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

PRINTED: 09/30/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495114	A. BUILDING _____ B. WING _____	R-C 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY CARE OF ARLINGTON, LLC	1785 SOUTH HAYES STREET ARLINGTON, VA 22202

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(F 000)	INITIAL COMMENTS	(F 000)		

An unannounced Medicare/Medicaid revisit to the standard survey conducted 8/2/16 through 8/4/16 was conducted 9/19/16 through 9/22/16. Four complaints were investigated during the survey. Significant corrections are required for compliance with the following Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567-B.

The census in this 240 bed facility was 147 at the time of the survey. The survey sample consisted of sixteen current resident reviews (Residents #101 through #105; 107 through 114 and 116 through 118) and two closed record reviews (Resident #106 and #115).

(F 279) SS=D 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

(F 279)

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under

This plan of correction is respectfully submitted as evidence of alleged compliance. This submission is not an admission that the deficiencies existed or that we are in agreement of them. It is an affirmation that corrections to the areas cited have been made and that the facility is in compliance with participation requirements.

F-Tag 279
Criterion #1- Correction
Resident # 103 smoking assessment was completed on 9/20/2016.

Resident # 103 smoking care plan initiated and individualized on 9/21/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Adm	10/5/16

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

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(F 279)	Continued From page 1 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, facility document review, and during the course of a complaint investigation, the facility staff failed to develop a CCP (comprehensive care plan) for one of 18 residents in the survey sample (Resident # 103). The facility staff failed to develop a CCP (comprehensive care plan) for Resident # 103 regarding smoking. Findings include: Resident # 103 was admitted to the facility on 07/20/16, with the most current readmission on 08/19/16. Diagnoses for Resident # 103 included, but were not limited to: anemia, HTN (high blood pressure), pneumonia, asthma, cellulitis of the right lower extremity and right knee replacement, and osteoarthritis. The most current MDS (minimum data set) with CAAS (care area assessment summary) was a 14 day admission assessment, dated 09/02/16. This MDS assessed the resident with a cognitive score of 13, indicating the resident was cognitively intact for daily decision making skills The resident was also assessed as requiring extensive assistance for transfers and ambulation. A complaint investigation was conducted on 09/19/16 through 09/22/16. The complaint	(F 279)	**Criterion #2- Other Potential** A 100% audits of all care plans of current residents who have been identified as smokers will be reviewed and revised by Social Services to ensure accurate information and intervention are addressed. A 100% audits of all smoking assessments of current residents who have been identified as smokers will be reviewed by Social Services to ensure accurate information in the medical record. **Criterion # 3- System Change** Licensed nursing staff and Social Services staff will be re-educated on the importance of completing and/or revising the comprehensive care plan and smoking assessment. Social Services will maintain an updated list of smokers. Any new residents who are admitted will be advised that the facility is a smoke free center per facility policy. The care plan will be updated as the resident's ability to smoke changes.	

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(F 279)	Continued From page 2	(F 279)		

alleged that the facility does not ensure smoking safety for residents.

On 09/20/16 at 8:50 a.m., Resident # 103 was interviewed in his room, with his wife present. The resident had a partial pack of cigarettes on the night stand beside his bed. The resident was asked about the cigarettes. The resident stated that he is a smoker, although he was trying to quit. The resident was asked if he goes outside to smoke alone. The resident stated that staff will ask me where I am going most of the time if they see me coming down the hall and I tell them I'm going to smoke and they will go with me. The resident stated, "She (pointing to his wife) goes with me most of the time." The resident further stated that there are specific times of when smoke breaks are. The resident was then asked if he ever went outside alone to smoke. The resident stated that, as a matter of fact he had went out last night (09/19/16) by myself and that he "got caught", the resident voiced that it was a little later than usual and his favorite nurse had caught him.

Resident # 103's clinical record was reviewed. No smoking assessment could be located within the clinical record.

The resident's current CCP was reviewed. No information was found on the resident's CCP regarding smoking.

The resident's current/active POS (physician's order sheet) was reviewed and documented, "...May participate in supervised field trips.." No information was found on the POS regarding smoking

Criterion #4- Monitoring

Weekly x 6 and every-other-week x 6 Social Services or designee will monitor the residents who smoke to ensure all smoking assessments and care plans remain up to date. Weekly x 8 ADON/designee will randomly audit 5 smoking assessments and care plans to ensure they are completed and updated. Analysis of the audits will be given to the QA Committee for additional oversight and recommendation.

Criterion #5- The facility dutifully alleges compliance of these tasks on or before 10/11/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement

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{F 279}	Continued From page 3	{F 279}		

On 09/20/16 at 10:45 a.m., the DON (director of nursing) was asked for the facility's smoking policy

The smoking policy was presented and reviewed. The policy documented, "Policy and Procedure Topic. Smoking...Date initiated: 09/01/16...The facility promotes a safe, healthy and smoke free environment...Residents who resided at the facility prior to August 11, 2016, and who smoked will continue to have the right to smoke at the facility following safe smoking protocols ..1. Prior to admission and during the admission process, the resident and/or responsible party will be advised in writing of the facility smoking policy. 2. The resident's desire to smoke and any needed assistance/supervision will be addressed in the resident's comprehensive plan of care...the facility does not allow for residents to keep any flammable smoking materials in their room...4. Identified resident (sic) who wishes (sic) to utilize the designated outdoor smoking areas will be assessed by the nursing department using the Safe Smoking Assessment..."

On 09/20/16 at approximately 4:00 p.m., in a meeting with the survey team, the administrator, DON (director of nursing) and the ADON (assistant director of nursing) were asked, where the smoking assessments were located for residents. The DON pointed to the computer and stated that they were in the computer. The above staff were informed that a smoking assessment could not be located for Resident # 103 and that the resident's CCP did not mention smoking.

On 09/21/16 at approximately 3:50 p.m., the DON, administrator and ADON were again made aware of concerns regarding the above

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(F 279) SS=D	Continued From page 4 information. The DON stated, that the resident did not tell them (facility staff) that he smoked and further stated that a smoking assessment had been completed and that information was on the CCP. The information was presented to this surveyor. This surveyor asked, if the DON if the assessment and care plan was completed after bringing it to the facility's attention on 09/20/16. The DON stated, "Yes." No further information or documentation was presented prior to the exit conference on 09/22/16 at 10.45 a.m. to evidence that Resident # 103 was assessed by facility staff to ensure the resident was safe to smoke and no evidence was found to evidence that a CCP was developed for Resident # 103 in regards to smoking. This is a complaint deficiency.	(F 279)		
(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	(F 280)	F-Tag 280 **Criterion # 1 Correction** Resident #112 care plan was revised on 10/3/16 to address stage 3 pressure injury development, goals, and current interventions. **Criterion #2 Other Potential** A 100% audit of care plans for residents with pressure ulcers will be done to ensure care plans are completed, reviewed and revised as needed. **Criterion # 3-System Change** Licensed nursing staff and MDS Coordinators will be re-educated on the importance of reviewing and revising the care plan to reflect resident's condition changes and current interventions.	

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(F 280) Continued From page 5 (F 280)

and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, clinical record review, facility document review and during the course of a complaint investigation the facility staff failed to review and revise the CCP (comprehensive care plan) for one of 18 residents. (Resident # 112).

The facility staff failed to review and revise the CCP for Resident # 112 in the area of pressure ulcers.

Findings include:

Resident # 112 was admitted to the facility on originally on 03/11/16, with the most current readmission on 07/05/16. Diagnoses for Resident # 112 included, but were not limited to: PVD (peripheral vascular disease), atrial fibrillation, ESRD (end stage renal disease) requiring hemodialysis, and arthritis

The most current MDS (minimum data set) was a significant change assessment dated 09/05/16. This MDS assessed the resident with a cognitive score of 15, indicating the resident was cognitively intact. The resident was also assessed as requiring extensive assistance with dressing, toileting, hygiene and bathing, with assistance of at least one staff member physical assist. The resident triggered in the CAAS (care area assessment summary) section for pressure

Criterion # 4-Monitoring
A weekly audit of 6 care plans for residents with pressure ulcers will be done x 6 weeks and then a random sample of 5 residents weekly x 4 weeks and then at least 2 residents weekly x 4 weeks by MDS Coordinator/designee to ensure that the care plan appropriately addresses pressure ulcer care. Finding will be reported to DON/ADON for trends and patterns. Analysis of the audits will be given to the QA Committee for additional oversight and recommendation.

Criterion #5- The facility dutifully alleges compliance of these tasks on or before 10/11/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement

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{F 280} Continued From page 6 {F 280}

ulcers.

During an interview with Resident # 112 on 09/19/16 at 4.00 p.m., the resident stated that there is a absence of care on the night shift as far as changing briefs. The resident stated that if he needs to be changed on the night shift, he will use the call bell to tell them (staff) and that staff will tell me (resident) that we (staff) have changed you already, you will have to wait. The resident stated that it is consistently on the night shift. The resident was asked, how this made him feel. The resident stated, "Pissed off!" The resident was then asked if he had a bruise on his bottom and was informed of a complaint that alleged the resident had a large bruised area over his bottom. The resident stated, that he could not see it, but there had been discoloration. The resident stated that he felt like the staff not changing him on night shift had contributed to the condition of his bottom. The resident was asked to clarify, and was asked if he (resident) thought the bruised area was from staff not changing him on the night shift. The resident stated, "Yes." The resident was then asked if he had any open areas on his bottom. The resident stated, "Yes."

Resident # 112's clinical records were reviewed.

A "Skin Observation Tool-Licensed Nurse" was reviewed dated 07/12/16 and timed 6:30 p.m.

This form had a picture of a human body, with numbers corresponding to 52 different areas over the body to accurately identify the location of concern on the body. The form also had a description area to the right of the body image that described skin conditions in detail, which documented:

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(F 280)	Continued From page 7	(F 280)		

"Suspected Deep Tissue Injury-Purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Stage I-Intact skin with no-blanchable redness of a localized area usually over a bony prominence...Stage II-Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough...Stage III-Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV [4]-Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present. Unstageable-Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown or black) in the wound bed..." Below this area on the form was an area to document the site (area on the body with number), the type (type of wound/area), length, width, depth, and stage.

This form (dated 07/12/16) above described area was blank, section 2 under "Notes" documented the following: "Wound care treatment continues as ordered."

On 09/21/16 at 8:10 a.m., LPN # 1 stated that the resident was offered a low air mattress prior to the stage III and that the resident refused.

The resident's CCP (comprehensive care plan) was reviewed and documented, "...Bathing and

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(F 280) Continued From page 8

Showering: (03/12/16) Avoid scrubbing and pat dry sensitive skin...provide sponge bath when a full bath or shower cannot be tolerated. .Bed mobility: The resident requires limited assistance by (1) staff to turn and reposition .n every two hours and as necessary...Resident is totally dependent on (1) staff for dressing..requires extensive assistance by (1) staff for personal hygiene...totally dependent on (1) staff for toilet use...Anticipate and meet the resident's needs...The resident needs prompt response to all request for assistance...monitor wound healing progress...encourage good nutrition and hydration in order to promote healthier skin...keep skin clean and dry..." No further information was located on the resident's CCP regarding pressure ulcer prevention interventions.

Resident # 112 was interviewed again on 09/21/16 at 8:50 a.m , the resident stated that he did not like the air mattress and specifically named the bed an air maxx. The resident stated that staff had ordered one and put on his bed back in March, when he was first admitted. The resident stated that the mattress would get air pockets in it and it was extremely difficult for him to move at all. The resident stated that he felt like he was in a hole and he did not feel like that was good for him. The resident was asked if he could move and turn himself. The resident stated that he needed assistance from staff because of his dialysis graft in his left arm, he was not suppose to put a lot of pressure or weight on that arm and that he has weakness and can't really turn himself very well. The resident stated that he felt like a new, regular type of mattress would be better for him.

Resident # 112's nutrition/dietary information was

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then reviewed.

A nutritional risk assessment, completed by the RD (Registered Dietitian) was reviewed dated 07/10/16. This assessment documented that the resident has a significant weight loss over the last 30, 90, and 180 days and that the resident typically consumes an average of 50%. The assessment additionally documented that the resident required extensive assistance from staff for walking and did not have any problems feeding himself. No albumin information was listed and the assessment documented that the resident had wounds on his right 2nd and 5th toes. This assessment documented that the resident was high risk.

A nutritional risk assessment completed by the RN (Registered Nurse) # 4, dated 09/02/16 documented that the resident had intake of 76-100% and had a stage III/VI pressure ulcers or multiple impaired areas, suspected deep tissue injury. This form did not include any additional information and assessed the resident as a moderate risk.

The RD wrote a dietary note on 09/01/16 at 6:11 p.m.,which documented: "Visited with [name of Resident # 112] to discuss recommendations to support wound healing...protein bars available to him at all times and he was encouraged to eat at least one daily to support wound healing..."

The RD was interviewed on 09/21/16 at 10:15 a.m. regarding Resident # 112. The RD was asked how often are residents seen the RD stated that is based on their risk. The RD was made aware that Resident # 112 was assessed as a high risk on 07/10/16, five days after his

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readmission on 07/05/16. The RD was asked if an albumin had been obtained for Resident # 112. The RD stated that an albumin, is really not a useful determination of nutritional status, as it once was. The RD was asked, she would order something like an albumin. The RD stated, no and went on to say the physician would normally order that. The RD was asked if she collaborates with the resident's physician in regards to wound healing strategies. The RD stated, "Not really." No specific nutritional recommendations were found for Resident # 112 on the 07/101/6 nutritional assessment. The resident's CCP was reviewed and documented to monitor the resident's intake, liberalize diet, and to monitor for decreased appetite. No other nutritional interventions were found for Resident # 112.

The administrator, DON (director of nursing) and ADON were made aware of concerns regarding Resident # 112 being found with a stage III and that the resident's CCP did not reflect sufficient or adequate interventions for the prevention and or treatment of the resident assessed high risk skin.

(F 309) SS=D 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING (F 309)

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:

F-Tag 309
Criterion #1-Correction
Resident #111 has not demonstrated any adverse outcome from not receiving his pain medicine as ordered. Resident has received pain medication as ordered by physician since 9/20/16. The physician was notified of the pain medication that had not been documented as having been administered.

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Based on staff interview, clinical record review and in the course of a complaint investigation, the facility staff failed to follow physician's orders for medication administration for one of 18 residents in the survey sample (Resident # 111)

The facility staff failed to ensure Resident # 111's pain medication (Fentanyl patch and Hydromorphone) was administered per physician's order for Resident # 111

Findings include:

Resident # 111 was admitted to the facility originally in 2014, with the most recent readmission on 09/03/16. Diagnoses for Resident # 111 included, but were not limited to: malignant melanoma (a metastatic cancer), lymphocytic leukemia (a type of cancer of the blood and bone marrow), seizure disorder, anxiety disorder, insomnia (inability to sleep), dementia (memory and cognitive problems) and neuropathy (weakness, numbness and pain/usually in the hands and feet).

The most current MDS (minimum data set) was a significant change assessment dated 09/02/16. This MDS assessed the resident with a cognitive score of "9", indicating the resident had moderate impairment in daily decision making skills. The resident was additionally assessed with pain on this MDS, as being frequent and severe. The resident also triggered for pain in the CAAS (care area assessment summary) section of this MDS.

During a complaint investigation on 09/19/16 through 09/22/16, Resident # 111's clinical records were reviewed. A complaint was investigated regarding Resident # 111, with an

(F 309)

Criterion # 2-Other Potential
A 100% audit will be done for current residents to ensure all residents have their medications available.

Criterion # 3-System Change
Nursing staff will be re-educated on the importance of communicating with the physician and pharmacy on availability of medication(s) being ordered.

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allegation that the resident was in pain, when visited by family on 09/16/16 though 09/18/16 and that the resident did not receive pain medication in a timely manner.

Resident # 111 s current POS (physician's order set) was reviewed and documented the resident had orders for the pain medication, including but not limited to a Fentanyl patch 12 mcg (micrograms)/hour every 72 hours. This medication start date was 09/04/16 (discontinue on 09/17/16 at 12:41 a.m.), a Fentanyl patch 25 mcg/hour every 72 hours, which was suppose to start on 09/18/16 at 9:00 a.m. and for Hydromorphone (dilaudid) 4 mg (milligrams) every 4 hours PRN (as needed).

A nursing note (ORDER NOTE) dated 09/17/16 and timed 12:46 a.m. documented that the Fentanyl 25 mcg patch/hr apply 1 patch every 72 hours order, had been put into the computer system.

A Nursing note (Orders Administration Note) was reviewed and documented on 09/17/16 at 1:22 a.m., "N/A [not available/not administered] at this time."

The resident's MARs (medication administration records) were reviewed for September 2016. It was documented on the MAR for September 17th at 0122 (1:22 a.m.) that the Fentanyl 12 mcg patch was removed.

A nursing note (Orders Administration Note) dated 09/17/16 and timed 10:34 a.m. documented, "Pharmacy will send medication. Resident is comfortable tolerated PRN [as needed] pain med well."

Criterion # 4- Monitoring

Daily x 2 weeks, 3x week x 2 weeks, and then weekly x 6 weeks, 5 current residents and 5 new admissions/re-admissions orders will be validated by Unit Managers and/or designee to ensure availability of ordered medications. Variances will be investigated and corrections made as appropriate. Findings will be given to DON/ADON for tracking of patterns. An analysis of the weekly audits will be provided to the QA Committee for additional oversight and recommendation.

Criterion #5- The facility dutifully alleges compliance of these tasks on or before 10/11/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement

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The resident's MARs were further reviewed and documented that Resident # 111 did not get his Fentanyl 25 mcg patch until 3:35 p.m. on 09/20/16, over 3 days later. No Fentanyl 25 mcg patch was in place for approximately 81 hours.

Additional review of the resident's MARs for PRN (as needed) pain medication administration did not evidence that any PRN pain medication was administered from 09/17/16 through 09/18/16 The PRN pain medication (dilaudid 4 mg) was administered, according to the MAR on 09/19/16 at 7:05 p.m., approximately 41 hours later.

The resident's CCP (comprehensive care plan) was reviewed and documented, ".. The resident is dependent on staff for meeting emotional, intellectual, physical, and social needs...all staff are to converse with resident while providing care...administer medications as ordered...The resident has lump under the R (right) armpit (has dx [diagnosis] of CLL [chronic lymphocytic leukemia]...Administer analgesics as per MD [medical doctor] orders...Give pain meds as ordered...The resident has pain r/t [relate to] leukemia, history of dvt [deep vein thrombosis], chronic pain syndrome...anticipate the resident's need for pain relief and respond immediately to any complaint of pain...monitor/record/report to nurse any s/sx [signs/symptoms] of non-verbal pain: changes in breathing...vocalizations...mood/behavior .resident prefers to have pain controlled by dilaudid...encourage non-pharmacological interventions...encourage support system of family and friends..."

The DON (director of nursing), administrator,

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ADON (assistant director of nursing), and the corporate nurse were made aware in a meeting with the survey team on 09/21/16 at 3:50 p.m. regarding the allegations of the complaint that Resident # 111 did not receive his pain medications in a timely manner.

No further information or documentation was presented prior to the exit conference on 09/22/16 at 10:45 a.m., to evidence that Resident # 111 received his pain medication in a timely or as ordered by the physician.

This is a complaint deficiency.

F 312 SS=D 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS

F 312

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, clinical record review and complaint investigation, the facility staff failed to provide fingernail care for one of 18 residents in the survey sample. Resident #104 was observed with long, dirty fingernails.

The findings include:

Resident #104 was admitted to the facility on 3/19/16 with a re-admission on 7/1/16. Diagnoses for Resident #104 included

F-Tag 312

Criterion # 1- Correction

Resident # 104 has not demonstrated any adverse outcome. On 9/20/16 resident # 104 was assisted with nail care.

Criterion # 2- Other Potential

A 100% audit of current residents will be conducted by Unit Managers/Designee to ensure nails are clean and trimmed as appropriate.

Criterion # 3-System Change

Direct care staff will be re-educated on when, how and who can provide nail care and the importance of providing nail care.

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Parkinson's disease, end stage renal disease, chronic obstructive pulmonary disease (COPD), diabetes and high blood pressure. The minimum data set (MDS) dated 7/20/16 assessed Resident #104 as cognitively intact. This MDS listed Resident #104 required the extensive assistance of one person for hygiene.

On 9/20/16 at 8:00 a.m. Resident #104 was observed in bed. The resident had tremors/shaking of both hands that the resident stated was due to her Parkinson's disease. Resident #104's fingernails on each hand were long extending approximately 1/4 inch beyond the end of her fingertips. There was a black substance under the 3rd and 4th fingernail of the resident's left hand. Resident #104 was interviewed at this time about her fingernails. Resident #104 stated her nails were extremely long and needed to be cut. Resident #104 stated she did not want long nails but wanted them trimmed/cleaned.

Resident #104's plan of care (revised 9/1/16) documented the resident required assistance with performing activities of daily living due to her disease processes. Care plan interventions to meet activity of daily living needs included, "Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse."

On 9/20/16 at 8:05 a.m. accompanied by licensed practical nurse (LPN) #1, Resident #104's fingernails were observed. LPN #1 was interviewed at this time about the condition of Resident #104's nails. LPN #6 stated she would have to get with the head nurse to see who was supposed to cut the resident's nails.

Criterion # 4- Monitoring

Weekly x 6 weeks 6 current residents' nails per unit will be checked by unit managers and/or designee to ensure nail care is being provided. Findings will be given to DON/ADON for tracking patterns. Variances will be corrected. An analysis of the weekly audits will be provided to the QA Committee for additional oversight and recommendation.

Criterion #5- The facility dutifully alleges compliance of these tasks on or before 10/11/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement

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On 9/20/16 at 8:10 a.m. the registered nurse unit manager (RN #3) was interviewed about Resident #104's long fingernails. RN #3 stated the nurse aides were supposed to trim nails. RN #3 stated for some diabetics the nurses were required to cut nails. Concerning Resident #104, RN #3 stated the nursing aides were supposed to trim and clean her fingernails.

These findings were reviewed with the administrator and director of nursing during a meeting on 9/20/16 at 4:00 p.m.

This was a complaint deficiency

F 314 SS=G 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES

F 314

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, clinical record review, facility document review and during the course of a complaint investigation the facility staff failed to ensure skin assessments for the prevention of a Stage III pressure ulcer for one of 18 residents, (Resident # 112) resulting in actual harm

F-Tag 314

Criterion # 1-Correction

Treatment plan for resident #112 was re-evaluated to ensure the best course of treatment to prevent and heal pressure ulcer.

Criterion # 2- Other Potential

A 100% Skin assessment "Skin Sweep" will be done to ensure skin integrity is being maintained and treatment (s) will be re-evaluated for current residents who have pressure ulcers.

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The facility staff failed to complete a weekly, full body skin assessment on Resident # 112 for over 6 weeks, as a result a Stage III pressure ulcer was found on the resident on 08/29/16.

Findings include:

Resident # 112 was admitted to the facility on originally on 03/11/16, with the most current readmission on 07/05/16. Diagnoses for Resident # 112 included, but were not limited to: PVD (peripheral vascular disease), atrial fibrillation, ESRD (end stage renal disease) requiring hemodialysis, and arthritis.

The most current MDS (minimum data set) was a significant change assessment dated 09/05/16. This MDS assessed the resident with a cognitive score of 15, indicating the resident was cognitively intact. The resident was also assessed as requiring extensive assistance with dressing, toileting, hygiene and bathing, with assistance of at least one staff member physical assist.

During an interview with Resident # 112 on 09/19/16 at 4:00 p.m., the resident stated that there is a absence of care on the night shift as far as changing briefs. The resident stated that if he needs to be changed on the night shift, he will use the call bell to tell them (staff) and that staff will tell me (resident) that we (staff) have changed you already, you will have to wait. The resident stated that it is consistently on the night shift. The resident was asked, how this made him feel. The resident stated, "Pissed off!" The resident was then asked if he had a bruise on his bottom and was informed of a complaint that alleged the

Criterion # 3-System Change

Licensed nursing staff will be re-educated on how to identify and document skin issues

Licensed Nursing staff will be re-educated on prevention of pressure ulcer
Licensed Nursing staff will be re-educated on how to check the computer dashboard for alerts on issues relating to skin integrity and what to do when an alert is present.

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resident had a large bruised area over his bottom. The resident stated, that he could not see it, but there had been discoloration. The resident stated that he felt like the staff not changing him on night shift had contributed to the condition of his bottom. The resident was asked to clarify, and was asked if he (resident) thought the bruised area was from staff not changing him on the night shift. The resident stated, "Yes." The resident was then asked if he had any open areas on his bottom. The resident stated, "Yes."

Resident # 112's clinical records were reviewed.

Nursing notes were reviewed and documented the following:

08/29/16 (2:53 p.m.) "Resident is alert and verbally responsive. Able to make needs known. Routine nursing care provided...Resident left for dialysis this after noon around 1415 [2:15 p.m.] in stable condition. No acute distress noted upon departure..."

08/29/16 (3:09 p.m.) "Assigned CNA [certified nursing assistant] reported to the wound nurse that the resident has an open area. Resident was assessed by the wound nurse and the writer. Circular shape open area 1 cm [centimeters] in length and 0.8 cm in width noted on resident's right upper buttock. No drainage, nor bleeding, slight slough noted. Resident c/o [complained of] mild pain. Dr. [name of physician] was notified frequent turning and positioning was through out this shift..."

08/29/16 (5:55 p.m.) "new skin area observed on a [sic] resident Rt [right] upper buttock (stage 3) MD [medical doctor]. new order give..."

Criterion # 4-Monitoring

2x weekly x 4 weeks and then weekly x 8 weeks, 6 residents' skin will be assessed randomly by Unit Managers and/or designee. Discrepancies will be addressed.

Weekly x 12 weeks, the DON/ADON and/or designee will observe 5 residents' skin condition. Any discrepancies will be addressed.

On a monthly basis, the ADON/designee will forward the findings to the QA committee for review.

Criterion #5- The facility dutifully alleges compliance of these tasks on or before 10/11/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement

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Resident # 112's wound records were then reviewed.

A "Skin Observation Tool-Licensed Nurse" was reviewed dated 07/12/16 and timed 6:30 p.m

This form had a picture of a human body, with numbers corresponding to 52 different areas over the body to accurately identify the location of concern on the body. The form also had a description area to the right of the body image that described skin conditions in detail, which documented:

"Suspected Deep Tissue Injury-Purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Stage I-Intact skin with non-blanchable redness of a localized area usually over a bony prominence...Stage II-Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough...Stage III-Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV [4]-Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present...Unstageable-Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown or black) in the wound bed..." Below this area on the form was an area to document the site (area on the body with

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number), the type (type of wound/area), length, width, depth, and stage

This form (dated 07/12/16) above described area was blank, section 2 under "Notes" documented the following: "Wound care treatment continues as ordered."

The skin observation tool form dated 08/29/16 was then reviewed and documented, "Site: 31 Right buttock Type: Pressure Length: 2 [cm] Width: 1.5 Depth: [no depth was documented] Stage: III.. Notes: new skin area observed on a [sic] resident Rt upper buttock (stage 3) MD...notified new order given. 50% G [granulation tissue] 50 % S [slough]..."

LPN (Licensed Practical Nurse) # 1, also known as the wound nurse was interviewed on 09/21/16 at 8:10 a.m. LPN # 1 was asked if weekly skin assessments are done. LPN # 1 stated, yes and they are completed by the floor nurses and are called "Skin Observation Tool-Licensed Nurse." The LPN stated that she does an initial assessment on admission and whenever there is a brand new area found. LPN # 1 stated that once an area is found, she will take care of the wound, by notifying the physician, rounding with the wound clinic if that is ordered for a resident, completing measurements regarding progress and dressing changes for that particular wound, per the physician's orders. LPN # 1 stated that the floor nurses are responsible for the full body weekly skin assessment.

The LPN was askec to look at Resident # 112's full body skin assessments. LPN # 1 pulled up the Skin Observation Tool forms located in the electronic clinical record. The LPN was made

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aware that the last one done prior to the stage III was completed on 07/12/16. The LPN was made aware that over 6 weeks had passed since the last assessment was completed and now the resident had a stage III. The LPN again verbalized that these are done by the floor nurses.

LPN # 1 was asked about Resident # 112's stage III pressure ulcer and how this was found. LPN # 1 stated that it was reported on 08/29/16 by CNA # 2 and there was slough and necrotic tissue. LPN # 1 stated that she and the floor nurse went into assess it and notified the physician. LPN # 1 was asked how this went from nothing to a stage III. LPN # 1 stated that she wondered the same thing and stated that she started to investigate herself and went into the computer to see if anything could be found.

LPN # 1 stated that she had found where CNA # 3 documented in the computer on 08/18/16 that the resident's bottom was red, but she did not report it to anyone.

LPN # 5, also known as the Unit manager was interviewed and was asked who is responsible for the resident's weekly full body skin assessments. LPN # 5 stated, the floor nurses. The LPN was asked where those would be. The LPN voiced in the computer and pulled up the skin observation tool form; the LPN was made aware that the last one completed before finding the stage III was on 07/12/16.

Both LPN's were reviewed the electronic clinical record and became aware that no full body skin assessments could be located for Resident # 112 after 07/12/16. Both LPN's agreed that the last

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one completed prior to finding the stage III on Resident # 112, was dated 07/12/16.

LPN # 5 stated that the weekly full body assessments should be done weekly and that it should documented in the POC (plan of care). LPN # 5 was asked to clarify what she meant by POC. The LPN stated that it is in the computer and it triggers for the nurses to complete, but she didn't know why they were not completed.

LPN # 1 stated that the resident was offered a low air mattress prior to the stage III and that the resident refused. LPN # 1 was asked for dates regarding the mattress refusal.

Nursing notes were again reviewed and did not document anything regarding Resident # 112's buttock skin condition, in the days leading up to the discovery of the stage III, on 08/29/16.

A weekly wound evaluation form was reviewed dated 07/28/16.. This form documented an area on the resident's right second toe.

A weekly wound evaluation form dated 08/18/16 was reviewed. This form documented an area on the left first toe.

A weekly wound evaluation form dated 08/25/16 was reviewed. This form documented an area on the left shin.

A weekly wound evaluation form dated 09/02/16 was reviewed. This form documented the area on the right upper buttock, as acquired pressure of stage III and that granulation tissue and necrotic tissue was present.

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The resident's CCP (comprehensive care plan) was reviewed and documented, "...Bathing and Showering: (03/12/16) Avoid scrubbing and pat dry sensitive skin...provide sponge bath when a full bath or shower cannot be tolerated...Bed mobility: The resident requires limited assistance by (1) staff to turn and reposition in every two hours and as necessary. .Resident is totally dependent on (1) staff for dressing. requires extensive assistance by (1) staff for personal hygiene...totally dependent on (1) staff for toilet use...Anticipate and meet the resident's needs...The resident needs prompt response to all request for assistance...monitor wound healing progress...encourage good nutrition and hydration in order to promote healthier skin...keep skin clean and dry..." No further information was located on the resident's CCP regarding pressure ulcer prevention interventions.

A Documentation survey report for August 2016 was reviewed for CNA documentation. In the Skin observation it was documented on 08/01/16 and 08/02/16 that the resident had a discoloration to the skin (no location specified). On 08/11/16 it was documented the resident had a red area (no location). On 08/18/16 it was documented that the resident had a red area (no location). On 08/24/16 it was documented that the resident had discoloration (no location). On 08/26/16 it was documented that the resident had a red area (no location). On 08/29/16 it was documented that the resident had an open area (no location).

Resident # 112 was interviewed again on 09/21/16 at 8:50 a.m., the resident stated that he did not like the air mattress and specifically named the bed an air maxx. The resident stated that staff had ordered one and put on his bed

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back in March, when he was first admitted. The resident stated that the mattress would get air pockets in it and it was extremely difficult for him to move at all. The resident stated that he felt like he was in a hole and he did not feel like that was good for him. The resident was asked if he could move and turn himself. The resident stated that he needed assistance from staff because of his dialysis graft in his left arm, he was not suppose to put a lot of pressure or weight on that arm and that he has weakness and can't really turn himself very well. The resident stated that he felt like a new, regular type of mattress would be better for him.

Resident # 112's nutrition/dietary information was then reviewed.

A nutritional risk assessment, completed by the RD (Registered Dietitian) was reviewed dated 07/10/16. This assessment documented that the resident has a significant weight loss over the last 30, 90, and 180 days and that the resident typically consumes an average of 50%. The assessment additionally documented that the resident required extensive assistance from staff for walking and did not have any problems feeding himself. No albumin information was listed and the assessment documented that the resident had wounds on his right 2nd and 5th toes. This assessment documented that the resident was high risk.

A nutritional risk assessment completed by the RN (Registered Nurse) # 4, dated 09/02/16 documented that the resident had intake of 76-100% and had a stage III/VI pressure ulcers or multiple impaired areas, suspected deep tissue injury. This form did not include any additional

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information and assessed the resident as a moderate risk.

The RD wrote a dietary note on 09/01/16 at 6:11 p.m.,which documented: "Visited with {name of Resident # 112} to discuss recommendations to support wound healing...protein bars available to him at all times and he was encouraged to eat at least one daily to support wound healing..."

The RD was interviewed on 09/21/16 at 10:15 a.m. regarding Resident # 112. The RD was asked how often are residents seen the RD stated that is based on their risk. The RD was made aware that Resident # 112 was assessed as a high risk on 07/10/16, five days after his readmission on 07/05/16. The RD was asked if an albumin had been obtained for Resident # 112. The RD stated that an albumin, is really not a useful determination of nutritional status, as it once was. The RD was asked, she would order something like an albumin. The RD stated, no and went on to say the physician would normally order that. The RD was asked if she collaborates with the resident's physician in regards to wound healing strategies. The RD stated, "Not really." No specific nutritional recommendations were found for Resident # 112 on the 07/10/16 nutritional assessment. The resident's CCP was reviewed and documented to monitor the resident's intake, liberalize diet, and to monitor for decreased appetite. No other nutritional interventions were found for Resident # 112.

On 09/21/16 at approximately 10:40 a.m., the ADON (assistant director of nursing) was interviewed and was asked how do you know who which residents are to receive weekly skin assessments. The ADON stated that on

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admission, MDS does their assessment and then enters it into the computer. The ADON stated that it doesn't matter if a resident had a current skin problem or not upon admission, skin assessment information is put into the system by MDS for assessments to be completed on each resident.

The ADON was asked why, full body skin assessments were not completed on Resident # 112 from 07/12/16 through 08/29/16, when the stage III pressure area was found on his buttocks. The ADON stated that she would look into it and get back to this surveyor.

On 09/21/16 at approximately 11:25 a.m. the ADON stated, "Even though it [weekly skin assessments] wasn't completed, we have a comprehensive assessment that was completed."

The comprehensive weekly nursing assessment evaluation forms were reviewed. This form reviews and touches on 12 different systems from vital signs to bladder to skin. The following were reviewed:

08/14/16 (4:36 p.m.) "...skin assessment-assessment will include skin color, skin temperature, skin integrity, turgor and condition...Normal findings indicate: skin color good/within norm; turgor is good; skin is warm/dry/intact, no skin problems...1A. Normal findings 1B. Abnormal findings from skin assessment [this was blank] 1C. New changes to the resident's skin integrity noted in the last 24 hours...No new areas...1D. New changes in skin integrity [this area was blank]..." This form additionally describes wound care and dressing, the entire area was blank, no preventative

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measures were marked, the entire area was blank.

08/21/16 (7:36 p.m.) "...skin assessment-assessment will include skin color, skin temperature, skin integrity, turgor and condition...Normal findings indicate: skin color good/within norm; turgor is good; skin is warm/dry/intact, no skin problems...1A. [area was blank-no information documented] 1B. Abnormal findings from skin assessment [this was blank] 1C. New changes to the resident's skin integrity noted in the last 24 hours...No new areas...1D. New changes in skin integrity [this area was blank].. " This form additionally describes wound care and dressing, the only information documented was, "treatment on right foot continues as ordered." No other information was documented in the wound care/dressing, preventative measures section.

08/27/16 (2:19 p.m.) "...skin assessment-assessment will include skin color, skin temperature, skin integrity, turgor and condition...Normal findings indicate: skin color good/within norm; turgor is good; skin is warm/dry/intact; no skin problems...1A. [area was blank-no information documented] 1B. Abnormal findings from skin assessment [this was blank] 1C. New changes to the resident's skin integrity noted in the last 24 hours...No new areas...1D. New changes in skin integrity [this area was blank]..." This form additionally describes wound care and dressing, the only information documented was, "treatment on right foot continues as ordered" and "encourage frequent turning and repositioning." No other information was documented in the wound care/dressing, preventative measures section.

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08/28/16 (10:30 p.m.) "..sk n assessment-assessment will include skin color, skin temperature, skin integrity, turgor and condition...Normal findings indicate: skin color good/within norm; turgor is good; skin is warm/dry/intact, no skin problems...1A. Normal findings 1B. Abnormal findings from skin assessment [this was blank] 1C. New changes to the resident's skin integrity noted in the last 24 hours. .No new areas...1D. New changes in skin integrity [this area was blank]..." This form additionally describes wound care and dressing, the only information documentec was, "treatable wounds present-treatment completed as orcered " No other information was documented in the wound care/dressing, preventative measures section.

The ADON stated that the wound physician could be reached if the survey team would like to speak with him.

An interview was conducted with wound physician on 09/21/16 at 3:35 p.m., via telephone with the survey team. The physician was asked Resident # 112 and the stage III pressure area that found. The physician stated that screening is done by nursing staff and bring any issue up to initiate treatment early, when they brought it to me it was a stage III. The physician stated that he was not sure who is doing the assessment and what they are reporting, which nurse. The physician was told about the lack of assessments and was made aware that a CNA documented redness on 08/18/16, but did not report it. The physician stated that a stage III could develop in 11 days. The physician stated that he was not sure of the facility's policy on skin assessments.

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The administrator, DON (director of nursing) and ADON were made aware of concerns regarding Resident # 112 being found with a stage III and the lack of weekly skin assessments, in a meeting with the survey team on 09/21/16 at 3:50 p.m. The facility policy and procedure was requested on skin assessment completion.

The "Skin Checks" policy and procedure was presented and reviewed on 09/22/16. The policy documented: "...The nursing facility is committed to identifying and implementing timely treatments to all skin conditions...Comprehensive skin checks will conducted on all residents at admission, readmission, weekly and as needed...abnormalities will be identified and documented in the clinical chart.. CNAs will monitor for skin changes throughout their shift...area of abnormality found by the aide will be reported to a licensed nurse who will assess...additional preventative interventions to prevent recurrence...detailed documentation...chart will be updated as needed to reflect the status of the skin condition...ADON or designee will review the documentation and monitor..."

On 09/22/16 the DON presented an email from the wound physician, which documented: "...To whom at [sic] may concern, ...several weeks ago he was noted to have a small buttock pressure injury about 1 cm [centimeter]...PI [pressure injury] is not clear however it is within the realm of possibility for it to develop at any time given surrounding environment .PI develop in short duration from 1 to 4 hours as is well noted in the literature..."

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On 09/22/16 at approximately 8:30 a.m., the "literature" the physician was referring to was requested by the survey team.

At approximately 9:50 a.m., the information was presented and reviewed. The "How much time does it take to get a pressure Ulcer? Integrated evidence from human, animal, and in vitro studies" Volume 54-Issue 10 -October, 2008 was reviewed and documented: "...Surprisingly, information regarding the timeframe for pressure onset, particularly for deep tissue injury onset, is scant..." The provided "literature" did not indicate or specify any information regarding a stage III pressure ulcer

No further information or documentation was presented to evidence that Resident # 112 had weekly full body skin assessments completed for the prevention of a stage III pressure ulcer; no further information and/or documentation was presented to evidence that Resident # 112's stage III pressure ulcer was unavoidable

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

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 resident interview, staff interview,

(F 323)

F-Tag 323

Criterion # 1- Correction

Smoking assessment was completed for resident # 103 on 9/20/16.

Criterion # 2-Other Potential

A 100% audit will be done by Social Services to ensure current residents who smoke have an updated smoking assessment and accurate information is in the medical record.

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clinical record review, facility document review, and during the course of a complaint investigation, the facility staff failed to assess one of 18 residents in the survey sample for smoking safety (Resident # 103).

The facility staff failed to assess Resident # 103 to ensure the resident was safe to smoke

Findings include:

Resident # 103 was admitted to the facility on 07/20/16, with the most current readmission on 08/19/16. Diagnoses for Resident # 103 included, but were not limited to: anemia, HTN (high blood pressure), pneumonia, asthma, cellulitis of the right lower extremity and right knee replacement, and osteoarthritis.

The most current MDS (minimum data set) with CAAS (care area assessment summary) was a 14 day admission assessment, dated 09/02/16. This MDS assessed the resident with a cognitive score of 13, indicating the resident was cognitively intact for daily decision making skills The resident was also assessed as requiring extensive assistance for transfers and ambulation.

A complaint investigation was conducted on 09/19/16 through 09/22/16. An allegation of smoking safety was an allegation within the complaint.

On 09/20/16 at 8:50 a.m , Resident # 103 was interviewed in his room, with his wife present. The resident had a partial pack of cigarettes on night stand beside his bed. The resident was asked about the cigarettes. The resident stated

Criterion # 3 System Change

Licensed Nursing staff and Social Services staff will be re-educated on the importance of completing and/or revising the comprehensive care plan and smoking assessment.
Any new residents who are admitted will be advised that the facility is a smoke free center per facility policy.
The care plan will be updated as the resident's ability to smoke changes.
On a monthly basis during the QA committee a list of current residents who smoke will be submitted by Social Services/designee.

Criterion # 4-Monitoring

Social Services will monitor the residents who smoke to ensure all smoking assessments and care plans remain up to date.
On a monthly basis Social Services will submit a listing of all residents that smoke to the QA committee for review.
Social Services will audit 15% of residents that smoke to ensure the policy is followed.

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that he is a smoker although he was trying to quit. The resident was asked if he goes outside to smoke alone. The resident stated that staff will ask me where I am going most of the time if they see me coming down the hall and I tell them I'm going to smoke and they will go with me. The resident stated, "She (pointing to his wife) goes with me most of the time." The resident further stated that there are specific times of when smoke breaks are. The resident was then asked if he ever went outside alone to smoke. The resident stated that, as a matter of fact he had went out last night (09/19/16) by myself and that he "got caught", the resident voiced that it was a little later than usual and his favorite nurse had caught him.

Resident # 103's clinical record was reviewed. No smoking assessment could be located within the clinical record.

The resident's current CCP was reviewed. No information was found on the resident's CCP regarding smoking.

The resident's current/active POS (physician's order sheet) was reviewed and documented, "...May participate in supervised field trips..." No information was found on the POS regarding smoking.

On 09/20/16 at 10:45 a.m., the DON (director of nursing) was asked for the facility's smoking policy.

The smoking policy was presented and reviewed. The policy documented, "Policy and Procedure Topic: Smoking...Date initiated: 09/01/16...The facility promotes a safe, healthy and smoke free

Criterion #5- The facility dutifully alleges compliance of these tasks on or before 10/11/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement

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environment...Residents who resided at the facility prior to August 11, 2016, and who smoked will continue to have the right to smoke at the facility following safe smoking protocols...1. Prior to admission and during the admission process, the resident and/or responsible party will be advised in writing of the facility smoking policy. 2. The resident's desire to smoke and any needed assistance/supervision will be addressed in the resident's comprehensive plan of care...the facility does not allow for residents to keep any flammable smoking materials in their room...4. Identified resident (sic) who wishes (sic) to utilize the designated outdoor smoking areas will be assessed by the nursing department using the Safe Smoking Assessment..."

On 09/20/16 at approximately 4:00 p.m., in a meeting with the survey team, the administrator, DON (director of nursing) and the ADON (assistant director of nursing) were asked, where the smoking assessments were located for residents. The DON pointed to the computer and stated that they were in the computer. The above staff were informed that a smoking assessment could not be located for Resident # 103.

On 09/21/16 at approximately 3:50 p.m., the DON, administrator and ADON were again made aware of concerns regarding the above information. The DON stated, that the resident did not tell them (facility staff) that he smoked and further stated that a smoking assessment had been completed. A smoking assessment for Resident # 103 was presented and reviewed. The smoking assessment was dated 09/20/16 and timed 5:04 p.m. The DON was asked, if this smoking assessment was completed after this surveyor brought the information to the facility's

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attention on 09/20/16 at 4:00 p.m., in a meeting with the survey team. The DON stated, "Yes."

No further information or documentation was presented prior to the exit conference on 09/22/16 at 10:45 a.m. to evidence that Resident # 103 was assessed by facility staff to ensure the resident was safe to smoke

F 371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY
SS=D

F 371

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities, and
(2) Store, prepare, distribute and serve food under sanitary conditions

F-Tag 371

Criterion # 1-Correction

Hairnets and gloves were available and issues were immediately corrected by DM on 9/20/16.

This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview and facility document review, the facility staff failed to prepare and distribute food in a sanitary manner on one of three units (Unit 2).

The facility staff failed to wear a hair net, while checking food temperatures on Unit 2.

During a resident interview with Resident # 112 on 09/19/16 at 4:00 p.m., the resident stated that the meals at the facility are cold at times.

On 09/20/16 at 8:25 a.m., the dining room area

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was observed. A steam table was set up with breakfast food items consisting of, but not limited to eggs, sausage, bread, oatmeal and grits.

The DA (dietary aide) # 1, had a hairnet on, as well as gloves. The DA was asked if temperatures are checked off of the steam table. The DA stated, yes and went on to say that the temperatures are checked downstairs first, then the food is brought up and then rechecked on the steam tables. The DA was asked to see the temperatures. The DA stated, "They are downstairs." The DA was questioned about the previous statement that food temperatures are checked downstairs and then upstairs. The DA then stated that she did not do them this morning because her thermometer was broken and the DM (dietary manager) was bringing her one.

At approximately 8:35 a.m., this surveyor left the dining room area and proceeded down the hall and met the DM in the hall. The DM was carrying coffee cups and was asked if food temperatures are checked downstairs and then upstairs. The DM stated, "Yes." The DM was then asked if she (the DM) had heard anything about a broken thermometer on Unit 2 (steam table) The DM stated, "No." The DM was asked if she could obtain a thermometer to check temperatures on the steam table on the Unit 2 dining room. The DM stated, "Yes." The DM dropped off the cups to the dining room and proceeded downstairs to obtain a thermometer.

At approximately 8.40 a.m., the DM returned and began checking temperatures on the food items on the steam table. The DM did not don (put on) a hairnet prior to being in food serving area and did not don gloves. The DM was asked if she

Criterion # 2-Other Potential

Meal observation audits have been done, no other unit/residents were identified as being impacted.

Criterion # 3-System Change

Dietary staff will be re-educated on the importance of donning gloves and hairnets at all times when on duty.

Criterion # 4-Monitoring

A 100% audit will be done during meal services by Dietician/Designee to ensure hairnets and gloves are being worn by dietary staff while on duty.

Each meal x 1 week, 2 meals a day x one week, then 1 meal a day x 2 week audits will be conducted by Dietician and/or designee to ensure hairnets and gloves are being worn by dietary staff while on duty.

Variances will be corrected and investigated. A summary of the weekly audits will be submitted to the QA Committee for additional oversight and recommendation.

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was suppose to have a hairnet and gloves on. The DM stated, "Yes Ma'am." The food temperatures were well above normal.

The DM was then asked for a policy regarding hair restraints.

A policy was later presented and reviewed on "Personnel Adherence to Sanitary Procedures", which documented: "...food services personnel shall follow appropriate sanitary procedures...hairnets or approved hats, covering all hair, must be worn at all times while on duty..."

The administrator, DON (director of nursing) and the ADON (assistant director of nursing) were made aware in a meeting with the survey team on 09/20/16 at approximately 4:00 p.m.

No further information or documentation was presented prior to the exit conference on 09/22/16 at 10:45 a.m

F 425 SS=D 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH

F 425

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident

Criterion #5- The facility dutifully alleges compliance of these tasks on or before 10/11/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement

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The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and complaint investigation, the facility staff failed to ensure medications were available for administration for two of 18 residents in the survey sample.

1. Resident #115 missed doses of the medications Singulair and Spironolactone because they were not available from pharmacy.

2. Resident #111 missed doses of the medication Aricept because it was not available.

The findings include:

1. Resident #115 missed a dose of the medication Singulair and missed two doses of the medication Spironolactone because the medications were not available for administration.

Resident #115 was admitted to the facility on 7/20/16 with diagnoses that included asthma, heart failure, high blood pressure and chronic kidney disease. The minimum data set (MDS) dated 8/17/16 assessed Resident #115 as cognitively intact.

Resident #115's clinical record documented a

F-Tag 425

Criterion #1-Correction

Resident # 111 has not demonstrated any adverse outcome. Aricept is available. The physician has been notified of the Aricept that was not documented as being administered.

Resident # 115 has been discharged home and did not demonstrate any adverse outcome prior to discharge.

Criterion # 2-Other Potential

A 100% audit will be done for current residents to ensure all residents have their medications available.

Criterion # 3-System Change

Licensed Nursing staff will be re-educated on the importance of ordering medication in a timely manner.

Licensed Nursing staff will be re-educated on the facility protocol when receiving new orders for medications that are not readily available.

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physician's order dated 7/21/16 for the medication Singulair 10 mg (milligrams) to be administered at each bedtime for the treatment of asthma. The record also documented a physician's order dated 7/21/16 for the medication Spironolactone 100 mg to be administered each day for treatment of congestive heart failure.

Resident #115's medication administration record (MAR) for August 2016 documented the Singulair was not administered on 8/22/16. The MAR documented the Spironolactone was not administered on 8/27/16 and 8/28/16. A nursing note dated 8/22/16 concerning the missed dose of Singulair stated, "Pharmacy to deliver. Not given." Concerning the missed doses of Spironolactone, a note dated 8/27/16 stated, "Medication on order. Not administered." A note dated 8/28/16 stated, "Medication on order."

On 9/21/16 at 1:05 p.m. the director of nursing (DON) was interviewed about the lack of availability of Resident #115's medications. The DON stated nurses were supposed to re-order medications from the pharmacy prior to exhausting the supply. The DON stated nurses were able to re-order medications directly from the pharmacy using their computer system. Concerning Resident #115's missed Singulair and Spironolactone in August 2016, the DON stated re-ordering the medications "was not done timely."

These findings were reviewed with the administrator and director of nursing during a meeting on 9/21/16 at 3:50 p.m.

This was a complaint deficiency.

Criterion # 4-Monitoring

2 times weekly and every week x 2 months, 3 current residents and 3 new admission/readmission orders will be audited by Unit Managers/designee to ensure availability of medication(s).

Variances will be investigated and corrected as appropriate. An analysis of the weekly audits will be provided to the QA Committee for additional oversight and recommendation.

Criterion #5- The facility dutifully alleges compliance of these tasks on or before 10/11/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement

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2. The facility staff failed to ensure the medication, Aricept (donepezil) (used in the treatment of confusion related to dementia) was available for administration for Resident # 111.

Findings include

Resident # 111 was admitted to the facility originally in 2014, with the most recent readmission on 09/03/16. Diagnoses for Resident # 111 included, but were not limited to: mestatic cancer, seizure disorder, anxiety disorder, insomnia (inability to sleep) and dementia.

The most current MDS (minimum data set) was a significant change assessment dated 09/02/16. This MDS assessed the resident with a cognitive score of "9", indicating the resident had moderate impairment in daily decision making skills. The resident also triggered for cognition in the CAAS (care area assessment summary) section of this MDS.

During a complaint investigation on 09/19/16 through 09/22/16. Resident # 111's clinical records were reviewed.

Resident # 111's current POS (physician's order set) was reviewed and documented an order for, Aricept 5 milligrams every night.

The resident's MARs (medication administration records) were reviewed for September 2016. On September 17th and 18th it was documented with an "O", indicating "Other/See Progress Notes."

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The resident's progress notes were then reviewed for September 2016. The progress note dated 09/17/16 and timed 9:49 p.m. documented, "Donepezil...5 mg tablet...Not available..." A progress note dated 09/18/16 and timed 8:24 p.m. documented, "Donepezil...5 mg tablet...Not available..."

The resident's current CCP (comprehensive care plan) documented, ". The resident has impaired cognitive function/dementia or impaired thought processess...related to frontal lobe dementia...communicate with the resident...cue, reorient and supervise as needed...administer medications as ordered..."

The DON (director of nursing), administrator, ADON (assistant director of nursing), and the corporate nurse were made aware in a meeting with the survey team on 09/21/16 at 3:50 p.m.

No further information or documentation was presented prior to the exit conference on 09/22/16 at 10:45 a.m., to evidence the facility had the medication Aricept available for administration, as ordered by the physician.

(F 431) SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	(F 431)		

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled

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Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, the facility staff failed to discard expired medications on one of 3 nursing units. An expired bottle of Lorazepam oral concentrate and three expired vials of injectable Lorazepam were available for use in the medication storage refrigerator on unit #3.

The findings include:

On 9/21/16 at 2:00 p.m. accompanied by licensed practical nurse (LPN) #6 the medication storage

F-Tag 431

Criterion #1- Correction

Removed all outdated medications from refrigerator. Narcotic medications were destroyed according to facility policy.

Criterion #2 – Other Potential

An audit of all refrigerators will be conducted to ensure medications are within date. Variances will be destroyed per protocol.

Criterion #3- System Change

Licensed nursing staff will be re-educated on the facility policy for destroying and returning expired medications and on destruction of narcotics. The DON/ADON will destroy narcotics twice weekly.

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refrigerator on unit #3 was inspected. Stored in the refrigerator and available for use was an unopened 30 milliliter bottle of Lorazepam concentrate (2 milligrams/milliliter) labeled by the manufacturer with an expiration date of 7/2016. Also in the refrigerator were three 1 (one) milliliter vials of injectable Lorazepam (2 milligrams/milliliter) labeled by the manufacturer with an expiration date of 8/2016.

On 9/21/16 at 2:00 p.m. LPN #6 was interviewed about the expired Lorazepam stored in the unit's refrigerator. LPN #6 stated the expired Lorazepam was prescribed for current residents on the unit. LPN #6 stated the expired medications should have been sent back to the pharmacy. LPN #6 stated pharmacy usually picked up out of date medications.

On 9/21/16 at 2:05 p.m. the director of nursing (DON) was interviewed. The DON stated the unit managers were supposed to check medication storage for expired medications. The DON stated she and the assistant director of nursing (ADON) were responsible for disposing of any narcotics.

The facility's policy titled Medication Disposal Policy (dated 9/13/16) stated, "Facility will obtain order to discontinue medications that are no longer in use by the resident... DON/ADON or Designee will retrieve discontinued/expired narcotics from the assigned nurse as soon as it is known that a resident has discharged or within 72 hours of discharge...Medications that are unable to be returned to the pharmacy should be disposed of according to applicable laws and guidelines... Unused non-narcotic prescriptions and over the counter (OTC) medications that do not meet criteria for return to the Pharmacy shall

Criterion #4- Monitoring

Unit Managers and/or designee will check refrigerators three times weekly x 2 months on each unit to ensure medications have not expired. Variances will be corrected and investigated. Findings from audits will be given to DON/ADON for trending patterns. A summary of the weekly audits will be submitted to the QA Committee for additional oversight, recommendation and the need for further monitoring.

Criterion #5- The facility dutifully alleges compliance of these tasks on or before 10/11/16. It is also worthy to note that the facility will be in and maintain compliance with the regulatory requirement

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(F 431)	Continued From page 43 be disposed of by the Unit Manager." These findings were reviewed with the administrator and director of nursing during a meeting on 9/21/16 at 3:50 p.m.	(F 431)		