STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495399	A. BUILDING _____ B. WING _____	C 08/03/2018

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CHATHAM HEALTH & REHABILITATION CENTER	100 RORER STREET CHATHAM, VA 24531

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 7/31/18 through 8/3/18. The facility was not in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. Two complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 07/31/18 through 08/03/18. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 110 certified bed facility was 82 at the time of the survey. The survey sample consisted of 18 current Resident reviews and 4 closed record reviews.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).	F 578		9/7/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/22/2018

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F 578	Continued From page 1 (i) 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 resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review the facility staff failed to ensure a complete and accurate DDNR (Durable Do Not Resuscitate) for 2 of 18 residents in the survey sample (Residents #18 and #47). The findings included: 1. The facility staff failed to ensure a complete and accurate DDNR for Resident #18 was in the clinical record.	F 578	The DDNR for Resident #18 has been completed appropriately, including the date. The DDNR for Resident #47 has been completed appropriately, including the signatures of the resident's responsible party. Current residents with DDNR orders are at risk. An audit was completed on 8/2/2018 and no further incompletions	

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F 578	Continued From page 2 Resident #18 was admitted to the facility on 11/22/17 with the following diagnosis of, but not limited to high blood pressure, dementia, anxiety disorder and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/29/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 9 out of a possible score of 15. Resident #18 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent 1 staff member for bathing. During the clinical record review on 8/1/18 at 8:20 am, the surveyor noted that the resident's DDNR was not dated. The surveyor requested and received copies of the DDNR that was on the resident's paper clinical record. The surveyor notified the administrative team of the above documented findings on 8/2/18 at 5:13 pm in the conference room. No further information was given to the surveyor prior to the exit conference on 8/3/18. 2. The facility staff failed to ensure Resident #47's DDNR (Durable Do Not Resuscitate) was signed by the resident's responsible party. Resident #47 was readmitted to the facility on 6/22/18 with the following diagnoses of, but not limited to high blood pressure, dementia, seizure disorder, Benign Prostatic Hyperplasia and urinary tract infection. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/29/18, the resident was coded as having a BIMS (Brief Interview for	F 578	were found. Social Service Director has been educated by the Administrator that this is under the prevue of her department. Social Services Director or designee will review new orders for DDNR and ensure that the durable order is completed accurately. This review will be documented daily for 4 weeks and then weekly for 8 weeks. The Social Services Director will report the findings of the monitoring to the monthly QA committee meeting for review and recommendations for the duration of the monitoring period.	

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F 578	Continued From page 3 Mental Status) score of 8 out of a possible score of 15. Resident #47 was also coded as requiring extensive assistance of 1 staff member for dressing, personal hygiene and being totally dependent on 1 staff member for bathing. During the clinical record review 8/1/18, the surveyor noted that the DDNR was not signed by the resident's representative. The surveyor notified the DON (director of nursing) of the above documented findings at 8:20 am. The surveyor notified the administrative team of the above documented findings on 8/2/18 at 5:13 pm in the conference room. No further information was provided to the surveyor prior to the exit conference on 8/3/18.	F 578		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened	F 583		9/7/18

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F 583	Continued From page 4 mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to ensure privacy during a wound care observation for 1 of 18 residents (Resident #54). The findings included: The facility staff failed to provide privacy during wound care for Resident #54. The clinical record of Resident #54 was reviewed 8/1/18 through 8/3/18. Resident #54 was admitted to the facility 2/15/12 with diagnoses that included but not limited to dementia with behavioral disturbances, atherosclerotic heart disease, tibia fracture, gastroesophageal reflux disease, edema, mood disorder, major depressive disorder, insomnia, diarrhea, dysphagia, sinusitis, and adult failure to thrive.	F 583	Apologies were made to Resident #54. Resident #54 is unresponsive. LPN#3 and CNA#6 were immediately reeducated. Other residents in a double room are at risk for this issue. Nursing staff will be reeducated concerning the expectation that privacy will be maintained during care. This will include that the curtain be pulled at all times that the resident is exposed in any way. The Director of Nursing or designee will observe care, including wound care, to ensure that the reeducation concerning the maintenance of privacy during care has been effective. Theses observations will be documented	

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F 583	Continued From page 5 Resident #54's significant change in assessment minimum data set (MDS) assessment with an assessment reference date (ARD) of 7/1/18 assessed the resident with short term memory problems, long term memory problems, and severely impaired cognitive skills for daily decision making. Resident #54's current comprehensive care plan was reviewed and identified that the resident was at risk for further skin breakdown/infection r/t (related to) decreased mobility/function, weakness, bladder and bowel incontinence, resident is comfort care, hx (history of) skin breakdown, skin tears, res (resident) uses right heel to dig/rub into left shin, causing irritation at times, O2 tubing. Skin breakdown to sacrum #1 6/15/18. Skin breakdown to sacrum #2 8/1/18. Interventions: Air mattress as ordered, assess for increased, decreased edema when giving care, float heels intermittently and as resident allows, incontinence products per routine and as needed, keep clean and dry, monitor for skin breakdown/infection, and treatments/medications as ordered. The surveyor observed wound care to Resident #54's sacral area. Wound care was done by licensed practical nurse #3 on 8/1/18 at 3:13 p.m. Certified nursing assistant #6 assisted the nurse. L.P.N. #3 knocked on the door and entered the resident's room. Blinds were already closed. The surveyor observed the privacy curtain between the two residents was not pulled. Resident #54's roommate was observed lying in bed during the wound care observation and clothing change. While L.P.N. #3 was preparing the wound care supplies on the table, C.N.A. #6 was removing	F 583	daily for 5 days and then weekly for 11 weeks. The Director of Nursing will report the findings of the monitoring to the monthly QA committee meeting for review and recommendations for the duration of the monitoring period.	

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F 583	Continued From page 6 the top of Resident #54 and then re-dressed the resident in a clean top. During the procedure, the privacy curtain remained opened to the roommate. L.P.N. #3 then removed the soiled dressing, cleaned the wound and applied a clean dressing to the sacral area of Resident #54. Once again, the privacy curtain was not pulled between Resident #54 and the roommate. Upon completion of the wound care observation, the surveyor asked certified nursing assistant if the curtain should be pulled between the two residents when care was provided. C.N.A. #6 stated yes. The surveyor interviewed L.P.N. #3 on 8/2/18 at 8:15 a.m. about privacy during the wound care observation. L.P.N. #3 was asked if the privacy curtain should be pulled. She stated "Yes." The surveyor informed the administrator, the director of nursing, the corporate registered nurse and administrative staff #1 of the above observation on 8/1/18 and requested the facility policy on privacy. The surveyor asked the director of nursing if the privacy curtain should be pulled between the two residents when care was provided. The DON stated yes. The surveyor reviewed the facility policy titled "Resident's Privacy" received 8/3/18 at 8:55 a.m. The policy read in part "2. A closed door, drawn curtain, or both, shields the resident from passersby, as well as their roommate." No further information was provided prior to the exit conference on 8/3/18.	F 583		
F 684	Quality of Care	F 684		9/7/18

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F 684 SS=D	Continued From page 7 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to provide services to meet the highest practicable level of well-being for 2 of 18 residents in the survey sample (Resident #76 and #18). The findings included: 1. The facility staff failed to obtain vital signs and suprapubic catheter output every shift as ordered by the physician for Resident #76. Resident #76 was admitted to the facility on 7/5/18 with the following diagnoses of, but not limited to high blood pressure, neurogenic bladder, Multiple Sclerosis, seizure disorder and depression. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/12/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #76 was also coded as requiring extensive assistance with personal hygiene and being totally dependent on 1 staff member for dressing and bathing.	F 684	The vital signs and suprapubic output for Resident #76 are being followed as ordered. The fentanyl patches for Resident #18 are now being disposed of according to pharmacy guidelines. Residents with orders for vital signs, suprapubic catheter output measurements, and fentanyl patches are at risk for this issue. Licensed nursing staff have been reeducated concerning the requirement to follow physician orders, including vital signs and suprapubic output. They have also been reeducated as to the appropriate process to destroy fentanyl patches as needed. The Director of Nursing or designee will observe nursing staff wasting fentanyl patches to ensure the reeducation has been effective. This will be documented 2 times a week for 4 weeks and then weekly	

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F 684	Continued From page 8 During the clinical record review on 8/3/18, the surveyor noted the following physician orders: " " ...Obtain vital signs every day and evening shift " Document Suprapubic cath (catheter) output every shift ..." The surveyor also reviewed the TAR (Treatment Administration Record) for the month of July 2018 for Resident #76. The surveyor noted that there were initials in the boxes for each shift (day, evening and night) but there were no amounts of output for each of these shifts. Under the section of "vital signs" in the electronic health record for Resident #76, there were vital signs obtained but they were not obtained as the physician had ordered for day and evening shifts. The surveyor notified the DON (director of nursing) and the corporate nurse of the above documented findings on 8/3/18 at 10:15 am. The DON stated, "these vital signs were not obtained as the physician had ordered and there are no amounts documented for the output of the suprapubic catheter every shift." No further information was provided to the surveyor prior to the exit conference on 8/3/18. 2. The facility staff failed to follow professional standards of practice in regards to disposal of Fentanyl patches for Resident #18. Resident #18 was admitted to the facility on 11/22/17 with the following diagnosis of, but not limited to high blood pressure, dementia, anxiety disorder and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment	F 684	for 8 weeks. The Director of Nursing or designee will review the charting for ordered vital signs and suprapubic output documentation. This will be documented daily for 7 days, 5 days a week for 3 weeks, and then weekly for 8 weeks The Director of Nursing will report the findings of the monitoring to the monthly QA committee meeting for review and recommendations for the duration of the monitoring period.	

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F 684	Continued From page 9	F 684		

Reference Date) of 3/29/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 9 out of a possible score of 15. Resident #18 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing.

The surveyor conducted a clinical record review on 8/1/18 on Resident #18's record. During this review, the surveyor noted on the POS (Physician Order Sheets) the following order: "Fentanyl Patch 72 hour 12 mcg/hour Apply 1 patch transdermally every 72 hours for pain and remove per schedule ..." The surveyor also reviewed the MAR (Medication Administration Record) for July 2018. The following dates were left blank: 7/5, 7/8 and 7/14.

The surveyor notified the DON (director of nursing) on 8/1/18 at approximately 9:15 am of the above. The DON reviewed the MAR with the surveyor. The DON stated, "The nurse should had initialed these dates when it was administrated. The surveyor requested the narcotic sheets for the month of July and the facility's policy on wasting of narcotics.

At 10 am, the DON provided copies of the facility's policy titled "Disposal/Destruction of ...Medications" which read in part, " ...Facility should enter the following information on the drug destruction form when medications are destroyed ...Amount of medication (dosage units) destroyed, Date of destruction and the signature of witnesses ..."

The surveyor and the DON reviewed the narcotic sheets for the Fentanyl patch administrated to the

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F 684	Continued From page 10 resident for the month of July. The nurse had signed out for the Fentanyl patch but there wasn't any signatures noted in the column under wastage. The surveyor asked the DON if she would expect her staff to sign out for the narcotic patch when administrated and have a witness when the narcotic was wasted. The DON stated, "The nurses should sign out for the narcotic, initial the MAR as the date that it was given and then there should be 2 nurses to sign that the patch was destroyed when removed from the resident. According to this narcotic sheet, the nurses did not have a witness as to what happened to the patch after it was removed from the resident." The surveyor notified the administrative team of the above documented findings on 8/2/18 at 5:13 pm. No further information was provided to the surveyor prior to the exit conference on 8/3/18.	F 684		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent	F 686		9/7/18

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F 686	Continued From page 11 new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow physician orders for skin assessments for 2 of 18 residents (Resident #35 and Resident #76). The findings included: 1. The facility staff failed to follow physician's orders to do skin checks twice weekly for Resident #35. The clinical record of Resident #35 was reviewed 8/1/18 through 8/3/18. Resident #35 was admitted to the facility 12/24/16 with diagnoses, that included but not limited to hypertension, symbolic dysfunction, bilateral primary osteoarthritis, anxiety, Type 2 diabetes mellitus, major depressive disorder, atrial fibrillation, polyneuropathy, and fracture of lower end of left tibia. Resident #35's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 6/17/18 assessed the resident with a BIMS of 14/15. Skin Conditions (Section M) assessed the resident to be at risk for developing pressure ulcers. Current comprehensive care plan initiated 12/27/16 identified a focus area that read "Resident is at risk for skin breakdown related to: decreased mobility, weakness, bowel and bladder incontinence, dx (diagnosis) of diabetes and edema, intermittent redness under bilateral breast at times, res (resident) scratches legs at times, hx (history) of daughter known to have been providing medical treatment to resident's legs with a dressing and doesn't want staff to	F 686	Skin assessments have been performed for both Residents #35 and #76. All skin issues are being addressed per physicians orders. Current residents with orders for bi weekly skin checks are at risk for this issue. Licensed nursing staff will be reeducated concerning the expectation that physician orders will be followed, including the orders for the bi weekly skin checks. The Director of Nursing or designee will monitor the documentation of the bi weekly skin checks to validate the effectiveness of the reeducation. This monitoring will be documented daily for 7 days, 5 days a week for 3 weeks, and then weekly for 8 weeks. The Director of Nursing will report the findings of the monitoring to the monthly QA committee meeting for review and recommendations for the duration of the monitoring period.	

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F 686	Continued From page 12	F 686		

remove it. Hx of res refusing dressing changes at times. Hx of daughter removes dressing to leg after staff has applied new dressing. Refusing to wear compression stocking at times. Red rashy areas to left foot/ankle and right hip. When res stands to toilet, she has some bladder leakage (from stress of moving). Interventions: Meds/labs/treatment as ordered."

The July 2018 physician order sheet was reviewed. Resident #35 has orders for skin checks twice weekly-start date 4/27/18.
The surveyor reviewed the electronic skin assessments. The last completed skin assessment was dated 6/30/18. The surveyor was unable to locate any biweekly skin assessments for July 2018.

The surveyor informed the director of nursing on 8/2/18 at 2:23 p.m. The DON reviewed the clinical record and stated the order for skin checks twice weekly was not entered into the computer to do them.

The surveyor informed the administrator, the director of nursing, the corporate registered nurse and administrative staff #1 in the end of the day meeting on 8/2/18 at 5:12 p.m.

No further information was provided prior to the exit conference on 8/3/18.

2. The facility staff failed to perform skin assessments as ordered by the physician for Resident #76.

Resident #76 was admitted to the facility on 7/5/18 with the following diagnoses of, but not limited to high blood pressure, neurogenic bladder, Multiple Sclerosis, seizure disorder and

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F 686	Continued From page 13 depression. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/12/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #76 was also coded as requiring extensive assistance with personal hygiene and being totally dependent on 1 staff member for dressing and bathing. During the clinical record review on 8/2 and 8/3/18, the surveyor noted the following physician order: " ...Skin checks twice weekly on Wednesdays and Saturdays second shift ..." The surveyor also reviewed the TAR (Treatment Administration Record) for the month of July. The following dates were left blank: 7/7, 7/11, 7/14, 7/18, 7/21 and 7/28. The surveyor notified the DON (director of nursing) of the above documented findings on 8/3/18 at approximately 10 am. The DON stated that she would review this and get back to the surveyor with her findings. At 11:00 am, the DON came back to the surveyor and stated, "I cannot find any skin assessments except for the one done on 7/25/18." The surveyor notified the administrative team of the above documented findings on 8/3/18 at 11:15 am. No further information was provided to the surveyor prior to the exit conference on 8/3/18.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		9/7/18

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F 690	Continued From page 14 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to ensure 3	F 690	Resident #60's Foley bag was covered as soon as the issue was identified and the	

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F 690	Continued From page 15 of 18 residents (Resident #60, Resident #47 and Resident #76) received the appropriate care and services for residents with an indwelling Foley catheter. The findings included: 1. The facility staff failed to ensure Resident #60's indwelling Foley catheter was covered by a privacy bag and failed to ensure urinary output was obtained and documented in the clinical record. The clinical record of Resident #60 was reviewed 7/31/18 through 8/3/18. Resident #60 was admitted to the facility 7/2/18 with diagnoses, that included but not limited to urinary tract infection, osteomyelitis of right calcaneus with necrotic plantar ulcer, muscle weakness, morbid obesity, opioid dependence, hx of alcohol abuse, severe protein-calorie malnutrition, edema, anemia, gastroesophageal reflux disease, end stage renal disease, hyperlipidemia, and sacral pressure ulcer. Resident #60's admission minimum data set (MDS) with an assessment reference date (ARD) of 7/9/18 assessed the resident with a BIMS Summary Score of 13/15. Resident #60 was assessed to not be delirious, psychotic or have behaviors that affected others. Bladder and Bowel was reviewed. Indwelling catheter was marked and urinary continence was marked with a "9"-not rated, resident had a catheter, urinary ostomy, or no urine output for the entire 7 days. Resident #60's current comprehensive care plan was reviewed. A focus area read "Resident has current UTI (urinary tract infection) and is at risk	F 690	documentation of the urinary output is now being documented according to physician orders. Residents #47 and #76 had their Foley bags covered as soon as the issue was identified. Residents with Foley bags are at risk for this issue. Facility staff will be reeducated that all Foley bags must be covered at all times. The Administrator and the Director of Nursing or designee will monitor residents with Foley bags to ensure there is a privacy coverage. This monitoring will be documented daily for 7 days, 5 days a week for 3 weeks, and then weekly for 8 weeks. The Administrator will report the findings of the monitoring to the monthly QA committee meeting for review and recommendations for the duration of the monitoring period.	

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F 690	Continued From page 16	F 690		

for further infection r/t (related to) Foley catheter. Noted with dark sediment urine, bleeding around catheter site noted. Date initiated 7/5/18. Interventions: Change Foley catheter as needed per order, document daily output as ordered, irrigate Foley catheter as ordered, provide privacy bag, anchor foley cath, report s/s (signs/symptoms) to MD (medical doctor), assess for s/s of UTI: foul smelling, cloudy urine, sediment, decreased output, labs as ordered, inform physician of abnormal labs (laboratory), treatments as ordered, notify physician if course of treatment appears to be ineffective, and Foley cath care as ordered.

(a) During the initial tour on 7/31/18 at 12:00 noon, the resident was observed in bed. Foley catheter was observed and the drainage bag was not observed to be in a privacy bag. The surveyor observed Resident #60 again on 7/31/18 at 1:00 p.m. Again, the Foley catheter was not in a privacy bag.

The surveyor informed the director of nursing on 7/31/18. The DON stated the Foley drainage bag should be in a privacy bag. The surveyor requested the facility policy on urinary care.

(b) The 7/16/18 telephone order read, "Document Foley Output every shift every shift for monitoring." The urologist consult dated 7/27/18 read "Stop Calcium Acetate. Monitor and call us if urine output < (less than) 1000 ml/day (milliliter/day)."

The surveyor reviewed the July 2018 treatment administration records. There was no recorded Foley output on 7/27/18 evening and night shift, no recorded Foley output on 7/28/18 night shift,

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no recorded Foley output on 7/29/18 night shift, no recorded Foley output 7/30/18 day shift, and no recorded Foley output 7/31/18 night shift.

The surveyor reviewed the July 2018 progress notes and found no evidence the Foley output was obtained and documented.

The surveyor informed the director of nursing of the above concern on 8/2/18 at 10:44 a.m.

The surveyor informed the administrator, the director of nursing, the corporate registered nurse, and administrative staff #1 of the above failure for staff to obtain and document Resident #60's Foley output every shift.

No further information was provided prior to the exit conference on 8/3/18.

2. The facility staff failed to place a privacy bag over the Foley catheter drainage bag for Resident #47.

Resident #47 was admitted to the facility on 12/6/17 with the following diagnoses of, but not limited to diabetes, high blood pressure and seizure disorder. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 4/16/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 3 out of a possible score of 15. Resident #47 was also coded as requiring extensive assistance of 1 staff member for dressing and was totally dependent on 1 staff member for personal hygiene and bathing.

During the initial tour of the unit on 7/31/18 2 pm, the surveyor observed the resident was sitting up in bed with the Foley catheter bag hanging on the

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side of the bed. The drainage bag that was hanging on the side of the bed did not have a privacy bag covering it.

At 4:00 pm, the surveyor went into the resident's room and again did not observe a privacy bag over the drainage bag.

The surveyor notified the administrative team of the above documented findings on 8/1/18 at 5:13 pm. The surveyor requested a copy of the policy on Foley catheters as it pertains to having a privacy bag over the drainage bag.

On 8/2/18 at 9:15 am, the DON came into the conference room and stated, "We don't have a policy on privacy bags over the drainage bag. But I do expect the staff to provide a privacy bag over the Foley catheter drainage bag. I will in service all the staff on this."

No further information was provided to the surveyor prior to the exit conference on 8/3/18.

3. The facility staff failed to place a privacy bag over the catheter drainage bag for Resident # 76.

Resident #76 was admitted to the facility on 7/5/18 with the following diagnoses of, but not limited to high blood pressure, neurogenic bladder, Multiple Sclerosis, seizure disorder and depression. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/12/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #76 was also coded as requiring extensive assistance with personal hygiene and

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F 690	Continued From page 19 being totally dependent on 1 staff member for dressing and bathing. On 8/2/18 at approximately 1:30 pm, the surveyor observed the suprapubic catheter bag hanging on the side of the bed without a privacy bag covering it. On 8/3/18 at 10:30 am, the surveyor again observed the suprapubic catheter drainage bag hanging from the side of the bed and there was not a privacy bag covering it. At 10:45 am, the surveyor notified the DON and the corporate nurse of the above documented findings. The DON stated, "I am in servicing all the staff on this. They should always make sure that the catheter bag has a privacy bag over it." No further information was provided to the surveyor prior to the exit conference on 8/3/18.	F 690		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph	F 756		9/7/18

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F 756	Continued From page 20 (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to have the medical doctor review the pharmacy recommendations for 4 of 18 residents in the survey sample. (Resident #17, #56 and #40) The findings included: 1. The facility staff failed to have the medical doctor review the pharmacy recommendations for Resident #17. Resident #17 was admitted to the facility on 7/17/15 with the following diagnoses of, but not	F 756	The physician has reviewed and written orders concerning the recommendations for the most recent pharmacy review for Residents #17, #56, and #40. Residents who have recommendations made by the pharmacist during the medical records review are at risk for this issue. The pharmacist has been reeducated that the attending physician must be listed for all medication recommendations made during the review.	

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F 756	Continued From page 21 limited to anxiety disorder, depression, high blood pressure, diabetes, dementia and Parkinson's disease. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/27/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score of 15. Resident #17 was also coded as requiring extensive assistance of 1 staff member for dressing and totally dependent on 1 staff member for personal hygiene and bathing. The surveyor performed a review of Resident 17's clinical record on 8/3/18. During this review, the surveyor noted pharmacy recommendations for the month of February and March that were signed by the nurse practitioner. At 12:35 pm, the surveyor notified the corporate nurse and the DON (director of nursing) of the above documented findings. The corporate nurse stated, "That was an oversight on our part. We will need to get pharmacy to send these to the medical doctor." No further information was provided to the surveyor prior to the exit conference on 8/3/18. 2. The facility staff failed to have the medical doctor review the pharmacy recommendations dated for 7/11/18 for Resident #56. Resident #56 was admitted to the facility on 6/28/18 with the following diagnoses of, but not limited to anemia, dementia and anxiety disorder. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/5/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 11 out of a	F 756	The Licensed nursing staff have been reeducated that the signed pharmacy recommendation is an order that must be entered into the resident's electronic chart as written. The Medical Records clerk has been reeducated that pharmacy recommendations must be filed into the resident's permanent chart. The Director of Nursing or designee will review all pharmacy recommendations to ensure the physician's name is listed on each where a medication recommendation is made.	

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possible score of 15. Resident #56 was also coded as requiring supervision of 1 staff member for dressing and extensive assistance of 1 staff member for personal hygiene and bathing.

During the clinical record review on 8/3/18, the surveyor noted that the pharmacist had marked the box which stated, "See report for any noted irregularities". The pharmacist dated this for 7/11/18.

On 8/3/18 at approximately 11:40 am, the surveyor notified the DON (director of nursing) of the above documented findings. The DON stated that she would go back to the chart and look to see if any papers had been filed wrong.

At 1:15 pm, the DON returned to the surveyor and stated, "I could not find any pharmacy recommendations for the date of 7/11/18 on this resident."

No further information was provided to the surveyor prior to the exit conference on 8/3/18.

3. The facility staff failed to implement the recommendations made by the contracting pharmacist for a gradual dose reduction (GDR) for Klonopin and failed to provide documentation in the clinical record that the attending physician was informed of the GDR for Resident #40.

Resident #40 was admitted to the facility 6/1/15 and readmitted 8/9/17 with diagnoses that included but not limited to hypothyroidism, hypertension, chronic kidney disease stage 3, asthma, Type 2 diabetes mellitus, gastroesophageal reflux disease, constipation, gout, anemia, overactive bladder, major

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depressive disorder, and non-rheumatic aortic stenosis.

Resident #40's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 6/19/18 assessed the resident with a BIMS Summary Score of 15/15.

Current comprehensive care plan initiated 3/2/16 included the focus area that read Resident #40 was at risk for adverse effects r/t (related to) psychoactive medication use: Depression, Anxiety. Interventions: Monitor for side effects: sedation, hypotension, EPS (extrapyramidal symptoms), anticholinergic sx (symptoms), H/A (headache), insomnia, anorexia, constipation. Pharmacy review per routine, reduction in medication when indicated.

The surveyor reviewed the June 2018 Medication Regimen Review completed 6/6/18. The June 2018 MRR read "GDR Klonopin." A review of the pharmacy Consultation Report read "Resident #40 receives Clonazepam which was decreased to 0.25 mg (milligrams) QAM (every morning) and 0.5 mg QHS (every bedtime) for anxiety 5/20/17. This was decreased to clonazepam 0.25 mg q 12 h (every 12 hours), 11/18/17, then to 0.25 mg at 1300 (1:00 p.m.), 2/23/18. Please re-evaluate continued use of Clonazepam and consider decrease to 0.25 mg at 1300 prn (as needed) anxiety x 14 days while monitoring for change in behaviors." The consultation report was signed by the former director of nursing on 6/13/18. The facility psychiatric nurse practitioner (NP) documented on the consultation report "Accepted GDR for Resident #40 6/15/18."

The July 2018 medication administration record

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was reviewed. The entry for Clonazepam (Klonopin) read "Klonopin 0.5 mg Give 1 tablet by mouth one time a day for anxiety start date 4/24/18."

Each box in the July 2018 medication administration record had been initialed that Resident #40 received Klonopin 0.5 mg from 7/1/18 through 7/31/18-not the ordered dose recommended by the pharmacist in June 2018.

The facility staff had failed to implement the recommendations made by the contracting pharmacist in June 2018.

The surveyor informed the director of nursing of the concern on 8/3/18 at 12:35 p.m. The DON reviewed the pharmacy recommendation and the order entered into the computer and stated the order was entered incorrectly into the computer. The DON provided the surveyor with the Controlled Medication Utilization Record for Resident #40. The form read "Clonazepam 0.5 mg tablet Take 0.5 mg (0.25 mg) by mouth every day at 1300 for anxiety."

(b). Also during the Medication Regimen Review, the surveyor was unable to locate the attending physician's review of the June 2018 which had recommendations for decreasing the dose of Klonopin as written above. The surveyor interviewed the corporate registered nurse on 8/3/18 at 12:08 p.m. The corporate RN stated that the attending physician referred all psychiatric medication concerns from the medication regimen review to the psychiatric nurse practitioner. The corporate RN stated the pharmacy would need to start sending them to the attending physician as well. The corporate RN

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F 756	Continued From page 25 stated it was an oversight. No further information was provided prior to the exit conference on 8/3/18.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758		9/7/18

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F 758	Continued From page 26 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure 4 of 18 residents (Resident #60, Resident #26, Resident #229, and Resident #56) were free of an unnecessary medication. The findings included: 1. The facility staff failed to identify and monitor resident specific target behaviors, identify non-pharmacological interventions, and monitor for effectiveness associated with the use of Remeron for Resident #60. The clinical record of Resident #60 was reviewed 7/31/18 through 8/3/18. Resident #60 was admitted to the facility 7/2/18 with diagnoses, that included but not limited to urinary tract infection, osteomyelitis of right calcaneus with necrotic plantar ulcer, muscle weakness, morbid obesity, opioid dependence, hx of alcohol abuse, severe protein-calorie malnutrition, edema, anemia,	F 758	Resident #60 now has monitoring of target behaviors, effectiveness of medication, side effects, and documentation of non-pharmacological interventions utilized associated with the use of Remeron. Resident #26 now has monitoring of target behaviors, effectiveness of medication, side effects, and documentation of non-pharmacological interventions utilized associated with the use of Remeron. Resident #229 now has monitoring of target behaviors, effectiveness of medication, side effects, and documentation of non-pharmacological interventions utilized associated with the use of Xanax. Resident #56 now has monitoring of	

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gastroesophageal reflux disease, end stage renal disease, hyperlipidemia, and sacral pressure ulcer.

Resident #60's admission minimum data set (MDS) with an assessment reference date (ARD) of 7/9/18 assessed the resident with a BIMS Summary Score of 13/15. Resident #60 was assessed to not be delirious, psychotic or have behaviors that affected others.

Resident #60's current comprehensive care plan was reviewed. A focus area read "At risk for adverse effects r/t (related to) psychoactive medication use, dx (diagnosis) depression. Date initiated 7/18/18. Interventions: Monitor for side effects: sedation, hypotension, EPS (extrapyramidal symptoms), anticholinergic sx (symptoms), H/A (headache), insomnia, anorexia, constipation, pharmacy review per routine, reduction in medication doses when indicated, report changes in behavior or mood state, report to physician any negative outcomes associated with the use of psychoactive drug."

Information about Remeron was found at www.drugs.com and read "Remeron Generic drug name: Mirtazapine MIRTAZAPINE is used to treat depression."

The clinical record revealed a physician order dated 7/30/18 for Remeron 30 mg (milligram) every bedtime for depression. The surveyor reviewed the July 2018 and August 2018 medication administration records (MARs). Remeron 30 mg had been administered 7/30/18, 7/31/18, and 8/1/18. The surveyor reviewed the July 2018 progress notes and the MARs and was unable to locate any monitoring of target

target behaviors, effectiveness of medication, side effects, and documentation of non-pharmacological interventions utilized associated with the use of Xanax, Lexapro, and Seroquel.

Current residents who have orders for Xanax, Lexapro, Remeron, and Seroquel are at risk for this issue. The Director of Nursing or designee will review the orders to ensure that the behavior monitoring is in place for all effected residents.

Licensed nursing staff will be reeducated concerning Xanax, Remeron, Lexapro, and Seroquel are among the medications that require monitoring of target behaviors, effectiveness of medication, side effects, and documentation of non-pharmacological interventions utilized in association with them. This education will include how to place the monitoring into the orders to ensure that it is part of the MAR and transcribing to the MAR to ensure documentation is completed.

The Director of Nursing or designee will review the behavior management documentation to ensure it is being completed as ordered. This review will be documented daily for 7 days, 5 days a week for 3 weeks, and then weekly for 8 weeks.

The Director of Nursing will report the findings of the monitoring to the monthly QA committee meeting for review and recommendations for the duration of the monitoring period.

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behaviors, effectiveness of medication, side effects, or documentation of non-pharmacological interventions utilized associated with the use of Remeron.

The surveyor interviewed licensed practical nurse #5 on 8/2/18 at 12:20 p.m. L.P.N. #5 stated, "The resident just started on the medication."

The surveyor informed the administrator, the director of nursing, the corporate registered nurse, and administrative staff #1 in the end of the day meeting on 8/2/18 at 5:12 p.m.

No further information was provided prior to the exit conference on 8/3/18.

2. The facility staff failed to identify and monitor resident specific target behaviors, identify non-pharmacological interventions, and monitor for effectiveness associated with the use of Remeron for Resident #26.

The surveyor reviewed Resident #26's clinical record 8/1/18 through 8/3/18. Resident #26 was admitted to the facility 10/7/2016 and readmitted 11/23/17 with diagnoses that included but not limited to left hip fracture (11/25/17), anxiety, Type 2 diabetes mellitus, gout, edema, Vitamin D deficiency, gastro-esophageal reflux disease, hypothyroidism, hyperlipidemia, constipation, schizophrenia, peripheral vascular disease, thrombocytopenia, and pseudobulbar affect.

Resident #26's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 6/5/18 assessed the resident with a BIMS Summary Score of 14/15 without any signs of delirium, psychosis, or behaviors that affected

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others. Resident #26 was assessed to be totally dependent on two plus persons for transfers. Resident #26 was coded as an 8/8 (activity did not occur) for walk in room and walk in corridor. Resident #26 was assessed to require extensive assistance of 2 plus persons for bed mobility. Resident #26 did not have any falls in the look-back period.

Resident #26's current comprehensive care plan initiated 10/13/16 had a focus area that read "Resident is at risk for adverse effects r/t (related to) psychoactive medication use: Dx (diagnosis): anxiety, bipolar disorder, depression, hx (history) of schizophrenia, hx mood disorder, hx of pseudobulbar affect. Interventions: Monitor for med side effects: sedation, hypotension, EPS (extrapyramidal symptoms), anticholinergic sx, H/A (headache), insomnia, anorexia, constipation, monitor for s/s (signs/symptoms) of anxiety, monitor for s/s of depression, medications for effectiveness, pharmacy review per routine, reduction in medication doses when indicated, report changes in behavior or mood state, report to physician any negative outcomes associated with use of psychoactive drug."

A physician order dated 7/9/18 "Remeron Tablet 15 mg (milligram) (Mirtazapine) Give 1 tablet by mouth at bedtime for depression."
Information about Remeron was found at www.drugs.com and read "Remeron Generic drug name: Mirtazapine MIRTAZAPINE is used to treat depression."

The July 2018 medication administration record was reviewed. Remeron 15 mg had been administered from 7/9/18 through 7/31/18. However, the surveyor was unable to locate any

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form of monitoring for the use of Remeron-targeted behaviors, effectiveness of medication, side effects, or documentation of non-pharmacological interventions utilized associated with the use of Remeron.

The surveyor informed the director of nursing on 8/2/18 at 1:40 p.m. that the surveyor was unable to locate targeted behaviors, monitoring for side effects or effectiveness, or non-pharmacological interventions prior to the use of Remeron. The DON stated it seemed the facility was having a problem with July medications.

The surveyor informed the administrator, the director of nursing, the corporate registered nurse, and administrative staff #1 of the above failure to implement monitoring for Resident #26's Remeron in the end of the day meeting on 8/2/18 at 5:12 p.m.

No further information was provided prior to the exit conference on 8/3/18.

3. The facility failed to monitor the use of a psychotropic medication, Xanax, for Resident #229.

Resident #229 was admitted to the facility on 7/23/18 with the following diagnoses of, but not limited to muscle weakness, heart failure, anxiety disorder and atrial fibrillation. The admission MDS (Minimum Data Set) was not completed at the time of this survey. According to the admission assessment made by the nurse, the resident was alert and oriented. The resident does require extensive assistance with dressing, personal hygiene and bathing.

During the clinical record review on 8/3/18, the

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surveyor noted that the resident was ordered Xanax 0.5 mg TID (three times a day). The surveyor could not find any behavioral monitoring sheets for Resident #229. However, there were behaviors being monitored for Lorazepam and Trazodone on the August, 2018 TAR (Treatment Administration Record).

The DON (director of nursing) and the corporate nurse were notified of the above documented findings on 8/3/18 at 11:45 am.

At 1:00 pm, the DON returned to the surveyor and stated, "They are not monitoring the behaviors for the Xanax. They are monitoring behaviors for Trazodone and Lorazepam."

No further information was provided to the surveyor prior to the exit conference on 8/3/18.

4. The facility staff failed to failed to monitor the use of psychotropic medications, Xanax, Lexapro and Seroquel for Resident #56.

Resident #56 was admitted to the facility on 6/28/18 with the following diagnoses of, but not limited to anemia, dementia and anxiety disorder. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/5/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 11 out of a possible score of 15. Resident #56 was also coded as requiring supervision of 1 staff member for dressing and extensive assistance of 1 staff member for personal hygiene and bathing.

During the clinical record review on 8/3/18, the surveyor noted that the resident had the following medications ordered:

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F 758	Continued From page 32 " Xanax 0.5 mg (milligram) TID (three times a day) po (by mouth) " Seroquel 25 mg TID po " Lexapro 5 mg daily po The surveyor reviewed the MAR (Medication Administration Record) and TAR (Treatment Administration Record) for July and August 2018. There was no documentation found for the month of July for monitoring behaviors. On the August TAR, the resident was being monitored for antianxiety, antidepressant and antipsychotic behaviors but no specific medication was documented as to this was being monitored. The DON (director of nursing) and corporate nurse were notified of the above documented findings on 8/2/18 at 1:15 pm. The DON stated that she would look into this and get back with the surveyor about findings. At approximately 1:45 pm, the DON returned to the surveyor and stated, "The nurses did not document which medication was being monitored. They were only monitoring for example, an antianxiety medication with intervention coded but it does not state which specific medication." No further information was provided to the surveyor prior to the exit conference on 8/3/18.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		9/7/18

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F 761	Continued From page 33 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Chatham F Tag 761 D Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to ensure medications were securely stored for 1 of 18 residents (Resident #26). The findings included: The facility staff failed to ensure the hand held nebulizer Breo for Resident #26 was stored in the medication cart when not in use. The surveyor reviewed Resident #26's clinical record 8/1/18 through 8/3/18. Resident #26 was admitted to the facility 10/7/2016 and readmitted	F 761	The hand held Breo nebulizer for Resident #26 was immediately taken back to the medication cart when the issue was identified. No other medications were found in the room of Resident #26 at that time. Residents who are ordered hand held Breo Nebulizers are at risk for this issue. All residents rooms have been inspected to ensure there are no other medications left in the room. Licensed nursing staff will be reeducated that all medications must be returned to the medication cart when the nurse leaves	

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F 761	Continued From page 34 11/23/17 with diagnoses that included but not limited to left hip fracture (11/25/17), anxiety, Type 2 diabetes mellitus, gout, edema, Vitamin D deficiency, gastro-esophageal reflux disease, hypothyroidism, hyperlipidemia, constipation, schizophrenia, peripheral vascular disease, thrombocytopenia, and pseudobulbar affect. Resident #26's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 6/5/18 assessed the resident with a BIMS Summary Score of 14/15 without any signs of delirium, psychosis, or behaviors that affected others. Current comprehensive care plan initiated 10/16/16 for Resident #26 was assessed to be at risk for altered cardiac/respiratory status d/t (due to) dx (diagnoses) of respiratory failure. Interventions: meds/labs (medications/laboratory tests) as ordered. Resident #26 was observed on 8/2/18 around 8:15 a.m. in bed with the head of the bed elevated. Breakfast tray was on the over-the-bed table. Cranberry juice, toast, scrambled eggs, and milk were observed to be untouched. Also on the over-the-bed table was an inhaler labeled "Breo." The surveyor requested the assistance of licensed practical nurse #5. The surveyor asked L.P.N. #5 if she had administered Resident #26's medications to her. L.P.N. #5 stated yes. The surveyor pointed to the Breo hand held inhaler observed on the table. L.P.N. #5 stated medications were not to be left on the table and in the room. Resident #26's physician's orders included one	F 761	the room. The Director of Nursing or designee will inspect resident rooms to identify if any medication has been left in the room. This inspection will be done daily for 7 days, 5 days a week for 3 weeks, and then weekly for 8 weeks. The Director of Nursing will report the findings of the monitoring to the monthly QA committee meeting for review and recommendations for the duration of the monitoring period.	

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F 761	Continued From page 35 for the inhaler that read "Breo Ellipta Aerosol Powder Breath Activated 100-25 mcg (micrograms)/Inh (inhalation) 1 vial inhale orally one time a day for SOB (shortness of breath) Rinse mouth after each use. Start Date 4/21/18." The surveyor did not find an order for Resident #26 to self-administer medications. The surveyor informed the administrator, the director of nursing, the corporate registered nurse and administrative staff #1 of the above concern during the end of the day meeting on 8/2/18 at 5:12 p.m. The surveyor requested the facility policy on the storage of medications. The surveyor reviewed the facility policy on storage of medications on 8/3/18 at 9:22 a.m. The policy titled "5.3 Storage and Expiration of Medications, Biologicals, Syringes, and Needles" read in part, "3.3 Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors." No further information was provided prior to the exit conference on 8/3/18.	F 761		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician,	F 773		9/7/18

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F 773	Continued From page 36 physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain physician ordered laboratory tests for 2 of 18 residents (Resident #26 and Resident #60). The findings included: The facility staff failed to obtain the physician ordered laboratory tests for Resident #26. The surveyor reviewed Resident #26's clinical record 8/1/18 through 8/3/18. Resident #26 was admitted to the facility 10/7/2016 and readmitted 11/23/17 with diagnoses that included but not limited to left hip fracture (11/25/17), anxiety, Type 2 diabetes mellitus, gout, edema, Vitamin D deficiency, gastro-esophageal reflux disease, hypothyroidism, hyperlipidemia, constipation, schizophrenia, peripheral vascular disease, thrombocytopenia, and pseudobulbar affect. Resident #26's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 6/5/18 assessed the resident with a BIMS Summary Score of 14/15 without any signs of delirium, psychosis, or behaviors that affected others. The clinical record revealed a physician order dated 5/10/18 that read "5/10/18 CBC (complete blood count), CMP (comprehensive metabolic	F 773	The physician was notified that the CMP (Comprehensive metabolic panel) was not obtained on 5/10/2018 as ordered for Resident #26. The physician discontinued the order for the labs and the resident, who is their own responsible party, was notified. The physician was notified that the urinalysis with culture and sensitivity were not obtained as ordered for Resident #60 on 7/27/2018. The physician discontinued the order for the labs and the resident, who is their own responsible party, was notified. Residents with orders for labs are at risk for this issue. Licensed nursing staff will be educated concerning accurate transcription and following physician orders for laboratory orders. The Director of Nursing or designee will review the orders in each morning clinical meeting and verify the accurate transcription into the lab requests. This order will be added to a follow up list that will be reviewed at each morning clinical meeting to verify that results have been	

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F 773	Continued From page 37 panel), A1C (Hemoglobin A1C), ESR (sed rate westergren)." The surveyor reviewed the laboratory section of the clinical record. A BMP (basic metabolic panel) dated 5/10/18 had been obtained instead of the CMP ordered. The surveyor informed the director of nursing (DON) of the laboratory results on 08/02/18 at 1:09 p.m. The DON stated a BMP was done instead of a CMP. The DON stated she would see which nurse completed the laboratory slip. The DON showed the surveyor the lab requests sheet. The laboratory requests slip was marked for a BMP-not a CMP as ordered by the physician. The surveyor informed the administrator, the director of nursing, the corporate registered nurse and administrative staff #1 of the above concern during the end of the day meeting on 8/2/18 at 5:12 p.m. No further information was provided prior to the exit conference on 8/3/18. 2. The facility staff failed to obtain a physician ordered urinalysis for Resident #60. The clinical record of Resident #60 was reviewed 7/31/18 through 8/3/18. Resident #60 was admitted to the facility 7/2/18 with diagnoses, that included but not limited to urinary tract infection, osteomyelitis of right calcaneus with necrotic plantar ulcer, muscle weakness, morbid obesity, opioid dependence, hx of alcohol abuse, severe protein-calorie malnutrition, edema, anemia,	F 773	received timely. This monitoring will be documented for each clinical meeting for 4 weeks and then weekly for 8 weeks. The Director of Nursing will report the findings of the monitoring to the monthly QA committee meeting for review and recommendations for the duration of the monitoring period.	

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gastroesophageal reflux disease, end stage renal disease, hyperlipidemia, and sacral pressure ulcer.

Resident #60's admission minimum data set (MDS) with an assessment reference date (ARD) of 7/9/18 assessed the resident with a BIMS Summary Score of 13/15. Resident #60 was assessed to not be delirious, psychotic or have behaviors that affected others. Bladder and Bowel was reviewed. Indwelling catheter was marked and urinary continence was marked with a "9"-not rated, resident had a catheter, urinary ostomy, or no urine output for the entire 7 days.

Resident #60's current comprehensive care plan was reviewed. A focus area read "Resident has current UTI (urinary tract infection) and is at risk for further infection r/t (related to) Foley catheter. Noted with dark sediment urine, bleeding around catheter site noted. Date initiated 7/5/18. Interventions: Change Foley catheter as needed per order, document daily output as ordered, irrigate Foley catheter as ordered, provide privacy bag, anchor Foley cath (catheter), report s/s (signs/symptoms) to MD (medical doctor), assess for s/s of UTI: foul smelling, cloudy urine, sediment, decreased output, labs as ordered, inform physician of abnormal labs (laboratory), treatments as ordered, notify physician if course of treatment appears to be ineffective, and Foley cath care as ordered.

Resident #60 had a physician order dated 7/27/18 to recheck ua c&s (urinalysis with culture and sensitivity). The surveyor was unable to locate the results of the urinalysis and C&S ordered on 7/27/18.

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F 773	Continued From page 39 The surveyor informed the director of nursing (DON) of the 7/27/18 order for the urinalysis and C&S on 8/2/18 at 10:44 a.m. The DON informed the surveyor 8/2/18 at 10:54 a.m. that the urinalysis and C&S were not done. The surveyor informed the administrator, the director of nursing, the corporate registered nurse and administrative staff #1 of the above concern during the end of the day meeting on 8/2/18 at 5:12 p.m. No further information was provided prior to the exit conference on 8/3/18.	F 773		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		9/7/18

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

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

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and

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F 842	Continued From page 41 determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for 4 of 18 residents (Resident #230, Resident #227, Resident #76, and Resident #73). The findings included: 1. The facility staff failed to ensure the C.N.A. (certified nursing assistant) ADL (activities of daily living) Tracking Forms for August 2017, September 2017 and October 2017 were complete and accurate for Resident #230. The clinical record of Resident #230 was reviewed 8/3/18. Resident #230 was admitted to the facility 3/1/2011 and readmitted 4/27/13 with diagnoses that included but not limited to chronic pain syndrome, left above the knee amputation, osteoarthritis, peripheral vascular disease, major depressive disorder, constipation, anxiety, hyperlipidemia, insomnia, atherosclerotic heart disease, hypertension, gastro-esophageal reflux disease, dementia with behavioral disturbances, idiopathic aseptic necrosis of bone, sensorineural hearing loss, repeated falls, and dysphagia. Resident #230's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/17/17 assessed the resident with a BIMS Summary Score of 01/15. No delirium, psychosis or behaviors that affected	F 842	The clinical records, Activity of Daily Living (ADL) Tracking Forms for Residents #230 and #227 have been reviewed and found to be accurate from the identification of the issue forward. The Treatment Administration Record (TAR) for Resident #76 has been reviewed and found to be accurate from the identification of the issue forward. The Pre-Admission Screening for Mental Illness, Mentally Retardation/Intellectual Disability, or Related Conditions (PASAAR)form is now complete with date included for Resident #73 Current Residents are at risk for these issues. An audit of all PASAAR forms will be completed to ensure that all are dated as required. The Admission Director and Director of Social Services have been reeducated to review all PASAAR forms for completion, including the date at the bottom of the page. The nursing staff have been reeducated that the ADL Tracking Forms must be completed by the end of the shift.	

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F 842	Continued From page 42 others were assessed. Functional status was reviewed. Resident #230 required total assistance of one person for bed mobility. Activity did not occur for transfers, locomotion on and off unit, and walk in room and corridor. Resident #230 required extensive assistance of one person for dressing, personal hygiene, and toilet use. Eating required limited assistance of one person. Swallowing and nutrition assessed the resident with a height of 68 inches and weighed 125 pounds. No weight gain or weight loss was indicated and the resident received a therapeutic diet/mechanically altered. Resident #230's current comprehensive care plan was reviewed. Focus area initiated read "Resident is at risk for altered nutritional status r/t (related to) decreased mobility/function. Hx (history) duodenal ulcer, gastritis, indigestion, dx (diagnosis) GERD (gastroesophageal reflux disease). Rsd (resident) is on a mechanically altered diet, hx (history) of weight loss, poor appetite, hx of refusing meals, edentulous. Date initiated 6/28/12. Interventions: Dental consults prn (as needed), diet as ordered by MD (medical doctor), encourage meal and snack completion, encourage res not to lie down immediately after meals, FEES study as ordered, fortified foods as ordered, monitor for alteration in oral mucosa, monitor for nausea and vomiting, monitor for weight variances, honor food preferences as able, monitor weights as ordered, monitor intake during meals, res is encouraged to eat all meals in the dining room, speech therapy screen as needed, supplements as ordered, thickened liquids as ordered. The surveyor reviewed the August 2017 through October 2017 C.N.A. (certified nursing assistant)	F 842	The Licensed nursing staff have been reeducated that the TAR must be completed prior to leaving at the end of the shift. They have also been reeducated that they must ensure that the ADL Tracking Form is completed by their Certified Nursing Assistants. The Director of Nursing or designee will review the documentation in the next daily clinical meeting to ensure completion of the TAR and ADL Tracking forms. Any missing documentation will be identified and the responsible employee will be called back into work to complete the documentation. This will be documented at each daily clinical meeting for 4 weeks and then weekly for 8 weeks. The Director of Social Services will review all PASAAR forms after a new admission to verify that the form is completed appropriately. This will be documented for each new admission for 4 weeks and then random admissions once a week for 8 weeks. The Director of Nursing and the Director of Social Services will report the findings of the monitoring to the monthly QA committee meeting for review and recommendations for the duration of the monitoring period.	

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ADL (activities of daily living) Tracking Forms.

August 2017- The 3-11 shift has holes on the following days for meal percentages-8/6/17, 8/8/17, 8/10/17 and what type of assistance was needed-holes on 8/1/17, 8/2/17, 8/3/17, 8/6/17, 8/8/17, 8/10/17, 8/14/17, 8/15/17, 8/16/17, 8/17/17 and 8/28/17. Snacks offered had holes in documentation on 8/23/17, 8/26/17 and 8/27/17.

September 2017- No documentation on 9/8/17 of food consumption at lunch. No documentation on 9/7/17, 9/18/17 on how much assistance was needed. The 3-11 shift failed to document the type of assistance needed for dinner from 9/7/17 through 9/9/17 and 9/11/17 and 9/29/17.

October 2017-There was no recorded food percentage for lunch on 10/12/17. The 3-11 shift had failed to document food percentages on 10/3/17, 10/9/17 through 10/13/17, and 10/17/17 through 10/26/17. The facility staff had failed to document assistance needed with meals on the following days: 10/3/17, 10/5/17 through 10/13/17 and 10/17/17 through 10/26/17.

The surveyor informed the director of nursing of the lack of documentation on the August 2017 through October 2017 C.N.A. ADL Tracking Forms on 8/3/18 at 8:44 a.m. The surveyor found numerous meals not documented with the percentage eaten and assistance required during this timeframe. The surveyor requested the facility policy on documentation.

The surveyor reviewed the facility policy titled "ADL Flow Record" on 8/3/18 at 8:55 a.m. The policy read in part "2. On each shift the Nursing Assistant will complete each ADL in the

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appropriate box utilizing the legend on the form. Information will be gathered from work throughout the day utilizing the Nursing Assistants Assignment sheets. 3. Actual meal consumption will be documented. 4. HS (bedtime) snacks will be documented with an A for Acceptance or R for refused. 6. The Nurse will review the ADL Flow Record at the end of the Nursing Assistants shift to ensure completeness."

The surveyor informed the administrator, the director of nursing, the corporate registered nurse and administrative staff #1 of the lack of documentation by staff on Resident #230's C.N.A. ADL Tracking Forms in the end of the day meeting on 8/3/18.

No further information was provided prior to the exit conference on 8/3/18.

2. The facility staff failed to ensure the Resident #227's C.N.A. ADL Tracking Forms were complete and accurate.

Resident #227 was admitted to the facility originally 9/14/17 and readmitted 11/15/17 with diagnoses that included but not limited to end stage renal disease (ESRD), dependence on renal dialysis, hyperlipidemia, dysphagia, dysarthria following cerebrovascular disease, acute respiratory failure, hypertension, anemia, convulsions, Type 2 diabetes mellitus, secondary hyperparathyroidism, expressive language disorder, Clostridium difficile, urinary tract infection, sepsis, and hemiplegia and hemiparesis following cerebra infarction affecting left non-dominant side.

Resident #227's 5-day minimum data set (MDS)

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assessment with an assessment reference date (ARD) of 11/10/17 assessed the resident with a BIMS Summary Score of 01/15. Resident #227 was without delirium or psychosis; however, the resident was assessed to have behaviors directed at others 1-3 days in the look back period. Functional status was reviewed. Resident #227 required limited assistance of 1 person for bed mobility. Transfers, locomotion on and off the unit, dressing, toilet use, and personal hygiene only occurred 1-2 times and required 1 person to assist. Resident #227 needed supervision of one person for eating. Swallowing/Nutritional Status (Section K) recorded a height of 69 inches and weight of 123 pounds. Weight gain (K0310) was marked "2" which indicated and read that the resident had gained weight; however, the resident was not on a physician-prescribed weight-gain regimen. Resident #227 received a mechanically altered therapeutic diet.

Resident #227's current comprehensive care plan identified the resident had increased nutrition/hydration risks related to: weakness, poor mobility, diabetes, renal patient, mechanically altered diet, therapeutic diet, thickened liquids. Date initiated 11/7/17. Interventions: Encourage adequate fluid, maintain monthly contact with dialysis dietician, monitor dietary intake, monitor weight per protocol, provide diet per order, provide supplements per order, respect resident dietary choices, ST (speech therapy) screen prn (as needed).

The surveyor reviewed the certified nursing assistant's ADL (activities of daily living) flow sheets for November 2017. There were no meal

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percentages recorded for 11/15/17-11/17/17 or refusals. Resident #227 did expire on 11/17/17 at 6:00 p.m.

The surveyor informed the administrator, the director of nursing, the corporate registered nurse and administrative staff #1 of the lack of documentation on the C.N.A. ADL Tracking Record for Resident #227 and requested the facility policy on documentation on 8/3/18.

The surveyor reviewed the facility policy titled "ADL Flow Record" on 8/3/18 at 8:55 a.m. The policy read in part "2. On each shift the Nursing Assistant will complete each ADL in the appropriate box utilizing the legend on the form. Information will be gathered from work throughout the day utilizing the Nursing Assistants Assignment sheets. 3. Actual meal consumption will be documented. 4. HS (bedtime) snacks will be documented with an A for Acceptance or R for refused. 6. The Nurse will review the ADL Flow Record at the end of the Nursing Assistants shift to ensure completeness."

The surveyor informed the administrator, the director of nursing, the corporate registered nurse and administrative staff #1 of the lack of documentation by staff on Resident #230's C.N.A. ADL Tracking Forms in the end of the day meeting on 8/3/18.

No further information was provided prior to the exit conference on 8/3/18.

3. The facility staff failed to have a complete and accurate clinical record for Resident #76.

Resident #76 was admitted to the facility on 7/5/18 with the following diagnoses of, but not

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limited to high blood pressure, neurogenic bladder, Multiple Sclerosis, seizure disorder and depression. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/12/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #76 was also coded as requiring extensive assistance with personal hygiene and being totally dependent on 1 staff member for dressing and bathing.

During the clinical record review on 8/3/18, the surveyor noted the following areas had numerous holes on the TAR (Treatment Administration Record) for July and August 2018:
"The amount of suprapubic output was not documented every shift
"There were no amounts of output from the colostomy bag were not documented on every shift
"Ensure suprapubic catheter bag is covered every shift
"Turn and reposition was not documented every shift.

The DON (director of nursing) and corporate nurse were notified at 11:45 am of the above documented findings. The DON stated, "If it's not documented then it's not done."

No further information was provided to the surveyor prior to the exit conference on 8/3/18.

4. The facility staff failed to have a complete and accurate clinical record for Resident #73.

Resident #73 was admitted to the facility on 12/6/17 with the following diagnoses of, but not

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 48 limited to dementia, manic depression and chronic obstructive pulmonary disease. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/19/18; the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 13 out of a score of 15. Resident #73 was also coded as requiring extensive assistance of 1 staff member for dressing, personal hygiene and bathing. During the clinical record review on 8/2 and 8/2/18, the surveyor noted on the PASAAR (Pre-Admission Screening for Mental Illness, Mentally Retardation/Intellectual Disability, Or Related Conditions) the date at the bottom of the page was left blank. The surveyor did note a date of 12/6/17 as the date the request was made. On 8/2/18 at 5:13 pm, the surveyor notified the administrative team of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 8/3/18.	F 842		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the	F 849		9/7/18

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F 849	Continued From page 49	F 849		

resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.

§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.

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(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice

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F 849	Continued From page 51	F 849		

administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:

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F 849	Continued From page 52 (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to coordinate hospice services for 1 of 18 residents in the survey sample (Resident #58). The findings included: Resident #58 was admitted to the facility on 10/6/16 with the diagnosis of Alzheimer's disease.	F 849	The documentation required for hospice is now in the medical record for Resident #58. Residents receiving hospice care are at risk for this issue. The hospice provider has been reeducated that all records pertaining to	

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F 849	Continued From page 53 On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/9/18, the resident was coded as having short and long term memory problems and was severly impaired in making daily decisions. Resident #58 was also coded as being totally dependent on 1 staff member for bathing, dressing and personal hygiene. During the clinical record review on 8/2/18, the surveyor noted the resident had been discharged from hospice services on 7/20/18. The surveyor notified the DON (director of nursing) and the corporate nurse at 4:00 pm. The DON stated, "I see where in this note, the resident would be discharged from hospice on 7/20/18, but I cannot find a physician order for this. Let me do some investigating on this." The surveyor notified the administrative team of the above documented findings on 8/2/18 at 5:13 pm. The surveyor also requested the plan of care and physician's order for the resident to be discharged from Hospice services. On 8/3/18 at 9:30 am, the DON provided copies of the physician order for the resident to be discharged from Hospice and also the plan of care. The surveyor asked the DON where this was found. The DON stated, "I had to call hospice and get them to fax this over to us." No further information was provided to the surveyor prior to the exit conference on 8/3/18.	F 849	any resident they are caring for in the facility must be in the medical record in a timely fashion. The Director of Social Services has been reeducated to look for documentation in the medical record from hospice when any notification of discharge from hospice is given. The Director of Social Services will review the medical record of any resident who will be discharged from hospice to ensure the order is in place. This will be documented for every resident discharged from hospice for the next 12 weeks. The Director of Social Services will report the findings of the monitoring to the monthly QA committee meeting for review and recommendations for the duration of the monitoring period.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		9/7/18

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The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

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

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism

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F 880	Continued From page 55 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility staff failed to follow established infection control procedures for 1 of 18 Residents, Resident #228. The findings included: For Resident #228 the facility staff failed to ensure foley catheter bag was not touching the floor. Resident #228 was admitted to the facility on 07/18/18. Diagnoses included but not limited to	F 880	Resident #228 Foley bag was immediately placed so that it would not touch the floor. Residents with drainage bags are at risk for this issue. Facility staff will be reeducated concerning the expectation that no drainage bag be in contact with the floor. This includes assessing residents' positioning changes in the plan to place the drainage bag.	

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F 880	Continued From page 56 clostridium difficile, anxiety, hypertension, and vancomycin resistant enterococcus. During initial tour of the facility on 07/31/18 at approximately 1230. The surveyor observed Resident #228 seated in his wheelchair, in his room. Surveyor observed Resident's foley catheter bag lying in the floor under the chair. Surveyor spoke with the Resident, who was alert and oriented. Surveyor observed Resident #228 again on 08/02/18 at approximately 0945. Resident was lying in bed with the foley catheter bag hanging from the side of the bed. The catheter drainage bag was resting on the floor. Surveyor observed Resident #228 on 08/02/18 at approximately 1130. Resident was lying in bed with the foley catheter bag hanging from the side of the bed. The catheter drainage bag was resting on the floor. Surveyor asked the DON (director of nursing) to accompany her to Resident's room at this time to observe the catheter bag. DON stated that the drainage bag should not be touching the floor. DON also stated that CNA (certified nurse's assistant) for the Resident stated that the Resident places his bed in the low position and that is why the bag is touching the floor. Surveyor requested a policy related to catheter usage on 08/02/18 at approximately 1455. The RNC (regional nurse consultant) stated that the facility does not have a policy specific to catheter use, or one stating that the catheter drainage bag should not be touching the floor. The concern of the foley catheter drainage bag touching the floor was discussed with the	F 880	The Director of Nursing or designee will observe the placement of drainage bags in the facility to ensure that all are off the floor. This will be documented daily for 7 days, 5 days a week, and then weekly for 8 weeks. The Director of Nursing will report the findings of the monitoring to the monthly QA committee meeting for review and recommendations for the duration of the monitoring period.	

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F 880	Continued From page 57 administrative team during a meeting on 08/02/18 at approximately 1710. No further information was provided prior to exit.	F 880		