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	495189	A. BUILDING _____ B. WING _____	C 02/18/2016

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/16/16 through 2/18/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 60 certified bed facility was 56 at the time of the survey. The survey sample consisted of 12 current Resident reviews (Residents #1 through #12) and 7 closed record reviews (Residents #13 through #19).	F 000		
F 155 SS=D	RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES CFR(s): 483.10(b)(4) The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 155		4/1/16

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

Electronically Signed | 03/11/2016

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F 155	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed for one resident (Resident #13) of 19 residents in the survey sample to implement the facility "Do Not Resuscitate" policy. For Resident #13, the facility staff initiated CPR (cardiopulmonary resuscitation) even though the resident had a DNR (Do Not Resuscitate) order. Resident #13 was originally admitted to the facility on 4/25/13 and readmitted after a hospitalization on 7/10/13 with the diagnoses of, but not limited to, hypertension, diabetes mellitus type II, post small bowel obstruction with lysis of adhesions, and dementia. A closed record review was conducted because Resident #13 died on 10/5/15 while at the facility. The most Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 9/27/15. The MDS coded Resident #13 with moderate cognitive impairment; was dependent on staff for bathing; required extensive assistance from staff for bed mobility, transfers, dressing, toileting and hygiene. On 2/17/15 at 10:00 a.m. Resident #13's clinical record was reviewed. The review revealed a physician's order for "DNR" dated 4/2/15. There was also a Durable Do Not Resuscitate Order in the clinical record signed by the physician and Resident #13's Responsible Party on 4/2/15	F 155	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of corrections constitute the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1- Resident #13 was discharged from the facility on 10/5/2015 2- Unit Manager or Designee will audit current residents for code status and ensure that there is a valid DNR order on the chart. 3- The Unit Manager or designee will educate current licensed nursing staff on the procedure to follow in validating code status for residents. 4-The Unit Manager or designee will review residents on a random weekly basis to ensure that there is a valid DNR order on the chart. The Unit Manager or designee will review any residents who require resuscitation to ensure that the appropriate measure was taken to follow the code status. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation.	

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which included the following directive:

"I hereby direct any and all qualified health care personnel, commencing on the effective date noted above, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation, and other advanced airway management, artificial ventilation, defibrillation, and related procedures) form the patient in the event of the patient's cardiac or respiratory arrest..."

A physician Progress Note dated 8/5/15 included Code Status as "DO NOT RESUSCITATE."

Review of nursing Progress Notes dated 10/5/15 at 16:10 (4:10 p.m.) read:
"1545 (3:45 p.m.) -resident with agonal respirations, unresponsive with pulse, within appox. 30 seconds resident without respirations or pulse, CPR initiated until DNR confirmed..."
The progress note was written by the Director of Nursing.

On 2/18/16 at 8:20 a.m. an interview was conducted with the Administrator (Admin-A) and the Director of Nursing (Admin-B). When asked how staff know if a resident is a DNR, Admin-B stated "It's in the chart. It's on the POS (physician order sheet) in the computer." When asked if there were any identifying markers of a resident with a DNR order, Admin-B stated "No identifying markers on the patients or door or any nature like that."

Review of facility policy titled "Do Not Resuscitate" included:

"Policy: CPR will not be initiated when there is a

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F 155	Continued From page 3 valid Do Not Resuscitate (DNR) order located on the patient's permanent medical record." On 2/18/16 at 8:35 a.m. an interview was conducted with Admin-B. When asked why CPR was initiated on Resident #13, Admin-B stated she "Wasn't sure of code status, I don't know every person's code status." She stated "Once I confirmed code status I ceased CPR." Admin-B stated she was the first responder. The facility staff did not present any further information regarding the findings.	F 155		
F 157 SS=D	COMPLAINT DEFICIENCY NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(b)(11) 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	F 157		4/1/16

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F 157	Continued From page 4 and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as 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 staff interview, facility documentation review, and clinical record review, the facility staff failed to notify the physician per physician order and/or Responsible Party of a change in condition, for 2 residents (Resident #8 & #17) in the survey sample of 19 residents. 1. For Resident #8, the facility staff failed to notify the physician of no bowel movement on 2 occasions in January and February of 2016 as was ordered, and failed to notify the doctor of Suppositories which were not given as ordered. 2. For Resident #17, the facility staff failed to notify the responsible party of Resident #17 eloping from the facility. The Findings included: Resident #8, was initially admitted to the facility on 6-5-15. Diagnoses included; Alzheimer's dementia, anxiety, gastro-esophageal reflux disease (GERD), pain, and severe constipation,	F 157	1- The order to notify the MD if no BM in 48 hours was discontinued for Resident #8 on 3/10/16. Resident #8 is having regular BMs. Resident #17 was discharged from the facility on 9/28/15. 2- The Unit Manager or designee will review shift report and orders for current residents to ensure that the MD and RP is notified of resident changes in condition. 3- The Unit Manager or designee will educate Licensed nursing staff on notification of MD and RP of resident changes in condition. The Unit Manager or designee will educate CNA staff on documentation of resident bowel movements. 4- The Unit Manager or Designee will review shift report and new orders on a random weekly basis to ensure that the RP and MD is appropriately notified of any resident changes in condition. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation.	

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leading to hospitalizations for small bowel impaction, and fecal impaction.

Resident #8's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 12-8-15. The Resident was coded with a Brief interview for mental status (BIMS) score of 3 points scored in a possible 15 points, indicating severe cognitive impairment. The Resident was coded as having no behavior problems, and required total assistance of staff for all activities of daily living, with the only exception being eating, which required extensive assistance. The Resident was also coded as always incontinent of bowel and bladder.

Resident #8 was observed on 2-17-16 on bed awake at 2:30 p.m. The Resident was found to be pleasant and alert, but confused. Resident #8 was again observed on 2-18-16 at 9:00 a.m. in bed resting with eyes closed. The Resident answered to name and was easily aroused, pleasant, smiling and talkative, but confused.

Resident #8 had a history of bowel impaction and bowel obstruction. The Resident was not administered bowel regimen agents, that were ordered, and the physician was not made aware of the lack of bowel movement in 3-4 days on 2 occasions, as was ordered, in January & February 2016.

The Bowel and Elimation report which is documented every day by Certified Nursing Assistants (CNA's) provided by the DON was reviewed. The report revealed that on 1-19-16, 1-20-16, and 1-21-16 (3 days), the Resident had no bowel movement, and on 2-13-16, 2-14-16,

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2-15-16, and 2-16-16 (4 days), the Resident had no bowel movement, and did not receive intervention of the Dulcolax Suppository according to the MAR (medication administration record). The Doctor was not notified of the omission of the suppository, nor was he notified that the Resident had not had a bowel movement for the above dates, as was ordered by the physician..

The Nursing progress notes were reviewed and revealed no notification of the doctor that this problem had occurred. Notification of this problem was specifically ordered for this Resident due to repeated hospitalizations in regard to this particular problem.

Physician orders were reviewed for Resident #8's bowel program, and revealed the following;

1. Check for bowel movement (BM) every 48 hours, if no BM contact LTC (Long Term Care Doctors) for further instructions every shift related to unspecified constipation. Ordered 7-2-15.

2. Dulcolax suppository 10 mg, insert one suppository rectally every 24 hours as needed for fecal impaction, Give if no BM (bowel Movement) in 48 hours. Ordered 7-3-15.

3. Miralax Powder give 17 grams by mouth one time per day related to constipation. Mix with 8 ounces of water. Ordered 11-20-15.

4. Senna Plus Tablet 8.6-50 mg (milligrams) give 2 tablets by mouth at bedtime related to constipation. Ordered 11-20-15.

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Review of the MAR revealed that the Dulcolax suppository was not given at any time in January or February 2016, despite the fact that on 2 occasions the Resident had no bowel movement for 3 days on 1 occasion, and for 4 days on 1 occasion.

No where in the clinical record was there evidence documented that the physician was notified, or aware, that the Resident had not had a bowel movement in 3-4 days. There was also no notification of the doctor that Dulcolax suppositories had not been administered, on both occasions, as had been ordered by the doctor.

Resident #8's most recent care plan was reviewed, and compared to the 7-2-15 canceled care plan. The Resident care plan must be developed to provided necessary care and services, and direct care to meet the identified needs of a resident. The findings are as follows:

The Area of focus on the new care plan was as follows; The Resident has potential for constipation related to decreased mobility. The created date was 7-2-15, however, the old 7-2-15 canceled care plan did not have these interventions on it, and no revision date exists for the changed interventions on the new care plan. Interventions were; Assess bowel sounds as needed. and Record bowel movement pattern each day. Describe amount, color, and consistency. The old care plan interventions on the 7-2-15 care plan were; Monitor meds for side effects of constipation. Keep physician informed of any problems. Monitor/document/report PRN (as needed) signs and symptoms of complications related to constipation.

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The (PRN) as needed, and routine medications to treat the constipation were not included, in either care plan, nor was the order to call the doctor if no bowel movement occurred in 48 hours.

The DON was interviewed and asked why the interventions were not in the care plan, why the doctor had not been notified of the lack of bowel movement, and why the Dulcolax suppository had not been administered as ordered,. The doctor was not notified of the dulcolx not being given. Her response was "I don't know."

Review of the facility's policy for Medication Administration revealed: medications are administered as prescribed in accordance with the written orders of attending physicians.

An interview was conducted with the Director of Nursing, (DON), and the administrator, at the end of day debrief on 2-17-16 at 5:00 p.m., and on 2-18-16 at 4:00 p.m.. They were made aware of the findings. No further information was provided by the facility.

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2. For Resident #17, the facility staff failed to notify the responsible party of Resident #17 eloping from the facility.

Resident #17, a female, was initially admitted to the facility 7/20/15 and readmitted after a hospitalization 8/31/15. Her diagnoses included cerebrovascular accident, atrial fibrillation, hyperlipidemia, cataract, depression, hypertension, vascular dementia, and constipation. Resident #17 died at the facility 9/28/15.

Resident #17's most recent MDS (minimum data set) with an ARD (assessment reference date) of 9/6/15 was coded as a significant change assessment. She was coded as having short and long term memory deficits and required limited to extensive assistance of one staff member to perform her activities of daily living. She was also coded as being continent of urine and bowels.

Review of Resident #17's clinical record revealed on 8/7/15 she was found wandering outside of the facility. The granddaughter of another Resident found Resident #17 and assisted her back inside the facility. No documentation was evident that Resident #17's daughter, her responsible party was informed of the elopement.

When interviewed, the DON (director of nursing) stated 2/18/16 at 5:15 p.m., there was no evidence that Resident #17's responsible party had been informed of the elopement 8/7/15. The

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F 157	Continued From page 10 DON stated she had been unaware, at the time of the investigation, that the responsible party had not been informed. The DON further stated the responsible party contacted her (the DON) after the responsible party had been informed of the elopement by the granddaughter of the other Resident. The administrator and DON were informed of the failure of the staff to inform the responsible party of Resident #17's elopement from the facility, 2/18/16 at 11:30 a.m	F 157		
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.13(c)(1)(ii)-(iii), (c)(2) - (4) The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225		4/1/16

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F 225	Continued From page 11 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation and clinical record review, the facility staff failed for two residents (Resident's #16 and #17) in a survey sample of 19 residents, to report an unusual occurrence timely. 1. For Resident #16, a misappropriation of property, related to missing narcotics, was identified on 3/14/15. The initial incident was not reported to the OLC (office of licensure and certification) until 3/19/15. 2. For Resident #17, the facility did not notify the SA (state agency) of an elopement that occurred on 8/7/15 until 8/10/15, three days after the incident. The findings included: 1. Resident #16 was initially admitted to the facility on 11/6/14 and readmitted after hospitalization on 2/2/15. Diagnoses included anemia, hypertension, and cancer.	F 225	1- Resident #17 was discharged from the facility on 9/28/15. Resident #16 was discharged from the facility on 4/29/15. 2- The DON or designee will review current resident Incidents to ensure that any unusual occurrences are investigated appropriately and reported appropriately to the agencies in the required time frame. 3- The Regional Nurse Consultant will educate the Administrator and Nursing Administrative staff on identification of unusual occurrences, alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of property. They will also be educated on reporting requirements to the State Agency. 4-The DON or designee will review resident incidents on a random weekly basis to ensure that any unusual occurrences are investigated appropriately and reported to the appropriate agencies in the required time	

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F 225	Continued From page 12 Resident #16's most recent MDS (minimum data set) with an ARD (assessment reference date) of 3/23/15 was coded as a quarterly assessment. The resident was coded as having a BIMS (brief interview of mental status) score of "15" out of a possible 15, or no cognitive impairment. Resident #16 was also coded as requiring limited assistance of one staff member to perform activities of daily living (ADL's). A review of the facility's initial Facility Reported Incident (FRI) dated 3/19/15 read, "Misappropriation of resident's property related to missing narcotics for _____ (Resident #16)." Review of the facility's follow-up investigation of the incident was dated 3/24/15 and read, "On 3/14/15, charge nurse, (Name) LPN (Licence Practical Nurse) B, and (Name) LPN C noticed that PRN (as needed) Tramadol for resident, _____(Name of Resident #16), was missing. The medication blister pack and the narcotic sheet for the medication was also missing. A thorough search of the medication carts, medication room and the unit was conducted and the medication could not be found. The Tramadol was received at the facility on 2/2/15 and no pills were administered from the medication to the resident according to the medication administration record (MAR). " "Tramadol is a narcotic-like pain reliever used to treat moderate to severe pain." drugs.com Review of the clinical record revealed no documentation on any administration of the PRN Tramadol. On 2/18/16 at 2:45 p.m., an interview was	F 225	frame. Results of the audits will be presented to the quarterly Quality Assurance committee for review and recommendation.	

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conducted with the director of nursing (DON) and the administrator. The DON stated, "I investigated the incident first to make sure that the Tramadol was received from the pharmacy and to make certain it wasn't somewhere in the facility."

Review of the facility investigation documentation revealed the incident was identified on 3/14/15 and was not reported to the OLC until 3/19/15.

Review of the facility's policy and procedure on abuse reporting revealed the following: "The Administrator will immediately (within 24 hours of knowledge of the allegation) notify the Virginia Department of Health Office of Licensure and Certification."

The Administrator was notified of the above findings, 2/18/16 at 6:00 p.m.

2. For Resident #17, the facility did not notify the SA (state agency) of an elopement that occurred on 8/7/15 until 8/10/15, three days after the incident.

Resident #17, a female, was initially admitted to the facility 7/20/15 and readmitted after a hospitalization 8/31/15. Her diagnoses included cerebrovascular accident, atrial fibrillation, hyperlipidemia, cataract, depression, hypertension, vascular dementia, and constipation. Resident #17 died at the facility 9/28/15.

Resident #17's most recent MDS (minimum data set) with an ARD (assessment reference date) of

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9/6/15 was coded as a significant change assessment. She was coded as having short and long term memory deficits and required limited to extensive assistance of one staff member to perform her activities of daily living. For ambulation, Resident #17 was coded as requiring limited assistance. She was also coded as being continent of urine and bowels.

Review of Resident #17's clinical record revealed on 8/7/15 she was found wandering outside of the facility. The granddaughter of another Resident found Resident #17 and assisted her back inside the facility.

The DON (director of nursing) stated 2/18/16 at 11:30 a.m., she had been unaware of the elopement until Resident #17's responsible contacted her 8/10/15 to discuss the elopement. The responsible party had been contacted by the family member of another Resident that had assisted her back into the facility.

Review of the facility investigation, revealed the investigation was not begun until 8/10/15 when Resident #17's responsible party contacted the facility. The SA was notified on 8/10/15. Staff statements were obtained and the Wanderguard system was checked.

The Wanderguard system is a safety system connected to the doors that notify the staff if a Resident with a Wanderguard bracelet gets too close to the door. The door locks for 15 seconds and an alarm sounds at the door and at the nursing station.

It was determined that Resident #17 exited the facility with a group of visitors, causing the door

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F 225	Continued From page 15 not to sound. Documentation revealed the door alarmed when Resident #17 was returned to the facility. Review of the facility's policy entitled "Abuse/Neglect/Misappropriation/Crime Determination Guidelines" included: "4. Centers are to report to the State Survey Agency any unusual incidents or occurrences to their reporting criteria and report any such occurrences immediately. Examples of unusual occurrences include: a. Any event involving a patient that is likely to result in legal action; b. Medication errors that result in the patient being hospitalized or dying; c. Suicides-attempted or successful; d. Death or serious injury associated with the use of restraints; e. Ingestion of toxic substances requiring medical interventions; f. Accidents or injuries of known origin that are unusual, such as a patient falling out of a window, a patient exiting the nursing home and sustaining an injury on Center property, or a patient being burned; g. A patient procuring and ingesting enough medication to result in an overdose; and h. Any unusual event involving a patient or patients that may result in media coverage or law enforcement involvement." The administrator and DON were informed of the failure of the facility staff to contact the SA of Resident #17's elopement and the delay of a timely investigation, 2/18/16 at 11:30 a.m.	F 225		
F 241	DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		4/1/16

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F 241 SS=D	Continued From page 16 CFR(s): 483.15(a) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to maintain dignity during a dressing change to a pressure area on the sacrum for one resident (Resident #6)in a survey sample of 19 residents. During a pressure ulcer dressing change, Resident #6's room window curtains remained open. Also, a male family member stayed in Resident #6's room to observe her while she was receiving incontinence care and dressing change to her sacral ulcer. The findings include: Resident #6 was admitted to the facility 11/6/15 and readmitted 12/15/16 with diagnoses that included but not limited to fracture of the right femur, urinary tract infection, hypertension, anxiety, diabetes, and cognitive communication deficit. Resident #6's most recent MDS (minimum data set) assessment with an ARD (assessment reference date) of 1/25/16 assessed the resident to have both short and long term memory problems and severe impaired cognitive skills for daily decision making. Resident #6 was coded as requiring extensive to total assistance with her activities of daily living, except eating in which she required supervision. She was incontinent of bowel and bladder and was coded for one unstagable pressure ulcer.	F 241	1- Resident #6 was discharged from the facility on 2/28/16. 2- Current residents with dressings will be observed while nursing staff are providing dressing changes to ensure that privacy is provided in an environment that maintains dignity and respect. 3- The Unit Manager or designee will educate licensed nursing staff on completing dressing changes in an environment that maintains dignity and respect in full recognition of his or her individuality. 4-The Unit Manager or designee will review residents with dressings on a random weekly basis to ensure that the dressing change is done in an environment that maintains dignity and respect in full recognition of his or her individuality. Results of the review will be presented to the quarterly Quality Assurance committee for review and recommendation.	

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On 2/17/16 at 2:30 p.m., an observation of a dressing change to Resident #6's unstagable sacral pressure ulcer was conducted. Facility staff members, LPN (licensed practical nurse) A and CNA (certified nursing assistant) A positioned Resident #6 on her left side and removed her incontinence wear. Resident #6 was exposed from the waist down. Resident #6 was supporting herself by holding on to the side rail. There was a large window beside Resident #6's bed (47 inches by 95 inches). The curtains of the window were wide open and never closed during her dressing change

Prior to starting the dressing change, Resident #6 had a bowel movement and LPN A and CNA A performed incontinence care. From the beginning of the dressing change, during the incontinence care and during the cleaning and redressing of Resident #6's wound, a male family member was in the room watching the Resident. After LPN A cleaned the wound, the male family member moved close to the bed and took a picture of the wound on Resident #6's sacrum. The man stated, "Your daughter wants me to take a picture of your wound." This wound observation ended at approximately 2:50 p.m.

On 2/17/16 at approximately 3:00 p.m., an interview was conducted with LPN A. She was asked the identity of the man in Resident #6's room during her incontinence care and dressing change. LPN A said the man was the resident's son-in-law, married to Resident #6's daughter, the responsible party (RP). LPN A said the RP had informed her that her husband would be coming to the facility.

The administrator and the DON were informed of staff's failure to maintain Resident #6's dignity during wound care to her sacrum with regards to the room window curtains not being closed and

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F 241	Continued From page 18 the male family member in the room during incontinence care taking a photo of her during a state of undress on 2/18/16 at 6:00 p.m.	F 241		
F 243 SS=D	RIGHT TO PARTICIPATE IN RESIDENT/FAMILY GROUP CFR(s): 483.15(c)(1)-(5) A resident has the right to organize and participate in resident groups in the facility; a resident's family has the right to meet in the facility with the families of other residents in the facility; the facility must provide a resident or family group, if one exists, with private space; staff or visitors may attend meetings at the group's invitation; and the facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation review, facility staff failed to provide privacy for a Group Interview. Facility staff failed to provide privacy during a Group Interview, by entering the room and gathering items for an unrelated activity. The Findings included: On 2-17-16 at 1:30 P.M. a Group Interview was conducted. The door was closed. There was a sign on the door that the Group Interview was being conducted. The residents were assured that their privacy would be respected, and that staff were not allowed to attend the meeting.	F 243	1- Current residents are provided privacy during group meetings. 2- Resident council meetings or other resident group meetings will be observed by the activities director or designee to ensure that the meetings are held in a private space without interruption, with staff or visitors attending by invitation only. 3- The Staff Development Coordinator or designee will educate facility staff on providing privacy during a group meeting, attending the group meeting by invitation only, and that there is a designated staff person responsible for providing assistance and responding to written requests that result from group meetings.	4/1/16

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F 243	Continued From page 19 Seven residents attended the group. They were in the process of sharing information about concerns they had about staff members, as well as other residents. Suddenly, a few residents, as well as the surveyor noticed staff members looking at the group through the glass door. Another staff member entered to get a soda from the drink machine. During the first half hour of the meeting 3 different staff members entered the room at different times, unannounced and proceeded to complete their various tasks. Each staff member and each time said that they "wouldn't be long". Staff were asked if they knew the meeting was private, and all stated that they knew that the meeting was private, and that they saw the sign on the door, but they would only be a minute. After that incident, the Residents stated that they saw the surveyor give a hand signal for the staff member not to enter the room. They generally became quieter and would not speak as openly as they had prior to the staff disrupting the Group Interview. They did state that they felt that they were being watched, and listened to. On 2-18-16 a review was conducted of facility documentation, revealing a Patient Rights Policy. It read, "Each patient shall be assured legal rights and care consistent with basic human dignity." On 2-18-16 at 4:40 P.M. an interview was conducted in the conference room with the facility Administrator, and Director of Nursing. When asked about the facility's expectation of the staff providing privacy during the Group Interview, the Administrator stated, "I would expect that they	F 243	4- The Activity Director or designee will monitor provision of a private space, attendance by invitation only, and follow-up of written concerns from resident group meetings. Results of the monitoring will be presented to the quarterly Quality Assurance committee for review and recommendation.	

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F 243	Continued From page 20 would assume that there was something important going on behind the door, even with the sign on the door, to honor that, and not enter." They were made aware of the findings at that time. No further information was provided.	F 243		
F 274 SS=D	COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE CFR(s): 483.20(b)(2)(ii) A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation review, the facility staff failed to complete a SCSA (significant change in status assessment) within 14 days after determination of a change in status for 1 Residents (Resident #8) of 19 residents in the survey sample. For Resident #8, the facility staff failed to assess the Resident for a significant change in condition after the Resident became completely dependent	F 274	1- A significant change in status has been initiated with an ARD of 3/8 for resident #8. 2- The MDSC or designee will review current residents with a completed MDS assessment in the last quarter with a noted decline or improvement in functional abilities to determine a need for a significant change assessment. 3- The Regional Data Analyst and Verification Specialist will educate the	4/1/16

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F 274	Continued From page 21 in the transferring, dressing, hygiene and toileting areas of their Activities of Daily Living (ADL's). The findings included: Resident #8, was initially admitted to the facility on 6-5-15. Diagnoses included; Alzheimer's dementia, anxiety, gastro-esophageal reflux disease (GERD), pain, and severe constipation, leading to hospitalizations for small bowel impaction, and fecal impaction. Resident #8's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 12-8-15. The Resident was coded with a Brief interview for mental status (BIMS) score of 3 points scored in a possible 15 points, indicating severe cognitive impairment. The Resident was coded as having no behavior problems, and required total assistance of staff for all activities of daily living, with the only exception being eating, which required extensive assistance. The Resident was also coded as always incontinent of bowel and bladder. The Most recent Full MDS assessment used for comparison, was an Admission Assessment with an Assessment Reference Date (ARD) of 6-12-15. The assessment after the admission assessment was a 5 day quarterly assessment, and was also reviewed with an ARD date of 7-8-15. The changes experienced by Resident #8 between these two assessments follow below: The Admit Assessment dated 6-12-15 coded Resident #8 as requiring extensive assistance of staff for transferring, dressing, hygiene, and toileting.	F 274	MDSC on requirements for a significant change in status-decline or improvement for residents. 4- The MDSC or designee will review residents that have a decline or improvement in functional abilities on a random monthly basis to ensure that a significant change assessment is completed appropriately. The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations.	

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F 274	Continued From page 22 The 5 day quarterly assessment dated 7-8-15 coded Resident #8 as being totally dependent on staff for transferring, dressing, hygiene, and toileting. . Review of the 2 MDS assessments completed (on 10-8-15, and 12-8-15), after the 2 initial assessments mentioned and compared above, reveals that the decline in ADL's continued to the time of survey and did not improve or change. A Significant Change assessment is required within 14 days of recognition of the change and when the change does not improve, or is self limiting. Staff had the opportunity for a significant change assessment to be completed in October of 2015, and did not complete one. On 2-17-16 The RN MDS coordinator was interviewed, and stated because all of the declines were in the ADL area of coding she thought that only counted as 1 change, and did not necessarily meet the requirement of a significant change. She was made aware of the need for a significant change assessment, and she stated she understood. On 2-17-16 at 5:00 p.m., at the end of the day debrief, the Administrator and DON (director of nursing) were notified of the findings. No further documentation was available to be presented.	F 274		
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d), 483.20(k)(1) A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279		4/1/16

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F 279	Continued From page 23 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 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to develop a comprehensive care plan for 1 Resident (Resident #8) in the survey sample of 19 residents. Resident #8' had no active care plan for 3 months. The careplan did not address 2 specific areas, they are; 1). No non-pharmacologic interventions until 2-8-16, with psychotropic medication ordered as needed on 7-1-15, and care planned interventions were not instituted. 2). Further the bowel program care plan was not active for 3 months, did not address interventions to reduce or mitigate targeted constipation as ordered by a physician. The findings include:	F 279	1- Resident #8□s current care plan is comprehensive and includes a care plan to address non-pharmacologic interventions for a psychotropic medication and a care plan to address the resident□s bowel program. 2- Current residents with psychotropic medication use and with the need for a bowel program were reviewed to ensure that a comprehensive care plan addresses the resident□s needs. 3- The Staff Development Coordinator or designee will educate licensed staff on development of a comprehensive care plan to include a care plan to address non-pharmacologic interventions for psychotropic medication use and to address a bowel program as indicated. 4- The Unit Manager or designee will	

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1). Resident #8, was initially admitted to the facility on 6-5-15. Diagnoses included; Alzheimer's dementia, anxiety, gastro-esophageal reflux disease (GERD), pain, and severe constipation, leading to hospitalizations for small bowel impaction, and fecal impaction.

Resident #8's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 12-8-15. The Resident was coded with a Brief interview for mental status (BIMS) score of 3 points scored in a possible 15 points, indicating severe cognitive impairment. The Resident was coded as having no behavior problems, and required total assistance of staff for all activities of daily living, with the only exception being eating, which required extensive assistance. The Resident was also coded as always incontinent of bowel and bladder.

Resident #8 was observed on 2-17-16 on bed awake at 2:30 p.m. The Resident was found to be pleasant and alert, but confused. Resident #8 was again observed on 2-18-16 at 9:00 a.m. in bed resting with eyes closed. The Resident answered to name and was easily aroused, pleasant, smiling and talkative, but confused.

The Resident's current doctor's orders and Medication Administration Record (MAR) were reviewed and revealed the following 5 orders for psychotropic medication administration;

1. Lorazepam (Ativan) 0.5 mg (milligrams) give one tablet by mouth every 8 hours as needed for anxiety related to Anxiety state unspecified. Ordered 7-1-15.

complete a random weekly audit to ensure that resident care plans are comprehensive and include a care plan to address non-pharmacologic interventions for psychotropic medication use and to address a bowel program as indicated. Issues noted will be referred to the Quality Assurance Committee for review and recommendation.

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2. Antianxiety medication (possible unwanted side effects):
Monitor for drowsiness, slurred speech, dizziness, nausea, aggressive/impulsive behavior.
Document "Y" (yes) if monitored and none of the above observed.
Document "N" (No) if monitored and any of the above was observed, then select chart code "other see nurses notes" and progress note findings every shift related to anxiety state.
Ordered 7-2-15.

3. Behaviors: Monitor for the following: Yelling, itching, picking at skin, restlessness (agitation), hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusing care.
Document "Y" (yes) if monitored and none of the above observed.
Document "N" (No) if monitored and any of the above was observed, then select chart code "other see nurses notes" and progress note findings every shift related to anxiety state.
Ordered 7-2-15.

4. Interventions utilized before use of Psychotropic Med (medication)/Hypnotic Med:
Document "Y" (yes) if not required.
Document "N" (No) if any of the above was utilized, then select chart code "other see nurses notes" and progress note interventions and non-pharmacologic interventions every shift related to anxiety state. Ordered 7-2-15.

No non-pharmacologic interventions were identified in the order, and did not appear before the 2-8-16 order change, (7 months later).

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5. On 2-8-16 the above order was changed to include non-pharmacologic interventions, the new order was as follows;
Interventions utilized before use of Psychotropic Med (medication)/Hypnotic Med:
1:1 (one staff to one resident), reassurance, redirect, activities.
Document "Y" (yes) if not required.
Document "N" (No) if any of the above was utilized, then select chart code "other see nurses notes" and progress note interventions and non-pharmacologic interventions every shift related to anxiety state.

Review of the MAR revealed that all documentation of the form was done by a check mark, as completed, however, there was no "N", or "Y", marked in any box for January or February 2016 to indicate what behaviors the Resident exhibited.

The as needed Ativan was administered in January 2016, and February 2016, on 1-1-16, 1-4-16, 1-5-16 1-9-16, 1-13-16, 1-17-16, 1-23-16, 1-25-16, 1-30-16, and 2-2-16, (10 occasions).

The Nursing Progress Notes were reviewed and revealed;
1-1-16 at 9:45 p.m. Ativan given for increased agitation, talked with patient, gave snack, ineffective.
1-4-16 at 6:35 p.m. Ativan given for increased anxiety/yelling, talked with patient, gave snack, ineffective.
1-5-16 at 8:09 p.m. Ativan given for agitation, could not redirect, snack given, no effect.
1-9-16 at 4:32 p.m. Ativan given for agitation/anxiety, unresolved by redirection and

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snack.
1-13-16 at 4:24 p.m. Ativan given for increased anxiety not able to redirect.
1-17-16 at 1:55 a.m. Ativan given for anxiety, cursing, yelling, resistive to care.
1-23-16 at 5:08 p.m. Ativan given for anxiety unresolved by redirection, snack, ADL's (activities of daily living).
1-25-16 at 3:00 a.m. Ativan given for Resident very agitated. Yelling obscenities loudly. unable to redirect.
1-30-16 at 4:47 p.m. Ativan given for Resident very agitated. Yelling obscenities loudly. Unable to redirect.
2-2-16 at 12:57 a.m. Ativan given for Resident very agitated. Yelling loudly.

In review of these records evidenced that of these 10 episodes, 7 of them happened in the evening between approximately 4:30 p.m., and 9:30 p.m., and 3 occurred in the middle of the night between approximately 1:00 a.m., and 3:00 a.m. No Resident behaviors were identified in 5 of the occurrences, and yelling was identified in 5 occurrences. The non-pharmacologic interventions recorded as used in 2 of the occurrences was talking, and a snack, 2 of redirection, and a snack, 1 of a snack only, 3 redirect only, and 2 with no interventions used.

The Resident's Cognitive, behavioral, and psychotropic Comprehensive care plan was reviewed on 2-17-16, and revealed a created date of 6-5-15 to 6-17-15, and it was canceled on 7-2-15. The Director of Nursing (DON) supplied the first copy of the discontinued 7-2-15 care plan and was asked why it had been canceled. She stated that it must be the old care plan, and she was asked to bring all care plans in their entirety

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to the surveyors for the period after the 7-2-15 care plan was discontinued, and up until the time of survey. The DON supplied the most recent care plan on 2-18-16, and the date showed the document was created on 10-1-15. The DON was again asked where the care plan between these two care plans was, and she stated that was all of the care plans that had been completed for the Resident, and she had no explanation as to why there was no active care plan at all for 3 months.

There was no care plan from 7-2-15 to the care plan created on 10-1-15 (3 months). The 10-1-15 care plan revealed the following;

As focus; The Resident exhibits adverse behavioral symptoms related to Alzheimer dementia with; Paranoid delusions, refuses care at times, anxiety with agitation, verbally abusive to staff at times, refuses labs.

Refusal of care, verbal abuse of staff, and refusal of lab draws are not clinically accepted reasons for administration of psychotropic medications and would be considered as used for staff convenience. Anxiety with agitation is not described in terms of specific behaviors.

The care plan interventions for the above were;
Administer medications as ordered, monitor and document for side effects, and effectiveness.
Explain all procedures allowing the resident time to adjust to changes.
If reasonable, discuss resident behavior, explain/reinforce why behavior is inappropriate and or unacceptable to the resident.
Offer 1:1 (one on one) interaction, reassurance, redirection, activity.

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Ask yes/no questions.
Cue, reorient, and supervise as needed.

Of these interventions only effectiveness of the medication, redirection, and talking to the Resident were documented as being used.

No episodes of paranoid delusions or hallucinations were documented in the clinical record.
A thorough review of Resident #8's clinical record revealed in the Psychiatric physician mental health progress notes on 8-5-15 and 12-2-15 documented that the Resident had a depressed mood and affect most of the day and nearly every day as witnessed by him, and reported by staff. The documents evidence that there was no indication that Resident #8 had hallucinations, paranoia, delusions or psychosis, and none were diagnosed by the expert in mental health. The Psychiatrist also stated the Resident was only moderately impaired, with logical and goal directed thinking with mild confusion, most recently in December 2015. No diagnosed need or continued use for the Ativan by the medical expert existed in the clinical record.

The monthly Registered Pharmacist evaluations were reviewed and revealed that there were no pharmacy recommendations for needed trials of psychotropic drug reduction from June 2015 through the time of survey. This is an 8 month period with no gradual dose reduction trials recommended, care planned or attempted.

The DON was interviewed on 2-18-16 at 11:00 a.m., and when asked what non-pharmacologic interventions were used for Resident #8, she stated that redirection, snacks, and talking to the

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Resident were used as interventions. Snacks do not appear on the current care plan. No activities are described in the care plan, nor is there a description of what redirection means. None of the other interventions were documented as used.

The care plan revealed a second area of focus as follows; The Resident uses psychotropic medication related to anxiety. The interventions for this were; Administer medications as ordered, monitor for side effects, and effectiveness.

Guidance is given by the National Institutes of Health, and Centers for Medicare and Medicaid Services as to the appropriate care and treatment of Residents with dementia in regard to psychotropic drugs. That guidance follows;

Care Process for a Resident with Dementia
Fundamental principles of care for persons with dementia include an interdisciplinary team approach that focuses holistically on the needs of the resident as well as the needs of the other residents in the nursing home. It is important for the facility to have systems and procedures in place to assure that assessments are timely and accurate; interventions are described, consistently implemented, monitored, and revised as appropriate in accordance with current standards of practice.
It is expected that a facility ' s approach to care for a resident with dementia follows a systematic care process in order to gather and analyze information necessary to provide appropriate care and services, and that the resident and/or family or representative is engaged throughout the process. It is expected that the resident ' s record reflects the implementation of the following care

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processes:
A. Recognition and Assessment;

B. Cause Identification and Diagnosis;

C. Development of Care Plan;

D. Individualized Approaches and Treatment;

E. Monitoring, Follow-up and Oversight;

Identifying the frequency, intensity, duration and impact of behaviors, as well as the location, surroundings or situation in which they occur may help staff and practitioners identify individualized interventions or approaches to prevent or address the behaviors. Individualized, person-centered interventions must be implemented to address behavioral expressions of distress in persons with dementia. In many situations, medications may not be necessary; staff/practitioners should not automatically assume that medications are an appropriate treatment without a systematic evaluation of the resident. Examples of techniques or environmental modifications that may prevent certain behavior related to dementia may include (but are not limited to):

Arranging staffing to optimize familiarity with the resident (e.g., consistent caregiver assignment);

Identifying, to the extent possible, factors that may underlie the resident ' s expressions of distress, as well as applying knowledge of lifelong patterns, preferences, and interests for daily activities to enhance quality of life and individualize routine care.

Understanding that the resident with dementia

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may be responding predictably given the situation or surroundings. For example, being awakened at night in his/her bedroom by staff and not recognizing the staff could elicit an aggressive response; and

Matching activities for a resident with dementia to his/her individual cognitive and other abilities and the specific behaviors in that individual based on the assessment.

Resident #8 had no gradual dose reductions attempted in the Ativan, no pharmacy review for medications revealed a need for trials of psychotropic drug reduction from June 2015 through the time of survey. Non-pharmacologic interventions that were care planned were not carried out, psychiatric evaluations were performed and diagnosed no delusions or hallucinations, and stated the Resident was only moderately impaired, with logical and goal directed thinking with mild confusion in December 2015. No assessment as to causative factors of behaviors exists in the clinical record, and care planning for the Resident was not done at all for 3 months, and not followed after it was completed.

2). Resident #8 also had a history of bowel impaction and bowel obstruction. The Resident was not administered bowel regimen agents, that were ordered, and the physician was not made aware of the lack of bowel movement in 3-4 days on 2 occasions, as was ordered, in January & February 2016.

The Bowel and Elimination report which is documented every day by Certified Nursing

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Assistants (CNA's) provided by the DON was reviewed. The report revealed that on 1-19-16, 1-20-16, and 1-21-16 the Resident had no bowel movement, and on 2-13-16, 2-14-16, 2-15-16 and 2-16-16, the Resident had no bowel movement.

The Nursing progress notes were reviewed and revealed no notification of the doctor that this problem had occurred. Notification of this problem was specifically ordered for this Resident due to repeated hospitalizations in regard to this particular problem.

Physician orders were reviewed for Resident #8's bowel program, and revealed the 4 following orders;

1. Check for bowel movement (BM) every 48 hours, if no BM contact LTC (Long Term Care Doctors) for further instructions every shift related to unspecified constipation. Ordered 7-2-15.

2. Dulcolax suppository 10mg, insert one suppository rectally every 24 hours as needed for fecal impaction, Give if no BM (bowel Movement) in 48 hours. Ordered 7-3-15.

3. Miralax Powder give 17 grams by mouth one time per day related to constipation. Mix with 8 ounces of water. Ordered 11-20-15.

4. Senna Plus Tablet 8.6-50 mg (milligrams) give 2 tablets by mouth at bedtime related to constipation. Ordered 11-20-15.

Review of the MAR revealed that the Dulcolax suppository was not given at any time in January or February 2016, despite the fact that on 2 occasions the Resident had no bowel movement

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for 3 days on 1 occasion, and for 4 days on 1 occasion.

No where in the clinical record was there evidence documented that the physician was ever notified, or aware, that the Resident had not had a bowel movement in 3-4 days. There was also no notification of the doctor that Dulcolax suppositories had not been administered, on both occasions, as had been ordered by the doctor.

Resident #8's most recent care plan was reviewed, and compared to the 7-2-15 canceled care plan. The Resident care plan must be developed to provided necessary care and services, and direct care to meet the identified needs of a resident. and the findings are as follows;

The Area of focus on the new care plan was as follows; The Resident has potential for constipation related to decreased mobility. The created date was 7-2-15, however, The old 7-2-15 canceled care plan did not have these interventions on it, and no revision date exists for the changed interventions on the new care plan. Interventions were; Assess bowel sounds as needed. and Record bowel movement pattern each day. Describe amount, color, and consistency. The old care plan interventions on the 7-2-15 care plan were; Monitor meds for side effects of constipation. Keep physician informed of any problems. Monitor/document/report PRN (as needed) signs and symptoms of complications related to constipation.

The (PRN) as needed, and routine medications to treat the constipation were not included, in either care plan, nor was the order to call the doctor if

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F 279	Continued From page 35 no bowel movement occurred in 48 hours. The DON was interviewed and asked why the interventions were not in the care plan, why the doctor had not been notified of the lack of bowel movement, and why the Dulcolax suppository had not been administered as ordered, and the doctor was not notified. Her response was "I don't know." Review of the facility's policy for Medication Administration revealed: medications are administered as prescribed in accordance with the written orders of attending physicians. An interview was conducted with the Director of Nursing, (DON), and the administrator, at the end of day debrief on 2-17-16 at 5:00 p.m., and on 2-18-16 at 4:00 p.m.. They were made aware of the findings. No further information was provided by the facility.	F 279		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.20(d)(3), 483.10(k)(2) 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,	F 280		4/1/16

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F 280	Continued From page 36 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 documentation review, Resident interview, and clinical record review, the facility staff failed to review and revise the comprehensive plan of care for one Resident (Resident #2) in a survey sample of 19 Residents. For Resident #2, the facility staff failed to discontinue restorative nursing services from Resident #2's care plan. The findings included: Resident #2, a female, was initially admitted to the facility 9/30/15. Her diagnoses included muscular weakness, gastroesophageal reflux disease, myasthenia gravis, hypertension, mood disorder, and major depressive disorder. Myasthenia gravis is a chronic autoimmune neuromuscular disease characterized by varying degrees of weakness of the skeletal (voluntary) muscles of the body. Resident #2's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1/7/16 was coded as a modification of a quarterly assessment. She was coded as having no memory deficits and was able to make her own	F 280	1- Resident #2□s care plan was revised to discontinue the restorative program on 2/18/16. 2- Current residents were reviewed to ensure that restorative care plans are present for those receiving active restorative services and the care plan has been revised for those who have been discontinued from restorative services. 3- The Staff Development Coordinator will educate licensed staff on revising a resident□s care plan when restorative services are initiated or discontinued. 4- The Unit Manager or designee will randomly review residents receiving restorative services and those who have been discontinued from restorative services to ensure that the care plan has been revised. Issues noted will be referred to the Quality Assurance Committee for review and recommendation.	

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daily life decisions. She was coded as requiring extensive assistance of one to two staff for all of her activities of daily living including bed mobility and transferring. Coding revealed she had not ambulated in her room and she was independent in her locomotion by wheelchair about the facility.

During a Resident interview, 2/17/16 at 8:10 a.m., Resident #2 stated she had exercised with the staff in the past. She was unable to recall when the exercise program had stopped.

Review of Resident #2's care plan revealed she was care planned to receive "Nursing Rehab/Restorative: Ambulation Program #2 stand by assist with ambulation, use walker as needed up to 15 feet up to 6x/week as resident is able to tolerate" and "Nursing Rehab/Restorative: Exercises lower extremity exercises as tolerated up to 6x/week." Both care planned interventions were revised on 1/5/16.

When asked for documentation of Resident #2's restorative nursing program, the DON (director of nursing) stated 2/17/16 at 5:20 p.m., Resident #2 had been refusing the restorative nursing services. The DON stated the care plan had not been updated when Resident #2 had refused the care. The DON further stated she could not determine when Resident #2 was discontinued from restorative services.

A calendar of Resident #2's restorative care revealed toward the end of January, 2015 Resident #2 had refused restorative services. Documentation revealed no further attempts were made for restorative after 1/22/16.

Guidance for the creation of an individualized

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F 280	Continued From page 38 care plan is provided by "Fundamentals of Nursing 7th Edition, Potter-Perry, page 268: In any health care setting a nurse is responsible for providing a written pan of care for all clients. The plan of care sometimes takes several forms...In hospitals and community-based settings, the client often receives care from more than one nurse, physician, or allied health professional. A written nursing care plan makes possible the coordination of nursing care, subspecialty consultations, and scheduling of diagnostic tests...You design a written plan to direct clinical nursing care and to decrease the risk of incomplete, incorrect, or inaccurate care. As the client's problems and status change, so does the plan. A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care, and listing outcome criteria to be used in evaluation. The written plan communicates nursing care priorities to other health care professionals. The nursing care plan enhances the continuity of nursing care by listing specific nursing interventions needed to achieve the goals of care. All nurses who care for a given client will then carry out these nursing interventions throughout a given day during a client's length of stay. A correctly formulated nursing care plan makes it easier to continue care from one nurse to another." The administrator and DON were informed of the failure of the staff to revise Resident #2's care plan to discontinue restorative nursing services, 2/18/16 at 11:20 a.m.	F 280		
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.20(k)(3)(i)	F 281		4/1/16

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F 281	Continued From page 39 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to follow professional standards of nursing for medication and treatment administration for two Residents (Residents' #2 and #7) in a survey sample of 19 Residents. 1. For Resident #2, the facility staff failed to administer Prilosec (for gastroesophageal reflux disease) on 1/11/16 at 6 a.m.; and 2. For Resident #7, the facility staff failed to administer Levothyroxine, Omeprazole, Carvedilol, and Gabapentin on 1/11/16 at 6 a.m. The findings included: 1. For Resident #2, the facility staff failed to administer Prilosec (for gastroesophageal reflux disease) on 1/11/16 at 6 a.m. Resident #2, a female, was initially admitted to the facility 9/30/15. Her diagnoses included muscular weakness, gastroesophageal reflux disease, myasthenia gravis, hypertension, mood disorder, and major depressive disorder. Myasthenia gravis is a chronic autoimmune neuromuscular disease characterized by varying degrees of weakness of the skeletal (voluntary) muscles of the body. Resident #2's most recent MDS (minimum data	F 281	1- Prilosec for Resident #2 was discontinued o 3/916. Resident #2 and #7 are receiving medications as ordered. 2- The Unit Manager or designee will review the medication administration records and treatment records of current residents to ensure that they are receiving their medications and treatments as ordered. 3- The Unit Manager or designee will educate current licensed staff on correct documentation guidelines for Medication Administration and Treatment Administration. 4-The Unit Manager or designee ill review documentation of medication and treatment administration on a random weekly basis to ensure that the residents are receiving medications and treatments as ordered. The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations	

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set) with an ARD (assessment reference date) of 1/7/16 was coded as a modification of a quarterly assessment. She was coded as having no memory deficits and was able to make her own daily life decisions. She was coded as requiring extensive assistance of one to two staff for all of her activities of daily living including bed mobility and transferring. Coding revealed she had not ambulated in her room and she was independent in her locomotion by wheelchair about the facility.

Review of Resident #2's clinical record revealed no evidence Prilosec 20 mg (milligram) had been administered 1/11/16 at 6 a.m. A valid physician's order was evident for the medication.

When interviewed, the DON (director of nursing) stated 2/18/16 at 11:30 a.m., she could find no evidence the medication had been administered.

Guidance is given at www.pdrhealth.com for administration of Prilosec:

"What should I avoid while taking this medication?

Do not change your dose or stop taking Prilosec without first talking to your healthcare provider."

Review of the facility's policy entitled "General Dose Preparation and Medication Administration" included:

"4. Prior to administration of medication, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following:
4.1.1 Verify each time a medication is administered that it is the correct medication, at

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the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident =, as set forth in Appendix 17: Facility Medication Administration Times Schedule:

5. During medication administration, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following:

5.4 Administer the medications within time frames specified by Facility policy;

6. After medication administration, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following'

Guidance for nursing practice for the administration of medications is included in, "Fundamentals of Nursing 7th Edition, p 336, The physician is responsible for directing medical treatment. Nurses follow physician's orders unless they believe the orders are in error or harm clients."

Also, same source, p. 707, "A medication order is required for every medication you administer to a client...Regardless of how you receive an order, compare the prescriber's written orders with the medication administration record (MAR) when the medication is initially ordered. Verify medication information whenever new MARs are written or distributed or when clients transfer from one nursing unit or health care setting to another. Once you determine that information on the client's MAR is accurate, use the MAR to prepare and administer medications."

The administrator and DON were informed of the

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failure of the staff to administer Prilosec on 1/11/16 at 6 a.m., 2/18/16 at 11:30 a.m.

2. For Resident #7, the facility staff failed to administer Aspirin, Levothyroxine, Omeprazole, Carvedilol, and Gabapentin on 1/11/16 at 6 a.m.

Resident #7, a female, was initially admitted to the facility 8/12/15 and readmitted after a hospitalization 12/15/15. Her diagnoses included peripheral vascular disease, arteriosclerotic cardiovascular disease, coronary bypass, hypokalemia, osteoarthritis, congestive heart failure, hypertension, angina, muscle weakness, allergic rhinitis, dysphagia, hypothyroidism, left bundle branch block, hyperlipidemia, chronic obstructive pulmonary disease, acute pancreatitis, Vitamin D deficiency, varicose veins, vascular dementia, and gastroesophageal reflux disease.

Resident #7's most recent MDS with an ARD of 12/18/15 was coded as a quarterly assessment . She was coded as having no memory deficits and was able to make her own daily life decisions. She was also coded as requiring extensive to total assistance of one staff member to perform her activities of daily living with the exception of eating. For eating, Resident #7 was coded as needing supervision.

Review of Resident #7's clinical record revealed no evidence the following medications were administered 1/11/6 at 6 a.m.:

Aspirin 81 mg (milligram) for heart failure

Levothyroxine 75 mcg (microgram) for hypothyroidism

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Omeprazole Delayed Release 20 mg for gastroesophageal reflux disease

Carvedilol 6.25 for hypertension

Gabapentin 300 mg for pain related to peripheral vascular disease and vascular ulcer

The DON stated 2/18/16 at 11:30 a.m. she was unable to determine if the medications were given and not documented for or just not administered. She further stated the expectation was for the staff to administer medications as ordered and to document them after they are administered.

Guidance is given at www.pdrhealth.com for administration of Prilosec (brand name for Omeprazole):

"What should I avoid while taking this medication?

Do not change your dose or stop taking Prilosec without first talking to your healthcare provider."

Guidance for administration of Aspirin at www.emedicinehealth.com:

"Aspirin protects you from having a clot-related stroke in the same way it protects you from having a heart attack.

Aspirin slows the blood's clotting action by reducing the clumping of platelets. Platelets are cells that clump together and help to form blood clots. Aspirin keeps platelets from clumping together, thus helping to prevent or reduce blood clots.

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During a heart attack, blood clots form in an already-narrowed artery and block the flow of oxygen-rich blood to the heart muscle (or to part of the brain, in the case of stroke). When taken during a heart attack, aspirin slows clotting and decreases the size of the forming blood clot. Taken daily, aspirin's anti-clotting action helps prevent a first or second heart attack."

For administration of Levothyroxine at www.nlm.nih.gov:

" Follow the directions on your prescription label carefully, and ask your doctor or pharmacist to explain any part you do not understand. Take levothyroxine exactly as directed. Do not take more or less of it or take it more often than prescribed by your doctor.

Levothyroxine controls hypothyroidism, but does not cure it. It may take several weeks before you notice a change in your symptoms. Continue to take levothyroxine even if you feel well. Do not stop taking levothyroxine without talking to your doctor."

For administration of Carvedilol at www.nlm.nih.gov:

" Try to take carvedilol at around the same time(s) every day. Follow the directions on your prescription label carefully, and ask your doctor or pharmacist to explain any part you do not understand. Take carvedilol exactly as directed. Do not take more or less of it or take it more often than prescribed by your doctor.

Carvedilol may help to control your condition but

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F 281	Continued From page 45 will not cure it. Continue taking carvedilol even if you feel well. Do not stop taking carvedilol without talking to your doctor. If you suddenly stop taking carvedilol, you may experience serious heart problems such as severe chest pain, a heart attack, or an irregular heartbeat." For administration of Gabapentin at www.nlm.nih.gov: "These medications should be taken at evenly spaced times throughout the day and night; no more than 12 hours should pass between doses. ... Follow the directions on your prescription label carefully, and ask your doctor or pharmacist to explain any part you do not understand. Take gabapentin exactly as directed. Do not take more or less of it or take it more often than prescribed by your doctor. Gabapentin may help to control your condition but will not cure it. Continue to take gabapentin even if you feel well. Do not stop taking gabapentin without talking to your doctor, even if you experience side effects such as unusual changes in behavior or mood. If you suddenly stop taking gabapentin tablets, capsules, or oral solution, you may experience withdrawal symptoms such as anxiety, difficulty falling asleep or staying asleep, nausea, pain, and sweating. The administrator and DON were informed of the failure of the staff to administer Aspirin, Levothyroxine, Omeprazole, Carvedilol and Gabapentin to Resident #7 per physician's orders, 2/18/16 at 11:30 a.m.	F 281		
F 309 SS=E	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		4/1/16

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F 309	Continued From page 46 CFR(s): 483.25 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 observation, resident interview, staff interview, facility documentation review and clinical record review, the facility staff failed to provide services to achieve the highest practicable level of well being for five residents (Resident #6, #10, #8, #7 and #13) in the survey sample of 19 residents. 1. For Resident #6, the facility staff failed to provide pain medication prior to the dressing change to her sacral ulcer; 2. For Resident #10, the facility staff failed to administer 14 medications in a timely manner. Resident #10 ' s medications were due for administration at 6:00 p.m. and were administered after 8:00 p.m. Resident #10 ' s medications were scheduled to be administer more than once daily and were ordered to treat hypertension, edema, nerve pain, diabetes, chronic pain, muscle pain, muscle inflammation, reflux, convulsions, low potassium, and cardiovascular disease. 3. For Resident #8, the facility staff failed to ensure gradual dose reductions,	F 309	1- Resident #6 was discharged from the facility on 2/28/16. Resident #10 is receiving medication timely as ordered. Resident #8 is having documented regular BMs. The Pharmacist consultant will review the medications for Resident #8 to identify any medication irregularities and to ensure that there is clear justification of clinical need for the medications. Resident #7 is receiving the Fentanyl Patch as ordered. Resident #13 was discharged from the facility on 10/5/15. 2- The Unit Manager or designee will audit current residents to ensure that pain medication is available and administered prior to dressing changes as needed. Medication Administration Pass observations will be completed on current Licensed staff to ensure that medications are available for administration, documented and received timely. Current residents receiving psychotropic medications will be reviewed to ensure Pharmacist consultant recommendations were reviewed for current residents to ensure that the recommendations have	

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F 309	Continued From page 47 non-pharmacologic interventions, psychiatric evaluations, assessment, and care planning for a Resident being administered psychotropic medications. Further, the Resident was not administered bowel regimen agents, that were ordered, and the physician was not made aware of the lack of bowel movement in 3-4 days on 2 occasions, as was ordered, in January & February 2016. 4. For Resident #7, the facility staff failed to administer a Fentanyl patch per physician ' s orders; 5. For Resident #13, the facility staff failed to perform a physician ordered blood glucose check. The findings included: 1. Resident #6 was admitted to the facility 11/6/15 and readmitted 12/15/15 with diagnoses that included but not limited to fracture of the right femur, urinary tract infection, hypertension, anxiety, diabetes, and cognitive communication deficit. Resident #6's most recent MDS (minimum data set) assessment with an ARD (assessment reference date) of 1/25/16 assessed the resident to have both short and long term memory problems and severe impaired cognitive skills for daily decision making. Resident #6 was coded for one unstagable pressure ulcer. Review of the comprehensive care plan revealed a plan of care for pain as well as a plan of care for a pressure ulcer to the sacrum. Interventions included were to medicate as ordered and to administer treatments as ordered.	F 309	been addressed and that there is a clear justification of clinical need for the medication, and that the non-pharmacological interventions, psychiatric evaluations, assessment and care planning is completed appropriately. The shift report will be reviewed to ensure that resident changes in condition are addressed appropriately and that the MD and RP are notified of any changes in condition. The Medication Administration Records for current residents requiring blood sugar checks will be reviewed to ensure that the blood glucose checks are documented appropriately. 3- The Unit Manager or designee will educate current licensed staff on assessing residents for pain prior to completing dressing changes and providing pain medication as ordered prior to dressing changes; appropriate timeframe for administration of medications, following recommended medication administration guidelines for documentation of medications and blood glucose results; identifying, assessing and providing appropriate interventions and notification of resident changes in condition; documentation of non-pharmacological interventions, care planning, needed psychiatric evaluations and will be educated on ensuring that pharmacist consultant recommendations are addressed in a timely manner. 4-The Unit Manager or designee will complete random weekly audits of blood glucose checks to ensure that the results are recorded appropriately, review shift report and ensure that changes in	

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F 309	Continued From page 48 On 2/17/16 at 2:20 p.m., an observation of a dressing change to Resident #6's unstagable sacral pressure ulcer was conducted. Facility staff members, LPN (licensed practical nurse) and CNA (certified nursing assistant) A positioned Resident #6 on her left side and removed her incontinence wear. During the repositioning, Resident #6 was very anxious and started yelling out for the staff to stop. LPN A encouraged Resident #6 that she was alright and that she was not going to fall. Resident #6 was supporting herself by holding onto the side rail. Prior to starting the dressing change, Resident #6 had a bowel movement and LPN A and CNA A performed incontinence care. Resident #6 continued to express discomfort. After receiving the incontinence care, Resident #6 said 'OW' when the old dressing was removed, as LPN A cleaned her wound with a 4x4 soaked in saline, and as LPN A applied the Santyl with a cotton tip stick to her wound. At no time during the dressing change was Resident # 6's pain assessed or was she offered anything for pain. The procedure ended at 2:45 p.m. Review of the physician orders revealed pain medication orders as follows: "2/5/20016, Percocet 5-325 mg (milligram) give 1 tablet by mouth two times a day for pain. 1/29/2016, Percocet 5-325 mg, give 1 tablet by mouth every six hours as needed for pain. 12/15/2015. Tylenol Tablet, give 500 mg by mouth every 8 hours as needed for pain. Review of the MAR (Medication Administration Record) revealed Resident #6 most recent pain medication was administered on 2/17/2016 at 9:00 a.m. On 2/17/16 at 3:00 p.m., the director of nursing (DON) was informed of the findings of the observation and she was asked if Resident #6	F 309	resident condition are addressed appropriately and that the MD and RP are notified of such changes. The Unit manager or designee will complete random monthly medication administration observations to ensure that medications are administered timely and available for administration and documented appropriately. The Unit Manager or designee will review Pharmacist consultant recommendations will be monitored on a monthly basis by the Unit Manager to ensure that the recommendations were addressed and that the residents receiving psychotropic medications have non-pharmacological interventions addressed, needed psychiatric evaluations, assessment, and an appropriate care plan. The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations	

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was given pain medication in anticipation of the dressing change. After taking some time to investigate, the DON stated, "No, I don't see where she received any pain medication after her scheduled dose of Percocet at 9:00 o'clock. The administration was informed of the findings, 2/18/2016 at 6:00 p.m.

2. For Resident #10, the facility staff failed to administer 14 medications in a timely manner. Resident #10 ' s medications were due for administration at 6:00 p.m. and were administered after 8:00 p.m. Resident #10 had medications scheduled to be administered more than once daily and were ordered to treat his hypertension, edema, nerve pain, diabetes, chronic pain, reflux, convulsions, low potassium, and cardiovascular disease.

Resident #10 was admitted to the facility on 07/30/2010 and readmitted after hospitalization of 09/08/2015. Diagnoses for Resident #10 included but are not limited to diabetes, chronic obstructive pulmonary disease, hypertension, heart failure, and glaucoma.

Resident #10's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/15/2015 coded Resident #10 with a BIMS (Brief Interview of Mental Status) score of 15, out of 15, cognitively intact. In addition, the MDS coded Resident #10 as independent in all of his Activities of Daily Living (ADL) care.

On 2/16/2016 and approximately 7:50 p.m. during a Medication Pour and Pass observation, Resident #10 was seen in his room, sitting on the edge of his bed. Resident #10 was receiving

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oxygen by way of a nasal cannula and both his legs and feet were swollen.

On 2/16/2016 at 8:15 p.m., RN (Registered Nurse) was observed preparing to administer medications to Resident #10. RN A asked Resident #10 about his pain and Resident #10 said '8' out of a 1-10 pain scale. RN A said she wanted to give the resident his pain medication first. At 8:20 p.m. RN A administered Oxycontin, five 20 mg (milligram) tablets (for pain). RN A washed her hands, and returned to the medication cart.

At 8:25 p.m., RN A proceeded to take Resident #10's medication pill cards from the medication cart while reviewing the computerized eMAR (electronic medication administration record).

At 8:30 p.m., RN A was observed popping the following pills into a medication cup: L-Arginine 500 mg (supplement); 3-Omega 3 capsule 100mg (dry eye syndrome); Vitamin C (supplement); Carvedilol 25 mg (for hypertension); Clonidine.3mg (for hypertension); Lasix 20 mg (for edema); Gemfibrozil 800 mg tablet(for hyperlipidemia); Pantoprazole Sodium 30 mg (hypopotassemia); Savella 100 mg (for myalgia-muscle pain and myositis-muscle inflammation); Clonazepam 1 mg (for convulsions); Hydralazine 100 mg (for hypertension); Isosorbide 20 mg (congestive heart failure); and Potassium Chloride 20 meq (milliequivalent) /15 ml (milliliter) (for hypopotassemia) was placed in a separate cup. A bottle of Restasis .4 ml vial (for dry eyes) was removed from the medication cart. RN A prepared an insulin syringe with 30 units of Lantus. RN A and started looking through the

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medication cart and said, "I can't find his Gabapentin. I am going to have to order it from the pharmacy stat. I'll give him these medications and then I'll call the pharmacy for the Gabapentin." RN A checked Resident #10's blood pressure and reported a reading of 196/99. RN A administered the medications she had prepared, washed her hands and returned to the medication cart.

At 8:50 p.m., RN A said Resident #10's blood sugar for his SSI (sliding scale insulin) was tested at 4:30 p.m. and it was a reading of 191 milligrams/deciliter. While at the medication cart, Resident #10 called out to RN A for his PRN (as needed) Nitrostat (for chest pain). Resident #10 said he was having chest pains. RN A placed the Nitrostat pill in a cup and prepared an insulin syringe with 15 Units of Humalog. At 8:57 p.m., RN A administered to Resident #10 the Nitrostat (sublingual-under the tongue) and gave an injection of 15 units of Humalog. This completed the Medication Pour and Pass observation, 9:00 p.m.

On 2/17/2016 at 8:30 a.m., a review of the medications administered during the Medication Pour and Pass Observation was conducted. Review of clinical recorded revealed the medications administered to Resident #10 between 8:00 p.m. and 9:00 p.m. were due to be administered at 6:00 p.m. The SSI of 15 units of Humalog was due at 4:30 p.m., but was administered at 8:57 p.m. The Gabapentin 400 mg that was not available during the Medication Pour and Pass Observation was due at 6:00 p.m. and it was delivered by the pharmacy and administered on 2/17/16 at 12:20 a.m.

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Review of the facility STAT Box contents revealed the availability of 4 - 400 mg capsules of Gabapentin.

Review of the eMAR revealed RN A did not document on any of the medications she had administered during the Medication Pour and pass, except the pain medication, Oxycontin.

A review of the Progress Notes revealed a nurse's note written by the oncoming night nurse, LPN D, on 2/17/16 at 2:44 a.m., "Upon night nurse administering 2300 meds and checking BS (blood sugar) , resident states, 'A nurse just came in here and gave me that medicine." Resident refused 2300 meds and states, 'I'm scared to take anything else now. I don't want to double dose.' Evening nurse states that she did give resident his 2300 (11:00 p.m.), meds and take his BS."

On 2/17/2016 at 4:00 p.m., an interview was conducted with RN A. RN A said she did not document on the medication she had administered during the Medication Pour and Pass because the battery on the computer on the medication cart went dead. RN A said she had returned to the facility now in order to do her documenting.

On 2/17/2016 at 5:00 p.m., during a briefing with the administrator and the DON, the concerns regarding the late administration of Resident #10's medications were discussed. The DON said the expectation was for the nursing staff to administer medications timely - "no more than an hour before or after the scheduled time."

On 2/17/2016 at 5:30 p.m., the DON provided a

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copy of Resident #10's February MAR with RN A's late entry documentation of the medications administered and a copy of hand written nurse's note that RN A had just written, which read,
" 2/16/2016, 2330 (Resident's name, Resident #10) informed me that he did not eat his dinner. Has received Humalog and Lantus. Also he declined his snack. So BGM (blood glucose monitoring) was repeated, found to be 70. Snack of choice given. Report to night nurse that BGM is 70.

2/16/2016 2430 (12:30 a.m.) Night nurse informed Gabapentin and 2330 meds given around midnight. Had received Nitrostat sublingual with good effect...."

In summation, Resident #10's medications were not administered timely. The physician ordered 4:30 p.m. SSI dose was delivered at 9:00 p.m. for a blood sugar reading that was obtained at 4:30 p.m. RN A's failure to assess a blood sugar prior to administering a sliding scale dose, resulted in Resident #10 having a blood sugar reading of 70. Most of the medications that were administered late were scheduled to be given again at 11:30 p.m. and these medications resulted in being administered again, just two and a half hours later. Due to the lack of documentation after medication administration, the oncoming nurse, LPN D, had prepared to administer medication that had already been administered by RN A.

The facility cited Mosby as the reference for professional nursing standards

The facility's policy on Medication Administration included the following;
"4.1 Facility staff should verify each medication is

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administered that is the correct medication, at the correct dose, at the correct route, at the correct time, for the correct residents.
6. After medication administration, Facility staff should document necessary medication administration/treatment information."

Guidance was given to nursing by Mosby's "Fundamentals of Nursing 7th Edition, Potter-Perry, p. 713, "After administering a medication, record it immediately on the appropriate record form. Never chart a medication before administering it. Recording immediately after administration prevents errors. The recording of a medication includes the name of the medication, dose, route, and exact time of administration."

The administration was informed of the findings 02/18/16 at 6:00 p.m.

3. For Resident #8, the facility staff failed to ensure gradual dose reductions, non-pharmacologic interventions, psychiatric evaluations, assessment, and care planning for a Resident being administered psychotropic medications. Further, the Resident was not administered bowel regimen agents, that were ordered, and the physician was not made aware of the lack of bowel movement in 3-4 days on 2 occasions, as was ordered, in January & February 2016

Resident #8, was initially admitted to the facility on 6-5-15. Diagnoses included; Alzheimer's dementia, anxiety, gastro-esophageal reflux

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disease (GERD), pain, and severe constipation, leading to hospitalizations for small bowel impaction, and fecal impaction.

Resident #8's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 12-8-15. The Resident was coded with a Brief interview for mental status (BIMS) score of 3 points scored in a possible 15 points, indicating severe cognitive impairment. The Resident was coded as having no behavior problems, and required total assistance of staff for all activities of daily living, with the only exception being eating, which required extensive assistance. The Resident was also coded as always incontinent of bowel and bladder.

Resident #8 was observed on 2-17-16 on bed awake at 2:30 p.m. The Resident was found to be pleasant and alert, but confused. Resident #8 was again observed on 2-18-16 at 9:00 a.m. in bed resting with eyes closed. The Resident answered to name and was easily aroused, pleasant, smiling and talkative, but confused.

The Resident's current doctor's orders and Medication Administration Record (MAR) were reviewed and revealed the following 5 orders for psychotropic medication administration;

1. Lorazepam (Ativan) 0.5 mg (milligrams) give one tablet by mouth every 8 hours as needed for anxiety related to Anxiety state unspecified. Ordered 7-1-15.

2. Antianxiety medication (possible unwanted side effects):
Monitor for drowsiness, slurred speech,

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dizziness, nausea, aggressive/impulsive behavior.
Document "Y" (yes) if monitored and none of the above observed.
Document "N" (No) if monitored and any of the above was observed, then select chart code "other see nurses notes" and progress note findings every shift related to anxiety state. Ordered 7-2-15.

3. Behaviors: Monitor for the following: Yelling, itching, picking at skin, restlessness (agitation), hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusing care.
Document "Y" (yes) if monitored and none of the above observed.
Document "N" (No) if monitored and any of the above was observed, then select chart code "other see nurses notes" and progress note findings every shift related to anxiety state. Ordered 7-2-15.

4. Interventions utilized before use of Psychotropic Med (medication)/Hypnotic Med:
Document "Y" (yes) if not required.
Document "N" (No) if any of the above was utilized, then select chart code "other see nurses notes" and progress note interventions and non-pharmacologic interventions every shift related to anxiety state. Ordered 7-2-15.

No non-pharmacologic interventions were identified in the order, and did not appear before the 2-8-16 order change, (7 months later).

5. On 2-8-16 the above order was changed to include non-pharmacologic interventions, the new

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order was as follows;
Interventions utilized before use of Psychotropic Med (medication)/Hypnotic Med:
1:1 (one staff to one resident), reassurance, redirect, activities.
Document "Y" (yes) if not required.
Document "N" (No) if any of the above was utilized, then select chart code "other see nurses notes" and progress note interventions and non-pharmacologic interventions every shift related to anxiety state.

Review of the MAR revealed that all documentation of the form was done by a check mark, as completed, however, there was no "N", or "Y", marked in any box for January or February 2016 to indicate what behaviors the Resident exhibited.

The as needed Ativan was administered in January 2016, and February 2016, on 1-1-16, 1-4-16, 1-5-16 1-9-16, 1-13-16, 1-17-16, 1-23-16, 1-25-16, 1-30-16, and 2-2-16, (10 occasions).

The Nursing Progress Notes were reviewed and revealed;
1-1-16 at 9:45 p.m. Ativan given for increased agitation, talked with patient, gave snack, ineffective.
1-4-16 at 6:35 p.m. Ativan given for increased anxiety/yelling, talked with patient, gave snack, ineffective.
1-5-16 at 8:09 p.m. Ativan given for agitation, could not redirect, snack given, no effect.
1-9-16 at 4:32 p.m. Ativan given for agitation/anxiety, unresolved by redirection and snack.
1-13-16 at 4:24 p.m. Ativan given for increased anxiety not able to redirect.

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1-17-16 at 1:55 a.m. Ativan given for anxiety, cursing, yelling, resistive to care.
1-23-16 at 5:08 p.m. Ativan given for anxiety unresolved by redirection, snack, ADL's (activities of daily living).
1-25-16 at 3:00 a.m. Ativan given for Resident very agitated. Yelling obscenities loudly. unable to redirect.
1-30-16 at 4:47 p.m. Ativan given for Resident very agitated. Yelling obscenities loudly. Unable to redirect.
2-2-16 at 12:57 a.m. Ativan given for Resident very agitated. Yelling loudly.

In review of these records it is evidenced that of these 10 episodes, 7 of them happened in the evening between approximately 4:30 p.m., and 9:30 p.m., and 3 occurred in the middle of the night between approximately 1:00 a.m., and 3:00 a.m. No Resident behaviors were identified in 5 of the occurrences, and yelling was identified in 5 occurrences. The non-pharmacologic interventions recorded as used in 2 of the occurrences was talking, and a snack, 2 of redirection, and a snack, 1 of a snack only, 3 redirect only, and 2 with no interventions used.

The Resident's Cognitive, behavioral, and psychotropic Comprehensive care plan was reviewed on 2-17-16, and revealed a created date of 6-5-15 to 6-17-15, and it was canceled on 7-2-15. The Director of Nursing (DON) supplied the first copy of the discontinued 7-2-15 care plan and was asked why it had been canceled. She stated that it must be the old care plan, and she was asked to bring all care plans in their entirety to the surveyors for the period after the 7-2-15 care plan was discontinued, and up until the time of survey. The DON supplied the most recent

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care plan on 2-18-16, and the date showed the document was created on 10-1-15. The DON was again asked where the care plan between these two care plans was, and she stated that was all of the care plans that had been completed for the Resident, and she had no explanation as to why there was no active care plan at all for 3 months.

There was no care plan from 7-2-15 to the care plan created on 10-1-15 (3 months). The 10-1-15 care plan revealed the following;

As focus; The Resident exhibits adverse behavioral symptoms related to Alzheimer dementia with; Paranoid delusions, refuses care at times, anxiety with agitation, verbally abusive to staff at times, refuses labs.

Refusal of care, verbal abuse of staff, and refusal of lab draws are not clinically accepted reasons for administration of psychotropic medications and would be considered as used for staff convenience. Anxiety with agitation is not described in terms of specific behaviors.

The care plan interventions for the above were;
Administer medications as ordered, monitor and document for side effects, and effectiveness.
Explain all procedures allowing the resident time to adjust to changes.
If reasonable, discuss resident behavior, explain/reinforce why behavior is inappropriate and or unacceptable to the resident.
Offer 1:1 (one on one) interaction, reassurance, redirection, activity.
Ask yes/no questions.
Cue, reorient, and supervise as needed.

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Of these interventions only effectiveness of the medication, redirection, and talking to the Resident were documented as being used.

No episodes of paranoid delusions or hallucinations were documented in the clinical record.
A thorough review of Resident #8's clinical record revealed in the Psychiatric physician mental health progress notes on 8-5-15, and 12-2-15 documented that the Resident had a depressed mood and affect most of the day and nearly every day as witnessed by him, and reported by staff. The documents evidence that there is no indication that Resident #8 had hallucinations, paranoia, delusions or psychosis, and none were diagnosed by the expert in mental health. The Psychiatrist also stated the Resident was only moderately impaired, with logical and goal directed thinking with mild confusion, most recently in December 2015. No diagnosed need or continued use for the Ativan by the medical expert existed in the clinical record.

The monthly Registered Pharmacist evaluations were reviewed and revealed that there were no pharmacy recommendations for needed trials of psychotropic drug reduction from June 2015 through the time of survey. This is an 8 month period with no gradual dose reduction trials recommended or attempted.

The DON was interviewed on 2-18-16 at 11:00 a.m., and when asked what non-pharmacologic interventions were used for Resident #8, she stated that redirection, snacks, and talking to the Resident were used as interventions. Snacks do not appear on the current care plan. No activities are described in the care plan, nor is there a

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description of what redirection means. None of the other interventions were documented as used.

The care plan revealed a second area of focus as follows; The Resident uses psychotropic medication related to anxiety. The interventions for this were; Administer medications as ordered, monitor for side effects, and effectiveness.

Guidance is given by the National Institutes of Health, and Centers for Medicare and Medicaid Services as to the appropriate care and treatment of Residents with dementia in regard to psychotropic drugs. That guidance follows;

Care Process for a Resident with Dementia
Fundamental principles of care for persons with dementia include an interdisciplinary team approach that focuses holistically on the needs of the resident as well as the needs of the other residents in the nursing home. It is important for the facility to have systems and procedures in place to assure that assessments are timely and accurate; interventions are described, consistently implemented, monitored, and revised as appropriate in accordance with current standards of practice.
It is expected that a facility ' s approach to care for a resident with dementia follows a systematic care process in order to gather and analyze information necessary to provide appropriate care and services, and that the resident and/or family or representative is engaged throughout the process. It is expected that the resident ' s record reflects the implementation of the following care processes:
A. Recognition and Assessment;

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F 309	Continued From page 62 B. Cause Identification and Diagnosis; C. Development of Care Plan; D. Individualized Approaches and Treatment; E. Monitoring, Follow-up and Oversight; Identifying the frequency, intensity, duration and impact of behaviors, as well as the location, surroundings or situation in which they occur may help staff and practitioners identify individualized interventions or approaches to prevent or address the behaviors. Individualized, person-centered interventions must be implemented to address behavioral expressions of distress in persons with dementia. In many situations, medications may not be necessary; staff/practitioners should not automatically assume that medications are an appropriate treatment without a systematic evaluation of the resident. Examples of techniques or environmental modifications that may prevent certain behavior related to dementia may include (but are not limited to): Arranging staffing to optimize familiarity with the resident (e.g., consistent caregiver assignment); Identifying, to the extent possible, factors that may underlie the resident ' s expressions of distress, as well as applying knowledge of lifelong patterns, preferences, and interests for daily activities to enhance quality of life and individualize routine care. Understanding that the resident with dementia may be responding predictably given the situation or surroundings. For example, being awakened at night in his/her bedroom by staff and not	F 309		

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recognizing the staff could elicit an aggressive response; and

Matching activities for a resident with dementia to his/her individual cognitive and other abilities and the specific behaviors in that individual based on the assessment.

Resident #8 had no gradual dose reductions attempted in the Ativan, no pharmacy review for medications revealed a need for trials of psychotropic drug reduction from June 2015 through the time of survey. Non-pharmacologic interventions that were care planned were not carried out, psychiatric evaluations were performed and diagnosed no delusions or hallucinations, and stated the Resident was only moderately impaired, with logical and goal directed thinking with mild confusion in December 2015. No assessment as to causative factors of behaviors exists in the clinical record, and care planning for the Resident was not done at all for 3 months, and not followed after it was completed.

Resident #8 also had a history of bowel impaction and bowel obstruction. The Resident was not administered bowel regimen agents, that were ordered, and the physician was not made aware of the lack of bowel movement in 3-4 days on 2 occasions, as was ordered, in January & February 2016.

The Bowel and Elimation report which is documented every day by Certified Nursing Assistants (CNA's) provided by the DON was reviewed. The report revealed that on 1-19-16, 1-20-16, and 1-21-16 the Resident had no bowel

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movement, and on 2-13-16, 2-14-16, 2-15-16, and 2-16-16, the Resident had no bowel movement.

The Nursing progress notes were reviewed and revealed no notification of the doctor that this problem had occurred. Notification of this problem was specifically ordered for this Resident due to repeated hospitalizations in regard to this particular problem.

Physician orders were reviewed for Resident #8's bowel program, and revealed the following 4 orders;

1. Check for bowel movement (BM) every 48 hours, if no BM contact LTC (Long Term Care Doctors) for further instructions every shift related to unspecified constipation. Ordered 7-2-15.

2. Dulcolax suppository 10mg, insert one suppository rectally every 24 hours as needed for fecal impaction, Give if no BM (bowel Movement) in 48 hours. Ordered 7-3-15.

3. Miralax Powder give 17 grams by mouth one time per day related to constipation. Mix with 8 ounces of water. Ordered 11-20-15.

4. Senna Plus Tablet 8.6-50 mg (milligrams) give 2 tablets by mouth at bedtime related to constipation. Ordered 11-20-15.

Review of the MAR revealed that the Dulcolax suppository was not given at any time in January or February 2016, despite the fact that on 2 occasions the Resident had no bowel movement for 3 days on 1 occasion, and for 4 days on 1 occasion.

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No where in the clinical record was there evidence documented that the physician was ever notified, or aware, that the Resident had not had a bowel movement in 3-4 days. There was also no notification of the doctor that Dulcolax suppositories had not been administered, on both occasions, as had been ordered by the doctor.

Resident #8's most recent care plan was reviewed, and compared to the 7-2-15 canceled care plan. The Resident care plan must be developed to provided necessary care and services, and direct care to meet the identified needs of a resident. and the findings are as follows;

The Area of focus on the new care plan was as follows; The Resident has potential for constipation related to decreased mobility. The created date was 7-2-15, however, The old 7-2-15 canceled care plan did not have these interventions on it, and no revision date exists for the changed interventions on the new care plan. Interventions were; Assess bowel sounds as needed. and Record bowel movement pattern each day. Describe amount, color, and consistency. The old care plan interventions on the 7-2-15 care plan were; Monitor meds for side effects of constipation. Keep physician informed of any problems. Monitor/document/report PRN (as needed) signs and symptoms of complications related to constipation.

The (PRN) as needed, and routine medications to treat the constipation were not included, in either care plan, nor was the order to call the doctor if no bowel movement occurred in 48 hours.

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The DON was interviewed and asked why the interventions were not in the care plan, why the doctor had not been notified of the lack of bowel movement, and why the Dulcolax suppository had not been administered as ordered, and the doctor was not notified of that. Her response was "I don't know."

Review of the facility's policy for Medication Administration revealed: medications are administered as prescribed in accordance with the written orders of attending physicians.

An interview was conducted with the Director of Nursing, (DON), and the administrator, at the end of day debrief on 2-17-16 at 5:00 p.m., and on 2-18-16 at 4:00 p.m.. They were made aware of the findings. No further information was provided by the facility.

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4. For Resident #7, the facility staff failed to administer a Fentanyl patch per physician's orders.

Resident #7, a female, was initially admitted to the facility 8/12/15 and readmitted after a hospitalization 12/15/15. Her diagnoses included peripheral vascular disease, arteriosclerotic cardiovascular disease, coronary bypass, hypokalemia, osteoarthritis, congestive heart failure, hypertension, angina, muscle weakness, allergic rhinitis, dysphagia, hypothyroidism, left bundle branch block, hyperlipidemia, chronic obstructive pulmonary disease, acute pancreatitis, Vitamin D deficiency, varicose veins, vascular dementia, and gastroesophageal reflux disease.

Resident #7's most recent MDS with an ARD of 12/18/15 was coded as a quarterly assessment . She was coded as having no memory deficits and was able to make her own daily life decisions. She was also coded as requiring extensive to total assistance of one staff member to perform her activities of daily living with the exception of eating. For eating, Resident #7 was coded as needing supervision. Resident #7 was coded as having no pain.

Resident #7 was observed and interviewed, 2/16/16 at 2:45 p.m. She was lying on her right side in bed, alert and verbally responsive.

Review of Resident #7's clinical record revealed a

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signed physician's order that included:

"12/15/15 Fentanyl Patch 72 hour 25 mcg/hr (micrograms per hour) Apply 1 patch transdermally every 72 hours for pain."

The patch was ordered in response to Resident #17's complaint of pain due to vascular ulcers and peripheral vascular disease.

Guidance for administration of Fentanyl patch was provided at www.nlm.nih.gov:

"Fentanyl patches are used to relieve severe pain in people who are expected to need pain medication around the clock for a long time and who cannot be treated with other medications. Fentanyl is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain.

How should this medicine be used?
Transdermal fentanyl comes as a patch to apply to the skin. The patch is usually applied to the skin once every 72 hours. Change your patch at about the same time of day every time you change it. Follow the directions on your prescription label carefully, and ask your doctor or pharmacist to explain any part you do not understand. Apply fentanyl patches exactly as directed."

A corresponding entry was noted on the eMAR (electronic medication administration record. Documentation on the eMAR and within the nursing notes revealed the Fentanyl patch had been unavailable for administration on 1/29/16. An entry was noted that the patch was available

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on 1/30/16 and administered at 10:07 a.m. The next time the Fentanyl patch was administered was on 2/1/6 (48 hours after the previous administration).

The DON (director of nursing) said 2/18/17 at 11:30 a.m., she had reviewed the eMAR and control medication sheets. She stated she had determined that when the patch came from the pharmacy on 1/30/16, the nurse administered the patch as it had not been available the day before (the regular administration day). When the nurse entered the one time dose order, for the patch on a day that was not the regular administration day, the nurse failed to changed the previous entry for the patch to be applied every 72 hours. On 2/1/16, the prompt came to the nurse administering medications to administer the patch, as the order had not been changed to reflect the administration on 1/30/16.

Guidance at www.nlm.nih.gov, "Fentanyl patches may be habit-forming. Do not apply more patches, apply the patches more often, or use the patches in a different way than prescribed by your doctor."

The administrator and DON were informed of the failure of the staff to administer Fentanyl patch per physician's orders, every 72 hours, 2/18/16 at 11:30 a.m.

5. For Resident #13, the facility staff failed to perform a physician ordered blood glucose check.

Resident #13 was originally admitted to the facility on 4/25/13 and readmitted after a hospitalization on 7/10/13 with the diagnoses of, but not limited

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to, diabetes mellitus type II, post small bowel obstruction with lysis of adhesions, hypertension and dementia.
Resident #13 was no longer in the facility therefore a closed record review was conducted.

The most Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 9/27/15. The MDS coded Resident #13 with moderate cognitive impairment; was dependent on staff for bathing; required extensive assistance from staff for bed mobility, transfers, dressing, toileting and hygiene.

On 2/17/15 at 10:00 a.m. Resident #13's clinical record was reviewed. The review revealed a physician's order dated 5/8/14 which read:

"BLOOD GLUCOSE CHECK two times a day..."

The Medication Administration Record (MAR) for October 2015 was reviewed and revealed no blood glucose result for 10/4/15 at 6:30 a.m. There was no result documented on the "Blood Sugar Summary" or in the "Progress Notes."

On 2/17/16 at 5:45 p.m. the Administrator and Director of Nursing were informed of the findings.

On 2/18/16 at 8:35 a.m. an interview was conducted with the Director of Nursing (Admin-B). When asked if there was any information found regarding the blood glucose check, Admin-B stated "I could not find any documentation regarding (the) blood sugar documentation."

The facility staff did not present any further information regarding the findings.

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F 323 SS=E	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(h) 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, facility documentation review and staff interview, the facility staff failed to provide a safe environment. A soccer ball size lint ball was observed in the dryer vent area. The findings included: During general observation of the facility, the laundry was observed. Other F was working in the laundry and had done so for seven years. Other F stated 2/17/16 at 10:50 a.m., she cleaned the dryer vents every third load. When asked, Other F removed the front of the dryers exposing the dryer vents. Within the #3 dryer, was a soccer ball size lint ball. Located within dryer #3's vent area was a black plastic tube, later identified as a vacuum attachment. On the actual screen part of the vent was a layer of lint approximately 1/4"-3/8". When observed, dryers 2 and 3 were also noted to have a 1/4" to 3/8" layer of lint on the dryer screen. Other F	F 323	1- The dryer vent area was cleaned on 2/18/16. 2- The lint traps on the dryers are cleaned at a minimum of every three loads. 3- The head of housekeeping will educate housekeeping staff on cleaning the dryer vents at a minimum of every three loads. 4- The head of housekeeping will complete random weekly observations of the dryer vents to ensure that the vents are free of excess lint. Issues noted will be reported to the Quality Assurance committee for review and recommendation.	4/1/16

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stated the lint on the screens was more than was usually seen and she had no understanding of the soccer ball size accumulation of lint from dryer #3.

Other F said she had been out for a few days and someone else had been working in the laundry. She said she did not check the lint areas in the morning, before starting, as the dryers should be cleaned at the end of the previous day.

Other E, the head of housekeeping, stated 2/17/16 at 2:30 p.m., documentation was evident that the dryer lint area had been cleaned at the end of the day on 2/16/16. A form was presented that indicated the dryer had been run for three loads on 2/16/16 and had been cleaned one time. Other E stated the presence of all that lint was "dangerous, could cause a fire."

Review of the facility's policy entitled "Infection Controls Cleaning Schedules" included:

"2. Clean the lint traps on the dryers a minimum of every third load. Document on Daily Processing Worksheet."

Other A, the head of maintenance, stated 2/18/16 at 2:25 p.m., he was surprised when he saw the amount of lint, not only the soccer ball size lint but the amount of the screens. He stated one of his maintenance staff had been in the laundry on 2/16/16 to thoroughly clean the lint vents on the dryers. Other A stated that was how the end of the vacuum had ended up in #3 dryer lint vent area. Other A said that amount of lint was dangerous, as it could cause a fire.

The administrator and DON (director of nursing)

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F 323	Continued From page 73 were informed of the failure of the staff to ensure an excessive amount of lint was not left in the dryers, a fire hazard, 2/18/16 at 11:30 a.m.	F 323		
F 329 SS=D	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.25(l) 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 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, clinical record review and facility documentation review, the facility staff failed for one resident (Resident #13) of 19	F 329	1- Resident #13 was discharged from the facility on 10/5/15. 2- The Unit Manager or designee will	4/1/16

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F 329	Continued From page 74 residents in the survey sample to ensure Resident #13 was free from unnecessary medications. For Resident #13, the facility staff failed to hold the blood pressure medication, Lisinopril, per physician ordered parameters. The findings included: Resident #13 was originally admitted to the facility on 4/25/13 and readmitted after a hospitalization on 7/10/13 with the diagnoses of, but not limited to, hypertension, diabetes mellitus type II, post small bowel obstruction with lysis of adhesions, and dementia. Resident #13 was no longer in the facility therefore a closed record review was conducted. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 9/27/15. The MDS coded Resident #13 with moderate cognitive impairment; was dependent on staff for bathing; required extensive assistance from staff for bed mobility, transfers, dressing, toileting and hygiene. On 2/17/15 at 10:00 a.m. Resident #13's clinical record was reviewed. The review revealed a physician's order dated 7/2/15 which read: "Lisinopril Tablet 5 MG (milligrams) Give 2.5 mg by mouth one time a day related to UNSPECIFIED ESSENTIAL HYPERTENSION...HOLD MEDICATION IS (sic-if) SBP <110 (systolic blood pressure (top number) is less than 110 mm Hg-millimeters of mercury).	F 329	review the medication administration record documentation for current residents to ensure that the medication parameters are followed and documented appropriately. 3-.The Unit Manager or designee will educate Licensed Nursing staff on appropriately following and documenting medications with parameters. 4-The Unit Manager or designee will review medications with parameters on a random weekly basis to ensure that the medication is held or administered as ordered and documented appropriately. The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations	

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Review of the September and October 2015 Medication Administration Record (MAR) revealed the following:

Blood pressure readings were not documented on the MAR, Blood Pressure Summary or in the Progress Notes that corresponded with the 9:00 a.m. administration of the Lisinopril September 1 through 23, 9/25 & 9/26. And, on 10/1, 10/2 and 10/5 the Lisinopril was documented as administered although the systolic blood pressure readings were below the physician ordered parameters (10/1=99, 10/2=101 and 10/5=105).

On 2/17/16 at 5:45 p.m. the Administrator and Director of Nursing were informed of the lack of blood pressure results in the clinical record and the Lisinopril not being held when the systolic blood pressure was below 110.

Review of the facility policy titled "General Dose Preparation and Medication Administration" included:
4. Prior to administration of medication, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following:...
4.1.5 If necessary, obtain vital signs."

On 2/18/16 at 8:35 a.m. an interview was conducted with the Director of Nursing (Admin-B). When asked if there was any other information regarding the blood pressure medication not being held or documented, Admin-B stated she "Could not find any documentation regarding blood pressure documentation." When asked if she expected the medication to be held and/or documented, Admin-B shook her head "yes."

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F 329	Continued From page 76 The facility staff did not present any further information regarding the findings.	F 329		
F 332 SS=D	FREE OF MEDICATION ERROR RATES OF 5% OR MORE CFR(s): 483.25(m)(1) The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and manufacturer's recommendations, the facility staff failed to ensure medications were administered with less than a 5% medication error rate for one Resident (Resident #10). 31 medications opportunities were observed with 2 errors (Neurotin and Humalog Insulin), resulting in a 6.4% error rate. For Resident #10, 13 medications scheduled to be administered at 6:00 p.m., were administered after 8:00 p.m. One medication (Neurotin) was not available for administration during the medication pass. And Sliding Scale Insulin (SSI) (Humalog) orders were not followed per physician orders. The findings included: Resident #10 was admitted to the facility on 07/30/2010 and readmitted after hospitalization of 09/08/2015. Diagnoses for Resident #10 included but are not limited to diabetes, chronic obstructive pulmonary disease, hypertension,	F 332	1- Resident #10 is receiving medications as ordered in a timely manner, is receiving medications as ordered and medications are available for administration. The Sliding Scale Insulin orders are being followed as ordered for resident #10. 2- The Unit Manager or designee will review current residents with Sliding Scale Insulin orders to ensure that the orders are followed as ordered. The Unit Manager or designee will review current resident medication orders and Medication carts to ensure that medications are available for administration. The Licensed Nursing staff will be observed during medication administration pass to ensure that medications are administered timely and as ordered. 3- The Unit Manager or designee will educate Licensed staff on proper method to refill medications, utilization of the facility STAT medication box for needed	4/1/16

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F 332	Continued From page 77 heart failure, and glaucoma. Resident #10's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/15/2015 coded Resident #10 with a BIMS (Brief Interview of Mental Status) score of 15, out of 15, cognitively intact. In addition, the MDS coded Resident #10 as independent in all of his Activities of Daily Living (ADL) care. On 2/16/2016 at approximately 7:50 p.m., during a Medication Pour and Pass observation, Resident #10 was seen in his room, sitting on the edge of his bed. Resident #10 was receiving oxygen by way of a nasal cannula and both of his feet and legs were swollen. On 2/16/2016 at 8:15 p.m., RN (Registered Nurse) A was observed preparing to administer medications to Resident #10. RN A asked Resident #10 about his pain and Resident #10 said '8' out of a 1-10 pain scale. RN A said she wanted to give the resident his pain medication first. At 8:20 p.m. RN A administered Oxycontin (a pain medication), five 20 mg (milligram) tablets and initialed administration of the medication on the narcotic sheet and in the eMAR (electronic Medication Administration Record). RN A washed her hands, returned to the medication cart and proceeded to take medications from Resident #10's medication cards while reviewing Resident #10's eMAR. At approximately 8:30 p.m., RN A was observed popping the following medications into a medication cup: L-Arinine 500 mg, 3-Omega 3 capsule 100mg, Vitamin C, Carvedilol 25 mg, Clonidine .3mg, 3-Lasix 20 mg, Gemfibrozil 800 mg tablet, Pantoprazole Sodium 30 mg, Savella	F 332	medication administration, following Sliding Scale Insulin orders. 4- The Unit Manager or designee will complete random weekly audits of residents with Sliding Scale Insulin orders to ensure that the orders are followed appropriately; complete random weekly audits of Medication Administration records and the Medication carts to ensure that medications are available for administration. The Unit Manager or designee will complete random monthly medication observations of Licensed staff to ensure that medications are administered timely and medications are available for administration. The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendati	

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100 mg, Clonazepam 1 mg, Hydralazine 100 mg, Isosorbide 20 mg. Potassium Chloride 20 meq (milliequivalent) /15 ml (milliliter) was placed in a separate cup. A bottle of Restasis .4 ml vial was removed from the medication cart for administration. . RN A prepared an insulin syringe with 30 units of Lantus. RN A then started looking through the medication cart and said, "I can't find his Gabapentin. I am going to have to order it from the pharmacy stat. I'll give him these medications and then I'll call the pharmacy for the Gabapentin." RN A checked Resident #10"s blood pressure and reported a reading of 196/99. RN A administered the medications she had prepared, washed her hands and returned to the medication cart.

At 8:50 p.m., RN A said Resident #10's blood sugar SSI was tested at 4:30 p.m. and it was a reading of 191. While at the medication cart, Resident #10 called out to RN A for his PRN (as needed) Nitrostat (for chest pain) . Resident #10 said he was having chest pain. RN A placed the Nitrostat pill in a cup and prepared an insulin syringe with 15 units of Humalog. At 8:57 p.m., RN A administered the Nitrostat (sublingual-under the tongue) and administered the 15 units of Humalog. This completed the Medication Pour and Pass observation, 9:00 p.m.

On 2/17/2016 at 8:30 a.m. a review of the medications administered during the Medication Pour and Pass Observation was conducted. Review of clinical recorded revealed the medications administered to Resident #10 on 2/16/16 between 8:00 and 9:00 p.m. were due to be administered at 6:00 p.m.

The director of nursing (DON) provided a copy of

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the pharmacy report indicating the arrival of the ordered Gabapentin that was not administered during the Medication Pour and Pass Observation on 2/16/16. According to the pharmacy delivery sheet, the Gabapentin was delivered on 2/17/2016 12:20 a.m.

Review of the facility STAT Box contents revealed Gabapentin was available for administration in the facility . The STAT Box contained 4 - 100 mg capsules of Gabapentin. Resident #10 was ordered to have Gabapentin 400 mg.

Review of the eMAR revealed RN A did not document on any of the medications she had administered during the Medication Pour and Pass, except the pain medication, Oxycontin.

A review of the Progress Notes revealed a nurse's note written by the oncoming night nurse, LPN D, on 2/17/16 at 2:44 a.m., "Upon night nurse administering 2300 meds and checking BS (blood sugar) , resident states, 'A nurse just came in here and gave me that medicine." Resident refused 2300 meds and states, 'I'm scared to take anything else now. I don't want to double dose." Evening nurse states that she did give resident his 2300 (11:00 p.m.) , meds and take his BS.

On 2/17/2016 at 4:00 p.m., an interview was conducted with RN A, the medication nurse on the Medication Pour and Pass Observation. RN A said she did not document on the medications she had administered during the Medication Pour and Pass because the battery of the computer on the medication cart went dead. RN A said she had now returned to the facility in order to do her documenting.

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On 2/17/2016 at 5:00 p.m., during a briefing with the administrator and the DON, the concerns regarding the late administration of Resident #10's medications were discussed. The DON said the expectation was for the nursing staff to administer medications timely - no more than an hour before or after the scheduled time."

On 2/17/2016 at 5:30 p.m., the DON provided a copy of Resident #10's February eMAR with RN A's late entry documentation of the administered medications and a copy of the hand written nurse's note RN A had just written, which read,

" 02/16/2016, 2330 (Resident's name) Resident #10 informed me that he did not eat his dinner. Has received Humalog and Lantus. Also he decline his snack. So BGM (blood glucose monitoring) was repeated, found to be 70. Snack of choice given. Report to night nurse that BGM is 70.

2/16/2016 2430 (12:30 a.m.) Night nurse informed Gabapentin and 2330 meds given around midnight. Had received Nitrostat sublingual with good effect...."

In summation, Resident #10's medications were not administered timely. A SSI dose was administered at 9:00 p.m. for a blood sugar reading of 191 that was obtained at 4:30 p.m. Some of the medications that were administered late were scheduled to be given again on the following shift and these medications resulted in being given in less than three hours apart. RN A's failure to assess a blood sugar prior to administering a sliding scale dose, resulted in Resident #10 having a low blood sugar reading of 70. Due to the lack of documentation after medication administration, the oncoming nurse,

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LPN D, had prepared to administer medication that had already been administered by RN A.

The facility cited Mosby as the reference for professional nursing standards.

The facility's policy on Medication administration included the following;
"4.1 Facility staff should Verify each medication is administered that is the correct medication, at the correct dose, at the correct route, at the correct time, for the correct residents.
6. After medication administration, Facility staff should document necessary medication administration/treatment information."

Guidance was given to nursing by Mosby's "Fundamentals of Nursing 7th Edition, Potter-Perry, p. 713, "After administering a medication, record it immediately on the appropriate record form. Never chart a medication before administering it. Recording immediately after administration prevents errors. The recording of a medication includes the name of the medication, dose, route, and exact time of administration."

"Gabapentin is an anti-epileptic medication, also called an anticonvulsant. It affects chemicals and nerves in the body that are involved in the cause of seizures and some types of pain. Gabapentin is used in adults to treat nerve pain caused by herpes virus or shingles (herpes zoster). Take Gabapentin exactly as prescribed by your doctor. Carvedilol is a beta-blocker. Beta-blockers affect the heart and circulation (blood flow through arteries and veins). Carvedilol is used to treat heart failure and hypertension (high blood pressure). It is also used after a heart attack that

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has caused your heart not to pump as well.
Clonidine lowers blood pressure by decreasing the levels of certain chemicals in your blood. This allows your blood vessels to relax and your heart to beat more slowly and easily. Clonidine is used to treat hypertension (high blood pressure).
Lasix (furosemide) is a loop diuretic (water pill) that prevents your body from absorbing too much salt, allowing the salt to instead be passed in your urine. Lasix treats fluid retention (edema) in people with congestive heart failure, liver disease, or a kidney disorder such as nephrotic syndrome....
Gemfibrozil helps reduce cholesterol and triglycerides (fatty acids) in the blood. High levels of these types of fat in the blood are associated with an increased risk of atherosclerosis (clogged arteries).
Pantoprazole is a proton pump inhibitor that decreases the amount of acid produced in the stomach. Pantoprazole is used to treat erosive esophagitis (damage to the esophagus from stomach acid),
Clonazepam is in a group of drugs called benzodiazepines (ben-zoe-dye-AZE-eh-peens). It affects chemicals in the brain that may become unbalanced and cause anxiety. Clonazepam is used to treat seizure disorders or panic disorder.
Hydrochlorothiazide is a thiazide diuretic (water pill) that helps prevent your body from absorbing too much salt, which can cause fluid retention.
Hydralazine is a vasodilator that works by relaxing the muscles in your blood vessels to help them dilate (widen).
Isosorbide mononitrate is in a group of drugs called nitrates. It dilates (widens) blood vessels, making it easier for blood to flow through them and easier for the heart to pump. Isosorbide mononitrate is used to prevent angina attacks

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F 332	Continued From page 83 (chest pain). Potassium is a mineral that is found in many foods and is needed for several functions of your body, especially the beating of your heart. Potassium chloride is used to prevent or to treat low blood levels of potassium (hypokalemia)." The administration was informed of the findings 02/18/16 at 6:00 p.m.	F 332		
F 333 SS=D	RESIDENTS FREE OF SIGNIFICANT MED ERRORS CFR(s): 483.25(m)(2) The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and manufacturer's recommendations, the facility staff failed to ensure medications were administered timely. Two significant medication errors occurred when medications were not administered timely. For Resident #10, 13 medications scheduled to be administered at 6:00 p.m., were administered between 8:00 p.m. - 9:00 p.m. 1. A sliding scale insulin (SSI) order was not administered per physician orders. 2. Gabapentin (a pain medication) was not available for administration during the medication pour and pass observation. The findings included: Resident #10 was admitted to the facility on 07/30/2010 and readmitted after hospitalization of	F 333	1- Resident #10 is receiving medications as ordered in a timely manner, is receiving medications as ordered and medications are available for administration. The Sliding Scale Insulin orders are being followed as ordered for resident #10. 2- The Unit Manager or designee will review current residents with Sliding Scale Insulin orders to ensure that the orders are followed as ordered. The Unit Manager or designee will review current resident medication orders and Medication carts to ensure that medications are available for administration. The Licensed Nursing staff will be observed during medication administration pass to ensure that medications are administered timely and	4/1/16

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F 333	Continued From page 84 09/08/2015. Diagnoses for Resident #10 included but are not limited to diabetes, chronic obstructive pulmonary disease, hypertension, heart failure, and glaucoma. Resident #10's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/15/2015 coded Resident #10 with a BIMS (Brief Interview of Mental Status) score of 15, out of 15, cognitively intact. In addition, the MDS coded Resident #10 as independent in all of his Activities of Daily Living (ADL) care. On 2/16/2016 at 7:50 p.m., Resident #10 was seen in his room, sitting on the edge of his bed. Resident #10 was on oxygen by way of a nasal cannula. Both of Resident #10's legs and feet were swollen. On 2/16/2016 at 8:15 p.m., a Medication Pour and Pass was conducted with RN (Registered Nurse) A as she administered medication to Resident #10. RN A asked Resident #10 about his pain and Resident #10 said '8' out of a 1-10 pain scale. RN A said she wanted to give the resident his pain medication first. At 8:20 p.m., RN A administer Oxycontin, five 20 mg (milligram) tablets. RN A washed her hands, returned to the medication cart and proceeded to prepare Resident #10's remaining medications. At 8:30 p.m. RN A was observed reviewing the eMAR (electronic Medication Administration Record) and she popped the following pills into a medication cup: L-Arinine 500 mg, 3-Omega 3 capsule 100mg, Vitamin C, Carvedilol 25 mg, Clonidine .3mg, 3-Lasix 20 mg, Gemfibrozil 800 mg tablet, Pantoprazole Sodium 30 mg, Savella 100 mg, Clonazepam 1 mg, Hydralazine 100 mg,	F 333	as ordered. 3- The Unit Manager or designee will educate Licensed staff on proper method to refill medications, utilization of the facility STAT medication box for needed medication administration, following Sliding Scale Insulin orders. 4- The Unit Manager or designee will complete random weekly audits of residents with Sliding Scale Insulin orders to ensure that the orders are followed appropriately; complete random weekly audits of Medication Administration records and the Medication carts to ensure that medications are available for administration. The Unit Manager or designee will complete random monthly medication observations of Licensed staff to ensure that medications are administered timely and medications are available for administration. The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations	

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Isosorbide 20 mg. Potassium Chloride 20 meq (milliequivalent) /15 ml (milliliter) was placed in a separate cup. A bottle of Restasis .4 ml vial was removed from the medication cart. RN A prepared an insulin syringe with 30 units of Lantus. RN A started looking through the medication cart and said, "I can't find his Gabapentin. I am going to have to order it from the pharmacy stat. I'll give him these medications and then I'll call the pharmacy for the Gabapentin." RN A checked Resident #10"s blood pressure and reported a reading of 196/99. RN A administered the medications she had prepared and returned to the medication cart.

At 08:50, RN A said Resident #10's blood sugar for his SSI was tested at 4:30 p.m. and it was a reading of 191. LPN A said, "He gets 15 units of Humalog" While at the medication cart, Resident #10 called out to RN A for his PRN (as needed) Nitrostat (for chest pain). Resident #10 said he was having chest pain. RN A prepared the Nitrostat and an insulin syringe with 15 U of Humalog. At 8:57 p.m., RN A administered the Nitrostat (sublingual-under the tongue) and administered the 15 unit of Humalog. This completed the Medication Pour and Pass observation, 9:00 p.m.

On 2/17/2016 at 8:30 a.m., a review of the medications administered during the Medication Pour and Pass Observation was conducted. Review of clinical recorded revealed the medications administered to Resident #10 were due to be administered at 6:00 p.m. All of the observed medications were administered between 8:00 and 9:00 p.m..

Review of the eMAR revealed RN A did not

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document on any of the medications she had administered during the Medication Pour and pass, except the pain medication, Oxycontin.

A review of the Progress Notes revealed a nurse's note written by the oncoming night nurse, LPN D, on 2/17/16 at 2:44 a.m., "Upon night nurse administering 2300 meds and checking BS (blood sugar) , resident states, 'A nurse just came in here and gave me that medicine." Resident refused 2300 meds and states, 'I'm scared to take anything else now. I don't want to double dose." Evening nurse states that she did give resident his 2300 (11:00 p.m.) , meds and take his BS.

A review of the physician orders for Sliding Scale Insulin were as follows: "Inject as per sliding scale: if 101-150 - 5 units; 151-180 = 10 units; 181-210 - 15 units; 211-250 = 20 units; 251-300 = 25 units; 301-350 = 30 units; 351-400 = 35 units; 301-450 = 40 units; 451-500=50 units. Subcutaneously before meals and at bedtime related to Diabetes." Scheduled times were 6:30 a.m.; 11:30; 16:30 (4:30 PM); and 11:30.

Guidance for Humalog Insulin administration was provided by Mosby's "Fundamentals of Nursing 7th Edition, Potter-Perry, p. 742, Humalog R insulin is a short acting insulin with Insulin is classified by rate of action, including rapid, short, intermediate, and long acting. Each type has a different onset, peak and duration of action. Insulin is ordered by a specific dose at select times or by sliding scale. A sliding scale dictates a certain dose based on the client's blood glucose level. Usually, rapid or short acting insulins are ordered for sliding scales. Onset for Lispro (Humalog) 15 min."

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On 2/17/2016 at 4:00 p.m., an interview was conducted with Registered Nurse (RN) A. RN A said she did not document on the medication she had administered during the Medication Pour and Pass because the battery on the computer on the medication cart went dead. RN A said she had returned to the facility now in order to do her documenting.

On 2/17/2016 at 5:00 p.m., during a briefing with the administrator and the DON, the concerns regarding the late administration of Resident #10's medications were discussed. The DON said the expectation was for the nursing staff to administer medications timely - no more than an hour before or after the scheduled time."

On 2/17/2016 at 5:30 p.m., the DON provided a copy of Resident #10's February MAR with RN A's documented medication administrations and a copy of the hand written nurse's note RN A had just written, which read,

" 2/16/2016, 2330 (Resident's name) Resident #10 informed me that he did not eat his dinner. Has received Humalog and Lantus. Also he decline his snack. So BGM (blood glucose monitoring) was repeated, found to be 70. Snack of choice given. Report to night nurse that BGM is 70.

2/16/2016 2430 (12:30 a.m.) Night nurse informed Gabapentin and 2330 (11:30 PM) meds given around midnight. Had received Nitrostat sublingual with good effect...."

Drugs.com provided the following information on the significant medications that were not administered timely:
"Gabapentin is an anti-epileptic medication, also

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called an anticonvulsant. It affects chemicals and nerves in the body that are involved in the cause of seizures and some types of pain. Gabapentin is used in adults to treat nerve pain caused by herpes virus or shingles (herpes zoster). Take Gabapentin exactly as prescribed by your doctor.
Carvedilol is a beta-blocker. Beta-blockers affect the heart and circulation (blood flow through arteries and veins). Carvedilol is used to treat heart failure and hypertension (high blood pressure). It is also used after a heart attack that has caused your heart not to pump as well.
Clonidine lowers blood pressure by decreasing the levels of certain chemicals in your blood. This allows your blood vessels to relax and your heart to beat more slowly and easily. Clonidine is used to treat hypertension (high blood pressure).
Lasix (furosemide) is a loop diuretic (water pill) that prevents your body from absorbing too much salt, allowing the salt to instead be passed in your urine. Lasix treats fluid retention (edema) in people with congestive heart failure, liver disease, or a kidney disorder such as nephrotic syndrome....
Gemfibrozil helps reduce cholesterol and triglycerides (fatty acids) in the blood. High levels of these types of fat in the blood are associated with an increased risk of atherosclerosis (clogged arteries).
Pantoprazole is a proton pump inhibitor that decreases the amount of acid produced in the stomach. Pantoprazole is used to treat erosive esophagitis (damage to the esophagus from stomach acid),
Clonazepam is in a group of drugs called benzodiazepines (ben-zoe-dye-AZE-eh-peens). It affects chemicals in the brain that may become unbalanced and cause anxiety. Clonazepam is used to treat seizure disorders or panic disorder.

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Hydrochlorothiazide is a thiazide diuretic (water pill) that helps prevent your body from absorbing too much salt, which can cause fluid retention.
Hydralazine is a vasodilator that works by relaxing the muscles in your blood vessels to help them dilate (widen).
Isosorbide mononitrate is in a group of drugs called nitrates. It dilates (widens) blood vessels, making it easier for blood to flow through them and easier for the heart to pump. Isosorbide mononitrate is used to prevent angina attacks (chest pain).
Potassium is a mineral that is found in many foods and is needed for several functions of your body, especially the beating of your heart. Potassium chloride is used to prevent or to treat low blood levels of potassium (hypokalemia)."
Resident #10's SSI dose of Humalog was administered at 8:57 p.m. for a blood sugar measurement of 191 that was taken at 4:30 p.m. RN A did not reassess the blood sugar level at 8:57 p.m. prior to administering 15 U of Humalog. This resulted in Resident #10 experiencing a significant drop in his blood sugar to 70. Review of Resident #10's February blood sugar levels reveal his lowest measured blood glucose level was 94.

Resident #10's Gabapentin was ordered stat and arrived 2/17/2016 12:20 a.m. The Gabapentin was administered by RN A after she received it. Review of the facility STAT Box contents revealed the availability of 4 - 400 mg capsules of Gabapentin. This medication was available for administration at the time of the Medication Pour and Pass, but was not retrieve from the stat box. The administrator and the DON were informed of the significant medication errors incurred during the Medication Pour and Pass Observation,

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F 333	Continued From page 90 2/18/16 at 6:00 p.m.	F 333		
F 425 SS=D	PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH CFR(s): 483.60(a),(b) 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. 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, facility documentation review, and clinical record review, the facility staff failed to ensure medications were available for administration for three Residents (Residents' #2, #7 and #10) in a survey sample of 19 Residents. 1. For Resident #2, Lotrimin cream, a medicated cream, was not available for administration on 2/10/16;	F 425	1- Resident #2 has medications available and is receiving medications as ordered. Resident #7 has medications available and is receiving medications as ordered. Resident #10 has medications available and is receiving medications as ordered. 2- The Unit Manager or designee will review current resident medication administration records and medication	4/1/16

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F 425	Continued From page 91 2. For Resident #7, Fentanyl patch 25 mcg (microgram) was not available for administration on 12/5/15, 1/20/16, 1/29/16, and 2/13/16; and 3. For Resident #10, the facility staff failed to have physician ordered Xalatan eye drops (for Glaucoma) available for use from 02/07/2016 through 02/11/2016. The findings included: 1. For Resident #2, Lotrimin cream, a medicated cream, was not available for administration on 2/10/16. Resident #2, a female, was initially admitted to the facility 9/30/15. Her diagnoses included muscular weakness, gastroesophageal reflux disease, myasthenia gravis, hypertension, mood disorder, and major depressive disorder. Myasthenia gravis is a chronic autoimmune neuromuscular disease characterized by varying degrees of weakness of the skeletal (voluntary) muscles of the body. Resident #2's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1/7/16 was coded as a modification of a quarterly assessment. She was coded as having no memory deficits and was able to make her own daily life decisions. She was coded as requiring extensive assistance of one to two staff for all of her activities of daily living including bed mobility and transferring. Coding revealed she had not ambulated in her room and she was independent in her locomotion by wheelchair about the facility. Review of Resident #2's clinical record revealed	F 425	carts to ensure that medications are available for administration. 3-The Unit Manager or designee will educate Licensed nursing staff on proper procedure to refill medications, utilization of the facility STAT medication box for needed medications. 4- The Unit Manager or designee will complete random weekly audits of medication administration records and medication carts to assure that resident medications are available as ordered. The Unit Manager or designee will complete random monthly medication administration observations to ensure that medications are available for administration. The results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendations	

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Resident #2 was receiving treatment for a rash in her groin. Her physician ordered "Lotrimin AF Cream 1% (Clotrimazole) to be apply to her groin twice a day..." on 12/1/15. Nurses' initials were evident on the eTAR (electronic treatment administration record) the medicated cream was being administered twice daily until 2/10/16 on evening shift. On the evening shift for 2/10/16, an entry was placed on the eTAR and nursing notes, that Lotrimin AF cream was not applied as it was not available.

When interviewed, the DON (director of nursing) stated 2/17/16 at 5:15 p.m., the facility had experienced some problems with the pharmacy. The DON said the pharmacy would not send medications or at times did not let the facility know that a new prescription from the physician was needed.

Review of the emergency supply of medications revealed Lotrimin AF cream was not available in the emergency supply.

The administrator and DON were informed of the failure of the staff to ensure Lotrimin AF cream was available for administration for Resident #2, 2/18/16 at 11:30 a.m.

2. For Resident #7, Fentanyl patch 25 mcg was not available for administration on 12/5/15, 1/20/16, 1/29/16, and 2/13/16.

Resident #7, a female, was initially admitted to the facility 8/12/15 and readmitted after a hospitalization 12/15/15. Her diagnoses included peripheral vascular disease, arteriosclerotic cardiovascular disease, coronary bypass, hypokalemia, osteoarthritis, congestive heart

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failure, hypertension, angina, muscle weakness, allergic rhinitis, dysphagia, hypothyroidism, left bundle branch block, hyperlipidemia, chronic obstructive pulmonary disease, acute pancreatitis, Vitamin D deficiency, varicose veins, vascular dementia, and gastroesophageal reflux disease.

Resident #7's most recent MDS with an ARD of 12/18/15 was coded as a quarterly assessment . She was coded as having no memory deficits and was able to make her own daily life decisions. She was also coded as requiring extensive to total assistance of one staff member to perform her activities of daily living with the exception of eating. For eating, Resident #7 was coded as needing supervision.

Review of Resident #7's clinical record revealed a signed physician's order that included:

"12/15/16 Fentanyl Patch 72 hour 25 mcg/hr (microgram per hour) Apply 1 patch transdermally every 72 hours for pain..."

A corresponding entry was noted in the eMAR (electronic medication administration record) with guidance for the used patch to be removed and a fresh Fentanyl patch to be applied every 72 hours. Review of the eMAR revealed a Fentanyl patch was not applied on 12/5/15, 1/20/16, 1/29/16, and 2/13/16. An entry within the nursing notes indicated the patch was not applied as it was not available from the pharmacy.

Documentation was evident that for the days indicated, an alternate pain medication, Hydrocodone-Acetaminophen 5-325 mg was administered.

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The DON stated at times, the pharmacy did not let the facility know that a new prescription was needed to fill Fentanyl patch. For the Fentanyl patch, a "hard script" or actual prescription from the physician is needed to refill the medication.

Review of the facility's emergency supply of medications revealed Fentanyl patch 25 mcg/hour was not available in the emergency supply.

Guidance is provided at www.nlm.nih.gov for use of Fentanyl patches:

"Do not stop using fentanyl patches without talking to your doctor. Your doctor will probably decrease your dose gradually. If you suddenly stop using fentanyl patches you may have symptoms of withdrawal. Call your doctor if you experience any of these symptoms of withdrawal: restlessness, teary eyes, runny nose, yawning, sweating, chills, muscle pain, large pupils (black circles in the center of the eyes), irritability, anxiety, backache, pain in the joints, weakness, stomach cramps, difficulty falling asleep or staying asleep, nausea, loss of appetite, vomiting, diarrhea, fast heartbeat, or rapid breathing."

The administrator and DON were informed of the failure of the staff to ensure Fentanyl patch 25 mcg/hr were available for administration to Resident #7, 2/18/16 at 11:30 a.m.

3. For Resident #10, the facility staff failed to have physician ordered Xalatan eye drops (for Glaucoma) available for use from 02/07/2016 through 02/11/2016.

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F 425	Continued From page 95 Resident #10 was admitted to the facility on 07/30/2010 and readmitted after hospitalization of 09/08/2015. Diagnoses for Resident #10 included but are not limited to diabetes, chronic obstructive pulmonary disease, hypertension, heart failure, and glaucoma. Resident #10's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/15/2015 coded Resident #10 with a BIMS (Brief Interview of Mental Status) score of 15, out of 15, cognitively intact. In addition, the MDS coded Resident #10 as independent in all of his Activities of Daily Living (ADL) care. A review of Resident #10's clinical record was conducted during the survey. The review showed a physician order dated 11/13/2015. The order read that Resident #10 was to get Xalatan eye drops in both eyes every day for glaucoma. A review of Resident #10's Medication Administration Record was conducted. The review showed Resident #10 did not get Xalatan eye drops from 02/07/2016 through 02/11/2016 . A review of the nurses notes from the medication nurse on those days read, "on order from pharmacy." The facility administration was informed of the findings during a briefing on 02/17/16 at approximately 2:45 p.m. The facility did not present any further information about the findings.	F 425		
F 428 SS=D	DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON CFR(s): 483.60(c) The drug regimen of each resident must be	F 428		4/1/16

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F 428	Continued From page 96 reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility record review, and clinical record review, the facility Registered Pharmacist staff failed to report and act upon medication irregularities for one Resident (Resident #8) in a survey sample of 19 Residents. For Resident #8, the facility staff failed to report and act upon a " Monthly Medication Regimen Review" that discussed the need for a gradual dose reduction trial after almost eight months during the administration of a psychotropic medication, Lorazepam (Ativan) PRN (as needed) without clear clinical justification of need. The findings included: Resident #8, was initially admitted to the facility on 6-5-15. Diagnoses included; Alzheimer's dementia, anxiety, gastro-esophageal reflux disease (GERD), pain, and severe constipation, leading to hospitalizations for small bowel impaction, and fecal impaction. Resident #8's most recent Minimum Data Set (MDS) assessment was a quarterly assessment	F 428	1- Resident #8 will be reviewed by the pharmacist consultant for a review of medication irregularities and the clinical need for the medication has been clarified. 2- Pharmacist consultant recommendations were reviewed for current residents to ensure that the recommendations have been addressed and that there is a clear justification of clinical need for the medication. 3- Licensed staff will be educated on ensuring that pharmacist consultant recommendations are addressed in a timely manner. 4- Pharmacist consultant recommendations will be monitored on a monthly basis by the Unit Manager to ensure that the recommendations were addressed. Issues noted will be referred to the Quality Assurance committee for review and recommendations.	

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with an Assessment Reference Date (ARD) of 12-8-15. The Resident was coded with a Brief interview for mental status (BIMS) score of 3 points scored in a possible 15 points, indicating severe cognitive impairment. The Resident was coded as having no behavior problems, and required total assistance of staff for all activities of daily living, with the only exception being eating, which required extensive assistance. The Resident was also coded as always incontinent of bowel and bladder.

Guidance for the administration of Ativan is given by the National Institutes of Health, and is as follows;
U.S. National Library of Medicine, National Institutes of Health (NIH) Guidance;
· "Ativan (Lorazepam) INDICATIONS AND USAGE
Lorazepam/Ativan (lorazepam) is indicated for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or ...
Ativan (Lorazepam) is indicated for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic.
The effect of Lorazepam Ativan (lorazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
WARNINGS
Pre-existing depression may emerge or worsen during use of benzodiazepines including

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lorazepam. Ativan (lorazepam) is not recommended for use in patients with a primary depressive ...
Pre-existing depression may emerge or worsen during use with Lorazepam or other benzodiazepines. Ativan (lorazepam) is not recommended for use in patients with a primary depressive disorder or psychosis.
Benzodiazepines, including lorazepam, both used alone and in combination with other CNS depressants, may lead to potentially fatal respiratory depression. (See PRECAUTIONS, Clinically Significant Drug Interactions)
Benzodiazepines, including lorazepam, may lead to physical and psychological dependence.
In general, benzodiazepines should be prescribed for short periods only (e.g. 2 to 4 weeks).
Extension of the treatment period should not take place without reevaluation of the need for continued therapy. Continuous long-term use of product is not recommended. Withdrawal symptoms (e.g. rebound insomnia) can appear following cessation of recommended doses after as little as one week of therapy. Abrupt discontinuation of product should be avoided and a gradual dosage-tapering schedule followed after extended therapy."

No episodes of paranoid delusions or hallucinations were documented in the clinical record.
A thorough review of Resident #8's clinical record revealed in the Psychiatric physician mental health progress notes on 8-5-15, and 12-2-15 documented that the Resident had a depressed mood and affect most of the day and nearly every day as witnessed by him, and reported by staff.
The documents evidence that there is no indication that Resident #8 had hallucinations,

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paranoia, delusions or psychosis, and none were diagnosed by the expert in mental health. The Psychiatrist also stated the Resident was only moderately impaired, with logical and goal directed thinking with mild confusion, most recently in December 2015. No diagnosed need or continued use for the Ativan by the medical expert existed in the clinical record.

The pharmacist, was unavailable for interview during suvey. "Medication Regimen Review's" were completed monthly according to the DON (director of nursing), and placed in the computer by the Registered Pharmacist (RPH). Then staff and the DON could access the Reviews via computer. The staff were to review and determine if any recommendations are made by the pharmacist, and if so, to act upon those recommendations. The DON was asked for a copy of the Pharmacy reviews to include the time frame from the date the Ativan was ordered by the physician, and it was supplied. No recommendations were made by the RPH from 6-15-15 until 2-18-16.

Resident #8 was observed on 2-17-16 on bed awake at 2:30 PM. The Resident was found to be pleasant and alert, but confused. Resident #8 was again observed on 2-18-16 at 9:00 a.m. in bed resting with eyes closed. The Resident answered to his/her name and was easily aroused, pleasant, smiling and talkative, but confused.

The Resident's current doctor's orders and Medication Administration Record (MAR) were reviewed and revealed the following 5 orders for psychotropic medication administration;

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1. Lorazepam (Ativan) 0.5 mg (milligrams) give one tablet by mouth every 8 hours as needed for anxiety related to Anxiety state unspecified. Ordered 7-1-15.

2. Antianxiety medication (possible unwanted side effects):
Monitor for drowsiness, slurred speech, dizziness, nausea, aggressive/impulsive behavior.
Document "Y" (yes) if monitored and none of the above observed.
Document "N" (No) if monitored and any of the above was observed, then select chart code "other see nurses notes" and progress note findings every shift related to anxiety state.
Ordered 7-2-15.

3. Behaviors: Monitor for the following: Yelling, itching, picking at skin, restlessness (agitation), hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusing care.
Document "Y" (yes) if monitored and none of the above observed.
Document "N" (No) if monitored and any of the above was observed, then select chart code "other see nurses notes" and progress note findings every shift related to anxiety state.
Ordered 7-2-15.

4. Interventions utilized before use of Psychotropic Med (medication)/Hypnotic Med:
Document "Y" (yes) if not required.
Document "N" (No) if any of the above was utilized, then select chart code "other see nurses notes" and progress note interventions and non-pharmacologic interventions every shift

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related to anxiety state. Ordered 7-2-15.

No non-pharmacologic interventions were identified in the order, and did not appear before the 2-8-16 order change, (7 months later).

5. On 2-8-16 the above order was changed to include non-pharmacologic interventions, the new order was as follows;
Interventions utilized before use of Psychotropic Med (medication)/Hypnotic Med:
1:1 (one staff to one resident), reassurance, redirect, activities.
Document "Y" (yes) if not required.
Document "N" (No) if any of the above was utilized, then select chart code "other see nurses notes" and progress note interventions and non-pharmacologic interventions every shift related to anxiety state.

Review of the MAR revealed that all documentation of the form was done by a check mark, as completed, however, there was no "N", or "Y", marked in any box for January or February 2016 to indicate what behaviors the Resident exhibited.

The as needed Ativan was administered in January 2016, and February 2016, on 1-1-16, 1-4-16, 1-5-16 1-9-16, 1-13-16, 1-17-16, 1-23-16, 1-25-16, 1-30-16, and 2-2-16, (10 occasions).

The Nursing Progress Notes were reviewed and revealed;
1-1-16 at 9:45 p.m. Ativan given for increased agitation, talked with patient, gave snack, ineffective.
1-4-16 at 6:35 p.m. Ativan given for increased anxiety/yelling, talked with patient, gave snack,

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ineffective.
1-5-16 at 8:09 p.m. Ativan given for agitation, could not redirect, snack given, no effect.
1-9-16 at 4:32 p.m. Ativan given for agitation/anxiety, unresolved by redirection and snack.
1-13-16 at 4:24 p.m. Ativan given for increased anxiety not able to redirect.
1-17-16 at 1:55 a.m. Ativan given for anxiety, cursing, yelling, resistive to care.
1-23-16 at 5:08 p.m. Ativan given for anxiety unresolved by redirection, snack, ADL's (activities of daily living).
1-25-16 at 3:00 a.m. Ativan given for Resident very agitated. Yelling obscenities loudly. unable to redirect.
1-30-16 at 4:47 p.m. Ativan given for obscenities very agitated. Yelling obscenities loudly. Unable to redirect.
2-2-16 at 12:57 a.m. Ativan given for Resident very agitated. Yelling loudly.

In review of these records it is evidenced that of these 10 episodes, 7 of them happened in the evening between approximately 4:30 p.m., and 9:30 p.m., and 3 occurred in the middle of the night between approximately 1:00 a.m., and 3:00 a.m. No Resident occurrences identified in 5 of the occurrences. The non-pharmacologic interventions ordered as used in 2 of the occupancies was talking, and a snack, 2 of redirection, and a snack, 1 of a snack only, 3 redirect only, and 2 with no interventions used.

There was no care plan from 7-2-15 to the care plan created on 10-1-15 (3 months). The 10-1-15 care plan revealed the following;

As focus; The Resident exhibits advanced

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Alzheimer symptoms related to Alzheimer dementia with; Paranoid delusions, refuses care at times, anxiety with agitation, verbally abusive to staff at times, refuses labs.

Refusal of care, verbal abuse of staff, and refusal of lab draws are not clinically accepted reasons for administration of psychotropic medications and should not be administrated for staff convenience. Anxiety with agitation is not described in terms of specific behaviors, and there is no indication in the clinical record of paranoid delusions.

The care plan interventions for the above were; Administer medications as ordered, monitor and document for side effects, and effectiveness.
Explain all procedures allowing the resident time to adjust to changes.
If reasonable, discuss resident behavior, explain/reinforce why behavior is inappropriate and or unacceptable to the resident.
reassurance on one) interaction, reassurance, redirection, activity.
Ask yes/no questions.
Cue, reorient, and supervise as needed.

Of these interventions only effectiveness of the medication, redirection, and talking to the Resident were documented as being used.

Resident #8 had no gradual dose reductions attempted in the Ativan, no pharmacy review for medications revealed a need for drug reduction from June 2015 through the time of survey. The Ativan did not have supporting documented reasons for use, or continued use, and had been used long term without RPH intervention.

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F 428	Continued From page 104 An interview was conducted with the Director of Nursing, (DON), and the administrator, at the end of day debrief on 2-17-16 at 5:00 p.m., and on 2-18-16 at 4:00 p.m.. They were made aware of the findings. No further information was provided by the facility.	F 428		
F 496 SS=D	NURSE AIDE REGISTRY VERIFICATION, RETRAINING CFR(s): 483.75(e)(5)-(7) Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new	F 496		4/1/16

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F 496	Continued From page 105 competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on staff interview and employee record review, the facility staff failed to ensure one CNA's (certified nursing assistant) of three certified nursing staff certification was verified after renewal. Employee #2's certification expired on 11/30/15 and the staff failed to verify valid certification until 12/17/16. The findings included: Employee #2's employee file was reviewed during employee record review. Documentation revealed Emp. #2's certification expired on 11/30/15. Documentation within the employee record revealed the certification was verified by HR (human resources) on 12/17/15 (17 days after the certification expired). Other D, the head of HR, stated 2/17/16 at 2:36 p.m., she checks everyone license/certification twice a month to determine which license/certification are due to expire. Other D provided documentation that Emp. #2 worked 12/1, 12/3, 12/4, 12/7, 12/8, 12/10, 12/12, 12/13, 12/14, and 12/15/15. Other D said she made sure no one worked on an expired license, however she stated she had no other verification of certification after renewal. The administrator and DON (director of nursing) were informed of the failure of the staff to verify	F 496	1- Employee #2□s certification was verified on 12/17/16. 2- Current staff requiring a license or certification were reviewed to ensure that the license or certification is currently active and verified in a timely manner. 3- The Regional HR consultant or designee will educate the current HR manager on verifying licenses and certifications prior to the expiration of the license or certification. 4- The Regional HR consultant or designee will complete a random monthly audit to ensure that licenses and certifications have been verified prior to the expiration. Issues noted will be referred to the Quality Assurance committee for review and recommendation.	

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F 496	Continued From page 106 certification after renewal for Emp. #2 in a timely manner, 2/17/16 at 5:15 p.m.	F 496		