STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E075	A. BUILDING _____ B. WING _____	09/15/2016

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F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 9/13/16 through 9/15/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 70 certified bed facility was 69 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Residents 1 through 13) and 2 closed record reviews (Residents 14 through 15).

F 157 SS=D 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as

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1. **How will corrective action be accomplished for those residents found to have been affected by the deficient practice?**

MD and responsible party were notified that medications were held per blood pressure parameters for resident #1. **10/28/2016**

MD was notified of the change in condition for resident #5. **10/28/2016**

MD was notified of the attempts to elope for resident #8. **10/28/2016**

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

Deanna S. Craft | Administrator | 10/3/16

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

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specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

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 notify the physician and or responsible party as required for three of 15 residents in the survey sample, Residents #1, #5 and #8.

1. The facility staff failed to notify the physician and/or the responsible party for holding Resident #1's medications on several occasions.

2. The facility staff failed to notify the physician when Resident #5 had a change in condition.

3. The facility staff failed to notify the physician on two occasions when Resident #8 attempted to elope (leave the facility) (6/19/16 and 8/4/16).

The findings include:

1. Resident #1 was admitted to the facility on 8/3/15 with diagnoses that included but were not limited to: peripheral vascular disease, history of a kidney transplant, hepatitis C, diabetes, blind in right eye, low vision in left eye, cancer of the prostate, anemia, and paralysis following a stroke.

2. How will the facility identify other residents having the potential to be affected by the same deficient practice?

DON or designee will audit Resident Medical records for the last 7 days to ensure the following:

- MD and responsible party are being notified of medications being held for blood pressure parameters. **10/28/2016**
- MD was notified of changes in condition. **10/28/2016**
- MD was notified of attempts to elope. **10/28/2016**

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The most recent MDS (Minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/10/16 coded the resident as being cognitive intact to make daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for transfers, dressing, toileting, and personal hygiene. He was coded as requiring limited assistance for moving on the unit and eating.

The physician order dated, 8/3/15, and signed by the physician on 8/16/16, documented, "Carvedilol (used to treat high blood pressure and/or heart failure (1)) 25 mg (milligrams) tab (tablet); take 1 tablet by mouth 2 times a day for blood pressure. Hold for SBP (systolic blood pressure) < (less than) 100 or HR (heart rate) < 55."

The July 2016 eMAR (electronic medication administration record) documented the medication was not given on 7/30/16. There was no documentation of notification to the physician that the ordered medications were held. The blood pressure was documented as 100/56 and was within the parameters for administration.

The August 2016 eMAR documented the medication was not given on 8/9/16 There was no documentation of notification to the physician that the ordered medications were held. The blood pressure was documented as 113/50 and was within the parameters for administration.

The physician order dated, 8/3/15, and signed by

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3. What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur?

- DON/Designee educated facility staff on notifying MD and responsible party of medications being held for blood pressure parameters. **10/28/2016**
- DON / Designee educated facility staff on notifying MD of changes in conditions. **10/28/2016**
- DON / Designee educated facility staff on notifying MD of attempts to elope. **10/28/2016**

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the physician on 8/16/16, documented, "Clonidine (used to treat high blood pressure (2)) 0.1 mg (milligram); take 1 tablet by mouth every eight hours for blood pressure. Hold for SBP (systolic blood pressure) < (less than) 110 or < 55."

The July 2016 eMAR documented the medication was not given on four days; 7/7/16, 7/9/16, 7/12/16 and 7/29/16. There was no documentation of notification to the physician that the ordered medications were held. The blood pressures were all within parameters for administration and were documented as:
7/7/16 at 8:30 p.m. - 100/78
7/9/16 at 1:22 p.m. - 139/47
7/12/16 at 5:46 a.m. - 109/56
7/29/16 at 2:04 p.m. - 125/52

The August 2016 eMAR documented the medication was not given on four days; 8/5/16, 8/8/16, 8/10/16 and 8/14/16. There was no documentation of notification to the physician that the ordered medications were held. The blood pressures were all within parameters for administration and were documented as:
8/5/16 at 5:02 a.m. - 110/50
8/8/16 at 1:39 p.m. - 120/50
8/10/16 at 6:12 a.m. - 112/62
8/14/16 at 5:33 a.m. - 112/82

The September 2016 eMAR documented the medication was not given on three days; 9/2/16, 9/10/16 and 9/11/16. There was no documentation of notification to the physician that the ordered medications were held. The blood pressures were all within parameters for administration and were documented as:
9/2/16 at 2:33 p.m. - 146/45
9/10/16 at 8:39 p.m. - 110/58

4. How does the facility plan to monitor it's performance to make sure that the solutions are sustained?

DON or designee will audit the medical record of 5 residents 3x/week for 2 weeks to ensure:

- MD and responsible party are being notified of medications being held for blood pressure parameters. **10/28/2016**
- MD was notified of changes in condition. **10/28/2016**
- MD was notified of attempts to elope. **10/28/2016**

DON will report results to the QA committee. Findings and results will be reflected in the QA minutes. **10/28/2016**

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9/11/16 at 6:03 a.m. - 128/54

The comprehensive care plan dated, 3/2/16 and revised on 5/26/16, documented in part, "Focus: (Resident #1) has hypertension (high blood pressure) r/t (related to) stroke and receives antihypertensive medications." The "Interventions" documented in part, "Give anti-hypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension (too low blood pressure when you stand), and increased heart rate (tachycardia) and effectiveness."

An interview was conducted with LPN (licensed practical nurse) #1 on 9/14/16 at 10:29 a.m. LPN #1 was asked if the physician should be notified when a medication is held or not administered per the physician order. LPN #1 stated, "We can call or fax the physician the reason why we didn't give a medication." When asked where the notification was documented, LPN #1 stated, "It's in a drop down box on the eMAR or in a nurse's note."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 9/14/16 at 11:15 a.m. ASM #2 was asked if the physician should be notified when a medication is held or not administered per the physician order. ASM #2 stated, "Yes, they have to let the doctor know they held the medication. An adjustment may be needed in the medication if it is held frequently." When asked where the notification is documented, ASM #2 stated, "It could be in a couple of places. Either on the eMAR or in a progress note."

The administrator and ASM #2 were made aware of the above concern on 9/14/15 at 5:10 p.m.

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No further information was provided prior to exit.
(1) This information was taken from the following website:
<http://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009479/?report=details>
(2) This information was taken from the following website:
<http://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009680/?report=details>

2. The facility staff failed to notify the physician and/or responsible party when Resident #5 had a change in condition.

Resident #5 was admitted to the facility on 8/13/08 with diagnoses that included but were not limited to: cardiomegaly (enlargement of the heart) (1), osteoarthritis, Alzheimer's disease, restlessness, agitation and tachycardia (rapid heartbeat (2)).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/20/16, coded the resident has being severely impaired to make daily cognitive decisions and having both short and long term memory difficulties. The resident was coded for being dependent upon one or more staff members for all of her activities of daily living.

The nurse's note dated, 4/11/16 at 1:08 p.m. documented, "Pt (patient) was up in Geri chair in dining room, became cold, non-responsive to verbal & (and) touch stimuli. Pt returned to room

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and lifted into bed, eyes not following = looking straight ahead but not glazed; pt did take hold of arm of chair with her left hand. B/P (blood pressure) 75/42, P (pulse) 46, O2 sat (oxygen saturation) 95% on room air, T (temperature) 95.8 Ax (axillary). Re-ck (recheck) on B/P @ (at) 12:20 (p.m.) 90/46 P 58. Pt had fecal release while responding. Manual cuff B/P @ 13:00 (1:00 p.m.) 102/56."

The nurse's note dated, 4/11/16 at 4:05 p.m. documented, "Pt was up in Geri chair in dining room, staff noticed pt. was not responding to touch or verbal stimuli. Pt immediately brought back to her room B/P 75/42 pt put to bed. T - 95.8 ax, P -59, O2 sat 95% room air, B/P 90/46. Pt eyes open following staff, was incontinent of large bm (bowel movement). At 13:20 (1:20 p.m.) B/P 102/56 pt resting still pale, no distress, O2 sat 95% room air, finger tips bluish & cool. At 14:30 (2:30 p.m.) pt. seems to be resting as normal for her no distress/problems notes; fingers normal color."

The nurse's note dated, 4/12/16 at 4:29 a.m. documented, "Temp (temperature) 97.7, pulse - 70, Resp (respirations) 16, BP 100/64. Resting quietly opens eyes when spoken to, smiles, confused conversation."

The next nurse's note was dated, 4/19/16 at 8:00 a.m. documented, "(Name of doctor) in to see, no new orders written."

Review of the physician progress note dated, 4/19/16, did not document any mention of the episode of 4/11/16.

The comprehensive care plan dated, 3/31/16,

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documented in part, "Focus: (Resident #5) has a diagnosis of hypertension and takes antihypertensive medications as ordered." The "Interventions" documented in part, "Medications and labs (laboratory test) as ordered. Observe for side effects of medications such as headache, drowsiness, anxiety, nausea, vomiting, malaise, rash muscle pain, etc. Report changes or concerns to MD (medical doctor) as indicated."

An interview was conducted with LPN (licensed practical nurse) #1 on 9/14/16 at 10:29 a.m. LPN #1 was asked what staff should do if a resident has a change in condition, such as a systolic blood pressure less than 100 and is not responsive to verbal or touch stimuli. LPN #1 stated, "Check the resident's vital signs and call the doctor." When asked where the notification to the physician would be documented, LPN #1 stated, "In the progress notes." When asked if the responsible party should be notified, LPN #1 stated, "Yes. After I have taken the vital signs and spoken to the doctor, then I would bring the RP (responsible party) up to date." When asked where that is documented, LPN #1 stated "In the nurse's notes."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 9/14/16 at 11:15 a.m. ASM #2 was what staff should do if a resident exhibits a change in condition. ASM #2 stated, "I expect them to take the resident's vital signs and call the doctor." When asked where the physician notification is documented, "ASM #2 stated, "It can be in several place; eMAR (electronic medication administration record) or the progress notes." When asked if a resident presents as unresponsive to verbal and touch stimuli, should

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the nurse notify the doctor and the family, ASM #2 stated, "Yes and document the notification in the clinical record." The nurse's note of 4/11/16 for Resident #5 was reviewed with ASM #2. ASM #2 stated, "I wasn't aware of the situation."

The facility policy, "Documentation" documented in part, "Changes in resident' pertinent facts, findings and observations will be documented and reported to the physician as indicated."

In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient.
The administrator and ASM #2 were made aware of the above concern on 9/14/15 at 5:10 p.m.

No further information was provided prior to exit.
(1) Barron's Medical Guide - Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 104.
(2) Barron's Medical Guide - Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 557.

3. The facility staff failed to notify the physician on two occasions when Resident #8 attempted to elope (leave the facility) (6/19/16 and 8/4/16).

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Resident #8 was admitted to the facility on 6/14/16 with diagnoses including, but not limited to: seizure disorder (1), dementia with behaviors, Alzheimer's disease and diabetes. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 8/21/16, she was coded as being moderately impaired for making daily decisions. She was coded as needing supervision only for locomotion (traveling on and off her unit).

On 9/14/16 at 10:15 a.m., Resident #8 was observed self-propelling her wheelchair from her doorway down the hall to the television room.

A review of the clinical record revealed the following nurses notes:

- 6/19/16 at 12:20 p.m.: "Resident tried to get out the door to find her kids, redirected and has had no further episodes of confusion..."

- 8/4/16 at 10:08 p.m.: "Resident tried to elope (lobby entrance, in between two glass door) when found. Resident stated she was looking for her daughter. Resident more confused than normal this evening...Continue to assess and monitor closely for exit seeking behavior."

Further review of the clinical record revealed a document entitled "Risk of Elopement/Wandering Evaluation" dated 8/19/16. The document included the following questions and answers: "Does the resident have a history of elopement at home, while in a facility or without staff knowledge? No...Is the wandering behavior a pattern that may be goal-directed or tied to the resident's past routine? (Ex [example]: worked

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2nd or 3rd shift, taking long walks, looking for someone/something)? No...Is the resident at risk for elopement? No." This document did not include a staff member's signature to identify its author.

On 9/14/16 at 11:10 a.m., LPN (licensed practical nurse) #5 was interviewed. She stated that if a resident attempts to elope, "we monitor them every 15 minutes until they calm down." She stated the staff members will attempt to redirect the resident. LPN #5 stated that if the elopement attempt is not successful, no further interventions would be necessary. When asked how long the 15 minute monitoring goes on, LPN #5 stated: "I'm not sure. I'm new here. I would have to find out." When asked if the physician should be notified of a resident's elopement attempt, LPN #5 stated: "I wouldn't call anyone if the attempt was not successful."

On 9/14/16 at 12:20 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated that any resident who attempts to elope should be redirected, and that the specific methods of redirection are dependent upon the individual resident. When asked if any follow-up is required for a resident who has attempted elopement, ASM #2 stated: "The nurse should follow up and document what happened." ASM #2 provided the surveyor with a document entitled "Behavior Plan" for Resident #8. The document contained no date and included the following: "Wandering/Exit Seeking: 15 minute checks as needed; Green bracelet to be worn; If resident is up at night, he (sic) should be directed to the TV room. Enjoys spending time in the TV room and watching TV; Direct resident to activities when available; Gently

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redirect resident out of inappropriate areas (using 1 person); 1:1 care as needed for inappropriate wandering as indicated; Encourage locomotion in secured/safe courtyard area as indicated; Assess resident for pain, hunger, and warmth; Notify physician as indicated to address concerns. Interventions above are to be used for behaviors. Refer to care plan as needed." When asked how this document is used, ASM #2 stated it is kept in a notebook at the nurses station and that staff can refer to it if the resident exhibits behaviors. ASM #2 was asked if the physician should be notified if a resident attempts an elopement. She stated: "The physician should be notified. It is a change in condition."

A review of Resident #8's comprehensive care plan dated 6/14/16 and most recently updated on 9/13/16 failed to reveal any information related to resident safety/elopement risk/elopement attempts.

On 9/14/16 at 5:15 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns.

A review of the facility policy entitled "Documentation" revealed, in part, the following: "Changes in resident's pertinent facts, findings and observations will be documented and reported to the physician as indicated."

No further information was provided prior to exit.
(1) "Seizures are symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. When people think of seizures, they often think of convulsions in which a person's body shakes rapidly and uncontrollably. Not all seizures cause

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F 157	Continued From page 12 convulsions. There are many types of seizures and some have mild symptoms. Seizures fall into two main groups. Focal seizures, also called partial seizures, happen in just one part of the brain. Generalized seizures are a result of abnormal activity on both sides of the brain." This information is taken from the website https://medlineplus.gov/seizures.html.	F 157		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. 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	F 280	**F280** **1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** The care plan for residents #8 and #11 was updated to include interventions to prevent elopement.	**10/28/2016**

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F 280	Continued From page 13 revise the comprehensive care plan for two of 15 residents in the survey sample, Resident # 11 and #8. 1. The facility staff failed to review and revise Resident #11's comprehensive care plan following two incidents where Resident #11 was found outside of the building. 2. The facility staff failed to update the comprehensive care plan for Resident #8 after she attempted to elope (leave the facility) on 6/19/16 and 8/4/16. The findings include: 1. The facility staff failed to review and revise Resident #11's care plan following two incidents where Resident #11 was found outside of the building. Resident #11 was admitted to the facility on 7/5/15 with diagnoses that included, but were not limited to; high blood pressure, heart disease, cognitive deficits related to cerebrovascular disease, muscle weakness, enlarged prostate and dementia. Resident #11's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/18/16. Resident #11 was coded as a 00 (zero) on the Brief Interview for Mental Status (BIMS), indicating that the resident was severely	F 280	**2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** DON or designee will audit care plans for residents who are at risk for elopement to ensure care plans reflect interventions to prevent elopement.	**10/28/2016**

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cognitively impaired. Section E, Behavior, coded Resident #11 as wandering with the behavior occurring "4 (four) to 6 (six) days" during the seven day look back period.

A review of Resident #11's clinical record revealed that Resident #11 had been found outside of the building on two occasions, 7/4/16 and 8/1/16.

A review of Resident #11's care plan did not reveal any documentation evidencing that the care plan had been reviewed or revised following the incidents of elopement.

On 9/15/16 at 10:30 a.m. an interview was conducted with RN (registered nurse) #1, the MDS coordinator. RN #1 was asked when a care plan should be updated, RN #1 stated; "I update the care plan with every MDS assessment, quarterly, annually and with any significant change. I would also update the care plan if anything new occurs such as a fall or a behavior." RN #1 was asked if a resident would be care planned for elopement. RN #1 stated that if a resident were to get out of the building then the care plan would be updated to reflect the incident and the interventions in place. RN #1 further stated, "If there's a new intervention that is not on the care plan then I revise the care plan." RN #1 was asked if the care plan reflects when it has been reviewed and no new interventions are put into place. RN #1 stated, "Not unless I create a date for the new review. We discuss the situation in the clinical meeting but we don't document in the care plan unless there is a new intervention." RN #1 was asked to state the purpose of the care plan. RN #1 stated, "It (the care plan) is utilized by the staff to demonstrate the specific needs and

3. What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur?

DON will educate MDS coordinator to update risk for elopement care plans for residents who have attempted to elope.

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approaches for the individual needs of the resident." RN #1 was asked to review Resident #11's care plan and show where the incidents when Resident #11 eloped were reviewed and revised on the care plan. RN #1 reviewed Resident #11's care plan and stated, "We reviewed the incidents and we talked about what happened but we did not document that we had reviewed the care plans."

A review of the facility policy titled; "Care Plan Policy" revealed, in part, the following documentation; "Purpose: Nursing care plans are arranged into the three parts which includes Care Plan Problem, Care Plan Goal, and Care Plan Interventions which should be utilized to provide individualized care according to the needs of the residents." Procedure: Reviews to the care plan will be completed as follows: Quarterly. Changes in the plan of care for the resident."

On 9/15/16 at approximately 11:30 a.m. a meeting was conducted with ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above referenced concerns. No further information was provided prior to the end of the survey process.

2. The facility staff failed to update the comprehensive care plan for Resident #8 after she attempted to elope (leave the facility) on 6/19/16 and 8/4/16.

Resident #8 was admitted to the facility on 6/14/16 with diagnoses including, but not limited to: seizure disorder (1), dementia with behaviors, Alzheimer's disease and diabetes. On the most

F 280

4. How does the facility plan to monitor it's performance to make sure that the solutions are sustained?

DON or designee will audit the medical record of 5 residents weekly for 2 weeks to ensure that the care plan for residents who are at risk elopement has been updated following elopement attempts. **10/28/2016**

DON will report results to the QA committee. Findings and results will be reflected in the QA minutes. **10/28/2016**

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recent MDS (minimum data set), a quarterly assessment with assessment reference date 8/21/16, she was coded as being moderately impaired for making daily decisions. She was coded as needing supervision only for locomotion (traveling on and off her unit).

On 9/14/16 at 10:15 a.m., Resident #8 was observed self-propelling her wheelchair from her doorway down the hall to the television room.

A review of the clinical record revealed the following nurses notes:

- 6/19/16 at 12:20 p.m.: "Resident tried to get out the door to find her kids, redirected and has had no further episodes of confusion..."

- 8/4/16 at 10:08 p.m.: "Resident tried to elope (lobby entrance, in between two glass door) when found. Resident stated she was looking for her daughter. Resident more confused than normal this evening...Continue to assess and monitor closely for exit seeking behavior."

Further review of the clinical record revealed a document entitled "Risk of Elopement/Wandering Evaluation" dated 8/19/16. The document included the following questions and answers: "Does the resident have a history of elopement at home, while in a facility or without staff knowledge? No...Is the wandering behavior a pattern that may be goal-directed or tied to the resident's past routine? (Ex [example]: worked 2nd or 3rd shift, taking long walks, looking for someone/something)? No...Is the resident at risk for elopement? No." This document did not include a staff member's signature to identify its author.

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A review of Resident #8's comprehensive care plan dated 6/14/16 and most recently updated on 9/13/16 failed to reveal any information related to resident safety/elopement risk/elopement attempts.

On 9/14/16 at 11:10 a.m., LPN (licensed practical nurse) #5 was interviewed. She stated that if a resident attempts to elope, "We monitor them every 15 minutes until they calm down." She stated the staff members will attempt to redirect the resident. She stated that if the elopement attempt is not successful, no further interventions would be necessary. When asked how long the 15 minute monitoring goes on, LPN #5 stated: "I'm not sure. I'm new here. I would have to find out." When asked if the resident's care plan should be updated after a resident attempts to elope, LPN #5 stated: "Yes, it should be updated." She stated that the nurse in charge of the resident is responsible for updating the care plan. When asked to review Resident #8's care plan for evidence of it being updated following the above-referenced elopement attempts, LPN #5 stated: "I don't see anything."

On 9/14/16 at 12:20 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated that any resident who attempts to elope should be redirected, and that the specific methods of redirection are dependent upon the individual resident. When asked if any follow-up is required for a resident who has attempted elopement, ASM #2 stated: "The nurse should follow up and document what happened." ASM #2 provided the surveyor with a document entitled "Behavior Plan" for Resident #8. The document contained no date and

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included the following: "Wandering/Exit Seeking: 15 minute checks as needed; Green bracelet to be worn; if resident is up at night, he (sic) should be directed to the TV room. Enjoys spending time in the TV room and watching TV; Direct resident to activities when available; Gently redirect resident out of inappropriate areas (using 1 person); 1:1 care as needed for inappropriate wandering as indicated; Encourage locomotion in secured/safe courtyard area as indicated; Assess resident for pain, hunger, and warmth; Notify physician as indicated to address concerns. Interventions above are to be used for behaviors. Refer to care plan as needed." When asked how this document is used, ASM #2 stated it is kept in a notebook at the nurses station and that staff can refer to it if the resident exhibits behaviors. ASM #2 was asked if the resident's care plan should be updated to include incidents of attempted elopement, ASM #2 stated that the care plan should be updated to reflect new interventions provided for a resident who attempts elopement. She stated that Resident #8's care plan was not updated. ASM #2 stated: "Theoretically, we would use the elopement assessments to generate new interventions and care plan updates."

On 9/14/16 at 5:15 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns.

A review of the facility policy entitled "Care Plans" revealed, in part, the following: "Care plans will be initiated at the time of admission. Reviews to the care plan will be completed as follows: Quarterly; changes in the plan of care for the resident."

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No further information was provided prior to exit.
(1) "Seizures are symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. When people think of seizures, they often think of convulsions in which a person's body shakes rapidly and uncontrollably. Not all seizures cause convulsions. There are many types of seizures and some have mild symptoms. Seizures fall into two main groups. Focal seizures, also called partial seizures, happen in just one part of the brain. Generalized seizures are a result of abnormal activity on both sides of the brain." This information is taken from the website https://medlineplus.gov/seizures.html.
Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care."

F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281	

The services provided or arranged by the facility must meet professional standards of quality.

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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 follow professional standards of practice for two of 15 residents in the survey sample, Residents #1 and #14.

1. a. For Resident #1, the facility staff failed to clarify the indications for administration of an as needed order for Lasix, a diuretic.

b. For Resident #1, the facility staff failed to clarify the physician ordered parameters for the administration of Clonidine (used to treat high blood pressure (1)).

2. The facility staff failed to clarify the specified indications for administration on Resident #14's physician order for Morphine (1).

The findings include:

1. a. For Resident #1, the facility staff failed to clarify the indications for administration of an as needed order for Lasix, a diuretic.

Resident #1 was admitted to the facility on 8/3/15 with diagnoses that included but were not limited to: peripheral vascular disease, history of a kidney transplant, hepatitis C, diabetes, blind in right eye, low vision in left eye, cancer of the prostate, anemia, and paralysis following a stroke.

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

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1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?

The physician's order for resident #1's diuretic, Lasix, has been clarified for proper diagnosis. **10/28/2016**

The physician's order for resident #1's parameters for the administration of Clonidine was clarified. **10/28/2016**

Resident # 14 has expired. **10/28/2016**

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assessment reference date of 7/10/16 coded the resident as being cognitive intact to make daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for transfers, dressing, toileting, and personal hygiene. He was coded as requiring limited assistance for moving on the unit and eating.

The physician order dated, 5/3/16 and signed by the physician on 8/16/16 and 9/13/16, documented, "Furosemide (Lasix) (used to treat edema and high blood pressure (1)) 40 mg (milligrams) take 1/2 tablet (20 mg) once daily as needed."

The eMAR (electronic medication administration record) for July 2016 documented, "Furosemide 40 mg tab (tablet), take 1/2 tablet (20 mg) by mouth once daily as needed." The Furosemide was documented as having been given on five days in July.

The eMAR for August 2016 documented the Furosemide had been given eight days.

The eMAR for September documented the Furosemide had been given three days.

The nurse's notes dated, 7/15/16 at 7:39 a.m. documented, "Lasix 20 mg po (by mouth) given for edema in lower legs. Results pending."

The nurse's note dated, 7/30/16 at 7:27 a.m. documented, "BP (blood pressure) 90/60 - Medication (CLONIDINE 0.1 MG) (used to treat high blood pressure (2)) HELD due to low BP @ (at) 0523 (5:23 a.m.) on 7/30/16. Also medicated resident @ 0523 with (LASIX) 20 MG (PO) for

2. How will the facility identify other residents having the potential to be affected by the same deficient practice?

The medical records for residents with physician's orders for as needed diuretics will be audited to ensure appropriate diagnosis is reflected on the medical record. **10/28/2016**

The medical records for residents with physician's orders for parameters for the administration of Clonidine will be audited to ensure the parameter orders are complete. **10/28/2016**

The medical records for residents with physician's orders for morphine will be audited to ensure morphine is administered for the diagnosis reflected on the medical record.

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bilateral leg edema. Reported to oncoming shift to check for results."

The nurse's note dated, 8/5/16 at 6:33 a.m. documented, "Lasix 20 mg po given @ 0506 (5:06 a.m.) for increased edema lower legs."

The nurse's note dated, 8/8/16 at 7:29 a.m. documented, "B/P 112/50 @ 0618 (6:18 a.m.) on 8-8-16. Held medication (CLONIDINE 0.1 MG) this am. Medicated resident with (LASIX 20 MG) (PO) @ 0643 (6:43 a.m.) for bilateral leg edema."

The nurse's note dated, 8/20/16 at 6:32 a.m. documented, "Lasix 20 mg po given @ 0512 (5:12 a.m.) for increased edema bilaterally lower legs. This is prn (as needed) dose. Refused to elevate legs @ this time."

The nurse's note dated, 8/25/16 at 3:33 p.m. documented, "Res. (resident) given prn Lasix at 1300 (1:00 p.m.) for increase weight gain and edema in lower extremities."

The nurse's note dated, 8/29/16 at 3:30 p.m. documented, "Resident's feet noted to be more edematous this a.m. when wound care nurse in to do treatment of foot. Prn Lasix 20 mg given at 10:00 a.m. with reduced swelling noted."

The nurse's note dated, 9/3/16 at 11:54 a.m. documented, "Res had PRN Lasix at 0600 (6:00 a.m.) for edema in BLE (bilateral lower extremities). Lasix was effective in removing some fluid."

An interview was conducted with LPN (licensed practical nurse) #1 on 9/14/16 at 10:29 a.m. LPN #1 was asked about the reason or indications for

3. What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur?

DON or designee will educate nursing staff to ensure:

- As needed orders of the diuretic, Lasix have the appropriate diagnosis. **10/28/2016**
- Nursing staff will clarify physician's orders for parameters of clonidine to ensure parameters are complete. **10/28/2016**
- Nursing staff will give PRN Morphine only for the indication ordered by the physician. **10/28/2016**

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administering Resident #1's PRN physician ordered Lasix 40 mg, take one half tablet once daily as needed. LPN #1 stated, "It's given for edema. You have to know your resident. If you know your resident you would know what it's for." When asked if this order should have a reason to give it, LPN #1 stated, "Yes, it needs to be clarified."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 9/14/16 at 11:15 a.m. When asked about the indications/reason for when Resident #1's PRN Lasix should be administered, ASM #2 stated, "That order should have a diagnosis or reason to give. The order should have been clarified."

The facility policy, "Physician Orders" documented in part, "Clarification of physician's orders will be done as indicated for orders that are incomplete, do not have appropriate diagnosis and/or illegible."

According to Fundamentals of Nursing, 6th edition Potter and Perry, 2005, page 846, "A medication order is required for any medication to be administered by a nurse...If the medication order is incomplete, the nurse should inform the prescriber and ensure completeness before carrying out any medication order."

The administrator and ASM #2 were made aware of the above concern on 9/14/16 at 5:10 p.m.

(1) This information was obtained from the website: http://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010414/?report=details

4. **How does the facility plan to monitor it's performance to make sure that the solutions are sustained?**

DON or designee will audit the medical record of residents with as needed diuretic, Lasix weekly for 2 weeks to ensure that the residents with physician's orders for as needed diuretic, Lasix include a proper diagnosis. **10/28/2016**

DON or designee will audit the medical records of residents with parameters for the administration of Clonidine weekly for 2 weeks to ensure that the parameters are complete and do not need clarified. **10/28/2016**

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(2) This information was obtained from the website: http://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009680/?report=details

b. For Resident #1, the facility staff failed to clarify the physician ordered parameters for the administration of Clonidine (used to treat high blood pressure (1)).

The physician order dated, 8/3/15, and signed by the physician on 8/16/16, documented, "Clonidine 0.1 mg (milligram); take 1 tablet by mouth every eight hours for blood pressure. Hold for SBP (systolic blood pressure) < (less than) 110 or < 55."

The July eMAR documented, "Clonidine 0.1 mg tab (tablet); take 1 tablet by mouth every eight hours for blood pressure. Hold for SBP < 110 or < 55." The eMAR documented on 7/9/16 at 1:22 p.m. "Blood Pressure: 139/47 medication held."

The August 2016 eMAR documented, "Clonidine 0.1 mg tab (tablet); take 1 tablet by mouth every eight hours for blood pressure. Hold for SBP < 110 or < 55." The August eMAR documented on 8/5/16, "Reason Medication was NOT given: bp (blood pressure) low, 110/50." On 8/8/16 at 1:47 p.m. the eMAR documented, "Reason Medication was NOT given: 120/50." On 8/10/16 at 6:12 a.m. the eMAR documented, "Reason Medication was NOT given: B/P LOW; 112/62". All of these readings were not below the physician prescribed parameters.

The September 2016 eMAR documented, "Clonidine 0.1 mg tab (tablet); take 1 tablet by

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mouth every eight hours for blood pressure. Hold for SBP < 110 or < 55." The September eMAR documented on 9/2/16 at 2:32 p.m., "Reason Medication was NOT given: low diastolic; 146/45." The note dated, 9/10/16 at 8:39 p.m. documented, "Reason Medication was NOT given: parameters; 110/58". The note dated, 9/11/16 at 6:03 a.m. documented, "Reason Medication was NOT given: B/P 128/54." All of these readings were not below the physician prescribed parameters.

On 9/14/16 at 10:29 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked what is expected of the nurse, when a medication order has parameters associated with the physician order. LPN #1 stated, "You take the blood pressure before you open the pill." When asked where this would be documented, "LPN #1 stated, "In the drop down box on the eMAR." LPN #1 was asked what staff should do if the physician order says to hold a blood pressure medication if the systolic blood pressure is less 110 or 55. LPN #1 stated, "You hold the medication if the blood pressure reading is below the parameters." LPN #1 was asked what the nurse should do if the ordered parameter is to hold for systolic blood pressure less than 110 and the systolic blood pressure reading is 110. LPN #1 stated, "You should give it as its (systolic blood pressure) not less than what the doctor ordered." LPN #1 was asked to review the order for Clonidine. LPN #1 was asked what hold for SBP < 110 or <55, meant and what did the < 55 mean, was this for a diastolic reading less than 55. LPN #1 stated, "That order needs to be clarified. It's normally the heart rate less than 55."

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An interview was conducted with administrative staff member (ASM) #2 on 9/14/16 at 11:15 a.m. ASM #2 was asked if a physician has ordered a parameter in which to give a medication, what is expected of the staff. ASM #2 stated, "The nurse should follow the physician's order for the parameters." When asked what the staff should do if the physician ordered parameter says to hold for less than 110 systolic blood pressure and the resident's reading is 110. ASM #2 stated, "The nurse should administer the medication because it is not less than the parameter." The order for Clonidine was reviewed with ASM #2. ASM #2 stated, "That (< 55) should be for heart rate." The eMARs were reviewed with ASM #2. ASM #2 stated, "That order needs to be clarified. It (< 55) should be for the heart rate, not the diastolic reading."

The administrator and ASM #2 were made aware of the above concerns on 9/14/16 at 5:10 p.m.

No further information was provided prior to exit.

2. The facility staff failed to clarify the specified indications for administration on Resident #14's physician order for Morphine (1).
Resident #14 was admitted to the facility on 1/13/15 with diagnoses including but not limited to: dementia, diabetes, high blood pressure, and depression. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 6/19/16, Resident #14 was coded as being severely cognitively impaired for making daily decisions.

A review of the clinical record for Resident #14

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revealed the following order, written 2/4/15 and signed most recently by the physician on 8/17/16: "Morphine Sulfate 20 mgs (milligrams)/5 ml (in 5 milliliters) soln (solution) Take 1 ml by mouth every 4 hours as needed for respiratory distress."

A review of the MAR (medication administration record) for Resident #14 revealed that she received Morphine on the following dates and for the following indications:

- "8/12/16 at 21:42 (9:42 p.m.) Reason for PRN (as-needed medication): pain."
- "8/13/16 at 17:58 (5:58 p.m.) Reason for PRN: screaming c/o (complaining of) right mid back pain."
- 8/14/16 at 01:54 (1:54 a.m.) Reason for PRN: Requested for right hip pain."

On 9/14/16 at 4:55 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. When asked if Morphine should be administered to a resident for pain if the order specifies that the indication for the Morphine is shortness of breath, ASM #2 stated: "Yes. In this case, it sounds like we had the wrong diagnosis. Morphine is usually given for when a resident is having pain. It is also given for air hunger in a resident who is on comfort care." When asked if anything should be done regarding a conflict between a specific order and ordinary uses for a medication, ASM #2 stated: "The nurse should call and get clarification for the medication."

On 9/15/16 at 9:00 a.m., LPN (licensed practical nurse) #9 was interviewed. When asked if she would administer Morphine to a resident for pain if the order for Morphine specified that it was to be given for a diagnosis of shortness of breath.

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she stated that she would not.

On 9/15/16 at 9:14 a.m., LPN #10 was interviewed. When asked if she would administer Morphine to a resident for pain if the order for Morphine specified that it was to be given for a diagnosis of shortness of breath, she stated she would. LPN #10 stated that she would have to call the doctor before she administered the Morphine for pain. She stated most residents under comfort care have Morphine ordered, and that nurses may give it in regard to the comfort of the resident.

On 9/14/16 at 5:15 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns. A policy on order clarification was requested.

No further information was provided prior to exit.

(1) "Morphine is used to relieve moderate to severe pain. Morphine extended-release tablets and capsules are only used to relieve severe (around-the-clock) pain that cannot be controlled by the use of other pain medications. Morphine extended-release tablets and capsules should not be used to treat pain that can be controlled by medication that is taken as needed. Morphine is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain." This information is taken from the National Institutes of Health website https://www.nlm.nih.gov/medlineplus/druginfo/meds/a682133.html.

The following information is provided in Fundamentals of Nursing, 6th edition (Potter and

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Perry, 2005, p.846): "A medication order is required for any medication to be administered by a nurse...If the medication order is incomplete, the nurse should inform the prescriber and ensure completeness before carrying out any medication order."

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Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

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 follow the physician orders for one of 15 residents in the survey sample, Resident #1.

1. a. The facility staff failed to monitor the heart rate prior to the administration of Carvedilol (used to treat high blood pressure and heart failure (1)) for Resident #1.

1. b. The facility staff failed to administer the blood pressure medications per the physician orders for Resident #1.

The findings include:

1.a. Resident #1 was admitted to the facility on

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1. **How will corrective action be accomplished for those residents found to have been affected by the deficient practice?**

Facility staff are monitoring the heart rate of resident #1 prior to the administration of Carvedilol per physician's orders. **10/28/2016**

Facility staff are administering blood pressure medications per physician's orders for resident #1. **10/28/2016**

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8/3/15 with diagnoses that included but were not limited to: peripheral vascular disease, history of a kidney transplant, hepatitis C, diabetes, blind in right eye, low vision in left eye, cancer of the prostate, anemia, and paralysis following a stroke.

The most recent MDS (Minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/10/16 coded the resident as being cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for transfers, dressing, toileting, and personal hygiene. He was coded as requiring limited assistance for moving on the unit and eating.

The physician order dated, 8/3/15, and signed by the physician on 8/16/16, documented, "Carvedilol 25 mg (milligrams) tab (tablet); take 1 tablet by mouth 2 times a day for blood pressure. Hold for SBP (systolic blood pressure) < (less than) 100 or HR (heart rate) < 55."

Review of the eMAR (electronic medication administration record) for July 2016 documented, "Carvedilol 25 mg tablet; take 1 tablet by mouth 2 times a day for blood pressure, hold for SBP < 100 or HR < 55." Of the 62 opportunities for documenting the heart rate, there were only 14 documented heart rate measurements.

Review of the eMAR for August 2016 documented, "Carvedilol 25 mg tablet; take 1 tablet by mouth 2 times a day for blood pressure, hold for SBP < 100 or HR < 55." Of the 62 opportunities for documenting the heart rate, there were only 19 documented heart rate

2. How will the facility identify other residents having the potential to be affected by the same deficient practice?

The medical record of residents with parameters for the administration of blood pressure medications will be audited by the DON / Designee to ensure:

- Heart rate is monitored prior to the administration of Carvedilol — **10/28/2016**
- Blood pressure medications with parameters are administered per the physician's orders. — **10/28/2016**

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measurements.

Review of the eMAR for September 2016 documented, "Carvedilol 25 mg tablet; take 1 tablet by mouth 2 times a day for blood pressure, hold for SBP < 100 or HR < 55." Of the 25 opportunities for documenting the heart rate, there were only seven documented heart rate measurements.

The "Weights and Vitals Summary" for 7/1/16 through 9/30/16 documented "Pulse Summary - 7/6/16 at 21:24 (9:24 p.m.) 58 bpm (beats per minute); 8/22/16 at 19:30 (7:30 p.m.) 62 bpm; and 9/2/16 at 21:41 (9:41 p.m.) 63 bpm."

The nurse's notes were reviewed from 7/1/16 through 9/13/16. The nurse's note dated, 7/22/16 at 12:20 a.m. documented, "At 2000 (8:00 p.m.) b/p (blood pressure) = 150/101 p (pulse) = 63." The nurse's note dated, 8/12/16 at 12:42 a.m. documented, "b/p = 154/76 p=67 at HS (hours of sleep), quiet evening." The nurse's note dated, 8/15/16 at 9:34 p.m. documented, "B/P 148/76. P 67 voiced no complaints." The nurse's note dated, 8/21/16 at 12:25 a.m. documented, "8/20/16 B/P 131/76, p = 80, meds (medications) given." The nurse's note dated, 8/22/16 at 12:24 a.m. documented, "Resident ate 100% of meal. B/P = 140/82 p = 78. Took meds well." The nurse's note dated, 8/27/16 at 10:33 p.m. documented, "No complaint of pain voiced. B/P 117/83, P 69." There was no other documentation of the resident's heart rate monitoring.

The comprehensive care plan dated, 3/2/16 and revised on 5/26/16, documented in part, "Focus: (Resident #1) has hypertension (high blood pressure) r/t (related to) stroke and receives

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3. **What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur?**

DON and /or designee will educate facility staff on:

- Obtaining a heart rate prior to the administration of Carvedilol **10/28/2016**
- Administering blood pressure medications per physician's orders **10/28/2016**

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antihypertensive medications." The "Interventions" documented in part, "Give anti-hypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension (too low blood pressure when you stand), and increased heart rate (tachycardia) and effectiveness."

On 9/14/16 at 10:29 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked if a physician order documents two parameters for the administration of a medication, should both measurements ordered be obtained, LPN #1 stated, "Yes and if it's out of the range you notify the doctor and hold the medication." The physician order for the Carvedilol was reviewed with LPN #1. When asked what the nurse should do prior to the administration of the medication, LPN #1 stated, "You have to take the blood pressure and pulse." When asked where the readings of the blood pressure and pulse are documented, LPN #1 stated, "There is a drop down box in the eMAR to document it." The eMARs for July, August and September were reviewed with LPN #1. When asked where the documentation of Resident #1's heart rate was located for the use of the Carvedilol, LPN #1 stated, "It should be where they documented the blood pressure, it's not there every time."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing; on 9/14/16 at 11:15 a.m. ASM #2 was asked what staff should do when there is a physician order for parameters for administering a medication. ASM #2 stated, "They should follow the parameters of the order." When asked if there are two physician ordered parameters for a medication, should both parameter readings be obtained before

4. How does the facility plan to monitor it's performance to make sure that the solutions are sustained?

DON or designee will audit the medical record of residents with physician's orders for Carvedilol x 2 weekly for 2 weeks to ensure that the resident's heart rate was obtained prior to the administration of the medication. **10/28/2016**

DON or designee will audit the medical record of 5 residents with physician's orders for blood pressure medications x2 weekly for 2 weeks to ensure medications are administered per physician's orders. **10/28/2016**

DON will report results to the QA committee. Findings and results will be reflected in the QA minutes. **10/28/2016**

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administering the medication, ASM #2 stated, "Yes, if that's the order." The order for Carvedilol was reviewed with ASM #2. When asked what is expected of the nurse prior to the administration of the medication, ASM #2 stated, "The nurse should take the blood pressure and heart rate." When asked where that is documented, ASM #2 stated, "In the drop down box on the eMAR or in a progress note." ASM #2 was asked to review Resident #1's eMARs and nurse's notes for July, August and September 2016. When asked where the documentation of Resident #1's pulse/heart rate was located, ASM #2 stated, "It's not there."

The facility policy, "Medication Administration" documented in part, "Note any medication perimeters (sic) ordered by the physician and document per order."

In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc. Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

The administrator and ASM #2 were made aware of the above concerns on 9/14/16 at5:10 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the website:
http://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009479/

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b. The facility staff failed to administer the blood pressure medications per the physician orders for Resident #1.

The physician order dated, 8/3/15, and signed by the physician on 8/16/16, documented, "Carvedilol 25 mg (milligrams) tab (tablet); take 1 tablet by mouth 2 times a day for blood pressure. Hold for SBP (systolic blood pressure) < (less than) 100 or HR (heart rate) < 55." The physician order dated, 8/3/15, and signed by the physician on 8/16/16, documented, "Clonidine (used to treat high blood pressure (1)) 0.1 mg (milligram); take 1 tablet by mouth every eight hours for blood pressure. Hold for SBP (systolic blood pressure) < (less than) 110 or < 55."

Review of the eMAR (electronic medication administration record) for July 2016 documented, "Carvedilol 25 mg tablet; take 1 tablet by mouth 2 times a day for blood pressure, hold for SBP < 100 or HR < 55." The eMAR documented on 7/30/16 at 7:52 a.m., "Reason Medication was NOT given: 100/56." The blood pressure was not less than 100.

The July eMAR documented, "Clonidine 0.1 mg tab (tablet); take 1 tablet by mouth every eight hours for blood pressure. Hold for SBP < 110 or < 55." The eMAR documented on 7/9/16 at 1:22 p.m. "Blood Pressure: 139/47 medication held."

The August 2016 eMAR documented, "Carvedilol 25 mg tablet: take 1 tablet by mouth 2 times a day for blood pressure, hold for SBP < 100 or HR < 55." The eMAR documented on 8/9/16 at 7:42 a.m., "Reason Medication was NOT given: B/P 113/50." The reading was not below the

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parameters and it was held.

The August 2016 eMAR documented, "Clonidine 0.1 mg tab (tablet); take 1 tablet by mouth every eight hours for blood pressure. Hold for SBP < 110 or < 55." The eMAR documented on 8/5/16, "Reason Medication was NOT given: bp (blood pressure) low, 110/50." On 8/8/16 at 1:47 p.m. the eMAR documented, "Reason Medication was NOT given: 120/50." On 8/10/16 at 6:12 a.m. the eMAR documented, "Reason Medication was NOT given: B/P LOW; 112/62". All of these readings were not below the physician prescribed parameters.

The September 2016 eMAR documented, "Clonidine 0.1 mg tab (tablet); take 1 tablet by mouth every eight hours for blood pressure. Hold for SBP < 110 or < 55." The eMAR documented on 9/2/16 at 2:32 p.m., "Reason Medication was NOT given: low diastolic; 146/45." The note dated, 9/10/16 at 8:39 p.m. documented, "Reason Medication was NOT given: parameters; 110/58". The note dated, 9/11/16 at 6:03 a.m. documented, "Reason Medication was NOT given: B/P 128/54." All of these readings were not below the physician prescribed parameters.

The comprehensive care plan dated, 3/2/16 and revised on 5/26/16, documented in part, "Focus: (Resident #1) has hypertension (high blood pressure) r/t (related to) stroke and receives antihypertensive medications." The "Interventions" documented in part, "Give anti-hypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension (too low blood pressure when you stand), and increased heart rate (tachycardia) and effectiveness."

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On 9/14/16 at 10:29 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked what is expected of the nurse, when a medication order has parameters associated with the physician order. LPN #1 stated, "You take the blood pressure before you open the pill " When asked where this would be documented, "LPN #1 stated, "In the drop down box on the eMAR." LPN #1 was asked what should be done if the physician order says to hold a blood pressure medication if the systolic blood pressure is less than 100 or 110. LPN #1 stated, "You hold the medication if the blood pressure reading is below the parameters." LPN #1 was asked what the nurse should do if the ordered parameter is to hold for systolic blood pressure less than 110 and the systolic blood pressure reading is 110. LPN #1 stated, "You should give it as its (systolic blood pressure) not less than what the doctor ordered." LPN #1 was asked to review the order for Clonidine. LPN #1 was asked to review the order for Clonidine. LPN #1 was asked what hold for SBP < 110 or <55, meant and what did the < 55 mean, was this for a diastolic reading less than 55. LPN #1 stated, "That order needs to be clarified. It's normally the heart rate less than 55."

An interview was conducted with administrative staff member (ASM) #2 on 9/14/16 at 11:15 a.m. ASM #2 was asked if a physician has ordered a parameter in which to give a medication, what is expected of the staff. ASM #2 stated, "The nurse should follow the physician's order for the parameters." When asked what the staff should do if the physician ordered parameter says to hold for less than 110 systolic blood pressure and

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the resident's reading is 110. ASM #2 stated, "The nurse should administer the medication because it is not less than the parameter." The order for Clonidine was reviewed with ASM #2. ASM #2 stated, "That (< 55) should be for heart rate." The eMARs were reviewed with ASM #2. ASM #2 stated, "That order needs to be clarified. It (< 55) should be for the heart rate, not the diastolic reading."

The facility policy, "Medication Administration" documented in part, "Note any medication perimeters (sic) ordered by the physician and document per order."
The administrator and ASM #2 were made aware of the above concerns on 9/14/16 at5:10 p.m.

No further information was provided prior to exit.

(1) This information was taken from the website: http://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009680/?report=details

F 323 SS=D 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES — F 323

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review it was

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determined that the facility staff failed to ensure adequate supervision and failed to implement new interventions after elopement attempts to ensure safety for two of 15 residents in the survey sample, Resident # 11 and #8.

1 The facility staff failed to implement new interventions for Resident #11 after he had been found outside of the building on 7/4/16. Resident #11 was found outside of the building a second time on 8/1/16.

2. The facility staff failed to accurately assess the risk for and provide interventions to prevent further elopement after elopement attempts on 6/19/16 and 8/4/16 for Resident #8.

The findings include:

1. The facility staff failed to implement new interventions for Resident #11 after he had been found outside of the building on 7/4/16. Resident #11 was found outside of the building a second time on 8/1/16.

Resident #11 was admitted to the facility on 7/5/15 with diagnoses that included, but were not limited to; high blood pressure, heart disease, cognitive deficits related to cerebrovascular disease, muscle weakness, enlarged prostate and dementia.

Resident #11's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/18/16. Resident #11 was coded as a 00 (zero) on the Brief Interview for Mental Status (BIMS), indicating that the resident was severely cognitively impaired. Section E, Behavior, coded

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1. **How will corrective action be accomplished for those residents found to have been affected by the deficient practice?**

The care plan for resident #11 was updated to include interventions after resident had been found outside the building. **10/28/2016**

An accurate elopement risk assessment was completed on resident #8 to assess the risk for and provide interventions for elopement. **10/28/2016**

2. **How will the facility identify other residents having the potential to be affected by the same deficient practice?**

DON or designee will audit assessments and care plans for residents who are at risk for elopement to ensure assessments are accurate and care plans reflect interventions to prevent elopement. **10/28/2016**

DON or designee will audit care plans for all residents who are at risk for elopement to ensure care plans reflect interventions to prevent elopement. **10/28/2016**

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Resident #11 as wandering with the behavior occurring "4 (four) to 6 (six) days" during the seven day look back period.

A review of Resident #11's nurses' notes revealed that Resident #11 had been found outside of the building on two separate occasions, 7/4/16 and 8/1/16. The following entries were documented in the nurses' notes:
"7/4/16 17:52 (5:52 p.m.) Res (Resident #11) noted to be walking around in parking lot beside of building condition unchanged (sic)."
"8/1/16 15:58 (3:58 p.m.) Resident seen ambulating outside of facility at 0810 (8:10) this a.m. Assisted back into facility with no sign of injury. Taken to MDR (middle dining room) for breakfast. Son (name of son) notified and fax to (name of doctor). Exit seeking behaviors continued after breakfast and resident combative with staff. Continues with exit seeking this afternoon but easier to redirect."
No further documentation related to these incidents was found in the clinical record.

A review of Resident #11's comprehensive care plan dated 3/21/16 revealed, in part, the following documentation; "Focus: (Name of Resident #11) is an elopement risk/wanderer d/t (due to) walking and or propelling self frequently in halls and to the doors and hx (history) of attempting to exit r/t (related to) his dementia. Date initiated: 3/21/16 Revision on: 6/7/16. Goal: (Name of Resident #11) will not leave facility unattended through the review date. Date initiated: 3/21/16. Revision on: 7/22/16. Interventions: Assess for fall risk. Date Initiated: 3/21/16. Delayed egress doors/alarm system. Date Initiated: 3/21/16. Revision on: 4/25/16. Distract resident from wandering by offering pleasant diversions, structured activities,

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3. **What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur?**

DON will educate MDS coordinators to accurately assess the risk for elopement and update risk for elopement interventions for residents who have attempted to elope or found outside the building. **10/28/2016**

4. **How does the facility plan to monitor it's performance to make sure that the solutions are sustained?**

DON or designee will audit the medical record of 5 residents weekly for 2 weeks to ensure that residents who are at risk for elopement have accurately completed elopement risk assessments and that new interventions have been implemented following elopement attempts or being found outside the building. **10/28/2016**

DON will report results to the QA committee. Findings and results will be reflected in the QA minutes. **10/28/2016**

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food, conversation, television, book. Date Initiated: 3/21/16. Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. Date Initiated: 3/21/16. Monitor location ever 60 min (minutes) every day. Document wandering behavior and attempted diversional interventions in behavior log. Date Initiated: 3/21/16. Revision on 3/30/16. Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. Date initiated: 3/21/16."

Further review of Resident #11's clinical record revealed, in part, a "Risk of Elopement/Wandering Evaluation" dated 7/15/16. The "Risk of Elopement/Wandering Evaluation" documented, in part, the following: "Resident ambulates with walker and is in w/c (wheel chair) and often goes to exit doors and pushes on door and expresses that he wants to go out. Resident is on a monitoring program so that staff checks his whereabouts every 30 minutes and when a door alarm rings staff immediately goes to doors."

On 9/15/16 at approximately 9:10 a.m. an interview was conducted with CNA (certified nursing assistant) #2. CNA #2 was asked to describe what was in place regarding Resident #11's wandering behaviors. CNA #2 stated, "We have to monitor him every 15 minutes, if there is an alarm we have to keep a check on him."

On 9/15/16 at 10:30 a.m. an interview was conducted with RN (registered nurse) #1, the MDS coordinator. RN #1 was asked what had been put into place to prevent Resident #11 from

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eloping out of the building. RN #1 stated that an elopement care plan was initiated on 3/21/16 and had been reviewed and revised with the MDS assessments. RN #1 was asked what was done following the 7/4/16 incident when Resident #11 was found outside in the parking lot. RN #1 stated, "We talked about it but didn't document our discussion. I looked at the interventions and we felt that we did not need any others at that time." RN #1 was asked how Resident #11 was able to get out of the building a second time on 8/1/16. RN #1 stated, "(Name of Resident #11) was able to get out through the housekeeping office which has a door to the outside of the building. All the other doors are alarmed. We did do education with housekeeping so that they would not leave their door unlocked." RN #1 was unable to provide evidence to demonstrate that the interventions in place on 7/4/16 had been reviewed or revised to prevent Resident #11 from exiting the building on 8/1/16. RN #1 was asked to explain the purpose of the document titled "Risk of Elopement/Wandering Evaluation." RN #1 stated that this document was completed at each MDS assessment, in this case the evaluation was completed with Resident #11's quarterly assessment on 7/18/16 and documented that Resident #11 was a high risk, RN #1 further stated that this was not reflected on Resident #11's care plan.

On 9/15/16 at 11:30 a.m. an interview was conducted with RN #3, a floor nurse. RN #3 was asked whether or not she was familiar with the care needed for Resident #11. RN #3 stated that she was. RN #3 was asked if she was aware of Resident #11 exhibiting behaviors. RN #3 stated that he would wander and that the staff needed to watch him otherwise he would try to get out of the

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building unattended. RN #3 was asked if she was aware that Resident #11 had been found outside of the building at any time. RN #3 stated that he had exited the building on several occasions. RN #3 was asked what was put into place after these incidents. RN # 3 stated, "I think they changed the codes on the door, closer monitoring. He (Resident #11) knows how to hold the bar on the door so it will release and he can get out. He wears a green bracelet so that if he gets out his address is on the bracelet. All the doors have alarms except for the housekeeper door and the kitchen door. We do 15 minute checks; we just have to watch him."

A review of the facility policy entitled "Elopement" revealed specific procedures for the facility staff to follow in case a resident is suspected to be missing. The policy did not address elopement risk assessment or prevention measures.

On 9/15/16 at approximately 11:30 a.m. a meeting was held with ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above findings.

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

2. The facility staff failed to accurately assess the risk for and provide interventions to prevent further elopement after elopement attempts on 6/19/16 and 8/4/16 for Resident #8.

Resident #8 was admitted to the facility on 6/14/16 with diagnoses including, but not limited

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to: seizure disorder, dementia with behaviors, Alzheimer's disease and diabetes. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 8/21/16, she was coded as being moderately impaired for making daily decisions. She was coded as needing supervision only for locomotion (traveling on and off her unit).

On 9/14/16 at 10:15 a.m., Resident #8 was observed self-propelling her wheelchair from her doorway down the hall to the television room.

A review of the clinical record revealed the following nurses notes:

- 6/19/16 at 12:20 p.m.: "Resident tried to get out the door to find her kids, redirected and has had no further episodes of confusion..."

- 8/4/16 at 10:08 p.m.: "Resident tried to elope (lobby entrance, in between two glass door) when found. Resident stated she was looking for her daughter. Resident more confused than normal this evening...Continue to assess and monitor closely for exit seeking behavior."

Further review of the clinical record revealed a document entitled "Risk of Elopement/Wandering Evaluation" dated 8/19/16. The document included the following questions and answers: "Does the resident have a history of elopement at home, while in a facility or without staff knowledge? No...Is the wandering behavior a pattern that may be goal-directed or tied to the resident's past routine? (Ex [example]: worked 2nd or 3rd shift, taking long walks, looking for someone/something)? No...Is the resident at risk for elopement? No." This document did not

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include a staff member's signature to identify its author.

Further review of the clinical record revealed no elopement risk assessment following the 6/19/16 elopement attempt.

On 9/14/16 at 11:10 a.m., LPN (licensed practical nurse) #5 was interviewed. LPN #2 stated that if a resident attempts to elope, "we monitor them every 15 minutes until they calm down." She stated the staff members will attempt to redirect the resident. She stated that if the elopement attempt is not successful, no further interventions would be necessary. When asked how long the 15 minute monitoring goes on, LPN #2 stated: "I'm not sure. I'm new here. I would have to find out." When asked if she could locate evidence of any 15 minute checks for Resident #8 since her admission to the facility, LPN #2 looked through the clinical record and stated: "Nope. I don't see anything here."

On 9/14/16 at 12:20 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated that any resident who attempts to elope should be redirected, and that the specific methods of redirection are dependent upon the individual resident. When asked if any follow-up is required for a resident who has attempted elopement, ASM #2 stated: "The nurse should follow up and document what happened." When asked how the facility staff knows a resident is at risk for elopement, ASM #2 stated: "We do an elopement assessment on admission, and then we reassess if a resident attempts elopement." When asked if new interventions to prevent elopement should be considered and documented if a resident has

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attempted elopement, ASM #2 stated: "Yes. Theoretically we would use the elopement assessments to generate new interventions and update the plan of care." When asked if the facility staff reassessed Resident #8's elopement risk following her first elopement attempt on 6/19/16, ASM #2 stated: "No. We did not." When asked if the above-referenced elopement risk assessment dated 8/9/16 was accurate, ASM #2 stated: "No, it's not. We obviously have some things to work on." ASM #2 provided the surveyor with a document entitled "Behavior Plan" for Resident #8. The document contained no date and included the following: "Wandering/Exit Seeking: 15 minute checks as needed; Green bracelet to be worn; If resident is up at night, he (sic) should be directed to the TV room. Enjoys spending time in the TV room and watching TV; Direct resident to activities when available; Gently redirect resident out of inappropriate areas (using 1 person); 1:1 care as needed for inappropriate wandering as indicated; Encourage locomotion in secured/safe courtyard area as indicated; Assess resident for pain, hunger, and warmth; Notify physician as indicated to address concerns. Interventions above are to be used for behaviors. Refer to care plan as needed." When asked how this document is used, ASM #2 stated it is kept in a notebook at the nurses station and that staff can refer to it if the resident exhibits behaviors. ASM #2 was asked if this document or the care plan includes any information that would alert staff to the fact that Resident #8 has attempted to elope two times since her admission three months ago, ASM #2 stated: "No. It is more what to do if she tries to do it."

A review of Resident #8's comprehensive care plan dated 6/14/16 and most recently updated on

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9/13/16 failed to reveal any information related to resident safety/elopement risk/elopement attempts.

On 9/14/16 at 5:15 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns.

A review of the facility policy entitled "Elopement" revealed specific procedures for the facility staff to follow in case a resident is suspected to be missing. The policy did not address elopement risk assessment or prevention measures.

No further information was provided prior to exit.

(1) "Seizures are symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. When people think of seizures, they often think of convulsions in which a person's body shakes rapidly and uncontrollably. Not all seizures cause convulsions. There are many types of seizures and some have mild symptoms. Seizures fall into two main groups. Focal seizures, also called partial seizures, happen in just one part of the brain. Generalized seizures are a result of abnormal activity on both sides of the brain." This information is taken from the website https://medlineplus.gov/seizures.html.

F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329	

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of

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adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to ensure a medication regimen free from unnecessary medications for one of 15 residents in the survey sample, Resident #5.

The facility staff failed to document the targeted behaviors for the use of Risperidone, an antipsychotic medication (1), for Resident #5.

The findings include:

Resident #5 was admitted to the facility on 8/13/08 with diagnoses that included but were not limited to: cardiomegaly (enlargement of the heart (2)), osteoarthritis, Alzheimer's disease,

F329

1. **How will corrective action be accomplished for those residents found to have been affected by the deficient practice?**

   Behavior monitoring sheet for resident # 5 has been completed to include the targeted behavior for the use of Risperidone. **10/28/2016**

2. **How will the facility identify other residents having the potential to be affected by the same deficient practice?**

   DON or designee will audit behavior monitoring sheets for residents with physician's orders for Risperidone to ensure targeted behaviors are documented. **10/28/2016**

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restlessness, agitation and tachycardia (rapid heartbeat (3)).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/20/16, coded the resident as being severely impaired to make daily cognitive decisions and as having both short and long term memory difficulties. The resident was coded as being dependent upon one or more staff members for all of her activities of daily living.

The physician order summary for September 2016 and signed by the physician on 8/30/16, documented, "Risperidone 0.5 MG (milligrams); take 1 tablet by mouth evening at 1700 (5:00 p.m.) for psychological behavior/symptoms of dementia."

The "Psychoactive Medication Monthly Flow Record" for June, July, August and September 2016 were reviewed. The form documented, "Section 1: Target Behavioral Symptoms." This was blank on all of the monthly forms.

The comprehensive care plan dated, 3/31/16, documented, "Focus: (Resident #5) has a diagnosis of agitation and behavioral/psychological symptoms of dementia and is receiving psychoactive medications." The "Interventions" documented in part, "Observe resident for any changes in behaviors. Report changes or concerns to MD (medical doctor) and family as indicated. Medications, labs (laboratory tests) and treatments as ordered."

An interview was conducted with LPN (licensed practical nurse) #1 on 9/14/16 at 11:14 a.m. LPN

F 329

3. What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur?

DON and/or designee will educate facility nurses to ensure that targeted behaviors are identified on the behavior monitoring sheets for residents with a physician's orders for Risperidone. **10/28/2016**

4. How does the facility plan to monitor it's performance to make sure that the solutions are sustained?

DON or designee will audit the behavior monitoring sheets of 5 residents with physician orders for Risperidone weekly for 2 weeks to ensure that behavior monitoring sheets have a targeted behavior documented. **10/28/2016**

DON will report results to the QA committee. Findings and results will be reflected in the QA minutes. **10/28/2016**

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#1 was asked what Resident #5's targeted behaviors were for the use of the Risperidone. LPN #1 stated, "We got him (the doctor) decreasing it. Let me check the chart." LPN #1 then went and got Resident #5's "Psychoactive Medication Monthly Flow Record" and reviewed them. LPN #1 stated, "We don't have a targeted behavior. She resists care and is combative at times." When asked if targeted behaviors should be identified, documented and monitored, LPN #1 stated, "Yes, but she hasn't had any lately."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing; on 9/14/16 at 11:15 a.m. ASM #2 was asked to review the "Psychoactive Medication Monthly Flow Record" for Resident #5. When asked what the targeted behavior was for Resident #5's use of the Risperidone, ASM #2 stated, "Her targeted behaviors are not listed on the behavior sheets." When asked if they should be documented and monitored, ASM #2 stated, "Yes, Ma'am."

The facility policy, "Psychoactive Medication Policy" documented in part, "Procedure: ...Nursing staff will document targeted behaviors and side effects related to the use of psychoactive medications as indicated."

The administrator and ASM #2 were made aware of the above concern on 9/14/16 at 5:10 p.m.

No further information was provided prior to exit.

(1)This information was taken from the following website: http://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012012/?report=details
(2) Barron's Medical Guide - Dictionary of Medical

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F 329	Continued From page 50 Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 104. (3) Barron's Medical Guide - Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 557.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to ensure the sanitation was maintained in the three compartment sink. The sanitation solution was found, on two occasions, not to be at the required level for proper sanitization of the dishware. The findings include: This surveyor observed the kitchen on 9/13/16 at 10:10 a.m. accompanied by other staff member (OSM) #2, the dietary manager. The three compartment sink was in use with pots draining on the drain board. OSM #2 was asked to test the sanitizing solution. OSM #2 tested and the	F 371	**F371** **1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** The Dietary Manager has completed a department in-service with the dietary employees on proper level of sanitizer for use in the 3 compartment sink. **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** The Dietary Manager has completed a department in-service with the dietary employees on proper level of sanitizer for use in the 3 compartment sink. Proper level of sanitizer will be maintained in the 3 compartment sink.	**10/28/2016** **10/28/2016** **10/28/2016**

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solution twice. Each time the solution was at 50 ppm (parts per million). When asked at what level the sanitizing solution should be at, OSM #2 stated, "Two hundred parts per million." OSM #2 proceeded to empty the sink.

On 9/14/16 at 8:40 a.m. an observation of the three compartment sink was conducted. The sink with the sanitizing solution had a large pot in it. OSM #3, a dietary aide, was asked to test the sanitizing solution in the sink. OSM #3 read the strip as 100 ppm. When asked what level should the sanitizing solution in the sink be at, OSM #3 stated, "Two hundred parts per million." OSM #3 removed the pot out of the sanitizing solution and put it on the side to drain. When asked if the pot was properly sanitized, OSM #3 stated, "No, its just habit to take it out of there and put to drain." OSM #3 removed the pot and put it back in the rinse sink while the sanitizing sink was refilling.

On 9/14/16 at 8:59 a.m. the sink was retested by OSM #2. The test strip read at 400 ppm. When asked if the facility uses chlorine or QAC (quaternary ammonium compounds (1)) for sanitizing, OSM #2 stated, "We use QAC." A copy of the facility policy and the manufacturer's instruction for the test strips was requested.

The facility policy, "Proper Three-Compartment Sink Wash Policy and Procedure" documented, "Clean and sanitize all compartments and drain boards before each use. 1. First sink, WASH - Hot soapy water. 2. Second Sink, Rinse - Hot clean water. 3. Third Sink, Sanitize - 50 ppm Chlorine or 200 ppm Quat. Immerse washed and rinsed utensils in sanitizer for one minute., AIR DRY clean items before storage or use. Do Not Towel Dry. Check or change sanitizer often.

3. What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur?

CDM will monitor level of sanitizer in the 3 compartment sink x5 weekly x2 week to ensure level is maintained per facility policy. **10/28/2016**

4. How does the facility plan to monitor it's performance to make sure that the solutions are sustained?

CDM will report results/ findings (from #3) and recommendations to the QA committee. **10/28/2016**

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F 371	Continued From page 52 Have proper chemical test kits available." The "QAC QR Test Strips" instructions documented, "1. Immerse pad in solution and remove immediately. 2. Hold strip level for 5 seconds. Shake off excess water from pad. Compare pad to color chart above." The administrator was made aware of the above concern on 9/14/16 at 10:13 a.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://nems.nih.gov/soc/Pages/Quaternary-Ammonium-Compounds-(QACs-or-Quats).aspx	F 371		
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide therapy services as ordered for one of 15 residents in the survey sample, Resident #6.	F 406	**F406** **1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** Resident #6 was evaluated by a Physical Therapist. Physical Therapist determined and documented that resident #6 would not benefit from physical therapy services.	**10/28/2016**

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The facility staff failed to conduct a physical therapy evaluation for Resident #6 as recommended by the physical therapy assistant and ordered by Resident #6's medical doctor.

The findings include.

Resident #6 was admitted to the facility on 2/19/14 with a readmission of 11/23/15 with diagnoses that included, but were not limited to; dementia, benign prostatic hyperplasia (BPH - an enlargement of the prostate), hematuria (blood in the urine), asthma, altered mental status, depression and chronic obstructive pulmonary disease.

Resident #6's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 8/17/16. Resident #6 was coded as a 99 on the Brief Interview for Mental Status (BIMS), indicating tha the resident was unable to complete the interview and required a staff assessment which coded Resident #6 as severely impaired with cognitive skills for daily decision making.

A review of Resident #6's clinical record revealed in part, the following telephone order; "(Resident #6's name) 8/3/16 8:00 a.m. TVO (telephone verbal order) PT (physical therapy) to evaluate and treat as indicated." The order was received by RN (registered nurse) #1, the MDS coordinator, noted (a process of order verification) by an LPN (licensed practical nurse) on 8/10/16 at 0400 (4:00 a.m.) and signed by the physician on 8/9/16.

Further review of Resident #6's clinical record did

2. How will the facility identify other residents having the potential to be affected by the same deficient practice?

DON/ Designee will review physician orders for the last 30 days to ensure that all orders for physical therapy have been addressed with appropriate documentation by the therapy department. **10/28/2016**

3. What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur?

RSM will educate therapy staff to complete evaluations as ordered in a timely fashion. (by priority of need, not to exceed 10 working days) **10/28/2016**

DON and/ or designee will audit physical therapy orders x2 weeks to ensure that orders for physical therapy services are completed timely and with appropriate documentation. **10/28/2016**

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not reveal any documentation that evidenced there had been a physical therapy evaluation.

On 9/14/16 at 10:05 a.m. an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 was shown the order for the physical therapy (PT) evaluation and was asked to provide evidence that the evaluation was completed as ordered. ASM #2 stated that physical therapy had determined that it would not be appropriate to conduct the therapy evaluation secondary to Resident #6's diagnosis of dementia. ASM #2 was asked to provide evidence of that documentation, ASM #2 stated that she did not know if there was any documentation.

On 9/14/16 at 2:05 p.m. an interview was conducted with OSM (other staff member) #1, the PTA (physical therapy assistant). OSM #1 was asked whether or not a physical therapy evaluation was completed for Resident #6. OSM #1 stated that she had done Resident #6's quarterly assessment for the MDS and had recommended a PT evaluation at that time. The information had been provided to the MDS Coordinator who then obtained an order from the physician. OSM #1 further stated, "We have lots of evaluation requests, PT is only here 1 (one) time each week and so it's overwhelming." OSM #1 was asked whether or not the evaluation was done as ordered. OSM #1 stated, "It was not done."

On 9/14/16 at 2:50 p.m. an interview was conducted with RN (registered nurse) #1, the MDS Coordinator. When asked about the order for Resident #6 to receive a PT evaluation, RN #1 stated that she was asked by the PTA to obtain

F 406

4. How does the facility plan to monitor it's performance to make sure that the solutions are sustained?

DON will report results to the QA committee. Findings and results will be reflected in the QA minutes.

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an order based on her quarterly PT screening for the MDS and PT requires an active order from the physician to conduct an evaluation. RN #1 was asked why it was not done. RN #1 stated, "I was aware it was not done, I knew he (Resident #6) was on the list to be evaluated but I don't know why it was never done." RN #1 was asked whether or not it should have been done. RN #1 stated, "Yes it should have been done."

On 9/14/16 at 5:10 p.m. an end of day meeting was conducted with ASM #1, the administrator and ASM #2, the director of nursing. ASM #1 and ASM #2 were made aware of the above findings. No further information was provided prior to the end of the survey process.

F 406

F 502 483.75(j)(1) ADMINISTRATION

SS=D

F 502

The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to perform a physician-ordered laboratory test for one of 15 residents in the survey sample, Resident #8.

The facility staff failed to perform a blood test for Lamictal (1) levels ordered on 8/8/16 for Resident #8.

The findings include:

F502

1. **How will corrective action be accomplished for those residents found to have been affected by the deficient practice?**

   Blood test for Lamictal for resident #8 was obtained on 10/03/16. **10/28/2016**

2. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** **10/28/2016**

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Resident #8 was admitted to the facility on 6/14/16 with diagnoses including, but not limited to: seizure disorder (2), dementia with behaviors, Alzheimer's disease and diabetes. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 8/21/16, she was coded as being moderately impaired for making daily decisions.

A review of Resident #8's clinical record revealed the following order, written 8/8/16 by the physician: "V.O. (verbal order) [name of physician]. Draw blood for Lamotrigine Level."

Further review of Resident #8's clinical record failed to reveal evidence of results from this laboratory test.

A review of the comprehensive care plan for Resident #8 dated 6/14/16 revealed, in part, the following: "[Name of resident] has a seizure disorder...Obtain and monitor lab/diagnostic work as ordered. Report results to MD (physician) and follow up as indicated.

On 9/14/16 at 11:10 a.m., LPN (licensed practical nurse) #5 was interviewed regarding the laboratory testing process. She stated that you must have a physician's order to draw a lab (laboratory test). LPN #5 stated that the nurse in charge of the resident when the lab test is ordered must fill out the lab request slip. She stated this slip includes the specific test that needs to be done. LPN #5 stated the nurse notifies the staff member assigned to draw the labs and puts the lab test on the calendar for the day it is to be drawn. She stated lab orders are verified by a second nurse (usually the night nurse) to ensure accuracy.

F 502

DON or designee will audit physician's orders for Lamictal levels to ensure blood tests are completed per the physician's orders. **10/28/2016**

3. **What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur?**

DON will educate Licensed staff that Lamictal levels should be performed per physician's orders. **10/28/2016**

4. **How does the facility plan to monitor it's performance to make sure that the solutions are sustained?**

DON or designee will monitor resident's with physician's orders for Lamictal levels to be obtained to ensure physician's orders are followed. **10/28/2016**

DON will report results to the QA committee. Findings and results will be reflected in the QA minutes. **10/28/2016**

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On 9/13/16 at 4:50 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of this concern.

On 9/14/16 at 8:25 a.m., ASM #1 stated the Lamictal level test was never performed. She stated the staff checked the wrong box on the lab request slip and a different laboratory test was performed in place of the Lamictal level.

A review of the facility policy entitled "Laboratory Policy and Procedure" revealed, in part, the following: "Purpose: To obtain for the residents of [name of facility] the appropriate laboratory levels to promote the best quality of life as indicated. Nursing staff will obtain the lab work per the MD order."

No further information was provided prior to exit.

(1) "Lamotrigine (Lamictal) extended-release (long-acting) tablets are used with other medications to treat certain types of seizures in patients who have epilepsy." This information is taken from the website https://medlineplus.gov/druginfo/meds/a695007.html.
(2) "Seizures are symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. When people think of seizures, they often think of convulsions in which a person's body shakes rapidly and uncontrollably. Not all seizures cause convulsions. There are many types of seizures and some have mild symptoms. Seizures fall into two main groups. Focal seizures, also called partial seizures, happen in just one part of the

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brain. Generalized seizures are a result of abnormal activity on both sides of the brain." This information is taken from the website https://medlineplus.gov/seizures.html

According to Fundamentals of Nursing, 5th Edition, Lippincott Williams & Wilkins, 2007, Page 165: "Laboratory tests are always interpreted in relation to the client's underlying health problems and treatment modalities. These results can also identify actual or potential health problems....Sometimes, laboratory tests and diagnostic procedures are used to judge the effectiveness of nursing interventions or medical treatment."

F 504 SS=D 483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN

The facility must provide or obtain laboratory services only when ordered by the attending physician.

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 perform a physician-ordered laboratory test for one of 15 residents in the survey sample, Resident #8.

The facility staff failed to perform a blood test for Lamictal (1) levels ordered on 8/8/16 for Resident #8.

The findings include:

Resident #8 was admitted to the facility on

F 502

F 504

F504

1. **How will corrective action be accomplished for those residents found to have been affected by the deficient practice?**

   Blood test for Lamictal for resident #8 was obtained on 10/03/16. **10/28/2016**

2. **How will the facility identify other residents having the potential to be affected by the same deficient practice?**

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6/14/16 with diagnoses including, but not limited to: seizure disorder (2), dementia with behaviors, Alzheimer's disease and diabetes. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 8/21/16, she was coded as being moderately impaired for making daily decisions.

A review of Resident #8's clinical record revealed the following order, written 8/8/16 by the physician: "V.O. (verbal order) [name of physician]. Draw blood for Lamotrigine Level."

Further review of Resident #8's clinical record failed to reveal evidence of results from this laboratory test.

A review of the comprehensive care plan for Resident #8 dated 6/14/16 revealed, in part, the following: "[Name of resident] has a seizure disorder...Obtain and monitor lab/diagnostic work as ordered. Report results to MD (physician) and follow up as indicated.

On 9/14/16 at 11:10 a.m., LPN (licensed practical nurse) #5 was interviewed regarding the laboratory testing process. She stated that you must have a physician's order to draw a lab (laboratory test). LPN #5 stated that the nurse in charge of the resident when the lab test is ordered must fill out the lab request slip. She stated this slip includes the specific test that needs to be done. LPN #5 stated the nurse notifies the staff member assigned to draw the labs and puts the lab test on the calendar for the day it is to be drawn. She stated lab orders are verified by a second nurse (usually the night nurse) to ensure accuracy.

F 504

DON or designee will audit physician's orders for Lamictal levels to ensure blood tests are completed per the physician's orders. **10/28/2016**

3. **What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur?**

DON will educate Licensed staff that Lamictal levels should be performed per physician's orders. **10/28/2016**

4. **How does the facility plan to monitor it's performance to make sure that the solutions are sustained?**

DON or designee will monitor resident's with physician's orders for Lamictal levels to be obtained to ensure physician's orders are followed. **10/28/2016**

DON will report results to the QA committee. Findings and results will be reflected in the QA minutes. **10/28/2016**

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On 9/13/16 at 4:50 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of this concern.

On 9/14/16 at 8:25 a.m., ASM #1 stated the Lamictal level test was never performed. She stated the staff checked the wrong box on the lab request slip and a different laboratory test was performed in place of the Lamictal level.

A review of the facility policy entitled "Laboratory Policy and Procedure" revealed, in part, the following: "Purpose: To obtain for the residents of [name of facility] the appropriate laboratory levels to promote the best quality of life as indicated. Nursing staff will obtain the lab work per the MD order."

No further information was provided prior to exit.

(1) "Lamotrigine (Lamictal) extended-release (long-acting) tablets are used with other medications to treat certain types of seizures in patients who have epilepsy." This information is taken from the website https://medlineplus.gov/druginfo/meds/a695007.html.
(2) "Seizures are symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. When people think of seizures, they often think of convulsions in which a person's body shakes rapidly and uncontrollably. Not all seizures cause convulsions. There are many types of seizures and some have mild symptoms. Seizures fall into two main groups. Focal seizures, also called partial seizures, happen in just one part of the brain. Generalized seizures are a result of

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F 504	Continued From page 61 abnormal activity on both sides of the brain." This information is taken from the website https://medlineplus.gov/seizures.html According to Fundamentals of Nursing, 5th Edition, Lippincott Williams & Wilkins, 2007, Page 165: "Laboratory tests are always interpreted in relation to the client's underlying health problems and treatment modalities. These results can also identify actual or potential health problems....Sometimes, laboratory tests and diagnostic procedures are used to judge the effectiveness of nursing interventions or medical treatment."	F 504		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for two of 15 residents in	F 514	**F514** **1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice?** Physician's progress note for 08/30/16, for resident #5, was obtained and placed on the medical record. Physician's progress notes accurately reflect correct dose of medications for resident #5.	**10/28/2016** **10/28/2016**

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F 514	Continued From page 62 the survey sample, Residents #5 and #8. 1.a. The facility staff failed to ensure the physician progress note of 8/30/16 was in the clinical record for Resident #5. b. The facility staff failed to ensure the physician progress notes were accurate with the current dose of medication for Resident #5. 2. The facility staff failed to document in the clinical record two falls for Resident #8 (7/22/16 and 8/8/16). The findings include: 1.a. Resident #5 was admitted to the facility on 8/13/08 with diagnoses that included but were not limited to: cardiomegaly (enlargement of the heart (1)), osteoarthritis, Alzheimer's disease, restlessness, agitation and tachycardia (rapid heartbeat (2)). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/20/16, coded the resident has being severely impaired to make daily cognitive decisions and as having both short and long term memory difficulties. The resident was coded as being dependent upon one or more staff members for all of her activities of daily living. The nurse's note dated, 8/30/16 at 3:06 p.m. documented, "(Name of doctor) in to see, no new orders." Review of the clinical record revealed the last physician progress note was dated on 7/14/16.	F 514	The falls of resident # 8 have been documented in the clinical record. **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** DON or designee will audit physician's visits for the last 30 days to ensure physician's progress notes are maintained in the medical record. DON or designee will audit physician's progress notes for the last 30 days to ensure physician's progress notes include accurate and current doses of medications listed. DON or designee will audit falls within the last 30 days to ensure falls are documented in the medical record.	**10/28/2016** **10/28/2016** **10/28/2016**

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On 9/14/16 at 10:00 a.m., an interview was conducted with administrative staff member (ASM) #2, the director of nursing. ASM #2 was asked the process and timeframe for the physician notes to be on the clinical record, if a doctor dictates their progress notes. ASM #2 stated, "They are usually here within a week." When asked where the progress note was for the doctor's visits of 8/30/16, ASM #2 stated, "I'll have to look for that."

On 9/14/16 at approximately 10:30 a.m. a copy of the physician's progress note was presented to this surveyor. The progress note was dated 8/30/16. At the bottom of the page was documented, "Printed on September 14, 2016."

On 9/14/16 at 11:30 a.m., an interview was conducted with ASM #3, the physician for Resident #5. ASM #3 was asked what process he follows for dictating his progress notes after examining a resident. ASM #3 stated, "I take notes on a piece of paper or on a copy of my last visit and then go back to my office and dictate them. After they are typed up, one of my office staff faxes it over to (Name of facility). They usually get there the next day after they are typed up." ASM #3 was informed the progress note for his 8/30/16 visit was not in the chart and was documented as having been printed on 9/14/16. ASM #3 stated, "More likely we missed that in my office. It may have been our fault in my office. I take full responsibility for that."

The facility policy, "Documentation" documented in part, "Documentation shall be complete, legible and entered into the medical record in a timely manner."

3. What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur?

DON or designee will educate Dr. Byrd that physician progress notes should be accurate and received at the facility in a timely manner, (7-10 days). **10/28/2016**

DON or designee will educate all licensed staff that falls should be documented in the medical record. **10/28/2016**

4. How does the facility plan to monitor it's performance to make sure that the solutions are sustained?

DON or designee will audit physician progress notes of 5 residents weekly for 2 weeks to ensure that physician's progress notes are accurate and placed on the medical record in a timely manner. **10/28/2016**

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The administrator and ASM #2 were made aware of the above findings on 9/14/16 at 5:10 p.m.

No further information was provided prior to exit.
(1) Barron's Medical Guide - Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 104.
(2) Barron's Medical Guide - Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 557.

b. The facility staff failed to ensure the physician progress notes were accurate with the current dose of medication for Resident #5.

The June 2016 POS (physician order summary), signed by the physician on 6/16/16, documented, "Risperidone (an antipsychotic medication (1)) 0.25 mg (milligrams); take 1 tablet by mouth every morning for psychological behavior/symptoms of dementia. Risperidone 0.5 mg; take 1 tablet by mouth evening at 1700 (5:00 p.m.) for psychological behaviors/symptoms of dementia."

The July 2016 POS, signed by the physician on 7/14/16, documented, Risperidone 0.5 mg; take 1 tablet by mouth evening at 1700 for psychological behaviors/symptoms of dementia." Handwritten on the POS was documented, "D/C Risperidone 0.25 mg." The physician's signature was documented under this order.

The August 2016 POS, signed by the physician on 8/30/16, documented, "Risperidone 0.5 mg; take 1 tablet by mouth evening at 1700 for psychological behaviors/symptoms of dementia."

F 514

DON or designee will audit fall incident reports weekly for 2 weeks to ensure falls are documented in the medical record. **10/28/2016**

DON will report results to the QA committee. Findings and results will be reflected in the QA minutes. **10/28/2016**

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The physician progress note dated, 6/16/16, documented, "Assessment/Plan: 6. Alzheimer's dementia - Continue Risperdal (Risperidone) at 0.5 mg twice daily. The patient's dementia is severe."

The physician progress note dated, 7/14/16, documented, "Assessment/Plan: 6. Alzheimer's dementia - Continue Risperdal (Risperidone) at 0.5 mg twice daily. The patient's dementia is severe."

The physician progress note dated, 8/30/16 documented, "Assessment/Plan: 6. Alzheimer's dementia - Continue Risperdal (Risperidone) at 0.5 mg twice daily. The patient's dementia is severe."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing; on 9/14/16 at 11:15 a.m. ASM #2 was asked to review the POS for June, July, and August 2016. ASM #2 was then asked to review the physician progress notes for June, July and August 2016. When asked if the physician progress notes should match what the current therapies ordered, ASM #2 stated, "Absolutely yes."

An interview was conducted with ASM #3, the resident's physician, on 9/14/16 at 11:39 a.m. When asked if his notes should reflect the resident's current treatment plan, ASM #3 stated, "Yes." When asked about his process for dictating his notes, ASM #3 stated, "I take notes on a copy of my previous visit and jot down notes, changes I've made. I go back to my office and within a day or the longest two days, I dictate the notes. My notes are templated and I obviously make changes when I dictate." The POS for June, July

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and August 2016 and his progress notes for June, July and August 2016 were reviewed with ASM #3. ASM #3 stated, "You are correct, I missed that. It should reflect what the current dose of the medication is."

A review of the facility policy entitled "Documentation" revealed, in part, the following: "Purpose: To ensure the facility's residents (sic) medical record reflects documentation of pertinent facts, findings and observations about residents...Documentation will include, but is not limited to active and relevant resident information, assessments, flowsheets, notes, diagnostic results, plans of care, and medication administration records."

The administrator and director of nursing were made aware of the above findings on 9/14/16 at 5:10 p.m.

No further information was provided prior to exit.

(1)This information was obtained from the following website: http://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012012/?report=details.

2. The facility staff failed to document in the clinical record two falls for Resident #8 (7/22/16 and 8/8/16).

Resident #8 was admitted to the facility on 6/14/16 with diagnoses including, but not limited

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to: seizure disorder (2), dementia with behaviors, Alzheimer's disease and diabetes. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 8/21/16, she was coded as being moderately impaired for making daily decisions. She was coded as having two falls during the look back period, with neither fall having caused a major injury.

A review of the clinical record for Resident #8 revealed the following nurses notes:

- 7/22/16 at 2:53 p.m.: "S/P (status-post, or following) fall on nocs (night shift)...vs (vital signs) wnl (within normal limits) as well as neuro (neurological) chks (checks) wnl..."

- 8/8/16 at 9:35 p.m.: "No apparent injuries noted from fall at this time."

Further review of the clinical record failed to reveal evidence of documentation of the falls to which these nurses notes referred.

A review of facility incident reports revealed reports of falls for Resident #8 occurring on 7/22/16 and 8/8/16.

On 9/14/16 at 11:10 a.m., LPN (licensed practical nurse) #5 was interviewed. She stated that if a resident falls, a nurses note should be written and an incident report should be completed. She stated the nurse in charge of the resident at the time of the fall is responsible for documenting this in the clinical record. When asked if the incident report is part of the resident's clinical record, LPN #5 stated: "No, I don't think it is."

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On 9/14/16 at 12:20 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated that every fall should be documented by the nurse in the resident's clinical record. She stated the falls should be included in the nurses notes, as well as in the incident report. When asked if the incident report is part of a resident's clinical record, ASM #2 stated: "No, the investigation is not a part of the clinical record."

On 9/14/16 at 5:15 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns.

A review of the facility policy entitled "Documentation" revealed, in part, the following: "Purpose: To ensure the facility's residents (sic) medical record reflects documentation of pertinent facts, findings and observations about residents...Documentation will include, but is not limited to active and relevant resident information, assessments, flowsheets, notes, diagnostic results, plans of care, and medication administration records."

No further information was provided prior to exit.

(1) "Seizures are symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. When people think of seizures, they often think of convulsions in which a person's body shakes rapidly and uncontrollably. Not all seizures cause convulsions. There are many types of seizures and some have mild symptoms. Seizures fall into two main groups. Focal seizures, also called partial seizures, happen in just one part of the brain. Generalized seizures are a result of

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abnormal activity on both sides of the brain." This information is taken from the website https://medlineplus.gov/seizures.html.