurate, LPN #5 stated that it was. When asked when the care plan would be updated, LPN #5 stated that the care plan would be updated for any changes in treatment such as new orders, any monitoring etc. When asked if care plans should be updated after falls, LPN #5 stated yes. LPN #5 stated that the floor nurses did not update the care plan that it was just her. LPN #5 stated that the quality assurance nurse updates and puts interventions in place after a resident has a fall on the care plan. When asked who has access to the care plan, LPN #5 stated that the IDT (interdisciplinary team) uses the care plan.

On 3/29/18 at 4:11 p.m., an interview was

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conducted with LPN #8, the quality assurance nurse. When asked who was responsible for updating the care plans after falls, LPN #8 stated that she was. LPN #8 stated after a fall, she and the IDT team would try to come up with interventions to prevent the resident from falling. When asked if she could find out if the care plan was updated after Resident #66's fall on 4/27/17, LPN #8 stated she would go check.

On 3/29/18 at 4:38 p.m., LPN #8 stated she could not find where the care plan was updated after Resident #66's fall on 4/27/17. LPN #8 stated that she was not responsible for updating care plans back in May of 2017.

On 3/29/18 at 5:47 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) and ASM #7, the facility owner were made aware of the above concerns.

2. The facility staff failed to revise Resident #98's comprehensive care plan to reflect that he chews tobacco.

Resident #98 was admitted to the facility on 4/21/15 with diagnoses that included but not limited muscle weakness, diabetes mellitus, chest pain, paranoid schizophrenia, chronic kidney disease, and high blood pressure. Resident #98's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/28/18. Resident #98 was coded as moderately impaired in cognitive function scoring 10 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #98 was coded as requiring extensive assistance from one staff member with most ADLs (activities of daily living).

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On 3/28/18 at 9:28 a.m., medication administration observation was conducted with LPN (licensed practical nurse) #1. At 9:44 a.m., LPN #1 and this writer entered Resident #98's room. Four chewing tobacco cans were noted on his bed. LPN #1 stated Resident #98 had been chewing tobacco since he has been here. LPN #1 stated Resident #98 was very protective over his tobacco.

Review of Resident #98's current care plan 11/1/16 and revised 2/1/18 failed to evidence a care plan reflecting his tobacco use. Review of Resident #98's care plan with resolved items, revealed that Resident #98 had a tobacco care plan that was resolved in December of 2017.

On 3/28/18 at approximately 3:30 p.m., an interview was conducted with LPN #1. When asked the purpose of the care plan, LPN #1 stated that the purpose of the care plan was to set fourth their directives. When asked if it was important that the care be accurate, LPN #1 stated that it was. When asked what nurses should be monitoring for a resident who uses chewing tobacco, LPN #1 stated that she would monitor the resident for any coughing, swallowing, and any changes in oral health. When asked how other nurses such as a new nurse, who has never worked with the resident, would know to monitor Resident #98 for those things if his tobacco use was not on the care plan, LPN #1 stated, "They wouldn't."

On 3/29/18 at 3:11 p.m., an interview was conducted with LPN (licensed practical nurse) #5, the care plan coordinator, regarding the purpose of the care plan. LPN #5 stated that the purpose

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of the care plan was to plan the care of the patient, determine goals, and how the resident will obtain these goals. When asked if it was important that the care plan was accurate, LPN #5 stated that it was. When asked when the care plan would be updated, LPN #5 stated that the care plan would be updated for any changes in treatment such as new orders, any monitoring etc.

On 3/29/18 at 5:05 p.m., further interview as conducted with LPN #5. LPN #5 stated that a while back she was presented a list of residents who smoked. LPN #5 stated she did not see Resident #98 on that list. LPN #5 also stated that she didn't realize that Resident #98 was still chewing the tobacco because she did not see anything in his chart about it. LPN #5 stated that she saw the tobacco care plan had been resolved in December, but she did not reinstate it. LPN #5 stated she should have called the unit manager to double check to see if Resident #98 was still using tobacco. When asked what interventions would be in place for a resident who chews tobacco, LPN #5 stated that she would add the following interventions: oral care and checking for sores.

On 3/29/18 at 5:47 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) and ASM #7, the facility owner were made aware of the above concerns.

3. The facility staff failed to revise Resident #47's comprehensive care plan after a fall on 5/20/17 and 6/13/17.

Resident #47 was admitted to the facility on

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3/23/16 with diagnoses that included but were not limited to anxiety disorder, Alzheimer's disease, unspecified dementia without behavioral disturbance, high blood pressure, muscle weakness, and major depressive disorder. Resident #47's most recent MDS (minimum data set) assessment was annual assessment with an ARD (assessment reference date) of 1/1/18. Resident #47 was coded as severely cognitively impaired in the ability to make daily decision scoring 03 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #47 was coded as requiring extensive assistance from two or more persons with most ADLS (activities of daily living).

Review of Resident #47's clinical record revealed that she had a fall on 5/20/17. The following was documented in a nursing note: "This nurse was receiving report from day shift nurse and day shift CNA (certified nursing assistant) came to nurses station and reported she observed (Name of Resident #47) on the floor on her buttocks in room 401 near her tall dresser. Resident assessed for injuries. No apparent injuries at this time...."

Review of Resident #47's current care plan dated 12/1/16 with revisions and resolved items failed to evidence that the care plan was updated after her 5/20/17 fall.

Review of Resident #47's incident report dated 5/20/17 failed to evidence that an intervention was put into place after her 5/20/17 fall.

Further review of Resident #47's clinical record revealed that she had another fall on 6/13/17. The following was documented: "Dietary manager

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informed this nurse resident was observed on the floor, upon entering the room resident was on the floor sitting on buttocks, when asked what she was doing she replied, "I was trying to get into my w/c (wheelchair)," no injury, denies hitting head, denies any pain or discomfort, VS (vital signs) as follows; BP (blood pressure) 1327/72 (sic), P (pulse) 73, R (respirations) 18, T (temperature) 97.6, 02 (oxygen) sat (saturation) 95 percent on room air, POA (power of attorney) and NP (nurse practitioner) notified."

Review of Resident #47's incident report dated 6/13/17 failed to evidence that an intervention was put into place after her 6/13/17 fall.

On 3/29/18 at 3:11 p.m., an interview was conducted with LPN (licensed practical nurse) #5, the care plan coordinator, regarding the purpose of the care plan. LPN #5 stated that the purpose of the care plan was to plan the care of the patient, determine goals and how the resident will obtain these goals. When asked if it was important that the care plan was accurate, LPN #5 stated that it was. When asked when the care plan would be updated, LPN #5 stated that the care plan would be updated for any changes in treatment such as new orders, any monitoring etc. When asked if care plans should be updated after falls, LPN #5 stated yes. LPN #5 stated that the floor nurses did not update the care plan that it was just her. LPN #5 stated that the quality assurance nurse updates and puts interventions in place after a resident has a fall on the care plan. When asked who has access to the care plan, LPN #5 stated that the IDT (interdisciplinary team) uses the care plan.

On 3/29/18 at 4:11 p.m., an interview was

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conducted with LPN #8, the quality assurance nurse. When asked who was responsible for updating the care plans after falls, LPN #8 stated that she was. LPN #8 stated that after a fall, she and the IDT team would try to come up with interventions to prevent the resident from falling. When asked if she could find out if the care plan was updated after Resident #47's fall on 5/20/17 and 6/13/17, LPN #8 stated that she would go check.

On 3/29/18 at 4:38 p.m., LPN #8 stated she could not find where the care plan was updated after Resident #47's falls on 5/20/17 and 6/13/17. LPN #8 stated that she was not responsible for updating care plans back in May and June.

On 3/29/18 at 5:47 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) and ASM #7, the facility owner were made aware of the above concerns.

4. The facility staff failed to revise Resident #384's comprehensive care plan to reflect a bruise that was obtained on 3/25/18.

Resident #384 was admitted to the facility on 3/13/18 with diagnoses that included but were not limited to unspecified dementia with behavioral disturbance, anxiety disorder, paranoid personality disorder, high cholesterol, bipolar disorder, unspecified Alzheimer's Disease and muscle weakness. Resident #384's most recent MDS (minimum data set) was admission assessment with an ARD (assessment reference date) of 3/20/18. Resident #384 was coded as severely cognitively impaired in the ability to make daily decisions scoring 03 out of possible 15 on

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the BIMS (Brief Interview for Mental Status) exam. Resident #384 was coded as requiring supervision only with most ADLs (activities of daily living).

Review of Resident #384's clinical record revealed the following nursing note dated 3/24/18: "Resident up walking throughout unit with purse on her shoulder. I noticed she had a limp, when assessing her I found a knot with swelling on lateral side of right foot. She is complaining it hurts and she can barely walk on it. I had her sit down and propped it up for as long as she would tolerate. Will continue to monitor.

The next note dated 3/24/18 at 6:32 p.m., and documented: "Resident noted with swelling and bruising to lateral side of right foot. Resident was asked how this happened and Resident was unable to explain due to dementia. (Name of NP) was called and order for x-ray of right foot 3V (three views). POA (power of attorney) (Name of POA) was called and notified. Dynamic Mobile Imaging was called and order placed for x-ray. X-ray was just obtained. Awaiting results. Resident is currently sitting up at nurses (sic) station with right foot propped up and ice pack applied. Staff is encouraging Resident to sit and rest foot as much as possible..."

A nursing note dated 3/25/18 documented the following: "X-ray result stated soft-tissue swelling in the tarsal region and otherwise negative examination..."

Review of Resident #384's care plan dated 3/13/18 failed to evidence the bruise to her right lateral foot.

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Review of Resident #384's current POS (physician order sheet) revealed the following active order: "elevate right foot as tolerated."

On 3/29/18 at 3:11 p.m., an interview was conducted with LPN (licensed practical nurse) #5, the care plan coordinator, regarding the purpose of the care plan. LPN #5 stated that the purpose of the care plan was to plan the care of the patient, determine goals and how the resident will obtain these goals. When asked if it was important that the care plan was accurate, LPN #5 stated that it was. When asked when the care plan would be updated, LPN #5 stated that the care plan would be updated for any changes in treatment such as new orders, any monitoring etc. LPN #5 stated the care plan would be updated immediately following a change.

On 3/30/18 at 10:30 a.m., observation of Resident #384's bruise was conducted. Her bruise was dark purplish blue that spread across the top of her entire right foot.

On 3/30/18 at 12:15 p.m., an interview was conducted with RN (registered nurse) #2, a nurse on the unit where Resident #384 resides. RN #2 stated that she hadn't been on the name of unit in a few months. When asked if Resident #384 had a bruise to her right foot, RN #2 stated that she did. RN #2 stated that she only knew about the bruise because she was called down to the unit as soon as the nurse assigned to Resident #384 discovered the bruise. When asked if staff are monitoring the bruise, RN #2 stated nursing staff should monitor the bruise for pulse, motor sensitivity, and color. When asked how the nursing staff would know to monitor the bruise, RN #2 stated a care plan should be in place for

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the bruise. When RN #2 was informed the care plan for the bruise was not put into place until 3/29/18, RN #2 stated that a care plan should have been put into place before 3/29/18.

On 3/29/18 at 5:47 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) and ASM #7, the facility owner were made aware of the above concerns.
5. The facility staff failed to revise Resident #130's care plan to include the resident's refusal of oxygen.

Resident #130 was admitted to the facility on 1/11/18 and readmitted on 2/2/18. Resident #130's diagnoses included but were not limited to pneumonia, diabetes and urinary tract infection. Resident #130's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/9/18, coded the resident as cognitively intact.

Review of Resident #130's clinical record revealed a physician's order dated 2/2/18 that documented, "O2 (Oxygen) @ (at) 2L (Liters) via n/c (nasal cannula) may titrate as needed."

On 3/29/18 at 7:30 a.m., Resident #130 was observed in a wheelchair in the bedroom. The resident was not receiving oxygen.

On 3/29/18 at 8:57 a.m., Resident #130 was observed in a wheelchair in the dining room. The resident was not receiving oxygen.

On 3/29/18 at 1:15 p.m., an interview was conducted with ASM (administrative staff member) #5 (the nurse practitioner), regarding Resident #130's oxygen therapy. ASM #5 stated

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F 657	Continued From page 201 Resident #130 refuses oxygen when she is up during the day. On 3/29/18 at 2:17 p.m., an interview was conducted with LPN (licensed practical nurse) #6, regarding Resident #130's oxygen therapy. LPN #6 stated Resident #130 does not like to use oxygen when she goes off the unit and the resident uses the oxygen at night. Review of Resident #130's comprehensive care plan initiated on 1/11/18 failed to reveal documentation regarding Resident #130's refusal of oxygen. On 3/29/18 at 3:11 p.m., an interview was conducted with LPN #5 (the care plan coordinator). LPN #5 confirmed a resident's care plan should be revised to include a resident's refusal of oxygen. On 3/29/18 at 5:48 pm., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility document titled, "Care Plan" documented, "11. The Care Plan will be available for review for all staff to consult for accuracy of care delivery. Recommendations for changes and updates can be made by staff to the Director of Nursing or designee with review by the Interdisciplinary team..." No further information was presented prior to exit.	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		

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F 658	Continued From page 202 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for four of 31 residents in the survey sample; Residents #83, #236, #69, and #99. 1. The facility staff failed to clarify Resident #8's orders regarding the timing of administration for Synthroid as related to the timing of administering an iron tablet, per administration recommendations for separating the two medications by at least 4 hours. The staff administered the Synthroid an hour and a half later than the scheduled time, giving it at the same time as the iron. 2. The facility staff failed to clarify Resident #236's physician order for Calcitrate (calcium citrate with Vitamin D). The dose prescribed and the dose dispensed by the pharmacy did not match. 3. The facility staff failed to document Resident # 69's oxygen flow rate of two to five to maintain the oxygen saturation above 92%. 4. The facility staff failed to clarify a physician's order to titrate oxygen as needed for Resident #99. The findings include:	F 658	F658 1. Corrective action has been accomplished for the alleged deficient practice in regards to residents #83, 236, 69, and 99. The order for synthroid for # 83 was clarified by the NP to be given 4 hours apart from iron. The order for Calcitrate for resident #236 was clarified by the NP and the pharmacy to be given in the correct dosage. The order for #69 and 99 for oxygen nasal cannula was clarified by the NP and corrected per order. 2. Current facility residents have the potential to be affected by the alleged deficient practice. 100% audit of medication orders for the last 30 days for accuracy has been completed. 100% of oxygen orders have been reviewed and corrected. Orders will be reviewed daily during morning meeting to assure continued compliance. 3. Measures put into place to assure alleged deficient practice does not recur include: Reeducation will be given to nursing to follow medication administration and oxygen administration per policy, with a focus on order clarification. 4. The Director of Nursing and/or designee will analyze/review for patterns/trends and report in the Quality Assurance committee meeting quarterly for a minimum of six months to evaluate the effectiveness of the plan and will adjust the plan as the committee may recommend, based on outcomes/trends identified from date. 5. Completion Date: May 11, 2018	

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1. The facility staff failed to clarify Resident #8's orders regarding the timing of administration for Synthroid as related to the timing of administering an iron tablet, per administration recommendations for separating the two medications by at least 4 hours. The staff administered the Synthroid an hour and a half later than the scheduled time, giving it at the same time as the iron.

*According to Synthroid.com,
- "Use SYNTHROID only as ordered by your doctor. Take SYNTHROID as a single dose, preferably on an empty stomach, one-half to one hour before breakfast.
Products such as iron and calcium supplements and antacids can lower your body's ability to absorb levothyroxine, so SYNTHROID should be taken 4 hours before or after taking these products."

Resident #83 was admitted to the facility on 4/11/17 with the diagnoses of but not limited to acute kidney failure, aspiration pneumonia, respiratory failure with hypoxia, dysphagia, chronic obstructive pulmonary disease, depression, shortness of breath, heart failure, hypothyroidism, hyperparathyroidism, insomnia, diabetes, dementia, anxiety disorder, restless leg syndrome, sleep apnea, high blood pressure, peripheral vascular disease, spinal stenosis, osteoporosis, chronic kidney disease, and benign prostatic hyperplasia. The resident was coded as cognitively intact in ability to make daily life decisions. The resident required total care for bathing; extensive care for transfers, dressing, toileting, and hygiene; independent for eating; and was incontinent of bowel and bladder.

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On 3/28/18 at 8:33a.m., LPN #2 (Licensed Practical Nurse) was observed preparing and administering the following medications to Resident #83:

Synthroid [1] 25 mcg (micrograms) (scheduled for 7:30 AM)
Allocution [2] 100 mg (milligrams)
Bro [3] 200-25 mcg
Iron [4] 325 mg
Neuron [5] 300 mg
Hydrastine [6] 50 mg
Motorola [7] 100 mg
Miramax [8] 17 gm (grams) (resident refused)
Zoo [9] 100 mg
Sportive [10] 18 mcg
Solace [11] 100 mg (resident refused)

On 3/28/18 at 8:58 a.m., LP #2 took the above medications to Resident #83 and administered them, including administering the Synthroid and Iron together. The Synthroid was administered an hour and a half later than the scheduled time, after the resident had eaten breakfast and did not have an empty stomach; and was not administered at least 4 hours apart from the iron.

On 3/29/18 at 9:24 a.m., LPN #2 was asked if nurses should have identified the iron and synthroid are being administered too close together. LPN #2 stated that they should have. When asked why the Synthroid was not administered at the scheduled time of 7:30 a.m., and was given an hour and a half late, LPN #2 stated there was no reason.

On 3/29/18 at 9:50 a.m., in an interview with OSM #7 (Other Staff Member, a pharmacist), he stated

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a lot of meds (medications) interfere with the absorption of synthroid. OSM #7 stated it should be separated by 4 hours from iron, and taken on an empty stomach. He stated he should have recognized this irregularity.

On 3/29/18 at 1:40 p.m., ASM (Administrative Staff Member) #5, a Nurse Practitioner) stated that Synthroid should be given a half-hour to an hour before a resident eats breakfast; and that "It should be given so many hours before or after iron. I don't remember why."

On 3/29/18 at 6:05 p.m., at the end of day meeting, the Administrator (ASM) #1, Director of Nursing (ASM #2), and the facility owner (ASM #7) were made aware of the findings. No further information was provided by the end of the survey.

Fundamentals of Nursing, Lippincott Williams & Wilkins, fifth edition, 2007. Page 557, "Nurses are expected to practice in a safe and prudent manner. Each nurse is responsible for being knowledgeable about the medication's actions, indications, contraindications, and any adverse effects. Knowledge of appropriate dosages and dosage schedules, routes and methods of administration, and actions to take if the client has an adverse reaction is also important..."

[1] Synthroid is used to treat thyroid deficiency. Information obtained from https://medlineplus.gov/druginfo/meds/a682461.html

[2] Allopurinol is used to treat gout. Information obtained from

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https://medlineplus.gov/druginfo/meds/a682673.html

[3] Breo is used to treat chronic obstructive pulmonary disease.
Information obtained from https://medlineplus.gov/druginfo/meds/a613037.html

[4] Iron is used to treat iron deficiency.
Information obtained from https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=iron&_ga=2.341338665.955481667.1522702603-191684010.1510852799

[5] Neurontin is used to treat seizures, postherpetic neuralgia, and restless leg syndrome.
Information obtained from https://medlineplus.gov/druginfo/meds/a694007.html

[6] Hydralazine is used to treat high blood pressure.
Information obtained from https://medlineplus.gov/druginfo/meds/a682246.html

[7] Metoprolol is used to treat high blood pressure.
Information obtained from https://medlineplus.gov/druginfo/meds/a682864.html

[8] Miralax is used to treat constipation.
Information obtained from https://medlineplus.gov/druginfo/meds/a603032.h

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[9] Zoloft is used to treat depression.
Information obtained from
https://medlineplus.gov/druginfo/meds/a697048.html

[10] Spiriva is used to treat chronic obstructive pulmonary disease.
Information obtained from
https://medlineplus.gov/druginfo/meds/a604018.html

[11] Colace is used to treat constipation.
Information obtained from
https://medlineplus.gov/druginfo/meds/a601113.html
2. The facility staff failed to clarify Resident #236's physician order for Calcitrate (calcium citrate with Vitamin D). The dose prescribed and the dose dispensed by the pharmacy did not match.

Resident #236 was admitted to the facility on 3/19/18 with diagnoses that included but were not limited to: diabetes, cancer of the colon, high blood pressure, low back pain, heart attack, specified disorders of bone density and structure, and heart failure.

There was not completed MDS (minimum data set) assessment completed at the time of survey.

The "Nursing Admission Assessment" dated 3/19/18, documented the resident was oriented to person and place, not to time and situation.

The medication administration observation was conducted on 3/28/18 at 8:27 a.m. with LPN

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(licensed practical nurse) #4. LPN #4 prepared Resident #236's medications. LPN #4 pulled a medication card with Calcitrate (calcium citrate with Vitamin D) 315/250 tablet. LPN #4 stated, "I can't give that, it doesn't match what the order says. I won't give it until I've checked the orders." LPN #4 proceeded to administer all other medications except the Calcitrate.

The physician order dated, 3/19/18, documented, "Calcium citrate + (plus) Tablet 315 - 200 MG (milligram); Give 1 tablet by mouth in the morning for supplement." (Calcium Citrate is the citrate salt of calcium. An element necessary for normal nerve, muscle, and cardiac function, calcium as the citrate salt helps to maintain calcium balance and prevent bone loss when taken orally). (1)

An interview was conducted with other staff member (OSM) #7, the pharmacist; on 3/28/18 at 2:45 p.m. OSM #7 was asked to review Resident #236's order for Calcitrate. Once reviewed, OSM #7 was asked if there is a discrepancy in what the order says and what is dispensed by the pharmacy, OSM #7 stated, "Yes the pharmacy should have clarified that order. There should have been communication between the pharmacy and the facility."

An interview was conducted with LPN #4 on 3/28/18 at 2:50 p.m. When asked what happens when she finds a discrepancy between the doctor's order and what the pharmacy sent, LPN #4 stated, "First, I don't give the medication. I tell the nurse practitioner. I see when it was started and how many times it was given. I call the pharmacy and tell them the order says one thing and they sent something else. I called the pharmacy today and they told me they didn't carry

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that strength, they only carry the 315/250 strength of the medication. I asked if they had called the facility to get the order changed to the 315/250 mg strength, and the pharmacist told me there were no records regarding this indicating the pharmacy had spoken to the facility. I then went back to the nurse practitioner and she changed the order to match what we had in the medication drawer."

An interview was conducted with OSM #8, the pharmacist at the pharmacy on 3/27/18 at 4:34 p.m. When asked about the process followed if there is an order that doesn't match what you have in stock, OSM #8 stated, "We should call the facility and tell them that what the doctor ordered is not in our stock and this is the dose we carry." When asked what happened with Resident #236's Calcitrate, OSM #8 stated, "I don't see a note on her profile that we called the facility."

The facility policy, "Transcribing Physician Orders" documented in part, "1. Review the order for clarity and completeness. If the order is not clear or complete, contact the physician giving the order and obtain clarification. Discontinue the original order and write a new order that is clear and complete...3. Verification of order completeness: a. Right Resident, b. Right Time, c. Right Route, d. Right dose."

The administrator, ASM (administrative staff member) #1, director of nursing, ASM #2, and ASM #7, owner of the facility were made aware of the above findings on 3/29/18 at 6:10 p.m.

No further information was provided prior to exit.

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(1) This information was obtained from the following website: https://pubchem.ncbi.nlm.nih.gov/compound/Calcium_citrate#section=Pharmacology-and-Biochemistry

3. The facility staff failed to document Resident # 69's oxygen flow rate when titrating the resident's oxygen to maintain oxygen saturations above 92% as ordered.

Resident #69 was admitted to the facility on 7/8/16 and readmitted on 8/25/17 with diagnoses that included but were not limited to: heart failure, diabetes, dementia, hypertension and difficulty sleeping.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 2/14/18 coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status). The resident was coded as needing assistance from staff for all activities of daily living. The resident was coded as receiving oxygen.

An observation was made on 3/28/18 at 8:05 a.m. of Resident #69. The resident was sitting on the side of the bed with oxygen via nasal cannula at 5 liters/minute via the oxygen concentrator. The resident was awake and alert and conversant.

An observation was made on 3/28/18 at 4:20 p.m. of Resident #69. The resident was sitting up in the chair next to her bed and the oxygen was turned off.

An observation was made on 3/29/18 7:50 a.m. of Resident #69. The resident was sitting on the side of the bed with oxygen via nasal cannula at

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one and a half liters via the oxygen concentrator.

Review of the March 2018 physician's orders documented, "O2 (oxygen) via nasal cannula (soft plastic prongs that fit in the nose to deliver oxygen). May titrate from 2LPM (liters per minute)-5 LPM to maintain O2 SAT (saturation) >90% every shift."

Review of the March 2018 treatment administration record (TAR) documented, O2 via nasal cannula. May titrate from 2LPM-5LPM to maintain O2 sat >90%." The oxygen saturation was documented every shift but the oxygen rate was not documented.

Review of the weights and vital summary record for March 2018 documented the oxygen saturations but not the oxygen flow rate.

Review of the nurse's notes documented the oxygen saturation level and the oxygen flow rate on nine occasions.

An interview was conducted on 3/29/18 at 1:15 p.m. with ASM (administrative staff member) #5, the nurse practitioner. When asked what staff were supposed to do if the physician ordered the oxygen to be titrated as needed, ASM #5 stated, "I don't normally write to titrate as needed because we want to keep them at the lowest liter we can to keep them comfortable. It really needs to be specific. I like to be specific for example I would write two liters to keep their oxygen saturation above 90. If they are going to increase the 02 they need to call for an order." When asked if it was important for the practitioner to know how much oxygen a resident needed to keep their oxygen saturation levels above 90%,

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ASM #5 stated, "Yes. It's important to know how many liters they're on."

An interview was conducted on 3/29/18 at 2:23 p.m. with LPN (licensed practical nurse) #9. LPN #9 was asked to look at the March 2018 TAR for the oxygen. When asked how staff would know what oxygen flow rate Resident #69 was on, LPN #9 stated, "It should be in (name of software)." LPN #9 reviewed Resident #69's nursing notes, and stated, "It should say here under the notes and it's not here." LPN #9 further reviewed the resident's notes and stated, "There's one here. It's a hit and miss kinda thing." When asked if it was important for staff to know what a resident's oxygen rate was, LPN #9 stated, "We need to know what her sats (saturations) are." When asked why staff needed to know the amount of oxygen being administered, LPN #9 stated, "Too much oxygen can be dangerous, I think some nurses think it's only for them (the oxygen flow rate) when it's really not."

Nursing Interventions and Clinical Skills, 2nd edition, Elkin, Perry and Potter 2000, page 936, "Oxygen is a drug and is administered and monitored with the same care as any other medication."

On 3/29/18 at 6:00 p.m. ASM (administrative staff member) #1, (the administrator), ASM #2, (the director of nursing) and ASM# 7, (the owner of the facility) were made aware of the findings.

No further information was provided prior to exit.

4. The facility staff failed to clarify a physician's order to titrate oxygen as needed for Resident

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#99.

Resident #99 was admitted to the facility on 6/9/17 and readmitted on 2/26/18 with diagnoses that included but were not limited to: heart failure, pneumonia, anemia, depression and cognitive communication deficit.

The most recent MDS, a significant change assessment, with an ARD of 3/5/18 coded the resident as 99 on the BIMS indicating the resident was not able to complete the exam. The resident was coded as understanding others and being understood and having intact short and long memory. The resident was coded as requiring assistance for all activities of daily living.

Review of the March 2018 physician's order documented, "O2 @4L (oxygen at four liters) via n/c may titrate as needed every shift."

Review of the March 2018 TAR documented, "O2 @4L via n/c may titrate as needed every shift." The oxygen was documented as being administered on each shift during March.

An interview was conducted on 3/29/18 at 1:15 p.m. with ASM (administrative staff member) #5, the nurse practitioner. When asked what staff were supposed to do if the physician ordered the oxygen to be titrated as needed, ASM #5 stated, "I don't normally write to titrate as needed because we want to keep them at the lowest liter we can to keep them comfortable. It really needs to be specific. I like to be specific for example I would write two liters to keep their oxygen saturation above 90. If they are going to increase the 02 they need to call for an order." When asked if it was important for the practitioner to

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F 658	Continued From page 214 know how much oxygen a resident was needing to keep their oxygen saturation levels above 90%, ASM #5 stated, "Yes. It's important to know how many liters they're on." An interview was conducted on 3/29/18 at 2:23 p.m. with LPN (licensed practical nurse) #9. LPN #9 was asked to look at Resident #99's order for oxygen. LPN #9 stated, "That needs to be clarified." When asked why, LPN #9 stated, "Too much oxygen can be dangerous. Oxygen is a medication." Nursing Interventions and Clinical Skills, 2nd edition, Elkin, Perry and Potter 2000, page 936, "Oxygen is a drug and is administered and monitored with the same care as any other medication." On 3/29/18 at 6:00 p.m. ASM #1, the administrator, ASM #2, the director of nursing and ASM #7, the facility owner were made aware of the findings. No further information was provide prior to exit. On 3/29/18 at 6:00 p.m. ASM (administrative staff member) #1, (the administrator), ASM #2, (the director of nursing) and ASM# 7, (the owner of the facility) were made aware of the findings.	F 658		
F 677 SS=D	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 personal and oral hygiene; This REQUIREMENT is not met as evidenced	F 677	F677 1. Corrective action has been accomplished for the alleged deficient practice in regards to residents #49 by assuring resident had a shower on his scheduled shower day.	

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by:
Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide activities of daily living care for one resident of 31 residents in the survey sample, (Resident # 49) who was coded as requiring extensive assistance from staff for bathing.

The facility staff failed to provide a shower for one week to Resident #49.

The findings include:

Resident #49 was admitted to the facility on 5/10/14 and readmitted on 6/7/17 with diagnoses that included but were not limited to: stroke, depression, diabetes, kidney disease and anemia.

The most recent minimum data set, a quarterly assessment, with an assessment reference date of 2/2/18 coded the resident as having 15 out of 15 on the brief interview for mental status indicating the resident was intact cognitively to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living. In section G of the MDS -- "Personal hygiene" the resident was coded as requiring extensive assistance from one staff member for bathing.

On 3/29/18 at approximately 3:20 p.m., Resident #49 approached this writer and asked to speak with me. The resident was followed to his room. Resident #49 stated he had not had a shower for two weeks stating, "They forgot about me." When asked if he had asked staff for his shower, Resident #49 stated yes he had. When asked

2. Current facility residents have the potential to be affected by the alleged deficient practice. 100% audit was completed of shower records to assure all residents due a shower has received one. An audit of shower records for 20 residents will be done weekly x 4 weeks then 40 residents a month x 2 more months to assure continued compliance.
3. Measures put into place to assure alleged deficient practice does not recur include: Reeducation will be given to nursing to offer and give showers per facility policy and chart accurately.
4. The Director of Nursing and/or designee will analyze/review for patterns/trends and report in the Quality Assurance committee meeting quarterly for a minimum of six months to evaluate the effectiveness of the plan and will adjust the plan as the committee may recommend, based on outcomes/trends identified from date.
5. Completion Date: May 11, 2018

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how it made him feel not to have a shower, Resident #49 stated, "It makes me feel bad."

A review of the shower sheets on the resident's unit did not evidence documentation that the resident received a shower on 3/16/18, 3/20/18, 3/23/18 and 3/27/18.

Review of the resident's documentation survey report for March 2018 did not evidence documentation that the resident received a shower on 3/20/18 or 3/23/18.

Review of the nurse's notes did not evidence documentation regarding the resident not receiving a shower.

An interview was conducted on 3/29/18 at 3:15 p.m. with LPN (licensed practical nurse) #9. When asked the process staff follow if a resident was not bathed, LPN #9 stated they would ask the next shift to do it. When asked if Resident #49 had received his bath on 3/20/18 on the 3:00 p.m. to 11:00 p.m. shift, LPN #9 stated, "There is no documentation that it was done. I've had to get after the staff lately to get the baths done because there's a lot of blank spaces on the shower log."

A request was made on 3/29/18 at approximately 4:30 p.m. of ASM (administrative staff member) #2, the director of nursing of evidence that the resident had received a bath/shower on 3/20/18 and 3/23/18.

On 3/29/18 at 5:00 p.m. a copy of the resident's bathing documentation was received. ASM #2 stated there was no documentation that the resident had been bathed on those days.

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An interview was conducted on 3/30/18 at 8:55 a.m. with CNA #4, the resident's aide. When asked how often residents were to have a shower or a bath, CNA #4 stated, twice a week. When asked what process staff followed if they could not get a shower or bath completed, CNA #4 stated, "On wing one you can't get everything done if there's only three aides, it's very rare to have three, usually have four to five. I give them the option to take their showers. We have to have three refusals and they have to refuse to the nurse as well when we are not doing it (shower). When asked why Resident #49 did not get a shower on 3/20/18, CNA #4 stated, "I couldn't get to his shower because one of the aides had to leave." I let my unit manager know and they said they'd have three to eleven (shift) do it." When asked about 3/23/18, CNA #4 stated, "(Name of CNA) isn't here today but she put 'NA' that means it wasn't done they didn't get a chance to get to it."

The CNA who cared for the resident on 3/23/18 was not available for interview.

On 3/30/18 at 2:50 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #7, the facility owner were made aware of the findings.

Review of the facility's policy titled, "BATH POLICY" documented 1. Residents will be offered whirlpool baths or showers on their assigned days."

No further information was provided prior to exit.

F 684	Quality of Care	F 684		

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§ 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, facility document review and clinical record review it was determined the facility staff failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, for two of 31 residents in the survey sample, Resident's #236 and #37.

1. The facility staff failed to follow the physician's orders for administering the prescribed medication for Calcium citrate to Resident #236.

2. The facility staff failed to weigh Resident #37 daily as ordered by the physician.

The findings include:

1. The facility staff failed to follow the physician's orders for administering the prescribed medication for Calcium citrate to Resident #236.

Resident #236 was admitted to the facility on 3/19/18 with diagnoses that included but were not limited to: diabetes, cancer of the colon, high

1. Corrective action has been accomplished for the alleged deficient practice in regards to residents #236 and 37. For resident #236 the nurse clarified the order for Calcium citrate with the NP and pharmacy and obtained the proper medication in the proper dose for the resident. For resident #37 the nursing staff was reeducated to follow MD/NP orders for weighing the resident daily as ordered.
2. Current facility residents have the potential to be affected by the alleged deficient practice. The Unit Managers or designee will conduct an audit of 10 residents per week for 4 weeks and 15 residents per month for the next 2 months to ensure physician's orders are being followed. A random sample of residents will be audited quarterly thereafter for 6 months to ensure continued compliance.
3. Measures put into place to assure alleged deficient practice does not recur include: Reeducation given to nursing staff to follow MD/NP orders with a focus on medication orders and weight orders per policy.
4. The Director of Nursing and/or designee will analyze/review for patterns/trends and report in the Quality Assurance committee meeting quarterly for a minimum of six months to evaluate the effectiveness of the plan and will adjust the plan as the committee may recommend, based on outcomes/trends identified from date.
5. Completion Date: May 11, 2018

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blood pressure, low back pain, heart attack, specified disorders of bone density and structure, and heart failure.

There was not completed MDS (minimum data set) assessment completed at the time of survey.

The "Nursing Admission Assessment" dated 3/19/18, documented the resident was oriented to person and place, not to time and situation.

The physician order dated, 3/19/18, documented, "Calcium citrate + (plus) Tablet 315 - 200 MG (milligrams); Give 1 tablet by mouth in the morning for supplement." (Calcium Citrate is the citrate salt of calcium. An element necessary for normal nerve, muscle, and cardiac function, calcium as the citrate salt helps to maintain calcium balance and prevent bone loss when taken orally). (1)

During the medication administration observation, on 3/28/18 at 8:27 a.m. with LPN (licensed practical nurse) #4, LPN #4 didn't give the prescribed medication for Calcium citrate as the label on the medication did not match the physician's order.

The medication card documented, "Calcitrate 315/250 mg." There were nine missing tablets from the card indicating that nine doses of the medication had been given.

The medication administration record (MAR) documented, Calcium citrate + (plus) Tablet 315 - 200 MG; Give 1 tablet by mouth in the morning for supplement." The medication was documented as having been administered for nine days.

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The care plan dated, 3/22/18, documented in part, "Focus: The resident has an alteration in musculoskeletal status r/t (related to) Osteopenia (a generalized term for any decrease in the amount of bone tissue). (2) The "Interventions" failed to evidence any documentation related to the calcium supplements.

An interview was conducted with LPN #4 on 3/28/18 at 2:50 p.m. When asked what happens when she finds a discrepancy between the doctor's order and what the pharmacy sent, LPN #4 stated, "First, I don't give the medication. I tell the nurse practitioner. I see when it was started and how many times it was given. I call the pharmacy and tell them the order says one thing and they sent something else. I called the pharmacy today and they told me they didn't carry that strength, they only carry the 315/250 strength of the medication. I asked if they had called the facility to get the order changed to the 315/250 mg strength, and the pharmacist told me there were no records regarding this indicating the pharmacy had spoken to the facility. I then went back to the nurse practitioner and she changed the order to match what we had in the medication drawer." When asked if the other nurses who documented the administration of the medication were following the physician's order, LPN #4 stated, "No, they were not."

The facility policy, "Medication Administration" documented in part, "4. Prior to administration of medication, facility staff should take all measures required by facility policy and applicable law, including but not limited to the following: 4.1.1. Verify each time a medication is administered that it is the correct medication, at the correct dose, at

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the correct route, at the correct rate, at the correct time for the correct resident."

According to "Fundamentals of Nursing", Seventh Edition, 2009: by Perry and Potter Chapter 35 "Medication Administration" Chapter 35, pg (page) 707 read: "Professional standards, such as the American Nurses Association's Nursing: Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights medication administration consistently every time you administer 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, and 6. The right documentation."

The administrator, director of nursing and owner of the facility were made aware of the above findings on 3/29/18 at 6:10 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website:
https://pubchem.ncbi.nlm.nih.gov/compound/Calcium_citrate#section=Pharmacology-and-Biochemistry
(2) Barron's Dictionary for Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 424
2. The facility staff failed to weigh Resident #37 daily as ordered by the physician.

Resident #37 was admitted to the facility on

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1/17/17 and readmitted on 12/11/17 with diagnoses that included but were not limited to: heart failure, shortness of breath, diabetes, stroke and kidney disease.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 1/22/18 coded the resident as having scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could perform after the tray was prepared. In section L -- Oral/Dental status documented the resident was coded as having no dental issues.

Review of the care plan initiated on 10/31/17 and revised on 1/15/18 documented "Focus. Resident is at risk for weight fluctuation of sign (significant) wt (weight) loss or gain due to resident history of CHF (congestive heart failure)...Interventions. Resident is weighed daily to monitor wt loss or gain."

Review of the March 2018 physician's orders documented, "Daily weight every night shift. Start Date 2/16/2018."

Review of the March 2018 treatment administration record (TAR) documented, "Daily weight every night shift. Start Date 2/16/2018" Further review of the TAR did not evidence documentation that the weight had been obtained on 3/4/18, 3/5/18, 3/12/18, 3/17/18, 3/18/18 and 3/24/18.

Review of the March 2018 weights and summary

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F 684	Continued From page 223 report documented the weight had been obtained on 3/5/18, 3/12/18 and 3/24/18. Three weights were not obtained on 3/4/18, 3/17/18, and 3/18/18, for the month of March as ordered. An interview was conducted on 3/29/18 at 2:14 p.m. with RN (registered nurse) #4, the resident's nurse and LPN (licensed practical nurse) #9. When asked if staff were expected to follow the physician's order, RN #4 stated "Yes." When asked who documented daily weights, RN #4 stated, "The aides put it in." LPN #9 stated, "No they don't put it in we do." When asked why Resident #37 had daily weights, RN #4 stated, "Because fluid overload is the major issue for her. She carries a lot of fluid and edema in her leg." On 3/29/18 at 6:00 p.m. ASM (administrative staff member), the administrator, ASM #2, the director of nursing and ASM #3, the facility owner were made aware of the findings. No further information was obtained prior to exit.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined	F 689	F689 1. Corrective action has been accomplished for the alleged deficient practice in regards to residents #66 and 47 regarding fall interventions. The resident's comprehensive care plan has been reviewed and revised and interventions have been put into place pertaining to falls. 2. Current facility residents have the potential to be affected by the alleged deficient practice. A 100% of fall reports have been audited beginning on Feb. 1, 2018. Fall reports will be audited daily during morning meeting for interventions.	

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that facility staff failed to ensure residents were free from accidents or hazards for two of 31 residents in the survey sample, Resident #66 and #47.

1. The facility staff failed to develop and implement fall preventive interventions after Resident #66 sustained a fall on 4/27/17.

2. The facility staff failed to develop and implement fall preventive interventions after Resident #47 fell on 5/20/17 and 6/13/17.

The findings include:

1. Resident #66 was admitted to the facility on 4/19/17 and readmitted on 2/11/18 with diagnoses that included but were not limited to unspecified dementia without behavioral disturbance, heart failure, gout, major depressive disorder, high blood pressure and atrial fibrillation. Resident #66's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 2/13/18. Resident #66 was coded as severely cognitively impaired in the ability to make daily decisions scoring 03 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #66 was coded as requiring extensive assistance from one staff member with most ADLs (activities of daily living).

Review of Resident #66's clinical record revealed the following note dated 4/27/17: "Resident yelled out for help and upon entering the room Resident (sic) was sitting on the floor in between the wheelchair legs she (sic) had stool all over (sic) she was able to move all extremities (sic) she was assisted to chair and taken to the shower

3. Measures put into place to assure alleged deficient practice does not recur include: Nursing staff will be educated on initiating an intervention following a fall. The Care Plan Coordinator and Quality Assurance Nurse will be reeducated to audit the 24 hour report daily assuring continued compliance.
4. The Director of Nursing and/or designee will analyze/review for patterns/trends and report in the Quality Assurance committee meeting quarterly for a minimum of six months to evaluate the effectiveness of the plan and will adjust the plan as the committee may recommend, based on outcomes/trends identified from date.
5. Completion Date: May 11, 2018

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(sic) she denies having any pain or discomfort (sic) Resident has some indentations on her back from where she was leaning against the wheelchair legs (sic) Resident was showered and now resting quietly in bed."

Review of Resident #66's fall report dated 4/27/17 failed to evidence that the care plan was updated or that a fall prevention intervention was put into place to prevent future falls.

Review of Resident #66's comprehensive care plan with resolved items and revisions, failed to evidence that her care plan was updated after the 4/27/17 fall.

Further review of Resident #66's clinical record revealed that she had a second fall on 2/8/18. Her care plan was updated after that fall and she had no major injuries.

On 3/29/18 at 3:11 p.m., an interview was conducted with LPN (licensed practical nurse) #5, the care plan coordinator, regarding the purpose of the care plan. LPN #5 stated that the purpose of the care plan was to plan the care of the patient, determine goals and how the resident will obtain these goals. When asked if it was important that the care plan was accurate, LPN #5 stated that it was. When asked when the care plan would be updated, LPN #5 stated that the care plan would be updated for any changes in treatment such as new orders, any monitoring etc. When asked if care plans should be updated after falls, LPN #5 stated yes. LPN #5 stated that the quality assurance nurse updates and puts interventions in place after a resident has a fall on the care plan. When asked who has access to the care plan, LPN #5 stated that the IDT

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(interdisciplinary team) uses the care plan.

On 3/29/18 at 4:11 p.m., an interview was conducted with LPN #8, the quality assurance nurse. When asked who was responsible for updating the care plans after falls, LPN #8 stated that she was. LPN #8 stated that after a fall, she and the IDT team would try to come up with interventions to prevent the resident from falling again. LPN #8 stated that if the IDT team could not come up with any further intervention, then she would document that the care plan was reviewed. LPN #8 stated that the date of each fall should still be updated on the care plan. When asked if she could find out what intervention was put into place after Resident #66's fall, LPN #8 stated that she would check.

On 3/29/18 at 4:38 p.m., LPN #8 stated that she could not find an intervention that was put into place after Resident #66's fall. LPN #8 stated that she was not responsible for determining interventions and updating the care plan at that time (May of 2017).

On 3/29/18 at 5:47 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) and ASM #7, the facility owner were made aware of the above concerns.

The facility policy titled, "Falls Management Program," documents in part the following: "The Falls Management Program is an interdisciplinary quality improvement initiative. It is designed to assist our facility in providing individualized, person-centered care and improving the fall care process and outcomes through educational and quality improvement tools. Procedure: When a fall occurs, staff will conduct a careful evaluation.

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2. Staff will monitor and manage a resident's response. 3. Falls Assessments will done (sic) upon admission , quarterly, annually and at change of condition. 4. A nurse will be appointed by the DON as the fall nurse coordinator. 5. The Fall nurse coordinator will appoint a fall team that will meet weekly. 6. Specific goals and key indicators will be set. 7. Comprehensive care plan will be driven by fall assessment and MDS CAA and will be completed by day 21 by care plan coordinator with input from fall team. 8. Recurrent falls will require adjustments to the care plan and a willingness to try both new and old interventions."

2. The facility staff failed to develop and implement fall preventive interventions after Resident #47 fell on 5/20/17 and 6/13/17.

Resident #47 was admitted to the facility on 3/23/16 with diagnoses that included but were not limited to anxiety disorder, Alzheimer's disease, unspecified dementia without behavioral disturbance, high blood pressure, muscle weakness, and major depressive disorder. Resident #47's most recent MDS (minimum data set) assessment was annual assessment with an ARD (assessment reference date) of 1/1/18. Resident #47 was coded as severely cognitively impaired in the ability to make daily decisions scoring 03 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #47 was coded as requiring extensive assistance from two or more persons with most ADLS (activities of daily living).

Review of Resident #47's clinical record revealed that she had a fall on 5/20/17. The following was

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documented in a nursing note: "This nurse was receiving report from day shift nurse and day shift CNA (certified nursing assistant) came to nurses station and reported she observed (Name of Resident #47) on the floor on her buttocks in room 401 near her tall dresser. Resident assessed for injuries. No apparent injuries at this time...."

Review of Resident #47's current care plan dated 12/1/16 with revisions and resolved items failed to evidence that the care plan was updated after her 5/20/17 fall.

Review of Resident #47's incident report dated 5/20/17 failed to evidence that an intervention was put into place after her 5/20/17 fall.

Further review of Resident #47's clinical record revealed that she had another fall on 6/13/17. The following was documented: "Dietary manager informed this nurse resident was observed on the floor, upon entering the room resident was on the floor sitting on buttocks, when asked what she was doing she replied, "I was trying to get into my w/c (wheelchair)," no injury, denies hitting head, denies any pain or discomfort, VS (vital signs) as follows; BP (blood pressure) 1327/72 (sic), P (pulse) 73, R (respirations) 18, T (temperature) 97.6, 02 (oxygen) sat (saturation) 95 percent on room air, POA (power of attorney) and NP (nurse practitioner) notified."

Review of Resident #47's incident report dated 6/13/17 failed to evidence that an intervention was put into place after her 6/13/17 fall.

On 3/29/18 at 3:11 p.m., an interview was conducted with LPN (licensed practical nurse) #5,

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the care plan coordinator, regarding the purpose of the care plan. LPN #5 stated that the purpose of the care plan was to plan the care of the patient, determine goals and how the resident will obtain these goals. When asked if it was important that the care plan was accurate, LPN #5 stated that it was. When asked when the care plan would be updated, LPN #5 stated that the care plan would be updated for any changes in treatment such as new orders, any monitoring etc. When asked if care plans should be updated after falls, LPN #5 stated yes. LPN #5 stated that the quality assurance nurse updates and puts interventions in place after a resident has a fall on the care plan. When asked who has access to the care plan, LPN #5 stated that the IDT (interdisciplinary team) uses the care plan.

On 3/29/18 at 4:11 p.m., an interview was conducted with LPN #8, the quality assurance nurse. When asked who was responsible for updating the care plans after falls, LPN #8 stated that she was. LPN #8 stated that after a fall, she and the IDT team would try to come up with interventions to prevent the resident from falling again. LPN #8 stated that if the IDT team could not come up with any further intervention, then she would document that the care plan was reviewed. LPN #8 stated that the date of each fall should still be updated on the care plan. When asked if she could find out what interventions were put into place after Resident #47's falls, LPN #8 stated that she would check.

On 3/29/18 at 4:38 p.m., LPN #8 stated that she could not find interventions that were put into place after Resident #47's falls. LPN #8 stated that she was not responsible for determining interventions and updating the care plan at that

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F 689	Continued From page 230 time (May and June 2017). On 3/29/18 at 5:47 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) and ASM #7, the facility owner were made aware of the above concerns.	F 689		
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	F 690	F690 1. Corrective action has been accomplished for the alleged deficient practice in regards to resident #132's catheter bag was not kept off the floor. The nurse immediately changed the position of the tubing and bag to keep the tubing and bag from touching the floor. 2. Current facility residents have the potential to be affected by the alleged deficient practice. A 100% audit of residents with catheters was completed by the unit manager to assure no catheter bag or tubing was touching the floor. Rounds will be made daily by unit manager or designee noting the catheter bag and tubing and report findings daily in morning meeting. 3. Measures put into place to assure alleged deficient practice does not recur include: Nursing staff will be reeducated on proper placement of catheter and tubing so it is not touching the floor. Nursing staff will also be reeducated in regards to infection control concerning catheters. 4. The Director of Nursing and/or designee will analyze/review for patterns/trends and report in the Quality Assurance committee meeting quarterly for a minimum of six months to evaluate the effectiveness of the plan and will adjust the plan as the committee may recommend, based on outcomes/trends identified from date. 5. Completion Date: May 11, 2018	

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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:
Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide services for an indwelling catheter for one of 31 residents in the survey sample, Resident #132.

The facility staff failed to ensure Resident #132's catheter bag was kept off the floor.

The findings include:

Resident #132 was admitted to the facility on 2/6/18 and readmitted on 3/8/18. Resident #132's diagnoses included but were not limited to acute respiratory failure, stroke and muscle weakness. Resident #132's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 3/15/18, coded the resident's cognition as severely impaired. Section G documented Resident #132 as requiring extensive assistance of two or more staff with bed mobility. Section H coded the resident as having an indwelling catheter (1).

Review of Resident #132's clinical record revealed a physician's order dated 3/9/18 for a catheter due to a wound.

Resident #132's care plan initiated on 3/8/18 failed to document information regarding an

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indwelling catheter.

On 3/29/18 at 7:44 a.m., Resident #132 was observed lying in a low bed. The resident's catheter bag was observed on the floor and on a fall mat lying on the floor.

On 3/29/18 at 3:47 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked where a catheter bag should be place when a resident is lying in bed. LPN #4 stated the catheter bag should be below the resident, should not touch the floor and should be in a privacy bag. At this time, LPN #4 was asked to observed Resident #132's catheter bag. LPN #4 and this surveyor entered Resident #132's room. The resident remained in a low bed and the catheter bag was observed on the floor. LPN #4 stated Resident #132's bed had to remain low. LPN #4 moved Resident #132's catheter bag to the other side of the bed and positioned the bag where it was not touching the floor.

On 3/29/18 at 5:48 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility document titled, "Indwelling Catheter Care" documented, "PURPOSE: To prevent infection...8. Maintain drainage bag below bladder and cover with dignity bag..."

No further information was presented prior to exit.

(1) "You have an indwelling catheter (tube) in your bladder. 'Indwelling' means inside your body. This catheter drains urine from your bladder into a bag outside your body." This information was

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F 690	Continued From page 233 obtained from the website: https://medlineplus.gov/ency/patientinstructions/000140.htm	F 690		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide respiratory care and services for ten of 31 residents in the survey sample, Resident #37, #95, #99, #69, #234, #235, #133, #130, #3 and #87. 1. The facility staff failed to change the oxygen humidifier as ordered by the physician and per the comprehensive care plan for Resident #37. 2. The facility staff failed to change the oxygen humidifier as ordered by the physician for Resident #95. 3. The facility staff failed to change and label the oxygen humidifier as ordered by the physician for Resident #99. 4. The facility staff failed to document Resident	F 695	F695 1. Corrective action has been accomplished for the alleged deficient practice in regards to resident #37, 95, and 99 oxygen humidifier was not changed per policy. The oxygen humidifier was changed immediately by the nurse. Regarding resident #69, 234, 235 documentation was not provided for oxygen rate or saturation. The nurse corrected the oxygen concentrator to deliver the correct liters after clarifying order with the NP, then documented the saturation of the resident. Regarding resident #133 and 130, 3, and 87, all orders were clarified and O2 concentrators were set at flow rate per NP's order. 2. Current facility residents have the potential to be affected by the alleged deficient practice. A 100% audit of residents ordered oxygen was completed by the unit manager to assure all components of oxygen therapy was within date per policy. The unit manager or designee will audit oxygen humidifiers and tubing daily for 4 weeks then weekly for 2 more months and report their findings to the DON or designee to assure continued compliance. 100% audit of oxygen orders will be completed by the Quality Assurance nurse and orders will be checked for accuracy daily in morning meeting for 3 months. 3. Measures put into place to assure alleged deficient practice does not recur include: Nursing staff will be reeducated on changing humidifiers and tubing per policy, focusing on infection control. Reeducation will be given on order clarification and documentation including following existing MD/NP order.	

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F 695	Continued From page 234 #69's oxygen rate with the oxygen saturations. 5. The facility staff failed to provide oxygen therapy according to professional standards of practice for Resident #234. 6. The facility staff failed to provide oxygen therapy according to professional standards of practice for Resident #235. 7. The facility staff failed to clarify physician's orders for Resident #133's oxygen. 8. The facility staff failed to clarify physician's orders for Resident #130's oxygen. 9. The facility staff failed to ensure Resident #3's oxygen orders were written and followed in accordance with professional standards for the safe administration for oxygen therapy. 10. The facility staff failed to ensure Resident #87's oxygen orders were written and followed in accordance with professional standards for the safe administration of oxygen therapy. The findings include: 1. Resident #37 was admitted to the facility on 1/17/17 and readmitted on 12/11/17 with diagnoses that included but were not limited to: heart failure, shortness of breath, diabetes, stroke and kidney disease. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 1/22/18 coded the resident as having scored 15 out of 15 on the BIMS (brief mental status), indicating the resident was	F 695	4. The Director of Nursing and/or designee will analyze/review for patterns/trends and report in the Quality Assurance committee meeting quarterly for a minimum of six months to evaluate the effectiveness of the plan and will adjust the plan as the committee may recommend, based on outcomes/trends identified from date. 5. Completion Date: May 11, 2018	

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cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could perform after the tray was prepared. The resident was coded as receiving oxygen.

An observation was made on 3/27/18 at 2:50 p.m., of Resident #37. The resident was sitting up in the wheelchair next to the bed with oxygen on at two liters per minute. The oxygen humidifier bottle was connected to the oxygen concentrator and was dated 3/19(2018).

An observation was made on 3/28/18 at 8:10 a.m. of Resident #37. The resident was sitting in the wheelchair next to the bed with the oxygen on at two liters per minute. The oxygen humidifier bottle was connected to the oxygen concentrator and as dated 3/19.

Review of the resident's comprehensive care plan initiated on, 11/4/17 documented, "Focus. The resident has COPD (chronic obstructed pulmonary disease) Interventions. Maintain oxygen equipment per facility protocol."

Review of the March 2018 physician orders documented, "change o2 (oxygen) tubing and bottle and clean filter q (every) sun (Sunday) 11-7 (11:00 p.m. to 7:00 a.m.) every night shift every Sun."

Review of the March 2018 treatment administration record (TAR) documented, "change o2 tubing and bottle and clean filter q sun 11-7 every night shift every Sun." It was documented that the tubing and water bottle had been changed on 3/25/18.

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An interview was conducted on 3/29/18 at 3:35 p.m. with LPN (licensed practical nurse) #6. When asked how often the oxygen tubing and humidifier were changed, LPN #6 stated, "It should be at least every Sunday, along with the tubing and the oxygen bottle." When asked to look at Resident #37's oxygen humidifier, LPN #6 stated, "Apparently it didn't get done. I will pull up my calendar. No it definitely didn't get done."

The night nurse was not available for interview.

On 3/29/18 at 6:00 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #7, the facility owner were made aware of the findings.

Review of the facility's policy titled, "POLICY RELATING TO OXYGEN AND NEBULIZER THERAPY" documented, "Standard: To provide any resident with an adequate supply of oxygen via nasal cannula or mask to maintain oxygen saturation levels at an optimum level. To provide any resident with an adequate supply of aerosol medication per order via mask or hand held mouthpiece. POLICY: All nursing/therapy staff is responsible for maintaining an adequate supply of oxygen to any resident requiring such or supplying an adequate amount of aerosol medication per order. PROCEDURE: 1. The night nurse will be responsible for cleaning oxygen concentrator, oxygen filters and nebulizer machines on Sunday. 2. The night nurse will be responsible for changing the water bottle and oxygen tubing as well as the nebulizer tubing, mask or mouth piece weekly on Sunday. 3 All water bottles, tubing, masks and mouthpieces will be dated."

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No further information was provided prior to exit.

2. The facility staff failed to change the oxygen humidifier as ordered by the physician for Resident #95.

Resident #95 was admitted to the facility on 2/17/16 and readmitted on 3/3/18 with diagnoses that included but were not limited to: intestinal bleeding, schizophrenia, heart failure and diabetes.

The most recent complete MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 2/23/18 coded the resident as having scored 15 out of 15 on the BIMS (brief mental status), indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring supervision for activities of daily living. The resident was coded as receiving oxygen.

Review of the physician's orders dated March 2018 documented, "Change mask and water bottle to concentrator q(every) Sunday night. Start date 3/5/2018."

Review of the care plan did not evidence documentation related to changing the oxygen humidifier as ordered by the physician.

An observation was made on 3/27/18 at 2:55 p.m. of Resident #95. The resident was lying in bed with the oxygen mask hanging over the side rail. The oxygen was set at three liters per minute via the oxygen concentrator. The humidifier bottle was dated "3/19/18."

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An observation was made on 3/28/18 at 8:05 a.m. of Resident #95. The resident was lying in the bed with eyes closed, the oxygen mask was on the resident. The oxygen was set at three liters per minute via the oxygen concentrator. The humidifier bottle was dated "3/19/18:.

An observation was made on 3/29/18 at 8:30 a.m. of Resident #95. The resident was lying in bed with eyes closed. The oxygen mask was hanging over the side rail. The humidifier bottle was labeled, "3/19/18."

An interview was conducted on 3/29/18 at 3:35 p.m. with LPN (licensed practical nurse) #6. When asked how often the oxygen tubing and humidifier were changed, LPN #6 stated, "It should be at least every Sunday, along with the tubing and the oxygen bottle and the oxygen bag which apparently she doesn't have." When asked to look at Resident #95's oxygen humidifier, LPN #6 stated, "Apparently it didn't get done. I'll pull up my calendar. No it definitely didn't get done."

The night nurse was not available for interview.

On 3/29/18 at 6:00 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #7, the facility owner were made aware of the findings.

An observation was made on 3/30/18 at 8:12 a.m. of Resident #95. The resident was lying in bed with eyes closed. The oxygen mask was hanging over the side rail. The humidifier bottle was labeled, "3/19/19."

No further information was provided prior to exit.

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3. The facility staff failed to change the oxygen humidifier as needed and label the oxygen humidifier as ordered by the physician for Resident #99.

Resident #99 was admitted to the facility on 6/9/17 and readmitted on 2/26/18 with diagnoses that included but were not limited to: heart failure, pneumonia, anemia, depression and cognitive communication deficit.

The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 3/5/18 coded the resident as 99 on the BIMS (brief mental status), indicating the resident was not able to complete the exam. The resident was coded as understanding others and being understood and having intact short and long term memory. The resident was coded as requiring assistance for all activities of daily living. The resident was coded as receiving oxygen.

An observation was made of Resident #99 on 3/27/18 at 2:35 p.m. The resident was lying in bed with eyes closed. A nasal cannula was in the resident's nose and the oxygen was on at four liters per minute via the oxygen concentrator. A water bottle was connected to the concentrator and was empty. The bottle or tubing were not dated.

An observation was made of Resident #99 on 3/28/18 at 8:13 a.m. The resident was sitting up in bed eating breakfast. The oxygen was on the resident via nasal cannula via the oxygen concentrator which was set at four liters/minute. The water bottle was full and the bottle was dated

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F 695	Continued From page 240 "3/27/18."	F 695		

An observation was made of Resident #99 on 3/29/18 at 8:30 a.m. The resident was sitting up in bed. The oxygen was on the resident via nasal cannula at four liters/minute via the oxygen concentrator.

Review of the March 2018 physician orders documented, "change oxygen tubing water bottle and clean filter every Sunday on night shift."

Review of the March 2018 TAR documented, "change oxygen tubing water bottle and clean filter every Sunday on night shift." It was documented that the water bottle had been changed on 3/25/18.

An interview was conducted on 3/29/28 at 3:15 p.m. with LPN #9. When asked how often the oxygen water bottle was changed, LPN #9 stated, "So it needs to be changed every Sunday night. We are running into his bubbler being empty and hospice gives it to us but we are still supposed to take care of it." When asked when the water bottle was checked, LPN #9 stated whenever they went into the room. When asked why the water bottle was changed every week, LPN #9 stated, "They are to be changed out weekly in case there's any bacteria buildup and the bubbler could be empty." When asked if the water bottle was to be dated, LPN #9 stated it was.

The night nurse was not available for interview.

On 3/29/18 at 6:00 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #7, the facility owner were made aware of the findings.

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No further information was provided prior to exit.

4. The facility staff failed to document Resident #69's oxygen rate with the oxygen saturations.

Resident #69 was admitted to the facility on 7/8/16 and readmitted on 8/25/17 with diagnoses that included but were not limited to: heart failure, diabetes, dementia, hypertension and difficulty sleeping.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 2/14/18 coded the resident as a 15 out of 15 on the BIMS (brief mental status). The resident was coded as needing assistance from staff for all activities of daily living. The resident was coded as receiving oxygen.

An observation was made on 3/27/18 at 2:46 p.m. of Resident #69. The resident was sitting on the side of the bed with oxygen via nasal cannula at three liters/minute via the oxygen concentrator. The resident removed the oxygen and walked to the bathroom.

An observation was made on 3/28/18 at 8:05 a.m. of Resident #69. The resident was sitting on the side of the bed with oxygen via nasal cannula at 5 liters/minute via the oxygen concentrator. The resident was awake and alert and conversant.

An observation was made on 3/28/18 at 4:20 p.m. of Resident #69. The resident was sitting up in the chair next to her bed and the oxygen was turned off.

An observation was made on 3/29/18 7:50 a.m. of

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Resident #69. The resident was sitting on the side of the bed with oxygen via nasal cannula at one and a half liters via the oxygen concentrator.

Review of the March 2018 physician's orders documented, "O2 (oxygen) via nasal cannual (soft plastic prongs that fit in the nose to deliver oxygen). May titrate from 2LPM (liters per minute)-5 LPM to maintain O2 SAT (saturation) >90% every shift."

Review of the March 2018 treatment administration record (TAR) documented, O2 via nasal cannula. May titrate from 2LPM-5LPM to maintain O2 sat >90%." The oxygen saturation was documented every shift but the oxygen rate was not documented.

Review of the weights and vital summary record for March 2018 documented the oxygen saturations but not the oxygen flow rate.

Review of the nurse's notes documented the oxygen saturation level and the oxygen flow rate on nine occasions.

An interview was conducted on 3/29/18 at 1:15 p.m. with ASM (administrative staff member) #5, the nurse practitioner. When asked what staff were supposed to do if the physician ordered the oxygen to be titrated as needed, ASM #5 stated, "I don't normally write to titrate as needed because we want to keep them at the lowest liter we can to keep them comfortable. It really needs to be specific. I like to be specific for example I would write two liters to keep their oxygen saturation above 90. If they are going to increase the 02 they need to call for an order." When asked if it was important for the practitioner to

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know how much oxygen a resident was needing to keep their oxygen saturation levels above 90%, ASM #5 stated, "Yes. It's important to know how many liters they're on."

An interview was conducted on 3/29/18 at 2:23 p.m. with LPN (licensed practical nurse) #9. LPN #9 was asked to look at the March 2018 TAR for the oxygen. When asked how would staff know what oxygen rate the resident was on, LPN #9 stated, "It should be in (name of software)." LPN #9 reviewed Resident #69's nurse's notes and stated, "It should say here under the notes and it's not here." LPN #9 further reviewed the resident's notes and stated, "There's one here. It's a hit and miss kinda thing." When asked if it was important for staff to know what a resident's oxygen rate was, LPN #9 stated, "We need to know what her sats (saturations) are." When asked why staff needed to know the amount of oxygen being administered, LPN #9 stated, "Too much oxygen can be dangerous, I think some nurses think it's only for them (the oxygen flow rate) when it's really not."

On 3/29/18 at 6:00 p.m. ASM #1, ASM #2 and ASM# 7 were made aware of the findings.
5. The facility staff failed to provide oxygen therapy according to professional standards of practice for Resident #234.

Resident #234 was admitted to the facility on 3/13/18 with diagnoses that included but were not limited to: fracture of her left femur, pain and chronic obstructive pulmonary disease (COPD) (COPD - a general term for chronic, non-reversible lung disease that is usually a combination of emphysema and chronic bronchitis). (1).

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The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 3/20/18, coded the resident as scoring a 14 on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for most of her activities of daily living except eating in which she was coded as independent. In Section O - Special Treatments, Procedures and Programs, it was documented the resident received oxygen therapy during the look back period.

The physician order dated, 3/13/18, documented, "O2 (oxygen) - 2 L (liters) - NC (nasal cannula - a tube with two prongs that insert into the nose) titrate as needed every shift."

The treatment administration record (TAR) for March 2018 documented, "O2 - 2 L - NC titrate as needed every shift." The oxygen was documented as administered each shift since 3/13/18. Each documented shift had the rate of "2" documented in the box for liter rate.

Observation was made of Resident #234 on 3/27/18 at 2:47 p.m. The oxygen was in use at 2.5 L/min (liters per minute). The resident was observed on 3/28/18 at 8:15 a.m. in bed with her oxygen in use, set at 1.5 L/min. Resident #234 was observed on 3/29/18 at 8:25 a.m. The oxygen was set at 1.5 L/min. and was in use.

On 3/29/18 at 9:22 a.m., LPN (licensed practical nurse) #2 went to Resident #234's room. LPN #2 was asked to read the oxygen administration rate.

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LPN #2 stated the oxygen was set at 1.5 L/min. When asked how often a nurse is to check the oxygen level, LPN #2 stated, "I usually check it when I give them their medications. Since no one has the correct rate, I guess it should be checked at the beginning of the shift." When asked how one reads the rate of oxygen delivery on the concentrator, LPN #2 stated, "The line should be in the center of the ball."

The comprehensive care plan dated, 3/15/18, documented in part, "Focus: The resident has COPD." The "Interventions" failed to evidence documentation related to the use of oxygen.

An interview was conducted with administrative staff member (ASM) #5, the nurse practitioner, on 3/29/18 at approximately 1:20 p.m. When asked about the order 'May titrate O2 as needed,' ASM #5 stated, "We try to keep them on the lowest dose of oxygen." When asked if she considers oxygen a medication, ASM #5 responded, "Yes." ASM #5 was asked how the nurse's know what rate of oxygen is appropriate for a resident and if it is in the nurse's scope of practice to adjust the rate of the oxygen. ASM #5 stated, "No, they need to talk to me to get orders."

Nursing Interventions and Clinical Skills, 2nd edition, Elkin, Perry and Potter 2000, page 936, "Oxygen is a drug and is administered and monitored with the same care as any other medication."

The administrator, director of nursing and owner of the facility were made aware of the above findings on 3/29/18 at 6:10 p.m.

No further information was provided prior to exit.

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6. The facility staff failed to provide oxygen therapy according to professional standards of practice for Resident #235.

Resident #235 was admitted to the facility on 3/22/18 with diagnoses that included but were not limited to: fracture of her leg, Parkinson's disease (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling, and muscle weakness) (1), falls, and chronic obstructive pulmonary disease (COPD) (COPD - a general term for chronic, non-reversible lung disease that is usually a combination of emphysema and chronic bronchitis). (2)

There was no completed MDS (minimum data set) assessment completed at the time of survey.

The "Nursing Admission Assessment" dated, 3/22/18 documented the resident was alert and oriented to time, place and person.

The resident was observed on 3/27/18 at 2:47 p.m., with oxygen in use via nasal cannula (a tube with two prongs that are inserted in the resident's nostrils) at 2 L/min (liters per minute). The resident was observed on 3/28/18 at 8:25 a.m. in a wheelchair by the nurse's station with no oxygen in use. Resident #235 was observed on 3/29/18 at 8:17 a.m. in the dining room with no oxygen in use. Her room was observed, the oxygen concentrator was running, and it was set between 1 and 1.5 L/min.

Review of the care plan dated, 3/23/18,

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documented in part, "Focus: The resident has altered respiratory status/difficulty breathing r/t (related to) COPD and chronic respiratory failure." The "Interventions" failed to evidence documentation of the administration of oxygen.

The review of the treatment administration record (TAR) documented, "O2 (oxygen) @ (at) 2 L (liters) via n/c (nasal cannula), titrate as needed every shift." The oxygen was documented as being administered every shift since admission on 3/22/18.

On 3/29/18 at 9:12 a.m., an interview was conducted with LPN (licensed practical nurse) #2. Resident #235 was in her room with her oxygen in use. LPN #2 was asked to verify the flow rate setting on the oxygen concentrator. LPN #2 verified the oxygen was set between 1 and 1.5 L/min. When asked what Resident #235's oxygen order was for, LPN #2 stated she had to check the orders. The orders were checked and LPN #2 stated, "It should be set at 2L/min." When asked what it meant to titrate as needed, LPN #2 stated, "It means it could go up or down." When asked if a nurse can make the decision as to what rate the resident should be on, LPN #2 stated, "Only a nurse practitioner or doctor can change the ordered rate." When asked is oxygen is considered a medication, LPN #2 stated, "Yes."

An interview was conducted with administrative staff member (ASM) #5, the nurse practitioner, on 3/29/18 at approximately 1:20 p.m. When asked what the order 'May titrate O2 as needed,' ASM #5 stated, "We try to keep them on the lowest dose of oxygen." When asked if she considers oxygen a medication, ASM #5 responded, "Yes." ASM #5 asked how the nurse's know what rate of

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oxygen is appropriate for a resident and is it in the nurse's scope of practice to adjust the rate of the oxygen. ASM #5 stated, "No, they need to talk to me to get orders."

Nursing Interventions and Clinical Skills, 2nd edition, Elkin, Perry and Potter 2000, page 936, "Oxygen is a drug and is administered and monitored with the same care as any other medication."

The administrator, director of nursing and owner of the facility were made aware of the above findings on 3/29/18 at 6:10 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary for Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437.
(2) Barron's Dictionary for Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.
7. The facility staff failed to clarify Resident #133's physician's order for oxygen.

Resident #133 was admitted to the facility on 3/8/18. Resident #133's diagnoses included but were not limited to heart failure, high blood pressure and chronic kidney disease. Resident #133's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/15/18, coded the resident's cognition as moderately impaired.

Review of Resident #133's clinical record revealed a physician's order dated 3/16/18 that documented, "O2 (Oxygen) @ (at) 2L (Liters) via n/c (nasal cannula) at all times may titrate as

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needed."

Resident #133's comprehensive care plan initiated on 3/19/18 documented, "The resident is resistive to care r/t (related to) wearing continuous O2..."

On 3/29/18 at 7:39 a.m., Resident #133 was observed lying in bed. The resident's oxygen concentrator was set at a rate between two and two and a half liters.

On 3/29/18 at 1:15 p.m., an interview was conducted with ASM (administrative staff member) #5 (the nurse practitioner), regarding Resident #133's oxygen order. ASM #5 was asked what is meant by a physician's order that documents, "May titrate as needed." ASM #5 stated she usually does not write an order that documents to titrate oxygen. ASM #5 stated she always wants to keep a resident's oxygen at the lowest liter to keep the resident comfortable and keep the resident's oxygen saturation at 90 percent. When asked if oxygen is a medication, ASM #5 stated, "Yes." When asked how a nurse is supposed to know the acceptable rate to titrate oxygen to, ASM #5 stated that is why she does not write orders to titrate oxygen. When asked if a nurse has the scope and authority to decide the rate of oxygen a resident should receive, ASM #5 stated, "If they are going to change how many liters they (residents) get, they (the nurses) need those specific orders."

On 3/29/18 at 2:17 p.m., an interview was conducted with LPN (licensed practical nurse) #6, regarding Resident #133's oxygen order. LPN #6 was asked what is meant by a physician's order to titrate oxygen as needed. LPN #6 stated,

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"Usually it means that we can take them off if needed or bring them down to one liter but we have to check their oxygen sats (saturations)." When asked if she can increase the oxygen, LPN #6 stated, "I usually never go up." When asked how nurses definitively know how to titrate oxygen when the order documents "Titrate as needed," LPN #6 stated, "I guess that there is no way to actually know." LPN #6 stated she has worked on wing two (in the facility) for a while and that is the way staff has interpreted the order. LPN #6 stated she calls the nurse practitioner if a resident is having issues.

On 3/29/18 at 5:48 p.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility document titled, "Transcribing Physician Orders" documented, "1. Review the order for clarity and completeness. If the order is not clear or complete, contact the physician giving the order and obtain clarification. Discontinue the original order and write a new order that is clear and complete..."

No further information was presented prior to exit.

8. The facility staff failed to clarify Resident #130's physician's order for oxygen.

Resident #130 was admitted to the facility on 1/11/18 and readmitted on 2/2/18. Resident #130's diagnoses included but were not limited to pneumonia, diabetes and urinary tract infection. Resident #130's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/9/18, coded the resident as cognitively intact.

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Review of Resident #130's clinical record revealed a physician's order dated 2/2/18 that documented, "O2 (Oxygen) @ (at) 2L (Liters) via n/c (nasal cannula) may titrate as needed."

Resident #130's comprehensive care plan initiated on 1/11/18 documented, "The resident has pneumonia r/t (related to) immobility...Oxygen therapy as ordered to maintain oxygen saturation above 90%..."

On 3/29/18 at 7:30 a.m., Resident #130 was observed in a wheelchair in the bedroom. The resident was not receiving oxygen.

On 3/29/18 at 8:57 a.m., Resident #130 was observed in a wheelchair in the dining room. The resident was not receiving oxygen.

On 3/29/18 at 1:15 p.m., an interview was conducted with ASM (administrative staff member) #5 (the nurse practitioner), regarding Resident #130's oxygen order. ASM #5 was asked what is meant by a physician's order that documents, "May titrate as needed." ASM #5 stated she usually does not write an order that documents to titrate oxygen. ASM #5 stated she always wants to keep a resident's oxygen at the lowest liter to keep the resident comfortable and keep the resident's oxygen saturation at 90 percent. When asked if oxygen is a medication, ASM #5 stated, "Yes." When asked how a nurse is supposed to know the acceptable rate to titrate oxygen to, ASM #5 stated that is why she does not write orders to titrate oxygen. When asked if a nurse has the scope and authority to decide the rate of oxygen a resident should receive, ASM #5 stated, "If they are going to change how many

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liters they (residents) get, they (the nurses) need those specific orders." ASM #5 stated Resident #130 refuses oxygen during the day.

On 3/29/18 at 2:17 p.m., an interview was conducted with LPN (licensed practical nurse) #6, regarding Resident #130's oxygen order. LPN #6 was asked what is meant by a physician's order to titrate oxygen as needed. LPN #6 stated, "Usually it means that we can take them off if needed or bring them down to one liter but we have to check their oxygen sats (saturations)." When asked if she can increase the oxygen, LPN #6 stated, "I usually never go up." When asked how nurses definitively know how to titrate oxygen when the order documents "Titrate as needed," LPN #6 stated, "I guess that there is no way to actually know." LPN #6 stated she has worked on wing two (in the facility) for a while and that is the way staff has interpreted the order. LPN #6 stated she calls the nurse practitioner if a resident is having issues.

On 3/29/18 at 5:48 p.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

9. The facility staff failed to ensure Resident #3's oxygen orders were written and followed in accordance with professional standards for the safe administration for oxygen therapy.

Resident #3 was admitted to the facility on 9/10/16 with the diagnoses of but not limited to atrial fibrillation, morbid obesity, chronic kidney disease, systemic inflammatory response syndrome, bladder obstruction, chronic ischemic

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heart disease, schizophrenia, Parkinson's disease, diabetes, high blood pressure, and bipolar disorder. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/14/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting, and hygiene; was independent for eating; and as incontinent of bowel and as having an indwelling catheter for bladder.

A review of the clinical record revealed one dated 8/16/17 for "Oxygen at 2-3 L/minute (liters per minute) via nasal cannula." There was nothing indicating when to administer 2 and when to administer 3 liters.

A review of the oxygen saturation log for Resident #3 for the month of March 2018 revealed that on one occasion on 3/1/18, the resident's oxygen saturation was at 94% and on one occasion on 3/22/18, the resident's oxygen saturation was 93%. The remaining 78 opportunities the oxygen saturation was documented was at 95% or above.

Observations made on 3/17/18 at 3:17 p.m., 3/28/18 at 8:29 a.m., and 3/29/18 at 8:12 a.m. revealed the resident's oxygen running at 3 liters via nasal cannula on each observation.

A review of the comprehensive care plan revealed one for "The resident has COPD (chronic obstructive pulmonary disease). This care plan was dated 8/17/17. Interventions included one for "Oxygen per MD (medical doctor) or NP (nurse practitioner) orders. Monitor

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for effectiveness." This intervention was dated 8/17/17.

On 3/29/18 at 11:07 a.m. in an interview with LPN #7 (Licensed Practical Nurse, the unit manager) she stated that she would increase the rate as needed within the confines of 2 to 3 liters, in order to keep sats (oxygen saturations) over 90. LPN #7 stated there should be parameters ordered (when to administer 2 and when to administer 3 liters). LPN #7 stated that Resident #3 has been maintained on 3 liters "since she has been here" and she wouldn't want to lower it because she would be afraid of causing respiratory distress.

On 3/29/18 at 1:15 p.m. in an interview with ASM #5 (Administrative Staff Member, a Nurse Practitioner), she stated that normally oxygen would be ordered at 2 liters to keep sats above 90. She stated she normally would not write orders to titrate. ASM #5 stated that oxygen is a medication, and if the nurses are going to change the liters given, there needs to have an order.

On 3/29/18 at 6:05 p.m. at the end of day meeting, the Administrator (ASM #1), Director of Nursing (ASM #2, and the facility owner (ASM #7) were made aware of the findings. No further information was provided by the end of the survey.

10. The facility staff failed to ensure Resident #87's oxygen orders were written and followed in accordance with professional standards for the safe administration of oxygen therapy.

Resident #87 was admitted to the facility on 8/16/17 with the diagnoses of but not limited to

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pneumonia, osteoporosis, bronchitis, hypothyroidism, diabetes, morbid obesity, depression, Parkinson's disease, epilepsy, high blood pressure, ischemic heart disease, pulmonary embolism, stroke, peripheral vascular disease, chronic obstructive pulmonary disease, respiratory failure, spinal stenosis, fibromyalgia, shortness of breath, dysphagia, and ataxia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/12/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive assistance for transfers, dressing, toileting, and hygiene; independent for eating; and as incontinent of bowel and bladder.

A review of the clinical record revealed an order dated 3/21/18 for "02 via nasal cannula. May titrate from 2LPM (liters per minute)-5LPM to maintain 02 Sat >90% (above 90%) QHS (at bedtime)." There was no directions for when to administer 2 liters, when to administer 3 liters, when to administer 4 liters, and when to administer 5 liters.

A review of the oxygen saturation log for March 2018 revealed that the resident's oxygen saturation was at 94% on one occasion on 3/17/18 and at 92% on one occasion on 3/13/18. The remaining 49 opportunities the oxygen saturation was documented, at 95% or higher.

On 3/28/18 8:27 a.m., and on 3/29/18 at 8:09 a.m., Resident #87's oxygen was running at 3 liters via nasal cannula.

A review of the care plan revealed one dated

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F 695	Continued From page 256 3/22/18 for "The resident has oxygen therapy." Interventions included one dated 3/22/18 for "O2 via nasal cannula as ordered. Notify MD (medical doctor) or NP (nurse practitioner) if O2 saturations fall below 90%." On 3/29/18 at 11:07 a.m., in an interview with LPN #7 (Licensed Practical Nurse, the unit manager) she stated that she would increase the rate as needed within the confines of 2 to 3 liters, in order to keep sats (oxygen saturations) over 90. She stated there should be parameters ordered (when to administer 2 and when to administer 3 liters). LPN #7 stated that Resident #3 has been maintained on 3 liters "since she has been here" and she wouldn't want to lower it because she would be afraid of causing respiratory distress.. On 3/29/18 at 1:15 p.m., in an interview with ASM #5 (Administrative Staff Member, a Nurse Practitioner), she stated that normally oxygen would be ordered at 2 liters to keep sats above 90. She stated she normally would not write orders to titrate. ASM #5 stated that oxygen is a medication, and if the nurses are going to change the liters given, there needs to have an order. On 3/29/18 at 6:05 p.m., at the end of day meeting, the Administrator (ASM #1), Director of Nursing (ASM #2, and the facility owner (ASM #6) were made aware of the findings. No further information was provided by the end of the survey.	F 695		
F 745 SS=E	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide	F 745		

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F 745	Continued From page 257 medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined the facility staff failed to provide medically related social services for seven of 31 residents in the survey sample, Residents #55, #74, #114, #98, #90, #89, and #37. 1. The facility staff failed to ensure medically related social services were provided in regards to the PASARR (Pre-admission screening and resident review) being completed for Resident #55. 2. The facility staff failed to ensure medically related social services were provided in regards to the PASARR (Pre-admission screening and resident review) being completed for Resident #74. 3. The facility staff failed to ensure medically related social services were provided in regards to the PASARR (Pre-admission screening and resident review) being completed for Resident #114. 4. The facility staff failed to ensure medically related social services were provided in regards to the preadmission screening and resident review (PASARR) being completed for Resident #98. 5. The facility staff failed to ensure medically related social services were provided in regards to the PASARR (preadmission screening and	F 745	F745 1. PASARR's have been completed on Residents #55, #74, #114, #98, #90, and #89. Dental services have been obtained for Resident #37. 2. A 100% audit will be completed to ensure residents have had a Preadmission Screening and Resident Review. The screening will be done for those residents identified as not having one. A 100% audit will be conducted of residents who have requested dental services to ensure their dental needs have been addressed. 3. Admissions and Social Services staff will be reeducated on obtaining the necessary PASARR on admission. Social Services staff will be reeducated on following policy and procedure for dental services. 4. Residents in need of dental services and new residents will be discussed in weekly risk management meetings to ensure dental appointments are being made and that PASARR's are being obtained on admission. Services will be obtained as needed. Any issues of noncompliance will be discussed in quarterly QA meetings so that a plan of action can be developed. 5. Completion Date: May 11, 2018	

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resident review) being completed for Resident #90.

6. The facility staff failed to ensure medically related social services were provided in regards to the PASARR (preadmission screening and resident review) being completed for Resident #89.

7. The facility staff failed to assist the resident in obtaining dental services for Resident #37.

The findings include:

1. The facility staff failed to ensure medically related social services were provided in regards to the PASARR (Pre-admission screening and resident review) being completed for Resident #55.

Resident #55 was admitted to the facility on 10/25/04 with the diagnoses of but not limited to Parkinson's disease, benign prostatic hyperplasia, diabetes, dementia, psychosis, depression, mood disorder, anxiety disorder, pseudobulbar affect, high blood pressure, and dysphagia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/7/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing, hygiene, toileting, dressing, and transfers; supervision for eating; and as incontinent of bowel and bladder.

Review of Resident #55's clinical record failed to reveal the resident's PASARR. Resident #55's comprehensive care plan failed to reveal

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documentation regarding the PASARR.

On 3/29/18 at 6:05p.m., at the end of day meeting, the Administrator, ASM (administrative staff member) #1, Director of Nursing, ASM #2 and ASM #7, the facility owner were made aware of the findings. A request was made for evidence of the PASARR.

On 3/30/18 at 9:33a.m., in an interview with OSM #3 (Other Staff Member, the social worker) she stated that she "was not told it was something that I had to do" (obtaining, performing PASARR's). She further stated that the facility did not have them for Resident #55. When asked what the purpose of a PASARR, OSM #3 stated, "some type of evaluation. I don't know what the purpose of it is for."

On 3/30/18 at 9:44a.m., in an interview with OSM #4, another social worker. OSM #4 stated, regarding a PASARR, "It is done at the hospital. They review the chart to make sure the resident doesn't have any mental illness or a mental disability to determine if there is a level 2 screening that needs to be processed by a psychologist, in order to make sure they (the residents) are safe to come to a facility, and are deemed that we can take care of them safely." When asked if a PASARR does not come from the hospital, is the social worker responsible for completing one, OSM #4 stated, "That was not communicated to me here." When asked the purpose of one, OSM #4 stated, "To make sure that if there is an issue, that we are able to handle their needs and how we can best meet their needs.

A review of the facility policy, "Job Description,

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Social Worker" documented, "In fulfilling his or her primary duties and responsibilities, the social worker shall exercise professional judgment in carrying out a variety of activities that maximize the well-being and quality of life of residents....Administrative: 1. Review facility policies and procedures as part of the facility's interdisciplinary team to assure compliance with state and federal regulations. 2. Participate in reviewing and setting policies concerning resident care and quality of life. 3. Participate in developing facility social work policies. 4. Develop, maintain and utilize a listing of current community resources that are useful to residents and their families/significant others. 5. Participate in quality assurance interdisciplinary team meetings. 6. Understand and meet all government requirements for social service documentation. 7. Document progress in meeting the psychosocial needs of residents....Clinical: 1. Complete a social history and psychological assessment for each resident that identifies social, emotional, and psychological needs...." There was nothing in the policy that directly specified PASARR as a requirement.

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

2. The facility staff failed to ensure medically related social services were provided in regards to the PASARR (Pre-admission screening and resident review) being completed for Resident #74.

Resident #74 was admitted to the facility on 8/26/13 with the diagnoses of but not limited to stroke, intestinal disease, depression, metabolic encephalopathy, dementia, schizoaffective

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disorder, dysphagia, gastrostomy feeding tube, cataracts, presbyopia, Parkinson's disease, schizophrenia, bipolar disorder, angina, diabetes, high blood pressure, hypothyroidism, and chronic obstructive pulmonary disease. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/16/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for transfers, dressing, and hygiene; extensive care for eating; and as incontinent of bowel and bladder.

Review of Resident #74's clinical record failed to reveal the resident's PASARR. Resident #74's comprehensive care plan failed to reveal documentation regarding the PASARR.

On 3/30/18 at 9:33a.m., in an interview with OSM #3 (Other Staff Member, the social worker) she stated that she "was not told it was something that I had to do" (obtaining, performing PASARR's). She further stated that the facility did not have them for Resident #55. When asked what the purpose of a PASARR, OSM #3 stated, "some type of evaluation. I don't know what the purpose of it is for."

On 3/30/18 at 9:44a.m., in an interview with OSM #4, another social worker. OSM #4 stated, regarding a PASARR, "It is done at the hospital. They review the chart to make sure the resident doesn't have any mental illness or a mental disability to determine if there is a level 2 screening that needs to be processed by a psychologist, in order to make sure they (the residents) are safe to come to a facility, and are deemed that we can take care of them safely."

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When asked if a PASARR does not come from the hospital, is the social worker responsible for completing one, OSM #4 stated, "That was not communicated to me here." When asked the purpose of one, OSM #4 stated, "To make sure that if there is an issue, that we are able to handle their needs and how we can best meet their needs.

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

3. The facility staff failed to ensure medically related social services were provided in regards to the PASARR (Pre-admission screening and resident review) being completed for Resident #114.

Resident #114 was admitted to the facility on 4/7/17 with the diagnoses of but not limited to deep vein thrombosis, ankle fracture, aspiration pneumonia, shortness of breath, edema, insomnia, dementia, schizophrenia, depression, anxiety disorder, high blood pressure, emphysema, chronic obstructive pulmonary disease, osteoarthritis, fibromyalgia, and chronic kidney disease,. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 3/6/18. The resident was coded as severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for hygiene, dressing, and transfers; limited assistance for toileting; independent for eating; and as continent of bowel and bladder.

Review of Resident #114's clinical record failed to reveal the resident's PASARR. Resident #114's

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comprehensive care plan failed to reveal documentation regarding the PASARR.

On 3/29/18 at 6:05p.m., at the end of day meeting, the Administrator, ASM (administrative staff member) #1, Director of Nursing, ASM #2 and ASM #7, the facility owner were made aware of the findings. A request was made for evidence of the PASARR.

On 3/30/18 at 9:33a.m., in an interview with OSM #3 (Other Staff Member, the social worker) she stated that she "was not told it was something that I had to do" (obtaining, performing PASARR's). She further stated that the facility did not have them for Resident #55. When asked what the purpose of a PASARR, OSM #3 stated, "some type of evaluation. I don't know what the purpose of it is for."

On 3/30/18 at 9:44a.m., in an interview with OSM #4, another social worker. OSM #4 stated, regarding a PASARR, "It is done at the hospital. They review the chart to make sure the resident doesn't have any mental illness or a mental disability to determine if there is a level 2 screening that needs to be processed by a psychologist, in order to make sure they (the residents) are safe to come to a facility, and are deemed that we can take care of them safely." When asked if a PASARR does not come from the hospital, is the social worker responsible for completing one, OSM #4 stated, "That was not communicated to me here." When asked the purpose of one, OSM #4 stated, "To make sure that if there is an issue, that we are able to handle their needs and how we can best meet their needs.

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

4. The facility staff failed to ensure medically related social services were provided in regards to the preadmission screening and resident review (PASARR) being completed for Resident #98.

Resident #98 was admitted to the facility on 4/21/15 with diagnoses that included but not limited muscle weakness, diabetes mellitus, chest pain, paranoid schizophrenia, chronic kidney disease, and high blood pressure. Resident #98's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/28/18. Resident #98 was coded as being moderately impaired in cognitive function scoring 10 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #98 was coded as requiring extensive assistance from one staff member with most ADLs (activities of daily living).

The most recent comprehensive MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 11/1/18, coded in Section A1500 - Preadmission Screening and Resident Review, the resident as not being currently considered by the state level II PASAAR process to have a serious mental illness and/or intellectual disability or a related condition.

Review of the clinical record failed to evidence a Preadmission Screening and Resident Review having been completed.

On 3/30/18 at 9:23 a.m., an interview was conducted with OSM (other staff member) #3, the social worker. OSM #3 stated that she was not

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aware that social services was responsible for completing the PASAAR. OSM #3 stated that it was brought to her attention that she had to complete PASAARS. When asked how long she had been the social worker, OSM #3 stated since April of 2010. When asked the purpose of the PASAAR, OSM #3 stated that she was not sure of the purpose or use of the PASAAR.

On 3/30/18 at 9:32 a.m., an interview was conducted with OSM #4, another social worker who was recently hired at the facility. When asked what a PASAAR was, OSM #4 stated that the PASAAR usually happens at the hospital and they review the resident's chart to see if a resident has a mental illness or disability and then will determine if a level two PASAAR needs to be done. OSM #4 stated that it ensures residents are safe to come to the facility and that the facility can meet the resident's needs. OSM #4 stated that no one had communicated to her that social services was to complete the PASAAR if the hospital did not do one. OSM #4 stated that in another state where she had worked previously, another department was responsible for completing PASAARS.

OSM #4 could not provide a PASAAR for Resident #98.

On 3/29/18 at 5:47 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) and ASM #7, the facility owner were made aware of the above concerns.
5. The facility staff failed to ensure medically related social services were provided in regards to the PASARR (preadmission screening and resident review) being completed for Resident #90.

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Resident #90 was admitted to the facility on 5/2/12 with diagnoses that included but were not limited to: Huntington's chorea (abnormal hereditary condition characterized by progressive involuntary rapid, jerky motions and mental deterioration, leading to dementia) (1), muscle weakness, schizophrenia (any of a group of mental disorders characterized by gross distortions of reality, withdrawal from social contacts, and disturbances of thought, language, perception and emotional response.) (2), and dysphagia (a condition in which swallowing is difficult or painful due to obstruction of the esophagus or muscular abnormalities of the esophagus.) (3)

The most recent MDS assessment, a quarterly assessment, with an assessment reference date of 2/22/18, coded the resident as scoring a two on the BIMS (brief interview for mental status) score indicating the resident is severely impaired to make cognitive daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living.

Review of the clinical record failed to evidence a Preadmission Screening and Resident Review having been completed.

On 3/29/18 at the end of the day meeting, a request was made for the PASARR for Resident #90.

An interview was conducted with other staff member (OSM) #3, the social worker, on 3/30/18 at 9:28 a.m. When asked if she had any knowledge of the PASARR for the residents,

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OSM #3 stated, "I explained to the business office manager that I was not told it was something that I should be doing. It came to our attention yesterday. The other social worker spoke with me this morning about PASARR. To my knowledge, we don't have any of the PASARRs." When asked what a PASARR is, OSM #3 stated, "It's some type of evaluation of that person." When asked what the purpose of a PASARR is, OSM #3 stated she did not know.

An interview was conducted with OSM #4, the other social worker, on 3/30/18 at 9:45 a.m. When asked what a PASARR is, OSM #4 stated, "My understanding is that it starts at the hospital and to determine if a resident has a mental illness or mental disability to make sure they are safe to come to the facility and if they need a psychologist or doctor so we can safely take care of them." When asked the purpose of the PASARR, OSM #4 stated it is so they can come to the facility. If one does not come from the hospital the admission did it in West Virginia, where I worked, but in Virginia it's referred to the social worker to complete." When asked if there is more to a PASAAR then being safe to come to the facility, OSM #4 stated, "If they have an issue so we can meet their needs. Level 2 screening is typically we get a notice with yes or no. The doctor sometimes has to decide if a resident is going to come here." OSM #4 stated, "Unfortunately it was not communicated to me that social services was to do it." When asked if she was provided with a job description, OSM #4 stated, "Yes, there is one in my file but it's pretty basic."

On 3/30/18 at 10:30 a.m. the director of nursing informed the survey team the facility did not have

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any policy on PASARR.

ASM (administrative staff member) #1, the administrator, was made aware of the above findings on 3/30/18 at 12:57 p.m.

No further information was provided prior to exit.
(1) Barron's Dictionary for Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 246.
(2) Barron's Dictionary for Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 522.
(3) Barron's Dictionary for Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 178.

6. The facility staff failed to ensure medically related social services were provided in regards to the PASARR (preadmission screening and resident review) being completed for Resident #89.

Resident #89 was admitted to the facility on 5/4/14 with a recent readmission of 3/18/18, with diagnoses that included but were not limited to: left shoulder pain, urinary tract infection, fracture of her leg, diabetes, depression, high blood pressure, stroke, and psychosis (major mental disorder in which the person is usually detached from reality and has impaired perceptions, thinking, responses and interpersonal relationships. (1)

The most recent MDS, a quarterly assessment, with an assessment reference date of 2/22/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily

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cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for most of her activities of daily living. In Section P - Restraints and Alarms, the resident was coded as using bed rails daily.

Review of the clinical record failed to evidence a Preadmission Screening and Resident Review having been completed.

On 3/29/18 at the end of the day meeting, a request was made for the PASARR for Resident #89.

An interview was conducted with other staff member (OSM) #3, the social worker, on 3/30/18 at 9:28 a.m. When asked if she had any knowledge of the PASARR for the residents, OSM #3 stated, "I explained to the business office manager that I was not told it was something that I should be doing. It came to our attention yesterday. The other social worker spoke with me this morning about PASARR. To my knowledge, we don't have any of the PASARRs." When asked what a PASARR is, OSM #3 stated, "It's some type of evaluation of that person." When asked what the purpose of a PASARR is, OSM #3 stated she did not know.

An interview was conducted with OSM #4, the other social worker, on 3/30/18 at 9:45 a.m. When asked what a PASARR is, OSM #4 stated, "My understanding is that it starts at the hospital and to determine if a resident has a mental illness or mental disability to make sure they are safe to come to the facility and if they need a psychologist or doctor so we can safely take care of them." When asked the purpose of the PASARR, OSM #4 stated it is so they can come

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to the facility. If one does not come from the hospital the admission did it in West Virginia, where I worked, but in Virginia it's referred to the social worker to complete." When asked if there is more to a PASAAR then being safe to come to the facility, OSM #4 stated, "If they have an issue so we can meet their needs. Level 2 screening is typically we get a notice with yes or no. The doctor sometimes has to decide if a resident is going to come here." OSM #4 stated, "Unfortunately it was not communicated to me that social services was to do it." When asked if she was provided with a job description, OSM #4 stated, "Yes, there is one in my file but it's pretty basic."

On 3/30/18 at 10:30 a.m. the director of nursing informed the survey team the facility did not have any policy on PASARR.

ASM (administrative staff member) #1, the administrator, was made aware of the above findings on 3/30/18 at 12:57 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary for Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 483.

7. The facility staff failed to assist the resident in obtaining dental services for Resident #37.

Resident #37 was admitted to the facility on 1/17/17 and readmitted on 12/11/17 with diagnoses that included but were not limited to: heart failure, shortness of breath, diabetes, stroke and kidney disease.

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The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 1/22/18 coded the resident as having scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could perform after the tray was prepared. In section L -- Oral/Dental status documented the resident was coded as having no dental issues.

An interview was conducted on 3/27/18 at 3:23 p.m. with Resident #37. During the interview, the resident stated that she had asked for dentures because she has many missing teeth her gums hurt sometimes when she eats, but was told it would be out of pocket and she couldn't afford them. When asked when she had requested the dentures, Resident #37 stated, "A couple weeks ago."

Review of the clinical record did not evidence documentation regarding the resident's request for dental services.

An interview was conducted on 3/29/18 at 2:30 p.m. with LPN #9. When asked how staff are made aware of a resident's dental issues, LPN #9 stated, "CNAs (certified nursing assistants) are supposed to perform their oral care, if there's any gum issues we report it to the doctor." When asked what staff did if a resident was requesting dentures, LPN #9 stated, "We would get a consult from the NP (nurse practitioner) to get an order for the oral surgeon."

An interview was conducted on 3/30/18 at 9:23

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F 745	Continued From page 272 a.m. with OSM (other staff member) #3, the social worker. When asked how she was made aware that a resident was asking for dental services, OSM #3 stated, "If they themselves tell me or they tell the staff. Also in the care plan meeting. I ask if everything's okay vision and dental wise." When asked what the process was for a Medicaid resident who asked for dentures, OSM #3 stated, "For long term care residents I look at see what Medicaid program they have. I'll look to see what dentist takes that insurance. I would call the dentist and ask how much would they cost, Medicaid residents could get a MAP adjustment." When asked why a Medicaid resident would be told the cost of the dentures would be out of pocket if funds were available through Medicaid, OSM #3 stated, "Um. It would have to be thought through to get a map adjustment." When asked if any resident had recently asked for dentures, OSM #3 stated, "No." When informed about Resident #37's request, OSM #3 stated, "She did recently ask me if I could find out. I did check her insurance and it was not covered." When asked about the map adjustment, OSM #3 stated, "That's my mistake I wasn't thinking that far out that it could be done for her." When asked if she told the resident she would have to pay for her dentures, OSM #3 stated, "I did, sorry." On 3/30/18 at approximately 2:30 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.	F 745		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services	F 755		

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F 755	Continued From page 273 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide a medication as ordered by the physician for Resident #236. The facility pharmacy failed to dispense and	F 755	F755 1. Corrective action has been accomplished for the alleged deficient practice in regards to residents #236 calcium citrate. The nurse clarified the order and medication was ordered and received from pharmacy per NP's order. 2. Current facility residents have the potential to be affected by the alleged deficient practice. The Unit Managers or designee will complete a 100% audit of new medication orders starting on 3/19/18 til 4/15/18, then 10 residents per week x 4 weeks, then 15 residents x 2 months. Results will be submitted to QAPI quarterly to ensure compliance. 3. Measures put into place to assure alleged deficient practice does not recur include: Reeducation will be given to nurses regarding clarifying orders before administering medication checking the 5 rights of medication administration per policy. 4. The Director of Nursing and/or designee will analyze/review for patterns/trends and report in the Quality Assurance committee meeting quarterly for a minimum of six months to evaluate the effectiveness of the plan and will adjust the plan as the committee may recommend, based on outcomes/trends identified from date. 5. Completion Date: May 11, 2018	

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provide the medication Calcium Citrate, as ordered by the physician, for Resident #236.

The findings include:

Resident #236 was admitted to the facility on 3/19/18 with diagnoses that included but were not limited to: diabetes, cancer of the colon, high blood pressure, low back pain, heart attack, specified disorders of bone density and structure, and heart failure.
was oriented to person and place, not to time and situation.
There was not completed MDS (minimum data set) assessment completed at the time of survey.

The "Nursing Admission Assessment" dated 3/19/18, documented the resident

The medication administration observation was conducted on 3/28/18 at 8:27 a.m. with LPN (licensed practical nurse) #4. LPN #4 prepared Resident #236's medications. LPN #4 pulled a medication card with Calcitrate (calcium citrate with Vitamin D) 315/250 tablet. LPN #4 stated, "I can't give that, it doesn't match what the order says. I won't give it until I've checked the orders." LPN #4 proceeded to administer all other medications except the Calcitrate.

The physician order dated, 3/19/18, documented, "Calcium citrate + (plus) Tablet 315 - 200 MG (milligram); Give 1 tablet by mouth in the morning for supplement." (Calcium Citrate is the citrate salt of calcium. An element necessary for normal nerve, muscle, and cardiac function, calcium as the citrate salt helps to maintain calcium balance and prevent bone loss when taken orally). (1)

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An interview was conducted with other staff member (OSM) #7, the pharmacist; on 3/28/18 at 2:45 p.m., OSM #7 was asked to review Resident #236's order for Calcitrate. Once reviewed, OSM #7 was asked if there is a discrepancy in what the order says and what is dispensed by the pharmacy, OSM #7 stated, "Yes the pharmacy should have clarified that order. There should have been communication between the pharmacy and the facility."

An interview was conducted with LPN #4 on 3/28/18 at 2:50 p.m. When asked what happens when she finds a discrepancy between the doctor's order and what the pharmacy sent, LPN #4 stated, "First, I don't give the medication. I tell the nurse practitioner. I see when it was started and how many times it was given. I call the pharmacy and tell them the order says one thing and they sent something else. I called the pharmacy today and they told me they didn't carry that strength, they only carry the 315/250 strength of the medication. I asked if they had called the facility to get the order changed to the 315/250 mg strength, and the pharmacist told me there were no records regarding this indicating the pharmacy had spoken to the facility. I then went back to the nurse practitioner and she changed the order to match what we had in the medication drawer."

An interview was conducted with OSM #8, the pharmacist at the pharmacy on 3/27/18 at 4:34 p.m. When asked about the process followed if there is an order that doesn't match what you have in stock, OSM #8 stated, "We should call the facility and tell them that what the doctor ordered is not in our stock and this is the dose we carry." When asked what happened with

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F 755	Continued From page 276 Resident #236's Calcitrate, OSM #8 stated, "I don't see a note on her profile that we called the facility." The facility policy, "Medication Administration" documented in part, "Procedure: The facility will follow (Name of Pharmacy)'s policy for medication administration." The attached policies from the pharmacy did not address providing the medications as prescribed by the physician. The administrator, ASM (administrative staff member) #1, director of nursing, ASM #2, and ASM #7, owner of the facility were made aware of the above findings on 3/29/18 at 6:10 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://pubchem.ncbi.nlm.nih.gov/compound/Calcium_citrate#section=Pharmacology-and-Biochemistry	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.	F 756	F756 1. Corrective action has been accomplished for the alleged deficient practice in regards to resident # 83. Resident #83 was scheduled Synthroid at 0730 and iron at 0900, less than 4 hours apart. The pharmacy and NP was notified of irregularity and the Synthroid was rescheduled to be 4 hours apart. 2. Current facility residents have the potential to be affected by the alleged deficient practice. The Quality Assurance Nurse or designee will audit 10 residents medication orders a week x 4 weeks, then 20 residents a month for 2 months to assure compliance. Any irregularities will be clarified with the NP/MD and pharmacy.	

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F 756	Continued From page 277 (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, 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 observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure the medication regimen was free of medication irregularities, for one of 31 residents in the survey sample; Resident #83. The facility staff, failed to recognize and report a medication irregularity for Resident #83, to the physician.	F 756	3. Measures put into place to assure alleged deficient practice does not recur include: Nurses will be reeducated to notify NP/MD and pharmacy with all medication irregularities for clarification. 4. The Director of Nursing and/or designee will analyze/review for patterns/trends and report in the Quality Assurance committee meeting quarterly for a minimum of six months to evaluate the effectiveness of the plan and will adjust the plan as the committee may recommend, based on outcomes/trends identified from date. 5. Completion Date: May 11, 2018	

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The findings include:

Resident #83 was admitted to the facility on 4/11/17 with the diagnoses of but not limited to acute kidney failure, aspiration pneumonia, respiratory failure with hypoxia, dysphagia, chronic obstructive pulmonary disease, depression, shortness of breath, heart failure, hypothyroidism, hyperparathyroidism, insomnia, diabetes, dementia, anxiety disorder, restless leg syndrome, sleep apnea, high blood pressure, peripheral vascular disease, spinal stenosis, osteoporosis, chronic kidney disease, and benign prostatic hyperplasia. The resident was coded as cognitively intact in ability to make daily life decisions. The resident required total care for bathing; extensive care for transfers, dressing, toileting, and hygiene; independent for eating; and was incontinent of bowel and bladder.

On 3/28/18 at 8:33 a.m., LPN #2 (Licensed Practical Nurse) was observed preparing and administering the following medications to Resident #83:

Synthroid [1] 25 mcg (micrograms) (scheduled for 7:30a.m.)
Allopurinol [2] 100 mg (milligrams)
Breo [3] 200-25 mcg
Iron [4] 325 mg
Neurontin [5] 300 mg
Hydralazine [6] 50 mg
Metoprolol [7] 100 mg
Miralax [8] 17 gm (grams) (resident refused)
Zoloft [9] 100 mg
Spiriva [10] 18 mcg
Colace [11] 100 mg (resident refused)

On 3/28/18 at 8:58 a.m., LPN #2 took the above

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medications to Resident #83 and administered them, including administering the Synthroid and Iron together. The Synthroid was administered an hour and a half later than the scheduled time, after the resident had eaten breakfast and did not have an empty stomach; and was not administered at least 4 hours apart from the iron.

A review of the clinical record revealed the March 2017 Physician's Order Sheet. This document indicated the Synthroid was ordered on 1/31/18 and the Iron was ordered on 11/30/17. A review of the March 2017 Medication Administration Record revealed the Synthroid was scheduled for 7:30a.m. and the Iron was scheduled for 9:00a.m.. Further review of the clinical record revealed the monthly pharmacy review of the resident's medication regimen, for February 2017. The pharmacist did not record this as a medication irregularity.

On 3/29/18 at 9:24 a.m., LPN #2 was asked if nurses should have identified the iron and synthroid are being administered too close together. LPN #2 stated that they should have. When asked why the Synthroid was not administered at the scheduled time of 7:30 a.m., and was given an hour and a half late, LPN #2 stated there was no reason.

On 3/29/18 at 9:50a.m. in an interview with OSM #7 (Other Staff Member, a pharmacist), he stated that a lot of meds interfere with the absorption of Synthroid. OSM #7 stated it (Synthroid) should be separated by 4 hours from iron, and taken on an empty stomach. OSM #7 stated he should have identified this irregularity. When informed information regarding this medication's

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prescribing and administration recommendations were obtained from the website Synthroid.com, he stated the information on that website would be the FDA approved information for this medication.

*According to Synthroid.com,
- "Use SYNTHROID only as ordered by your doctor. Take SYNTHROID as a single dose, preferably on an empty stomach, one-half to one hour before breakfast.
Products such as iron and calcium supplements and antacids can lower your body's ability to absorb levothyroxine, so SYNTHROID should be taken 4 hours before or after taking these products."

On 3/29/18 at 1:40p.m., ASM #5 (Administrative Staff Member, a Nurse Practitioner) stated that Synthroid should be given a half-hour to an hour before a resident eats breakfast; and that "It should be given so many hours before or after iron. I don't remember why."

A review of the facility policy, "Medication Regimen Review" documented, "Medication Regimen Review (MRR) is a thorough evaluation of the medication regimen by a pharmacist, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication. The review includes preventing, identifying, reporting, and resolving medication-related problems, medication errors, or other irregularities in collaboration with other members of the interdisciplinary team."

On 3/29/18 at 6:05 p.m., at the end of day meeting, the Administrator (ASM) #1, Director of Nursing (ASM #2), and the facility owner (ASM

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#7) were made aware of the findings. No further information was provided by the end of the survey.

[1] Synthroid is used to treat thyroid deficiency.
Information obtained from
https://medlineplus.gov/druginfo/meds/a682461.html

[2] Allopurinol is used to treat gout.
Information obtained from
https://medlineplus.gov/druginfo/meds/a682673.html

[3] Breo is used to treat chronic obstructive pulmonary disease.
Information obtained from
https://medlineplus.gov/druginfo/meds/a613037.html

[4] Iron is used to treat iron deficiency.
Information obtained from
https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=iron&_ga=2.341338695.955481667.1522702603-191684010.1510852799

[5] Neurontin is used to treat seizures, postherpetic neuralgia, and restless leg syndrome.
Information obtained from
https://medlineplus.gov/druginfo/meds/a694007.html

[6] Hydralazine is used to treat high blood pressure.
Information obtained from

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F 756	Continued From page 282 https://medlineplus.gov/druginfo/meds/a682246.html [7] Metoprolol is used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a682864.html [8] Miralax is used to treat constipation. Information obtained from https://medlineplus.gov/druginfo/meds/a603032.html [9] Zoloft is used to treat depression. Information obtained from https://medlineplus.gov/druginfo/meds/a697048.html [10] Spiriva is used to treat chronic obstructive pulmonary disease. Information obtained from https://medlineplus.gov/druginfo/meds/a604018.html [11] Colace is used to treat constipation. Information obtained from https://medlineplus.gov/druginfo/meds/a601113.html	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F 758	F758 1. Corrective action has been accomplished for the alleged deficient practice in regards to resident #97, 235, and 99. Resident #97 had an appropriate diagnosis added for Seroquel, Resident # 235 had an appropriate diagnosis of anxiety for Xanax, and resident #99 nurse was reeducated to document non-pharmacological interventions attempted before medicating with prn anti-anxiety medication.	

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F 758	Continued From page 283 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or	F 758	2. Current facility residents have the potential to be affected by the alleged deficient practice. Quality Assurance Nurse or designee will complete a 100% audit of psychotropic medications for proper diagnosis and documentation, including non-pharmacological interventions, then 10 residents a week x 4 weeks, then 20 residents a month x 2 months. 3. Measures put into place to assure alleged deficient practice does not recur include: Nurse will be reeducated to add appropriate diagnosis to psychotropic medications and document non-pharmacological interventions attempted before medicating with prn psychotropic medications per policy. 4. The Director of Nursing and/or designee will analyze/review for patterns/trends and report in the Quality Assurance committee meeting quarterly for a minimum of six months to evaluate the effectiveness of the plan and will adjust the plan as the commnittee may recommend, based on outcomes/trends identified frorn date. 5. Completion Date: May 11, 2018	

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prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to ensure three of 31 sampled residents, (Residents #97, #235 and #99) were free of unnecessary medications.

1. The facility staff failed to ensure there was an appropriate diagnosis for the administration and use Quetiapine Fumarate (Seroquel) an antipsychotic medication, for Resident #97.

2. The facility staff failed to ensure there was an appropriate diagnosis for the use of Xanax an anti-anxiety medication, for Resident #235.

3. The facility staff failed to ensure there were targeted behaviors documented and non-pharmacological interventions were attempted for the use of an anti-anxiety medication for Resident #99.

The findings include:

1. The facility staff failed to ensure there was an appropriate diagnosis for the administration and use Quetiapine Fumarate (Seroquel) an antipsychotic medication, for Resident #97.

Resident # 97 was admitted to the facility on 11/19/17, with a most recent readmission on 3/15/18 with diagnoses that included but were not limited to: bladder infections, hypotension (too low blood pressure), malnutrition, depression, difficulty sleeping, asthma, and has a colostomy.

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The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 2/27/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating she was capable of making her daily decisions. In Section N - Medications, the resident was coded as receiving seven days of an antipsychotic medication during the look back period.

The physician order dated, 3/15/18, documented, "Quetiapine Fumarate * Tablet 100 mg (milligrams); give 1 tablet by mouth at bedtime related to other specified anxiety disorders."

*Quetiapine Fumarate (Seroquel) is an antipsychotic medication used to treat schizophrenia and bipolar disorders. (1)

Review of the comprehensive care plan dated, 3/15/18, failed to evidence a care plan to address the use of an antipsychotic medication for Resident #97.

An interview was conducted with administrative staff member (ASM) #5, the nurse practitioner on 3/29/18 at approximated 1:20 p.m. When asked why Resident #97 was on Seroquel, ASM #5 stated, "That was prescribed by (name of psychiatrist). He would give the diagnosis for it." When asked if Seroquel is administered for anxiety, ASM #5 stated, "I would not use that here in this setting. I defer to psych (psychiatry). ASM #5 verified the order was written under her name. ASM #5 stated, "They put them under my name as I am the full time nurse practitioner." When asked if that makes her responsible for those orders, ASM #5 stated, "It means I agree with those orders."

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An interview was conducted with LPN #11, the QA (quality assurance) nurse, on 3/29/18 at 1:53 p.m. When asked if the psychiatrist sees Resident #97, LPN #11 stated, "He does not see her. She came from the hospital with that order."

An interview was conducted with ASM #2, the director of nursing, on 3/29/18 at 3:52 p.m., regarding what Seroquel is. ASM #2 stated, "It's an antipsychotic medication prescribed for schizophrenia, Tourette's and a few others psychotic diagnoses." ASM #2 was asked to read the physician order for Resident # 97's Seroquel. When asked if the order is acceptable, ASM #2 stated, "No, it's not. I went through her medical record and I can't find out why she is on it. I can't find an acceptable diagnosis."

The facility policy, "Psychotropic Drug Policy" documented, "Policy: All resident drug regimen will be free of unnecessary psychotropic drugs. Procedure: 1. All psychotropic drugs will have an appropriate diagnosis. 2. Medications will be reviewed by pharmacy monthly and concerns addressed with the physician. 3. The resident on psychotropic medication will be followed by a psychiatrist or physician.

The administrator, ASM #1, director of nursing, ASM #2 and owner of the facility, ASM #7, were made aware of the above findings on 3/29/18 at 6:10 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cf

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2. The facility staff failed to ensure there was an appropriate diagnosis for the use of Xanax an anti-anxiety medication, for Resident #235.

Resident #235 was admitted to the facility on 3/22/18 with diagnoses that included but were not limited to: fracture of her leg, Parkinson's disease (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling, and muscle weakness) (1), falls, and chronic obstructive pulmonary disease (COPD) (COPD - a general term for chronic, non-reversible lung disease that is usually a combination of emphysema and chronic bronchitis). (2)

There was no completed MDS (minimum data set) assessment completed at the time of survey.

The "Nursing Admission Assessment" dated, 3/22/18 documented the resident was alert and oriented to time, place and person.

The physician order dated, 3/22/18, documented, "Xanax* Tablet 0.25 MG (milligrams); Give 1 tablet by mouth every 24 hours as needed for insomnia take one tab (tablet) at night as needed for sleep." There was no stop date ordered.

*Xanax is used to treat symptoms of anxiety, including anxiety caused by depression. It is also used to treat panic attacks in some patients." (3)

The medication administration record for March 2018 documented, "Xanax Tablet 0.25 MG; Give

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1 tablet by mouth every 24 hours as needed for insomnia take one tab at night as needed for sleep." The medication had not been administered since admission to the facility.

Review of the care plan dated, 3/22/18, failed to evidence documentation related to insomnia or the use of an anti-anxiety medication.

An interview was conducted with LPN (licensed practical nurse) #10, on 3/29/18 at 8:44 a.m. When asked what Xanax is used for, LPN #10 stated, "For anxiety." When asked if Xanax can be prescribed for sleep, LPN #10 stated, "I don't believe so." When asked how long a prescribed PRN (as needed) anti-anxiety medication can be used, LPN #10 stated, he would need to check. At 9:08 a.m. LPN #10 stated, "A PRN anti-anxiety medication should be re-evaluated every 14 days." When asked if it should have a stop date, LPN #10 stated, "Yes."

An interview was conducted with administrative staff member (ASM) #5, the nurse practitioner, on 3/29/18 at 9:03 a.m. When asked what Xanax is used for, ASM #5 stated, "Mostly anxiety." When asked if it can be prescribed for sleep, ASM #5 stated, "I don't usually prescribe that if the resident is having problems, then I refer to psych (psychiatry)." When asked how long a PRN anti-anxiety medication can be prescribed for, ASM #5 stated, "The new regulations are for it to be prescribed for 14 days and then reevaluated."

The administrator, director of nursing and owner of the facility were made aware of the above findings on 3/29/18 at 6:10 p.m.

No further information was provided prior to exit.

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(1) Barron's Dictionary for Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437.
(2) Barron's Dictionary for Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.
(3) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008896/?report=details.
3. The facility staff failed to ensure there were targeted behaviors documented and non-pharmacological interventions were attempted for the use of Lorazepam an anti-anxiety medication, for Resident #99.

Resident #99 was admitted to the facility on 6/9/17 and readmitted on 2/26/18 with diagnoses that included but were not limited to: heart failure, pneumonia, anemia, depression and cognitive communication deficit.

The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 3/5/18 coded the resident as 99 on the BIMS (breif interview for mental status) indicating the resident was not able to complete the exam. The resident was coded as understanding others and being understood and having intact short and long-term memory. The resident was coded as requiring assistance for all activities of daily living.

Review of the resident's care plan initiated on 3/19/18 documented "Focus. The resident uses anti-anxiety medications r/t (related to) Anxiety disorder. Interventions. Monitor/record occurrence of for (sic) target behavior symptoms

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	495142	A. BUILOING _____ B. WING _____	C 03/30/2018

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EVERGREEN HEALTH AND REHAB	380 MILLWOOD AVENUE WINCHESTER, VA 22601

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETION DATE
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and document per facility protocol."

Review of the March 2018 physician's orders documented, "LORazepam (1) Tablet 0.5 MG (milligrams) Give 1 tablet by mouth every four hours as need for anxiety."

Review of the March 2018 medication administration record (MAR) documented, "LORazepam Tablet 0.5 MG (milligrams) Give 1 tablet by mouth every four hours as need for anxiety." It was documented that the resident received the medication eleven times in March 2018.

Review of the MAR did not evidence documentation regarding the resident's behaviors of agitation.

Review of the nurse's notes did not evidence documentation as to the resident's targeted behaviors or why the lorazepam was given except on one occasion.

An interview was conducted on 3/29/18 at 2:32 p.m. with LPN (licensed practical nurse) #9. When asked about the process staff follows prior to giving an anti-anxiety medication, LPN #9 stated, "You would go in and assess his anxiety." LPN #9 stated, "Try to distract them. Verbalize with him, change the TV show, put on music." When asked if that would be documented, LPN #9 stated, "Yes there should be some non-pharmacological items that are written." When asked where that would be written, LPN #9 stated, "In the nurses' notes." When asked about Resident #99's targeted behaviors, LPN #9 stated, "He's very obvious, he gets hallucinations or increased confusion." When asked to review

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F 758	Continued From page 291 the resident's notes for the lorazepam administration, LPN #9 stated, "That's not written as it should be." On 3/29/18 at 6:00 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #7, the facility owner were made aware of the findings. No further information was provided prior to exit. 1. Lorazepam -- Lorazepam is an orally available benzodiazepine used widely in the therapy of anxiety and insomnia. As with most benzodiazepines, lorazepam therapy has not been associated with serum aminotransferase or alkaline phosphatase elevations, and clinically apparent liver injury from lorazepam has not been reported and must be very rare, if it occurs at all. This information was obtained from: https://livertox.nih.gov/Lorazepam.htm	F 758		
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	F 761	F761 1. Corrective action has been accomplished for the alleged deficient practice in regards to unlabeled open bottle of Levemir insulin on wing three cart, unlabeled bottle of lorazepam in wing three medication refrigerator, and an unlabeled bottle of lorazepam intensol in the medication refrigerator on the journey unit. The bottles had been opened and an open date was not recorded on the bottle, the bottles of medication were destroyed and reordered and labeled with an open date per policy.	

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F 761	Continued From page 292 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 facility document review, it was determined that the facility staff failed to label and store medications in a safe manner in one of seven medication carts (a medication cart on wing three) and two of four unit medication refrigerators (wing three unit and journey unit). 1. The facility staff failed to label an open date on a vial of opened levemir insulin in a medication cart on wing three. 2. The facility staff failed to label an open date on a bottle of opened lorazepam intensol in the wing three medication refrigerator. 3. The facility staff failed to label an open date on a bottle of opened lorazepam intensol in the medication refrigerator on the journey unit. The findings include: 1. The facility staff failed to label an open date on a vial of opened levemir insulin (1) in a medication cart on wing three.	F 761	2. Current facility residents have the potential to be affected by the alleged deficient practice. A 100% audit of the facilities medication carts and medication refrigerators were audited by the Unit Managers for expired and unlabeled medications. The Unit Managers or designee will audit med carts and med refrigerators daily x 4 weeks then weekly x 2 months to assure compliance. 3. Measures put into place to assure alleged deficient practice does not recur include: Nurses were reeducated to date medication bottles when opened per policy. 4. The Director of Nursing and/or designee will analyze/review for patterns/trends and report in the Quality Assurance committee meeting quarterly for a minimum of six months to evaluate the effectiveness of the plan and will adjust the plan as the committee may recommend, based on outcomes/trends identified from date. 5. Completion Date: May 11, 2018	

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On 3/28/18 at 10:50 a.m., observation of a medication cart on wing three was conducted with LPN (licensed practical nurse) #2. An open vial of levemir insulin was observed in the medication cart. The vial was not labeled with an open date. LPN #2 was asked what should be done when a vial of levemir is opened. LPN #2 stated, "Write an open date on it." When asked why, LPN #2 stated, "So we know when it expires." LPN #2 confirmed no open date was labeled on the vial of levemir.

The levemir manufacturer's instructions documented, 'Refrigerated LEVEMIR vials should be discarded 42 days after initial use. Unrefrigerated LEVEMIR vials should be discarded 42 days after they are first kept out of the refrigerator..."

The facility pharmacy policy titled, "Storage and Expiration of Medications, Biologicals, Syringes and Needles" documented, "5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened."

On 3/29/18 at 5:48 pm., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern

No further information was presented prior to exit.

(1) Levemir insulin is used to treat diabetes. This information was obtained from the website:

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https://medlineplus.gov/druginfo/meds/a606012.html

2. The facility staff failed to label an open date on a bottle of opened lorazepam intensol (1) in the wing three medication refrigerator.

On 3/28/18 at approximately 10:50 a.m., observation of the wing three medication refrigerator was conducted with LPN (licensed practical nurse) #2. An open bottle of lorazepam intensol was observed in the refrigerator. The bottle was not labeled with an open date. LPN #2 was asked if staff should have labeled the bottle with an open date. LPN #2 stated, "They should have." When asked why, LPN #2 stated, "Cause it's only good for a certain amount of time after opened."

The lorazepam intensol manufacturer's instructions documented, "Discard opened bottle after 90 days."

The facility pharmacy policy titled, "Storage and Expiration of Medications, Biologicals, Syringes and Needles" documented, "5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened."

On 3/29/18 at 5:48 pm., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern

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No further information was presented prior to exit.

(1) Lorazepam intensol is used to relieve anxiety. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682053.html

3. The facility staff failed to label an open date on a bottle of opened lorazepam intensol (1) in the medication refrigerator on the journey unit.

On 3/28/18 at 10:30 a.m., observation of the journey unit medication refrigerator was conducted with LPN (licensed practical nurse) #1. An opened bottle of lorazepam intensol was observed in the refrigerator. The bottle was not labeled with an open date. LPN #1 confirmed the bottle was open without an open date labeled on the bottle. LPN #1 was asked how long the medication was good for after being opened. LPN #1 stated the manufacturer's expiration date was 6/19/18 and the bottle was only recently opened so she would have to ask the director of nursing if the medication expired a certain amount of time after being opened.

On 10/28/18 at approximately 10:50 a.m., an interview was conducted with LPN #2. LPN #2 was asked if staff should label a bottle of lorazepam intensol with an open date and confirmed they should. When asked why, LPN #2 stated, "Cause it's only good for a certain amount of time after opened."

The lorazepam intensol manufacturer's instructions documented, "Discard opened bottle after 90 days."

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F 761	Continued From page 296 The facility pharmacy policy titled, "Storage and Expiration of Medications, Biologicals, Syringes and Needles" documented, "5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened." On 3/29/18 at 5:48 pm., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern No further information was presented prior to exit. (1) Lorazepam intensol is used to relieve anxiety. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682053.html	F 761		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and	F 791	F791 1. Corrective action has been accomplished for the alleged deficient practice in regards to facility failing to provide dental services for resident #37. A dental exam was scheduled on Friday, March 30, 2018 for resident #37. 2. Current facility residents have the potential to be affected by the alleged deficient practice. An 100% audit will conducted of residents who have requested dental services or been referred to Social Service by staff since February 1, 2018 until March 31, 2018 assuring each instance has been addressed, then 25% of referrals x 3 months.	

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F 791	Continued From page 297 (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, it was determined the facility staff failed to provide dental services for one of 31 residents in the survey sample, Resident # 37. The facility staff failed to provide dental services as requested by Resident #37.	F 791	3. Measures put into place to assure alleged deficient practice does not recur include: Social Workers will be reeducated to follow facility policy and procedure for dental services. 4. The Director of Nursing and/or designee will analyze/review for patterns/trends and report in the Quality Assurance committee meeting quarterly for a minimum of six months to evaluate the effectiveness of the plan and will adjust the plan as the committee may recommend, based on outcomes/trends identified from date. 5. Completion Date: May 11, 2018	

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The findings include:

Resident #37 was admitted to the facility on 1/17/17 and readmitted on 12/11/17 with diagnoses that included but were not limited to: heart failure, shortness of breath, diabetes, stroke and kidney disease.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 1/22/18 coded the resident as having scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living except for eating which the resident could perform after the tray was prepared. In section L -- Oral/Dental status documented the resident was coded as having no dental issues.

An interview was conducted on 3/27/18 at 3:23 p.m. with Resident #37. During the interview, the resident stated that she had asked for dentures because she has many missing teeth and her gums hurt sometimes when she eats, but was told it would be out of pocket and she couldn't afford them. When asked when she had requested the dentures, Resident #37 stated, "A couple weeks ago."

Review of the clinical record did not evidence documentation regarding the resident's request for dental services.

An interview was conducted on 3/29/18 at 2:30 p.m. with LPN (licensed practical nurse) #9.

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When asked how staff are made aware of a resident's dental issues, LPN #9 stated, "CNAs (certified nursing assistants) are supposed to perform their oral care, if there's any gum issues we report it to the doctor." When asked what staff did if a resident was requesting dentures, LPN #9 stated, "We would get a consult from the NP (nurse practitioner) to get an order for the oral surgeon."

An interview was conducted on 3/30/18 at 9:23 a.m. with OSM (other staff member) #3, the social worker. When asked how she was made aware a resident was asking for dental services, OSM #3 stated, "If they themselves tell me or they tell the staff. Also in the care plan meeting. I ask if everything's okay vision and dental wise." When asked what the process was for a Medicaid resident who asked for dentures, OSM #3 stated, "For long term care residents I look at see what Medicaid program they have. I'll look to see what dentist takes that insurance. I would call the dentist and ask how much would they cost, Medicaid residents could get a MAP adjustment." When asked why a Medicaid resident would be told the cost of the dentures would be out of pocket if funds were available through Medicaid, OSM #3 stated, "Um. It would have to be thought through to get a map adjustment." When asked if any resident had recently asked for dentures, OSM #3 stated, "No." When informed of Resident #37's request, OSM #3 stated, "She did recently ask me if I could find out. I did check her insurance and it was not covered." When asked about the map adjustment, OSM #3 stated, "That's my mistake I wasn't thinking that far out that it could be done for her." When asked if she told the resident she would have to pay for her dentures, OSM #3 stated, "I did, sorry."

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F 791	Continued From page 300 An interview was conducted with administrative staff member (ASM) #1, the administrator, on 3/30/18 at 8:52 a.m. When asked if they had a contract with a dentist, ASM #1 stated the facility did not. They do have several local dentist that will see resident, even those on Medicaid. There have been additional services added since the new Medicaid rules. The local department of social services is good about MAP adjustments for dentures. On 3/30/18 at approximately 2:30 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit.	F 791		
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	F 812	F812 1. Corrective action has been accomplished for the alleged deficient practice in regards to facility failing to store, prepare, and serve food in a sanitary manner. The wet nested dishes were immediately cleaned and dried and the storage rack containing steam table pans was cleaned and free from debris. The staff was educated on infection control and proper food serving. 2. Current facility residents have the potential to be affected by the alleged deficient practice. The dietary manager or designee will monitor stainless steel storage racks in the kitchen weekly x 30 days then monthly, to ensure there is no items wet nesting or in need of cleaning. All racks in the kitchen will be power washed on an annual basis. Dining room observations will be done in at least three dining room areas weekly x 4 weeks, then one dining room area weekly x 2 months.	

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F 812	Continued From page 301 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to store, prepare, and serve food in a sanitary manner. 1. The facility staff failed to ensure dishes were not wet nesting; and that a storage rack containing steam table pans was clean and free from debris. 2. The facility staff failed to serve food in a sanitary manner during the 3/27/18 dinner service observation. The facility staff touched the inside rim of the glass where the resident would drink and the rim of a bowl served to residents with her bare hands. 3. The facility staff failed to serve food in a sanitary manner in the journey dining room. The facility staff were observed touching resident plates, and food with their bare hands. The findings include: 1. The facility staff failed to ensure dishes were not wet nesting; and that a storage rack containing steam table pans was clean and free from debris. On 3/27/18 at 2:58 p.m., an inspection of the kitchen was conducted with OSM #1 (Other Staff Member, the dietary manager). During this inspection, the following was observed:	F 812	3. Measures put into place to assure alleged deficient practice does not recur include: Staff will be reeducated on infection control r/t serving food to the residents. Dietary staff will be reeducated on procedures of wet nesting and cleanliness of kitchen with a focus on infection control. 4. The Director of Nursing and/or designee will analyze/review for patterns/trends and report in the Quality Assurance committee meeting quarterly for a minimum of six months to evaluate the effectiveness of the plan and will adjust the plan as the committee may recommend, based on outcomes/trends identified from date. 5. Completion Date: May 11, 2018	

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Two plastic storage tubs containing plastic drinking cups, which were all, stacked within each other, and wet nesting.

A large multi-shelf wire-rack storage cart was with a slightly tacky residue substance on the wire rack surface, and dust sticking to the surface on each shelf. A large assortment of steam table pans were stored on this rack, inverted, so that the rim of the top side that the food goes in, was touching the surface of the dusty, sticky rack shelves.

On 3/27/18 at approximately 3:15 p.m., OSM #1 stated that these items should not be stored this way. She stated the glasses should be dry before stacking. OSM #1 stated the wire rack is only cleaned annually.

A review of the facility policy, "Food Storage" documented, "a. Dry Storage Practice: 3. Keep shelving and floor clean and dry at all times." There was nothing in the policy regarding the storage of wet dishes.

On 3/30/18 at 10:50AM, the Administrator was made aware of the findings. No further information was provided by the end of the survey.

According to the Federal Food and Drug regulations:

4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils.
(A) Equipment food-contact surfaces and utensils shall be clean to sight and touch.
(B) The food-contact surfaces of cooking equipment and pans shall be kept free of

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encrusted grease deposits and other soil accumulations.
(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.

4-901.11 Equipment and Utensils, Air-Drying Required.
Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms to equipment or utensils.
2. The facility staff failed to serve food in a sanitary manner during the 3/27/18 dinner service observation.

A dining observation was conducted on 3/27/18 at 5:20 p.m. CNA (certified nursing assistant) #5 was observed stirring sugar into a cup of tea with her bare hands while holding the rim of the glass where the resident would drink from. CNA #5 then left the dining room without washing her hands and returned with paper covered straws that she put into her pocket and then sanitized her hands. CNA #5 then took the lid off a bowl of soup, put her bare thumb inside the rim of the bowl, and served it to a resident.

An interview was conducted on 3/29/18 at 3:45 p.m. with CNA #5. When asked when staff washed their hands, CNA #5 stated after any contact with a resident. When the dining observations were shared, CNA #5 stated, "Oh, I shouldn't have done that."

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On 3/29/18 at 6:00 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #7, the facility owner were made aware of the findings.

Review of the facility's policy titled, "Hand Washing" did not address food service.

No further information was provided prior to exit.
3. The facility staff failed to serve food in a sanitary manner in the journey dining room. The facility staff were observed touching resident plates, and food with their bare hands.

On 3/27/17 at 5:30 p.m., observation of the dining experience was conducted. At 5:30 p.m., CNA (certified nursing assistant) #6 was observed grabbing the top (rim) of glasses with her bare hands and giving them to residents. At 5:31 p.m., CNA #6 was observed guiding a resident to her chair by holding her arm. CNA #6 then grabbed (using the same hand) the rim of a glass and served it to a different resident. CNA #6 did not sanitize her hands in between guiding the resident to her chair and grabbing the rim of a glass. At 5:33 p.m., CNA #6 was observed holding a plate so close to her body; it was touching her scrub top. CNA #6 then served this plate to a resident. At 5:38 p.m., CNA #6 was observed for a second time holding a plate so close to her body; it was touching her scrub top. CNA #6 then served this plate to a resident. At 5:41 p.m., CNA #6 was observed on two occasions using her bare hands to remove a bread roll off a piece of chicken so she could cut the chicken. At 5:42 p.m., CNA #6 was observed opening a butter wrapper with her bare hands. Her bare fingers touched the edge of the butter square. CNA #6 then mixed the entire butter

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F 812	Continued From page 305 square into a puree dish and served this to a resident. CNA #6 did not sanitize her hands during the entire dining observation. On 3/29/18 at 4:54 p.m., an interview was conducted with CNA #6. When asked how she would serve food to residents in a sanitary manner, CNA #6 stated that she would not touch the food as much as possible. When asked if she had touched the food during dinner on 3/27/18, CNA #6 stated that she might have touched something. When asked why the staff should not be touching food with their bare hands, CNA #6 stated that hands could transfer germs. CNA #6 stated she also did not wash her hands in between serving residents. When asked how she should hold a plate, CNA #6 stated she should hold the plate away from her body. When asked why a plate should not be touching a scrub top, CNA #6 stated, "For the same reason." CNA #6 stated germs from the scrub top could be transferred to to the plate. CNA #6 stated there could be bodily fluids on their scrub tops since they stand close to residents while changing and turning them. CNA #6 confirmed she might have been holding the plate too close to her scrub top. On 3/29/18 at 5:47 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) and ASM #7, the facility owner were made aware of the above concerns. A policy could not be provided regarding the above concerns.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F 842		

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F 842	Continued From page 306 (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is 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.	F 842	F842 1. Corrective action has been accomplished for the alleged deficient practice in regards to a paper containing the resident's names and information for wing 2 was found on a dresser in resident #234 room. The paper was removed and the CNA was educated on HIPAA and the importance of protecting health information. For resident #130, the resident did not have complete documentation of resident's refusal of oxygen therapy. Documentation was added to the resident's record to reflect the refusal of oxygen and a care plan was developed for resident's refusal also. 2. Current facility residents have the potential to be affected by the alleged deficient practice. An audit of daily rounds will be made by the unit manager or designee of the units x 4 weeks, then biweekly x 4 weeks, then weekly x 4 weeks, to assure no health information is unattended in a resident area, assuring HIPAA compliance. An audit of 20 resident's records will be audited for resident refusals x 4 weeks, then 20 residents x 2 months. Care plans will be updated as needed. 3. Measures put into place to assure alleged deficient practice does not recur include: Nurses and CNAs will be reeducated on HIPAA and the importance of confidentiality and nurses will be reeducated on documentation of resident refusals. 4. The Director of Nursing and/or designee will analyze/review for patterns/trends and report in the Quality Assurance committee meeting quarterly for a minimum of six months to evaluate the effectiveness of the plan and will adjust the plan as the committee may recommend, based on outcomes/trends identified from date. 5. Completion Date: May 11, 2018	

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

§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, facility document review and clinical record review, it was determined the facility staff failed to maintain confidentiality of resident information; and failed to maintained an accurate clinical record for two of 31 residents in the survey sample, Resident #234 and #130.

1. A paper, containing all the resident names on the unit and some of the vital signs recorded, was found on the dresser in Resident #234's room.

2. The facility staff failed to document Resident

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#130's refusal of oxygen.

The findings include:

1. A paper, containing all the resident names on the unit and some of the vital signs recorded, was found on the dresser in Resident #234's room.

Resident #234 was admitted to the facility on 3/13/18 with diagnoses that included but were not limited to: fracture of her left femur, pain and chronic obstructive pulmonary disease (COPD) (COPD - a general term for chronic, non-reversible lung disease that is usually a combination of emphysema and chronic bronchitis). (1).

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 3/20/18, coded the resident as scoring a 14 on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions.

On 3/28/18 at 8:15 a.m. a piece of paper containing, a list of all residents on Resident #234's unit was found sitting, face up, on the dresser in Resident #234's room. The paper contained names, vital sign, if the resident was on oxygen, if the resident was on intake and output and what kind of lifts or wheelchairs the residents required. The dresser was located against the wall at the foot of the bed, placed between both beds. Resident #234's daughter was sitting in the chair in the corner. She would have passed the paper to get to her mother's side of the room. The paper remained on the dresser from 8:15 a.m. until 9:40 a.m.

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On 3/28/18 at 9:40 a.m., this surveyor accompanied LPN (licensed practical nurse) #4 into Resident #234's room. When asked if the paper should be in the room, LPN #4 stated, "No, it shouldn't be here."

The facility policy, "Electronic Medical Record Storage" documented in part, "It is the policy of this facility to maintain the privacy and security of confidential personal information and other highly sensitive data it collects in electronic format, when applicable."

The administrator, administrative staff member (ASM) #1, director of nursing, ASM #2, and owner of the facility, ASM #7, were made aware of the above findings on 3/29/18 at 6:10 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary for Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.
2. The facility staff failed to document Resident #130's refusal of oxygen.

Resident #130 was admitted to the facility on 1/11/18 and readmitted on 2/2/18. Resident #130's diagnoses included but were not limited to pneumonia, diabetes and urinary tract infection. Resident #130's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/9/18, coded the resident as cognitively intact.

Review of Resident #130's clinical record revealed a physician's order dated 2/2/18 that documented, "O2 (Oxygen) @ (at) 2L (Liters) via

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n/c (nasal cannula) may titrate as needed."

On 3/29/18 at 7:30 a.m., Resident #130 was observed in a wheelchair in the bedroom. The resident was not receiving oxygen.

On 3/29/18 at 8:57 a.m., Resident #130 was observed in a wheelchair in the dining room. The resident was not receiving oxygen.

On 3/29/18 at 1:15 p.m., an interview was conducted with ASM (administrative staff member) #5 (the nurse practitioner), regarding Resident #130's oxygen therapy. ASM #5 stated Resident #130 refuses oxygen when she is up during the day.

On 3/29/18 at 2:17 p.m., an interview was conducted with LPN (licensed practical nurse) #6, regarding Resident #130's oxygen therapy. LPN #6 stated Resident #130 does not like to use oxygen when she goes off the unit and the resident uses the oxygen at night. When asked if Resident #130's refusal of oxygen should be documented, LPN #6 stated the refusal should be documented in nurses' notes.

Review of Resident #130's January 2018, February 2018 and March 2018 nurses' notes failed to reveal documentation of Resident #130's refusal of oxygen.

Review of Resident #130's comprehensive care plan initiated on 1/11/18 failed to reveal documentation regarding Resident #130's refusal of oxygen.

On 3/29/18 at 5:48 p.m., ASM #1 (the administrator) and ASM #2 (the director of

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F 842	Continued From page 311 nursing) were made aware of the above concern. On 3/30/18 at 12:30 p.m., ASM #2 stated the facility did not have a policy regarding documentation in the clinical record. No further information was presented prior to exit.	F 842		
F 880 SS=F	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 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	F 880	F880 1. Corrective action has been accomplished for the alleged deficient practice in regards to Legionella water testing, the facility has put into place a policy and procedure for testing water for Legionella. Resident #132's catheter bag was touching the floor, the nurse readjusted the bag and tubing to keep the bag off the floor. The O2 tubing for #235 was contaminated when the CNA place the cannula and tubing on the bed, the nurse discarded the tubing and replaced with new tubing per policy. Resident # 47's bathroom was cleaned and sanitized by CNAs and Housekeeping staff. Nurse placed resident's #83 inhaler in her pocket, the nurse removed the inhaler and disinfected it per policy. After administering resident #49's medications the nurse the nurse touched her face and neck without sanitizing her hands and did not sanitize the blood pressure cuff and stethoscope, when this was pointed out the nurse immediately sanitized hands and equipment.	

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F 880	Continued From page 312 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. §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, staff interview, facility document review and clinical record review, it	F 880	2. Current facility residents have the potential to be affected by the alleged deficient practice. 100% audit of residents rooms was completed assuring rooms were clean, then Unit managers will audit 20 rooms per week x 4 weeks, then 50 rooms per month x 2 months to validate rooms are clean per policy. Medication pass related to infection control will be observed by Unit Manager or designee, 5 nurses per week x 4 weeks, then 2 nurses per week x 2 months. A 100% audit of residents with catheters was completed by the unit managers to assure no catheter bag or tubing was touching the floor, Rounds will be made daily by unit manager or designee noting the catheter bag and tubing and report findings daily in morning meeting. 3. Measures put into place to assure alleged deficient practice does not recur include: Nurses and CNAs will be reeducated in infection control and hand washing, to assure compliance. 4. The Director of Nursing and/or designee will analyze/review for patterns/trends and report in the Quality Assurance committee meeting quarterly for a minimum of six months to evaluate the effectiveness of the plan and will adjust the plan as the committee may recommend, based on outcomes/trends identified from date. 5. Completion Date: May 11, 2018	

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was determined that the facility staff failed to maintain a complete infection control program and failed to follow infection control practices for five of 31 residents in the survey sample, Residents #132, #235, #47, #83, and #49.

1. The facility staff failed to develop and implement policies and procedures for water management and the detection and prevention of Legionella.

2. The facility staff failed to ensure Resident #132's indwelling catheter bag was kept off the floor.

3. The facility staff failed to follow infection control practice for the administration of oxygen for Resident #235.

4. The facility staff failed to maintain infection control practices and ensure Resident #47 had a clean bathroom.

5. The facility staff failed to follow infection control practices during medication preparation and administration for Resident #83.

6. The facility staff failed to sanitize her hands after touching her face and neck and failed to sanitize the blood pressure cuff and stethoscope after using it on Resident #49.

The findings include:

1. The facility staff failed to develop and implement policies and procedures for water management and the detection and prevention of Legionella (1).

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On 3/28/18 at 5:00 p.m., an interview was conducted with ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing). ASM #1 stated the facility did not have any policies, procedures, or a program for water management and the detection and prevention of Legionella. ASM #1 stated she had looked at a company that does water testing and was in the process of developing a program. ASM #1 and ASM #2 was made aware this was a concern.

No further information was presented prior to exit.

(1) "Legionnaire disease is an infection of the lungs and airways. It is caused by legionella bacteria.
Causes: The bacteria that cause Legionnaire disease have been found in water delivery systems. They can survive in the warm, moist air conditioning systems of large buildings, including hospitals." This information was obtained from the website:
https://medlineplus.gov/ency/article/000616.htm

2. The facility staff failed to ensure Resident #132's indwelling catheter bag was kept off the floor.

Resident #132 was admitted to the facility on 2/6/18 and readmitted on 3/8/18. Resident #132's diagnoses included but were not limited to acute respiratory failure, stroke and muscle weakness. Resident #132's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 3/15/18, coded the resident's cognition

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as severely impaired. Section G documented Resident #132 as requiring extensive assistance of two or more staff with bed mobility. Section H coded the resident as having an indwelling catheter (1).

Review of Resident #132's clinical record revealed a physician's order dated 3/9/18 for a catheter due to a wound.

Resident #132's care plan initiated on 3/8/18 failed to document information regarding an indwelling catheter.

On 3/29/18 at 7:44 a.m., Resident #132 was observed lying in a low bed. The resident's catheter bag was observed on the floor and on a fall mat lying on the floor.

On 3/29/18 at 3:47 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked where a catheter bag should be place when a resident is lying in bed. LPN #4 stated the catheter bag should be below the resident, should not touch the floor and should be in a privacy bag. At this time, LPN #4 was asked to observed Resident #132's catheter bag. LPN #4 and this surveyor entered Resident #132's room. The resident remained in a low bed and the catheter bag was observed on the floor. LPN #4 stated Resident #132's bed had to remain low. LPN #4 moved Resident #132's catheter bag to the other side of the bed and positioned the bag where it was not touching the floor.

On 3/29/18 at 5:48 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

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The facility document titled, "Indwelling Catheter Care" documented, "PURPOSE: To prevent infection...8. Maintain drainage bag below bladder and cover with dignity bag..."

No further information was presented prior to exit.

(1) "You have an indwelling catheter (tube) in your bladder. 'Indwelling' means inside your body. This catheter drains urine from your bladder into a bag outside your body." This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000140.htm

3. The facility staff failed to follow infection control practice for the administration of oxygen for Resident #235.

Resident #235 was admitted to the facility on 3/22/18 with diagnoses that included but were not limited to: fracture of her leg, Parkinson's disease (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling, and muscle weakness) (1), falls, and chronic obstructive pulmonary disease (COPD) (COPD - a general term for chronic, non-reversible lung disease that is usually a combination of emphysema and chronic bronchitis). (2)

There was no completed MDS (minimum data set) assessment completed at the time of survey.

The "Nursing Admission Assessment" dated, 3/22/18 documented the resident was alert and oriented to time, place and person.

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Resident #235 was observed on 3/27/18 at 2:47 p.m. in bed with her oxygen on via a nasal cannula (a tube with two prongs that insert in the nose).

On 3/28/18 at 7:53 a.m., Resident #235 was observed in the dining room, being assisted to eat by a staff member. No oxygen was in use. Observation was made of the resident's room at this time; the oxygen tubing was lying on the bed on the incontinence pad. The date on the tubing was documented as "3/26/18." At 8:25 a.m., Resident #235 was observed in the nurse's station area in her wheelchair with no oxygen in use. On 3/29/18 at 8:17 a.m., Resident #235 was observed in the dining room being assisted with breakfast. There was no oxygen in use. Observation was made of the resident's room at this time. The nasal cannula and oxygen tubing was observed in the resident's bed sitting on the incontinence pad. The tubing was dated 3/26/18. On 3/29/18 at 8:39 a.m. CNA (certified nursing assistant) #1 took Resident #235 back to her room and applied the oxygen tubing that was on the bed.

The physician order dated, 3/22/18, documented, "O2 (oxygen) @ (at) 2L (liters per minute) via N/C (nasal cannula) may titrate as needed."

The care plan dated, 3/23/18, failed to evidence documentation related to the use of oxygen.

An interview was conducted with CNA #3 on 3/29/18 at 8:50 a.m. When asked where a nasal cannula and oxygen tubing is stored when not in use, CNA #3 stated, "In the patient's set up bag hanging off the concentrator." When asked if a nasal cannula and oxygen tubing that was on the

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bed, on an incontinent pad would be reapplied to a resident, CNA #3 stated, "No."

An interview was conducted with LPN (licensed practical nurse) #2 on 3/29/18 at 9:12 a.m. When asked where a nasal cannula and oxygen tubing should be stored when not in use, LPN #4 stated, "We have a bag on the concentrator. It's labeled with the room number and the resident's name." LPN #4 was informed of the observations of Resident #235's nasal cannula and oxygen tubing being on the incontinence pad on the bed and was informed of the nasal cannula and oxygen tubing being reapplied to Resident #235. LPN #4 stated, "That needs to be changed immediately." LPN #4 proceeded to get new tubing for Resident #235.

The facility policy, "Policy Related to Oxygen and Nebulizer Therapy" did not address the storage of oxygen tubing when not in use.

In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 648. "Box 34-2 Sites for and Causes of Health Care-Associated Infections under Respiratory Tract -- Contaminated respiratory therapy equipment."

The administrator, ASM (administrative staff member) #1, ASM #2, the director of nursing and ASM #7. the owner of the facility were made aware of the above findings on 3/29/18 at 6:10 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary for Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and

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Chapman, page 437.
(2) Barron's Dictionary for Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.
4. The facility staff failed to maintain infection control practices and ensure Resident #47 had a clean bathroom.

Resident #47 was admitted to the facility on 3/23/16 with diagnoses that included but were not limited to anxiety disorder, Alzheimer's disease, unspecified dementia without behavioral disturbance, high blood pressure, muscle weakness, and major depressive disorder. Resident #47's most recent MDS (minimum data set) assessment was annual assessment with an ARD (assessment reference date) of 1/1/18. Resident #47 was coded as being severely cognitively impaired in the ability to make daily decision scoring 03 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #47 was coded as requiring extensive assistance from two or more persons with most ADLS (activities of daily living).

On 3/27/18 at 4:12 p.m., observation of Resident #47's bathroom was conducted. A brown substance resembling feces was observed dried to the bathroom floor.

On 3/28/18 at 7:30 a.m., observation of Resident #47's bathroom was conducted. The brown substance remained on the floor.

On 3/28/18 at 7:42 a.m., an interview was conducted with CNA (certified nursing assistant) #5. When asked how often CNA's round on their residents, CNA #5 stated that she was not sure because she was not technically a CNA. CNA #5

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stated that she passes out water, snacks etc. CNA #5 stated that when CNAs first get onto the unit they should be checking their residents and the rooms. CNA #5 stated that checking the rooms included the bathrooms. CNA #5 stated that she would also check the rooms for cleanliness. When asked if she had been in Resident #47's room yet, CNA #5 stated that she had. When asked if she had checked Resident #47's bathroom, CNA #5 stated that she had not. CNA #5 followed this writer to Resident #47's bathroom. When asked CNA #5 what she saw on the bathroom floor, CNA #5 confirmed there was a brown substance on the floor but could not identify what it was. CNA #5 stated, "She uses a lift to go to the bathroom, so there is no reason why that is on the floor." When asked if she was implying the brown substance was feces, CNA #5 stated, "It better not be."

On 3/28/18 at 7:46 a.m., an interview was conducted with LPN (licensed practical nurse) #1, Resident #47's nurse. When asked when she first starts her rounding in the morning, LPN #1 stated that first she will get report, and then do rounds, looking at residents and rooms. When asked who was responsible for checking the resident's bathrooms for cleanliness, LPN #1 stated, "We are all responsible." LPN #1 followed this writer to Resident #47's bathroom. LPN #1 confirmed that there was a brown substance on the floor. LPN #1 could not identify what the substance was. LPN #1 stated that she had not yet been in Resident #47's room and she was not sure, how often housekeeping rounded on the unit. LPN #1 stated, "It depends."

On 3/30/18 at 8:18 a.m., further interview was conducted with LPN #1. When asked who

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cleaned the brown substance off the floor of Resident #47's bathroom, LPN #1 stated that she did, and then told housekeeping to sanitize behind her. When asked if Resident #47's bathroom was a clean environment, LPN #1 stated, "No I don't consider that a clean environment."

On 3/30/18 at 8:30 a.m., an interview was conducted with OSM (other staff member) #9, the Director of Housekeeping. When asked the housekeeping schedule, OSM #9 stated that her staff will do rounds in the morning until breakfast trays come onto the floor. During breakfast, her staff will clean offices and the lobby. OSM #9 stated that when the trays are off the floor, her staff would go back to cleaning the rooms. What asked what cleaning entailed, OSM #9 stated that her staff would sweep, and mop both the floors, including the bathrooms, dust and collect trash. OSM #9 stated that her staff would make several rounds throughout the day and check the rooms for trash, things on the floor. etc. OSM #9 stated that her staff leave at 3 p.m. When asked if nursing staff will call/alert them if there is feces or anything like that on the bathroom floor, OSM #9 stated that typically nursing staff clean up any bodily fluids and then housekeeping will come behind them and sanitize. OSM #9 stated that they have to be alerted in order for them to know which room to sanitize. OSM #9 stated that she has a floor tech that is present after 3:00 p.m. that can sanitize rooms. OSM #9 stated that her staff were not made aware of the brown substance in Resident #47's bathroom. OSM #9 stated that there was no communication to her department.

On 3/30/18 at 8:55 a.m., an interview was

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conducted with CNA #4. When asked why it was important to ensure bodily fluids were free from the residents' floor, CNA #4 stated that bodily fluids can carry diseases and that staff should try to prevent cross contamination, especially if a resident has a roommate.

On 3/29/18 at 5:47 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) and ASM #7, the facility owner were made aware of the above concerns.

5. The facility staff failed to follow infection control practices during medication preparation and administration for Resident #83.

Resident #83 was admitted to the facility on 4/11/17 with the diagnoses of but not limited to acute kidney failure, aspiration pneumonia, respiratory failure with hypoxia, dysphagia, chronic obstructive pulmonary disease, depression, shortness of breath, heart failure, hypothyroidism, hyperparathyroidism, insomnia, diabetes, and dementia. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting, and hygiene; independent for eating; and as incontinent of bowel and bladder.

On 3/28/18 at 8:33 a.m., LPN #2 (Licensed Practical Nurse) was observed preparing and administering the following medications to Resident #83:

Synthroid [1] 25mcg (micrograms) (scheduled for 7:30AM)
Allopurinol [2] 100 mg (milligrams)

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Breo [3] 200-25 mcg
Iron [4] 325 mg
Neurontin [5] 300 mg
Hydralazine [6] 50 mg
Metoprolol [7] 100 mg
Miralax [8] 17 gm (grams) (resident refused)
Zoloft [9] 100 mg
Spiriva [10] 18 mcg
Colace [11] 100 mg (resident refused)

On 3/28/18 08:55 a.m., after preparing the medications, LPN #2 collected the medication cups (2 cups), the water cup, and both inhalers in her hands. LPN #2 then put the inhalers into her pocket. Locked cart with using her elbow, and took the medications to the resident, whose room was on another hall, far removed from where she had the medication cart positioned.

On 3/28/18 at 9:09 a.m., in an interview with LPN #2, she stated she "probably should not put the inhalers in my pocket." When asked why that would be a concern, LPN #2 stated, "Infection control." LPN #2 stated she should have moved the med cart to his room and that would have prevented all the issues of trying to carry everything.

On 3/29/18 at 6:05 p.m., at the end of day meeting, the Administrator (ASM [administrative staff member] #1), Director of Nursing (ASM #2), and the facility owner (ASM #7), were made aware of the findings. No further information was provided by the end of the survey.

According to Potter and Perry's, Fundamentals of Nursing, 6th edition, page 847, "For safe administration, the nurse uses aseptic technique when handling and giving medications."

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[1] Synthroid is used to treat thyroid deficiency.
Information obtained from
https://medlineplus.gov/druginfo/meds/a682461.html

[2] Allopurinol is used to treat gout.
Information obtained from
https://medlineplus.gov/druginfo/meds/a682673.html

[3] Breo is used to treat chronic obstructive pulmonary disease.
Information obtained from
https://medlineplus.gov/druginfo/meds/a613037.html

[4] Iron is used to treat iron deficiency.
Information obtained from
https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=iron&_ga=2.341338695.955481667.1522702603-191684010.1510852799

[5] Neurontin is used to treat seizures, postherpetic neuralgia, and restless leg syndrome.
Information obtained from
https://medlineplus.gov/druginfo/meds/a694007.html

[6] Hydralazine is used to treat high blood pressure.
Information obtained from
https://medlineplus.gov/druginfo/meds/a682246.html

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[7] Metoprolol is used to treat high blood pressure.
Information obtained from https://medlineplus.gov/druginfo/meds/a682864.html

[8] Miralax is used to treat constipation.
Information obtained from https://medlineplus.gov/druginfo/meds/a603032.html

[9] Zoloft is used to treat depression.
Information obtained from https://medlineplus.gov/druginfo/meds/a697048.html

[10] Spiriva is used to treat chronic obstructive pulmonary disease.
Information obtained from https://medlineplus.gov/druginfo/meds/a604018.html

[11] Colace is used to treat constipation.
Information obtained from https://medlineplus.gov/druginfo/meds/a601113.html

6. The facility staff failed to sanitize her hands after touching her face and neck and failed to sanitize the blood pressure cuff and stethoscope after using it on Resident #49.

Resident #49 was admitted to the facility on 5/10/14 and readmitted on 6/7/17 with diagnoses that included but were not limited to: stroke, depression, diabetes, kidney disease and anemia.

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	495142	A. BUILOING _____ B. WING _____	C 03/30/2018

NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
EVERGREEN HEALTH AND REHAB	380 MILLWOOD AVENUE WINCHESTER, VA 22601

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 326	F 880		

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 2/2/18 coded the resident as having scored 15 out of 15 on the BIMS (brief interview for mental status) exam, indicating the resident was intact cognitively to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.

A medication administration observation was conducted on 3/28/18 at 8:12 a.m. with LPN (licensed practical nurse) #6. LPN #6 wiped her mouth with her left index finger and then rubbed her neck with her right hand. She did not wash her hands. LPN #6 brought Resident #49 via wheelchair down to his room. LPN #6 got the blood pressure cuff and stethoscope out of the medication cart and took them into the resident's room. LPN #6 wiped the stethoscope off with an alcohol wipe, put the blood pressure cuff on the resident's arm and checked the blood pressure. LPN #6 then took the blood pressure cuff off the resident put it under her arm and returned it to the medication cart without sanitizing it.

An interview was conducted on 3/28/18 at 2:40 p.m. with LPN #6. When asked when staff wash their hands, LPN #6 stated, "Sometimes before and definitely after seeing a resident." When asked what staff did if they touched their face or neck, LPN #6 stated, "We can use the hand sanitizer." When asked why staff sanitized their hands, LPN #6 stated, "To keep from spreading any germs from our face." When asked what staff did with medical equipment after using it on a resident and before putting it back into the medication cart, LPN #6 stated, "I usually don't do anything." When asked if the blood pressure cuff

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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F 880	Continued From page 327 and stethoscope were dirty after using them on a resident, LPN #6 stated, "Yes." On 3/29/18 at 6:00 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #7, the facility owner were made aware of the findings. Review of the facility's policy titled, "General Dose Preparation and Medication Administration" documented, "Applicability this Policy 6.0 sets forth the procedures relating to general dose preparation and mediation administration. Facility staff should also refer to facility policy regarding medication administration and should comply with applicable law and testate Operations Manual when administering medications. Procedure 2. Prior to preparing or administering medications, authorized and competent facility staff should follow facility's infection control policy (e.g., handwashing). 6.4 Clean any reusable equipment or supplies." No further information was provided prior to exit.	F 880		