STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495109	A. BUILDING _____ B. WING _____	C 06/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF UNIVERSITY PARK	2420 PEMBERTON RD RICHMOND, VA 23233

(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 6/11/18 through 6/15/18. The facility was found to be in compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 06/11/18 through 06/15/18. Significant 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 145 certified bed facility was 140 at the time of the survey. The survey sample consisted of 47 current resident reviews. Resident #s: 114, 43, 9, 7, 42, 69, 57, 85, 132, 24, 2, 333, 334, 50, 61, 13, 128, 60, 16, 238, 117, 342, 28, 99, 97, 78, 20, 102, 19, 72, 96, 83, 338, 98, 130, 90, 5, 15, 116, 86, 5, 335, 106, 56, 336, 121, 95 and 3 and three closed record reviews, Resident #s: 133, 115 and 135.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 550		7/27/18

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

Electronically Signed | 07/06/2018

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F 550	Continued From page 1 her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide dignity for three of 50 residents in the survey sample (Residents #5, #86 and Resident #19). 1. The facility staff failed to clean Resident #5's chin and shirt after lunch on 6/13/18.	F 550	The Laurels of University Park wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged compliance is July 27, 2018 Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either	

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F 550	Continued From page 2 2. The facility staff failed to provide a dignified dining experience for Resident #86. Resident #86 was seated at a table but was not served her tray nor assisted with feeding for approximately 18 minutes after her two tablemate's were fed. 3. The facility staff failed to provide a dignified dining experience for Resident #19. Resident #19, arrived at the table prior to another resident, sat across the table and watched the other resident being fed. Resident #19 was not fed his meal until 5:47 p.m., 26 minutes after the staff started to feed the other resident. The findings include: 1. The facility staff failed to clean Resident #5's chin and shirt after lunch on 6/13/18. Resident #5 was admitted to the facility on 10/4/16. Resident #5's diagnoses included but were not limited to Alzheimer's disease (1), irritable bowel syndrome (2) and major depressive disorder. Resident #5's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/9/18, coded the resident's cognition as severely impaired. Section G coded Resident #5 as requiring extensive assistance of one staff with bed mobility, eating and personal hygiene. On 6/13/18 at 1:23 p.m., Resident #5 was observed sitting up in bed and feeding herself pasta with red sauce. On 6/13/18 at 2:58 p.m., Resident #5 was observed lying in bed. A red substance was observed on her chin and shirt.	F 550	the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. F Tag 550: Resident #5: No negative outcome occurred as a result of this practice. Guest□s face was washed and nails trimmed. Resident # 86: No negative outcome occurred as a result of this practice. Resident was fed her meal. Resident # 19 No negative outcome occurred as a result of this practice. Resident was fed his meal. Residents receiving ADL care have the potential to be affected. The DON/Designee will educate licensed nursing staff on providing appropriate ADL care. NHA will provide education to department managers on room rounds and the importance of identifying dignity issue with appearance and cleanliness. The DON/Designee will provide education to licensed nursing and CNA The administrative team/designees will conduct rounds on all current residents following a meal to identify any ADL	

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F 550	Continued From page 3 On 6/13/18 at 4:05 p.m., Resident #5 was observed by this surveyor and RN (registered nurse) #1. The resident was lying in bed. A red substance remained on the resident's chin and shirt. RN #1 confirmed the substance should not be present on the resident's chin or shirt. RN #1 stated the staff should be washing residents' faces after lunch. RN #1 was asked how she would feel if she was left lying in bed with a substance on her chin and shirt. RN #1 stated she would not like it. On 6/13/18 at 6:12 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility document titled, "FEDERAL RESIDENT RIGHTS AND FACILITY RESPONSIBILITIES" documented, "(a) Residents Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. (1) Dignity, Respect and Quality of Life. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident." No further information was presented prior to exit. (1) "Alzheimer's disease (AD) is the most common form of dementia among older people.	F 550	needs. The administrative team/designee will conduct rounds following meals for 5 days. The administrative team/designee will continue to monitor through weekly rounds for 4 weeks. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee. Continued compliance will be monitored through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion date: July 27, 2018	

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Dementia is a brain disorder that seriously affects a person's ability to carry out daily activities." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=alzheimers+disease&_ga=2.143186225.545294603.1529491200-139120270.1477942321

(2) "Irritable bowel syndrome (IBS) is a problem that affects the large intestine. It can cause abdominal cramping, bloating, and a change in bowel habits. Some people with the disorder have constipation. Some have diarrhea. Others go back and forth between the two. Although IBS can cause a great deal of discomfort, it does not harm the intestines." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=irritable+bowel+syndrome

2. The facility staff failed to provide a dignified dining experience for Resident #86. Resident #86 was observed seated at a table, but was not served her tray, or assisted with feeding for approximately 18 minutes after her two tablemate's were fed.

Resident #86 was admitted to the facility on 7/20/15, with diagnoses that included but were not limited to: dementia, high blood pressure, difficulty swallowing, and muscle weakness.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 5/13/18, coded the resident as scoring a 99 on the BIMS

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(brief interview for mental status) score, indicating that she unable to complete the BIMS interview. She was coded as having memory problems and had moderately impaired cognitive skills for daily decision making. Resident #86 was documented as to rarely able make herself understood, as well as rarely understanding others. Resident #86 was coded as requiring extensive assistance of two persons physical assistance for bed mobility and transfers, and one person physical assistance for dressing, toileting, personal hygiene and eating.

On 6/11/18 at 5:01 p.m. an observation of the activity room dining area was performed. At that time, Resident #86 was brought into the dining area via a geriatric chair and placed at a table with 2 other residents. At that time CNA (certified nursing assistant) #5 noted that Resident #86 was a "feeder" (Resident #86, needed assistance with being fed her meal).

On 6/11/18 at 5:20 p.m., Resident #86's tablemate was served her tray and CNA #5 proceeded to open her food containers and prepare to feed her.

On 6/11/18 at 5:24 p.m., Resident #86's other table mate was served his tray and assistance was provided to him to open his containers. Resident #86 still had not been served a tray.

On 6/11/18 at 5:38 p.m., Resident #86 was rolled via her geriatric chair to another table in the back of the activity room that was covered with newspapers and magazines. CNA #5 moved the magazines and placed Resident #86's tray in front of her and began opening the containers and assisting her with her feeding.

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F 550	Continued From page 6	F 550		

On 6/11/18 at 5:49 p.m., Resident #86 was rolled out of the dining room and down the hall to sit in front of the nurse's station.

On 6/14/18 at 4:15 p.m., an interview was conducted with CNA #5. When asked to describe what she considered a dignified dining experience, CNA #5 stated that she liked to make sure music was on and enjoyed talking to the residents while she was assisting them with feeding. When asked why Resident #86 did not receive a tray for 18 minutes after the rest of the table, the CNA #5 stated Resident #86 "Takes a little longer to feed", so she tries to feed the people who eat faster first. When asked how it would make her feel to sit at a table without any food when everyone else had some, CNA #5 stated, "It would make me feel uncomfortable".

A review of Resident #86's comprehensive care plan dated 5/9/18 documented in part that the Resident "requires assistance with meals".

A review of the facility's policy "Guests' Rights/Dignity-Dietary Guidelines" documented that "13. All guests at each table shall be served their meals at the same time".

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #4, corporate liaison and ASM #5, the clinical resource specialist, were made aware of the above concerns on 6/14/18 at 6:14 p.m.

No further information was provided prior to exit.
3. The facility staff failed to provide a dignified dining experience for Resident #19. Resident #19, arrived at the table prior to another resident,

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sat across the table and watched the other resident being fed. Resident #19 was not fed his meal until 5:47 p.m., 26 minutes after the staff started to feed the other resident.

Resident #19 was admitted to the facility on 8/14/15, with diagnoses that included but were not limited to: corticobasal degeneration (Corticobasal degeneration is a progressive neurological disorder characterized by nerve cell loss and atrophy [shrinkage] of multiple areas of the brain including the cerebral cortex and the basal ganglia.) (2), muscle weakness, lack of coordination, and abnormal posture. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/31/18, coded the resident as capable of understanding others and making himself understood. Resident #19 was coded as scoring a "4" on the BIMS (brief interview for mental status) score, indicating he was severely impaired to make cognitive daily decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance of one staff member for eating.

Resident #19's comprehensive care plan dated, 1/25/18 and revised on 3/8/18, failed to evidence a nutritional care plan or documentation of assistance required for eating.

Observation was made of the evening meal on 6/11/18 at 4:53 p.m. in the activity room/dining room. Resident #19 was observed at the back table of the dining room, seated in a reclining Geri chair with another resident who was also seated in a reclining Gerri chair.

On 6/11/18 at 5:21 p.m. CNA (certified nursing

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assistant) #4 was observed starting to the other resident seated in a reclining Gerri chair. Resident #19, who arrived at the table prior to this resident, sat across from the table and watched the resident being fed. At 5:33 p.m., CNA #4 told Resident #19 that she would feed him next. At 5:45 p.m., CNA #4 finished feeding the other resident. CNA #4 told Resident #19, he was up next. CNA #4 washed her hands and prepared Resident #19's meal. Resident #19 ate his first bite of food at 5:47 p.m., 26 minutes after the staff started to feed the other resident.

An interview was conducted with CNA #4 on 6/13/18 at 4:18 p.m. When asked how Resident #19 would feel sitting for almost a half an hour while she fed Resident #7, CNA #4 stated, "He was probably hungry." When asked if she felt this could be a dignity concern, CNA #4 stated, "It feels like one."

The facility policy, "Guests' rights and dignity shall be maintained at all times by all dietary staff/professionals" documented in part, "13. All guests at each table shall be served their meals at the same time."

The administrator and director of nursing were made aware of the above concern on 6/13/18 at 6:15 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437.
(2) This information was obtained from the following website:

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F 550	Continued From page 9 https://www.ninds.nih.gov/Disorders/All-Disorders/Corticobasal-Degeneration-Information-Page#disorders-r1	F 550		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph	F 580		7/27/18

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F 580	Continued From page 10 (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to notify the physician of a potential need to alter treatment for one of 50 residents in the survey sample, Resident # 60. The facility staff failed to notify the physician of Resident # 60's blood sugars when they were greater than 250. The findings include: Resident # 60 was admitted on 04/06/17 and a readmission on 06/07/18 with diagnoses that included but were not limited to anemia (1) fractured right femur (2), diabetes mellitus (3), hypertension (4) and depressive disorder (5). Resident # 60's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/27/18 coded Resident # 60 as scoring a 9 (nine) on the brief	F 580	Ftag 580 Resident #60: No negative outcome occurred as a result of this practice. Blood sugar parameters have been reviewed and updated by the physician Insulin dependent residents in the facility have the potential to be affected by this practice. DON or designee will educate licensed nursing staff on following blood sugar parameters as ordered by the physician. DON or designee will audit MARs of current insulin dependent diabetics for the last 30 days. DON or designee will monitor insulin order changes and new admissions weekly for 4 weeks. Additional education and/or	

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interview for mental status (BIMS) of a score of 0 (zero) - 15, 9 (nine) being moderately impaired of cognition for making daily decisions. Resident # 60 was coded as being totally dependent of one staff member for activities for ADLs (activities of daily living) and supervision with eating.

The physician's order for Resident # 60 dated 06/13/2018 documented, "Accu-checks AC (before meals) and HS before meals and at bedtime for DM (diabetes mellitus). Notify MD (medical doctor) if BS (blood sugar) < (less than) 70 or > (greater than) 250. Start Date: 05/18/2018."

The eMAR (electronic medication administration record) dated "May 2018" for Resident # 60 documented, "Accu-checks AC (before meals) and HS (before meals and at bedtime) for DM (diabetes mellitus). Notify MD (medical doctor) if BS (blood sugar) < (less than) 70 or > (greater than) 250. Start Date: 05/18/2018." Further review of the eMAR documented the following blood sugars greater than 250:
On 05/18/18 at 9:00 p.m. BS (blood sugar) 348.
On 05/19/18 at 4:30 p.m. BS 431 and at 9:00 p.m. 430.
On 05/20/18 at 6:30 a.m. BS 391 and at 11:30 a.m. BS 291.
On 05/21/18 at 4:30 p.m. BS 391 and at 9:00 p.m. BS 510.
On 05/22/18 at 6:30 a.m. BS 283, at 4:30 p.m. BS 471 and at 9:00 p.m. BS 418.
On 05/23/18 at 11:30 a.m. BS 370.
On 05/25/18 at 11:30 a.m. BS 256 and at 4:30 p.m. BS 257.
On 05/26/18 at 4:30 p.m. BS 363 and at 9:00 p.m. BS 376.
On 05/29/18 at 9:00 p.m. BS 291.

counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee.

Continued compliance will be monitored through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns.

Completion date:
July 27, 2018

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	495109	A. BUILDING _____ B. WING _____	C 06/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF UNIVERSITY PARK	2420 PEMBERTON RD RICHMOND, VA 23233

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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On 05/30/18 at 11:30 a.m. BS 271 and at 9:00 p.m. BS 324.
On 05/31/18 at 9:00 p.m. BS 266.

The eMAR (electronic medication administration record) dated "June 2018" for Resident # 60 documented, "Accu-checks (brand of glucometer used to check blood sugars) AC (before meals) and HS before meals and at bedtime for DM (diabetes mellitus). Notify MD (medical doctor) if BS (blood sugar) < (less than) 70 or > (greater than) 250. Start Date: 05/18/2018." Further review of the eMAR documented the following blood sugars greater than 250:
On 06/03/18 at 4:30 p.m. BS (blood sugar) 299.
On 06/09/18 at 6:30 a.m. BS 251.
On 06/11/18 at 11:30 a.m. BS 317, 4:30 p.m. BS 326 and at 9:00 p.m. BS 312.
On 06/12/18 at 9:00 a.m. BS 327.

The comprehensive care plan dated 02/21/18 for Resident # 60 documented, "Need. BLOOD SU (sugar): At risk for fluctuation blood sugars R/T (related to): Diabetes. Date initiated: 02/21/2018." Under "Interventions" it documented, "Observe and document s/sx (signs and symptoms) of complications from fluctuating blood sugar. Report abnormal findings to physician. Date initiated: 02/21/2018."

Review of the facility's nursing "Progress Notes" dated 05/18/18 through 06/12/18 failed to evidence documentation of physician notification of Resident # 60's blood sugars over 250.

On 06/14/18 at 10:52 a.m. an interview was conducted with LPN (licensed practical nurse) # 4 regarding Resident # 60's blood sugars. After reviewing the physician's order for notification if

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blood sugars over 250, the May and June eMARs and the progress notes dated 05/18/18 through 06/12/18, LPN # 4 was asked if the physician was notified for the dates Resident # 60's blood sugars were above 250. LPN # 4 stated, "No. The physician should have been notified for the blood sugar over 250. When asked how she would you notify the physician LPN # 4 stated, "I would notify by phone or in person if they are in the building." When asked where it would documented that the physician was notified, LPN # 4 stated, "In the nurse's note if it was abnormally high or low."

On 06/15/18 at 8:40 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing regarding Resident # 60's blood sugars. After reviewing the physician's order for notification if blood sugars were over 250, the May and June eMARs and the progress notes dated 05/18/18 through 06/12/18, ASM # 2 was asked if the physician was notified for the dates Resident # 60's blood sugars were above 250. ASM # 2 stated, "No. Notification should have been documented in the progress notes." ASM # 2 further stated, "The order should have been clarified to be blood sugars less than 60 or greater than 400, but regardless the order should have been followed.

On 06/14/18 at approximately 6:15 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, and ASM # 5, clinical resource specialist, were made aware of the above findings.

No further information was provided prior to exit.

References:

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F 580	Continued From page 14 (1) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html . (2) You had a fracture (break) in the femur in your leg. It is also called the thigh bone. You may have needed surgery to repair the bone. You may have had surgery called an open reduction internal fixation. In this surgery, your surgeon will make a cut to open your fracture. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000166.htm. (3) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (5) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.	F 580		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3)	F 607		7/27/18

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F 607	Continued From page 15 §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement the facility abuse policy for one of 50 residents in the survey sample, Resident #5. The facility staff failed to implement the abuse policy for investigating and reporting an injury of unknown origin when Resident #5 was observed with a bruise to the right side of her chin on 5/21/18. The findings include: Resident #5 was admitted to the facility on 10/4/16. Resident #5's diagnoses included but were not limited to Alzheimer's disease (1), irritable bowel syndrome (2) and major depressive disorder. Resident #5's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/9/18, coded the resident's cognition as severely impaired. Section G coded Resident #5 as requiring extensive assistance of one staff with bed mobility, eating and personal hygiene.	F 607	Ftag 607 Resident # 5: No negative outcome occurred from this practice. The incident report investigating the bruise was located after the annual state survey. All residents have the potential to be affected. The NHA or designee will educate licensed nursing staff; and department managers of the importance of doing a complete investigation on all bruises and injuries. Also, that all injuries of unknown origin are to be reported to the NHA for review and reporting per abuse and neglect regulations. DON or designee will audit the last 30 days of skin assessments for any identified injuries to ensure proper investigation and/or reporting to regulatory agencies has occurred.	

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F 607	Continued From page 16 Review of Resident #5's clinical record revealed a nurse's note dated 5/21/18 that documented, "Resident observed with a bruise to the right side of her chin." Another nurse's note dated 5/21/18 documented, "Rp (Responsible party) and MD (medical doctor) made aware of bruise to right side of face. Zero s/s (signs or symptoms) of distress. Denies of pain and discomfort. Denies of abuse and mistreatment." Further review of Resident #5's clinical record failed to reveal an investigation regarding the bruise, a determination of the cause of the bruise, and failed to reveal the injury was reported to the state agency and other officials in accordance with state law. On 6/13/18 at 6:12 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were asked to provide the investigation regarding Resident #5's facial bruise that was observed on 5/21/18. The former director of nursing who was employed on 5/21/18 was no longer employed at the facility. On 6/14/18 at 2:24 p.m., ASM #2 stated the facility staff was looking for the investigation regarding the bruise on Resident #5's face. On 6/14/18 at 2:37 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated she completed an investigation and turned the investigation in to the former director of nursing when a bruise was observed on Resident #5's chin on 5/21/18. RN #1 was asked to explain the investigation. RN #1 stated Resident #5 was noted with a bruise on her chin so she talked with the CNAs (certified nursing assistants) and they said she is easily startled when she	F 607	DON or designee will continue to monitor all skin assessments 5 times a week for 4 weeks for identified injuries to ensure the investigation is completed and any injury of unknown origin is reported to the regulatory agency. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee. Continued compliance will be monitored through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion date: July 27, 2018	

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F 607	Continued From page 17	F 607		

wakes up and hits her face, and staff. RN #1 stated Resident #5 easily bruises. When asked if she could definitively conclude how the bruise occurred, RN #1 stated, "Since I didn't see it happen, not 100%." RN #1 was asked if she could provide any evidence of the investigation that was completed. RN #1 stated she talked to CNA #6.

On 6/14/18 at 2:51 p.m., an interview was conducted with CNA #6. CNA #6 stated RN #1 came to her regarding Resident #5's bruise and CNA #6 stated she was unaware of the bruise so RN #1 showed her. CNA #6 stated sometimes Resident #5 is very "jumpy," throws her hands up and hits herself in the face when morning care is provided.

On 6/14/18 at 6:14 p.m., an interview was conducted with ASM #1, the administrator, and ASM #2 the director of nursing. ASM #1 and ASM #2 were asked what should occur if a bruise is found on a resident. ASM #1 stated, "There should be an investigation to find out what the origin of it is." When asked the facility process for the investigation, ASM #1 stated staff interviews, resident interviews, a care plan review and a medical history review should be completed. When asked the facility process for reporting an injury of unknown origin, ASM #1 stated a facility reported incident report should be sent to the office of licensure, adult protective services and the ombudsman. ASM #1 stated she knew an investigation had been completed but she could not provide any evidence. ASM #1 and ASM #2 were made aware of the above concern.

The facility document titled, "ABUSE

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PROHIBITION, INVESTIGATION, AND REPORTING" documented in part, "I. 'Injury of Unknown Source' (must be reported immediately to the administrator or designee)- An injury should be classified as an 'injury of unknown source' when both of the following conditions are met: 1. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and 2. The injury is suspicious because of: a. the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma)...III. Investigation: A. The person(s) observing an incident of guest abuse or suspecting guest abuse must immediately report such incidents/suspicions to the Administrator. If the Administrator is not immediately available, the allegation should be reported to a charge nurse, social worker, or nursing administration to ensure that the guest is safe. The supervisor/management person in charge will then immediately notify the Administrator. When an incident of guest abuse is alleged, the incident must be reported to the charge nurse regardless of the time lapse since the incident occurred. The following information should be reported: 1. The name of the guest. 2. The date and time that the incident occurred. 3. The location of the incident. 4. The name(s) of the person(s) committing the incident, if known. 5. The name(s) of any witness (es) to the incident. 6. The type of abuse that was committed (e.g., verbal, physical, sexual, misappropriation, etc.) 7. Other information that may be requested...D. The Administrator will appoint a representative to investigate the incident. The Administrator will initiate the Investigation of Alleged Abuse, Mistreatment, or Misappropriation and make the appropriate notifications as outlined on the form.

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E. The Administrator or designee will coordinate an immediate investigation in accordance with the investigation guidelines in this policy. The representative in charge of the investigation will consult with the Administrator daily concerning the progress of the investigation. A copy of the findings will be provided to the Administrator within five (5) working days of the occurrence of the incident. The investigation may consist of but is not limited to: 1. An interview with the person(s) reporting the incident. 2. Interviews with any witnesses to the incident. 3. An interview with the guest. 4. A review of the guest's medical record. 5. An interview with staff members (on all shifts) who had contact with the guest during the period of the alleged incident. 6. Interviews with the guest's roommate, family members, and visitors. 7. Physical assessment of other potentially affected guests. 8. A review of all circumstances surrounding the incident... C. The Administrator is responsible for ensuring that all allegations of mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are immediately reported to the State Agency and other officials in accordance with federal regulations and state guidelines."

No further information was presented prior to exit.

(1) "Alzheimer's disease (AD) is the most common form of dementia among older people. Dementia is a brain disorder that seriously affects a person's ability to carry out daily activities." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=alzheimers+disease&_ga=2.143186225.545294603.1529491200-139120270.1477942321

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F 607	Continued From page 20 (2) "Irritable bowel syndrome (IBS) is a problem that affects the large intestine. It can cause abdominal cramping, bloating, and a change in bowel habits. Some people with the disorder have constipation. Some have diarrhea. Others go back and forth between the two. Although IBS can cause a great deal of discomfort, it does not harm the intestines." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=irritable+bowel+syndrome	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		7/27/18

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F 609	Continued From page 21 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to report an injury of unknown origin to the state agency and other officials in accordance with state law for one of 50 residents in the survey sample, Resident #5. The facility staff failed to notify the state agency and other officials in accordance with state law when Resident #5 presented with a bruised chin on 5/21/18 and the staff could not definitely conclude the cause. The findings include: Resident #5 was admitted to the facility on 10/4/16. Resident #5's diagnoses included but were not limited to Alzheimer's disease (1), irritable bowel syndrome (2) and major depressive disorder. Resident #5's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/9/18, coded the resident's cognition as severely impaired. Section G coded Resident #5 as requiring extensive assistance of one staff with bed mobility, eating and personal hygiene. Review of Resident #5's clinical record revealed a nurse's note dated 5/21/18 that documented, "Resident observed with a bruise to the right side	F 609	Ftag 609 Resident #5: No negative outcome occurred from this practice. The incident report investigating the bruise was located after the annual state survey. All residents currently in the facility have the potential to be affected. The NHA or designee will educate licensed nursing staff; and department managers of the importance of doing a complete investigation on all bruises and injuries. Also, that all injuries of unknown origin are to be reported to the NHA for review and reporting per abuse and neglect regulations DON or designee will audit the last 30 days of skin assessments for any identified injuries to ensure proper investigation and/or reporting to regulatory agencies has occurred. DON or designee will continue to monitor all skin assessments 5 times a week for 4 weeks for identified injuries to ensure the investigation is completed and any injury of unknown origin is reported to the	

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of her chin." Another nurse's note dated 5/21/18 documented, "Rp (Responsible party) and MD (medical doctor) made aware of bruise to right side of face. Zero s/s (signs or symptoms) of distress. Denies of pain and discomfort. Denies of abuse and mistreatment." Further review of Resident #5's clinical record failed to reveal an investigation regarding the bruise, a determination of the cause of the bruise, and failed to reveal the injury was reported to the state agency and other officials in accordance of the law.

On 6/13/18 at 6:12 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were asked to provide the investigation regarding Resident #5's facial bruise that was observed on 5/21/18.

The former director of nursing who was employed on 5/21/18 was no longer employed at the facility. On 6/14/18 at 2:24 p.m., ASM #2 stated the facility staff was looking for the investigation regarding the bruise on Resident #5's face.

On 6/14/18 at 2:37 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated she completed an investigation and turned the investigation in to the former director of nursing when a bruise was observed on Resident #5's chin on 5/21/18. RN #1 was asked to explain the investigation. RN #1 stated Resident #5 was noted with a bruise on her chin so she talked with the CNAs (certified nursing assistants) and they said she is easily startled when she wakes up and hits her face, and staff. RN #1 stated Resident #5 easily bruises. When asked if she could definitively conclude how the bruise occurred, RN #1 stated, "Since I didn't see it

regulatory agency. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee.

Continued compliance will be monitored through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns.

Completion date:
July 27, 2018

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happen, not 100%." RN #1 was asked if she could provide any evidence of the investigation that was completed. RN #1 stated she talked to CNA #6.

On 6/14/18 at 2:51 p.m., an interview was conducted with CNA #6. CNA #6 stated RN #1 came to her regarding Resident #5's bruise and CNA #6 stated she was unaware of the bruise so RN #1 showed her. CNA #6 stated sometimes Resident #5 is very "jumpy," throws her hands up and hits herself in the face when morning care is provided.

On 6/14/18 at 6:14 p.m., an interview was conducted with ASM #1, the administrator and ASM #2, the director of nursing. ASM #1 and ASM #2 were asked what should occur if a bruise is found on a resident. ASM #1 stated, "There should be an investigation to find out what the origin of it is." When asked the facility process for the investigation, ASM #1 stated staff interviews, resident interviews, a care plan review and a medical history review should be completed. When asked the facility process for reporting an injury of unknown origin, ASM #1 stated a facility reported incident report should be sent to the office of licensure, adult protective services and the ombudsman. ASM #1 stated she knew an investigation had been completed but she could not provide any evidence. ASM #1 also confirmed the incident was not reported to the state agency or other state officials. ASM #1 and ASM #2 were made aware of the above concern.

The facility document titled, "ABUSE PROHIBITION, INVESTIGATION, AND REPORTING" documented, "I. 'Injury of Unknown

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F 609	Continued From page 24	F 609		

Source' (must be reported immediately to the administrator or designee)- An injury should be classified as an 'injury of unknown source' when both of the following conditions are met: 1. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and 2. The injury is suspicious because of: a. the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma)...IV. Initial Reporting: A. All allegations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property must be reported immediately to the Administrator. If the Administrator is implicated in the allegation, it should be reported immediately to the Director of Nursing who will then notify the Regional Manager. B. All phases of the reporting process will be kept confidential. C. The Administrator is responsible for ensuring that all allegations of mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are immediately reported to the State Agency and other officials in accordance with federal regulations and state guidelines."

No further information was presented prior to exit.

(1) "Alzheimer's disease (AD) is the most common form of dementia among older people. Dementia is a brain disorder that seriously affects a person's ability to carry out daily activities." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=alzheimers+disease&_ga=2.143186225.545294603.1529491200-139120270.1477942321

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F 609	Continued From page 25 (2) "Irritable bowel syndrome (IBS) is a problem that affects the large intestine. It can cause abdominal cramping, bloating, and a change in bowel habits. Some people with the disorder have constipation. Some have diarrhea. Others go back and forth between the two. Although IBS can cause a great deal of discomfort, it does not harm the intestines." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=irritable+bowel+syndrome	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review	F 610	Ftag 610	7/27/18

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F 610	Continued From page 26 and clinical record review, it was determined that the facility staff failed to evidence a thorough investigation of an injury of unknown origin for one of 50 residents in the survey sample, Resident #5. The facility staff failed to provide evidence of a complete and thorough investigation when Resident #5 presented with a bruise to the right side of her chin on 5/21/18. The findings include: Resident #5 was admitted to the facility on 10/4/16. Resident #5's diagnoses included but were not limited to Alzheimer's disease (1), irritable bowel syndrome (2) and major depressive disorder. Resident #5's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/9/18, coded the resident's cognition as severely impaired. Section G coded Resident #5 as requiring extensive assistance of one staff with bed mobility, eating and personal hygiene. Review of Resident #5's clinical record revealed a nurse's note dated 5/21/18 that documented, "Resident observed with a bruise to the right side of her chin." Another nurse's note dated 5/21/18 documented, "Rp (Responsible party) and MD (medical doctor) made aware of bruise to right side of face. Zero s/s (signs or symptoms) of distress. Denies of pain and discomfort. Denies of abuse and mistreatment." Further review of Resident #5's clinical record failed to reveal an investigation regarding the bruise and a determination of the cause of the bruise. On 6/13/18 at 6:12 p.m., ASM (administrative	F 610	Resident #5: Resident #5: No negative outcome occurred from this practice. The incident report investigating the bruise was located after the annual state survey. All residents who reside in the facility have the potential to be affected. The NHA or designee will educate licensed nursing staff; and department managers of the importance of doing a complete investigation on all bruises and injuries. Also, that all injuries of unknown origin are to be reported to the NHA for review and reporting per abuse and neglect regulations DON or designee will audit the last 30 days of skin assessments for any identified injuries to ensure proper investigation and/or reporting to regulatory agencies has occurred. DON or designee will continue to monitor all skin assessments 5 times a week for 4 weeks for identified injuries to ensure the investigation is completed and any injury of unknown origin is reported to the regulatory agency. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee. Continued compliance will be monitored through the facility□s quality assurance program. Additional education and monitoring will be initiated for any	

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F 610	Continued From page 27 staff member) #1 (the administrator) and ASM #2 (the director of nursing) were asked to provide the investigation regarding Resident #5's facial bruise that was observed on 5/21/18. The former director of nursing who was employed on 5/21/18 was no longer employed at the facility. On 6/14/18 at 2:24 p.m., ASM #2 stated the facility staff was looking for the investigation regarding the bruise on Resident #5's face. On 6/14/18 at 2:37 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated she completed an investigation and turned the investigation in to the former director of nursing when a bruise was observed on Resident #5's chin on 5/21/18. RN #1 was asked to explain the investigation. RN #1 stated Resident #5 was noted with a bruise on her chin so she talked with the CNAs (certified nursing assistants) and they said she is easily startled when she wakes up and hits her face, and staff. RN #1 stated Resident #5 easily bruises. When asked if she could definitively conclude how the bruise occurred, RN #1 stated, "Since I didn't see it happen, not 100%." RN #1 was asked if she could provide any evidence of the investigation that was completed. RN #1 stated she talked to CNA #6. On 6/14/18 at 2:51 p.m., an interview was conducted with CNA #6. CNA #6 stated RN #1 came to her regarding Resident #5's bruise and CNA #6 stated she was unaware of the bruise so RN #1 showed her. CNA #6 stated sometimes Resident #5 is very "jumpy," throws her hands up and hits herself in the face when morning care is provided.	F 610	identified concerns. Completion date: July 27, 2018	

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On 6/14/18 at 6:14 p.m., an interview was conducted with ASM #1, the administrator and ASM #2, the director of nursing. ASM #1 and ASM #2 were asked what should occur if a bruise is found on a resident. ASM #1 stated, "There should be an investigation to find out what the origin of it is." When asked the facility process for the investigation, ASM #1 stated staff interviews, resident interviews, a care plan review and a medical history review should be completed. ASM #1 stated she knew an investigation had been completed but she could not provide any evidence. ASM #1 and ASM #2 were made aware of the above concern.

The facility document titled, "ABUSE PROHIBITION, INVESTIGATION, AND REPORTING" documented, "I. 'Injury of Unknown Source' (must be reported immediately to the administrator or designee)- An injury should be classified as an 'injury of unknown source' when both of the following conditions are met: 1. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and 2. The injury is suspicious because of: a. the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma)...III. Investigation: A. The person(s) observing an incident of guest abuse or suspecting guest abuse must immediately report such incidents/suspicions to the Administrator. If the Administrator is not immediately available, the allegation should be reported to a charge nurse, social worker, or nursing administration to ensure that the guest is safe. The supervisor/management person in charge will then immediately notify the Administrator. When an incident of guest abuse is alleged, the incident

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must be reported to the charge nurse regardless of the time lapse since the incident occurred. The following information should be reported: 1. The name of the guest. 2. The date and time that the incident occurred. 3. The location of the incident. 4. The name(s) of the person(s) committing the incident, if known. 5. The name(s) of any witness (es) to the incident. 6. The type of abuse that was committed (e.g., verbal, physical, sexual, misappropriation, etc.) 7. Other information that may be requested...D. The Administrator will appoint a representative to investigate the incident. The Administrator will initiate the Investigation of Alleged Abuse, Mistreatment, or Misappropriation and make the appropriate notifications as outlined on the form. E. The Administrator or designee will coordinate an immediate investigation in accordance with the investigation guidelines in this policy. The representative in charge of the investigation will consult with the Administrator daily concerning the progress of the investigation. A copy of the findings will be provided to the Administrator within five (5) working days of the occurrence of the incident. The investigation may consist of but is not limited to: 1. An interview with the person(s) reporting the incident. 2. Interviews with any witnesses to the incident. 3. An interview with the guest. 4. A review of the guest's medical record. 5. An interview with staff members (on all shifts) who had contact with the guest during the period of the alleged incident. 6. Interviews with the guest's roommate, family members, and visitors. 7. Physical assessment of other potentially affected guests. 8. A review of all circumstances surrounding the incident...

No further information was presented prior to exit.

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F 610	Continued From page 30 (1) "Alzheimer's disease (AD) is the most common form of dementia among older people. Dementia is a brain disorder that seriously affects a person's ability to carry out daily activities." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=alzheimers+disease&_ga=2.143186225.545294603.1529491200-139120270.1477942321 (2) "Irritable bowel syndrome (IBS) is a problem that affects the large intestine. It can cause abdominal cramping, bloating, and a change in bowel habits. Some people with the disorder have constipation. Some have diarrhea. Others go back and forth between the two. Although IBS can cause a great deal of discomfort, it does not harm the intestines." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=irritable+bowel+syndrome	F 610		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the	F 622		7/27/18

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services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care

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F 622	Continued From page 32 institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to evidence that all the required information was provided to	F 622	Ftag 622 Resident #15: Has returned to the facility. No negative outcome has occurred from	

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F 622	Continued From page 33 the receiving provider for a facility-initiated transfer for eleven of 50 residents in the survey sample, #15, #114, #57, #115, #90, #43, #95, #117, #42, #60, #28 1. The facility staff failed to evidence that all required information was provided to the receiving provider for Resident #15's facility-initiated transfer on 2/27/18. 2. The facility staff failed to evidence that all required information was provided to the receiving provider for Resident #114's facility-initiated transfer on 1/24/18. 3. The facility staff failed to evidence that all required information was provided to the hospital upon Resident #57's transfer to the hospital on 3/19/18. 4. The facility staff failed to evidence that the comprehensive care plan goals were provided to the hospital upon Resident #115's transfer to the hospital on 6/5/18. 5. The facility staff failed to provide the receiving facility with a copy of the resident's care plan goals for Resident #90's facility-initiated transfer on 5/29/18. 6. The facility staff failed to send the comprehensive care plan goals upon Resident #43's facility initiated transfer to the hospital on 3/29/18. 7. The facility staff failed to send care the comprehensive plan goals upon Resident #95's facility initiated transfer to the hospital on 3/16/18.	F 622	this practice. Resident #114: Has returned to the facility. No negative outcome has occurred from this practice. Resident #57: Has returned to the facility. No negative outcome has occurred from this practice. Resident #115: Has returned to the facility. No negative outcome has occurred from this practice. Resident #90: Has returned to the facility. No negative outcome has occurred from this practice. Resident #43: Has returned to the facility. No negative outcome has occurred from this practice. Resident #95: Has returned to the facility. No negative outcome has occurred from this practice. Resident #117: Has returned to the facility. No negative outcome has occurred from this practice. Resident #42: Has returned to the facility. No negative outcome has occurred from this practice. Resident #60: Has returned to the facility. No negative outcome has occurred from this practice.	

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F 622	Continued From page 34 8. The facility staff failed to send the comprehensive care plan goals upon Resident #117's facility initiated transfer to the hospital on 5/5/18. 9a. The facility staff failed to evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer on 03/30/18 and 04/06/18 for Resident # 42. 9b. The facility staff failed to provide documentation from the physician evidencing the specific needs the facility could not meet, facility's efforts to meet the those needs and the specific needs the receiving facility could provide to meet the needs of Resident # 42 for a facility initiated transfer on 03/30/18 and 04/06/18. 10a. The facility staff failed to evidence that all required information was provided to the receiving provider for a facility-initiated transfer on 06/04/18 for Resident # 60. 10b. The facility staff failed to provide documentation from the physician evidencing the specific needs the facility could not meet, facility's efforts to meet the those needs and the specific needs the receiving facility could provide to meet the needs of Resident # 60 for a facility initiated transfer on 06/04/18. 11a. The facility staff failed to evidence that all required information was provided to the receiving provider for a facility-initiated transfer on 02/06/18 and 03/03/18 for Resident # 28. 11b. The facility staff failed to provide documentation from the physician evidencing the	F 622	Resident #28: Has returned to the facility. No negative outcome has occurred from this practice. All residents have the potential to be affected. The DON or designee will educate licensed nursing staff on documentation required in the medical record for hospital transfers and documents required to be sent with the resident to the hospital. The DON or designee will educate the attending physicians on documentation required for hospital transfers. The DON or designee will audit the last 14 days of hospital transfers for appropriate documentation. Nursing administration will monitor documentation of hospital transfers 5 times daily for 4 weeks. Review of hospital transfers will remain a process during clinical the meeting. Medical records will maintain a tracking log for physician documentation of hospital transfers. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee. Continued compliance will be monitored through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date:	

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specific needs the facility could not meet, facility's efforts to meet the those needs and the specific needs the receiving facility could provide to meet the needs of Resident # 28 for a facility initiated transfer on 03/03/18 and 03/19/18.

The findings include:

1. Resident #15 was admitted to the facility on 6/22/15 and readmitted on 3/3/18 with diagnoses that included but were not limited to COPD (chronic obstructive pulmonary disease), osteoporosis, muscle weakness and cognitive communication deficit. Resident #15's most recent MDS (minimum data set) assessment was a 14 day scheduled assessment with an ARD (assessment reference date) of 3/17/18. Resident #15 was coded as being severely impaired in cognitive function scoring 03 out of 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #15's clinical record revealed that she had been transferred to the hospital on 2/27/18. The following nursing note was documented: "guest sent to (Name of hospital), due to abnormal mood and behavior, vs (vital signs) were stable, guest has shown no interest in eating or doing normal activities (going out of room) etc. md (medical doctor) notified, rp (responsible party) (name of RP) notified as well."

The following nurse practitioner note was documented on 2/27/18: "...f/u (follow up) on her productive cough and feeling fatigued x 5 days now. She reports that her nausea and vomiting has resolved. Patient reports not feeling well. She is in bed again today. She denies CP (chest pain), shortness of breath, or edema. Advised

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her nurse to send patient to ER (emergency room) for evaluation and treatment as all labs are negative."

Further review of the clinical record revealed Resident #15 was admitted back to the facility on 3/5/18 with diagnoses of encephalopathy (1) related to acute kidney failure (2) and an L3 osteoporotic compression fracture (3).

Review of Resident #15's clinical record failed to evidence that the following information was provided to the receiving provider at the time of transfer on 2/27/18:

1. Contact information of the practitioner responsible for the care of the resident.
2. Resident representative information including contact information.
3. All special instructions or precautions for ongoing care, as appropriate.
4. Advance Directive information.
5. Care Plan Goals.

On 6/14/18 at 10:42 a.m., an interview was conducted with LPN (licensed practical nurse) #4. When asked what documents were sent with the resident at the time of transfer, LPN #4 stated that code status, medication lists, and the resident's RP and MD (medical doctor) contact information were sent with the resident at the time of transfer. LPN #4 stated that a transfer form was sent with the resident that also documented the resident's insurance, vital signs, allergies etc. When asked if nurses sent the comprehensive care plan or care plan goals with the resident at the time of transfer, LPN #4 stated, "No." LPN #4 stated that she does not normally document the paperwork that was sent with the resident. LPN

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#4 stated that a carbon copy of the transfer sheet was usually kept on the clinical record.

The carbon copy of Resident #15's transfer sheet could not be found in the clinical record.

On 6/14/18 at approximately 5 p.m., ASM (administrative staff member) #1, the administrator was made aware of the above concerns.

The facility policy titled, "Discharge of Guest," did not address the above concerns.

(1) Encephalopathy is a term for any diffuse disease of the brain that alters brain function or structure. Encephalopathy may be caused by infectious agent (bacteria, virus, or prion), metabolic or mitochondrial dysfunction, brain tumor or increased pressure in the skull, prolonged exposure to toxic elements (including solvents, drugs, radiation, paints, industrial chemicals, and certain metals), chronic progressive trauma, poor nutrition, or lack of oxygen or blood flow to the brain. The hallmark of encephalopathy is an altered mental state." This information was obtained from The National Institutes of Health. https://www.ninds.nih.gov/Disorders/All-Disorders/Encephalopathy-Information-Page.

(2) Acute Kidney Failure is a potentially reversible reduction in the capacity of the kidney to excrete nitrogenous wastes and maintain fluid and electrolyte homoeostasis, which usually occurs over hours to days. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2596697/.

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(3) L3 osteoporotic compression fracture-fracture of the vertebrae related to osteoporosis. Vertebral compression fractures are a prevalent disease affecting osteoporotic patients. The risk of developing a vertebral fracture is strongly associated with decreasing bone density. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3693826/.

2. The facility staff failed to evidence that all required information was provided to the receiving provider for Resident #114's facility-initiated transfer on 1/24/18.

Resident #114 was admitted to the facility on 12/18/17 and readmitted on 3/6/18 with diagnoses that included but were not limited to peripheral vascular disease, muscle weakness, schizophrenia, and end stage renal disease. Resident #114's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 5/22/18. Resident #114 was coded as being intact in cognitive function scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status exam.

Review of Resident #114's clinical record revealed that she had been sent out to the hospital on 1/24/18 due to altered mental status. The following note was documented by the physician on 1/31/18: "Pt (patient) was readmitted from (Name of hospital) (1/24-1/30) due to AMS (altered mental status) due to severe hyperkalemia (1) due to missed HD

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(hemodialysis) (2)..."

Further review of the clinical record revealed that Resident #114 often refused dialysis appointments.

Review of Resident #114's clinical record failed to evidence that the following information was provided to the receiving provider at the time of transfer on 1/24/18:

1. Contact information of the practitioner responsible for the care of the resident.
2. Resident representative information including contact information.
3. All special instructions or precautions for ongoing care, as appropriate.
4. Advance Directive information.
5. Care Plan Goals.

On 6/14/18 at 10:42 a.m., an interview was conducted with LPN (licensed practical nurse) #4. When asked what documents were sent with the resident at the time of transfer, LPN #4 stated that code status, medication lists, and the resident's RP and MD (medical doctor) contact information were sent with the resident at the time of transfer. LPN #4 stated that a transfer form was sent with the resident that also documented the resident's insurance, vital signs, allergies etc. When asked if nurses sent the comprehensive care plan or care plan goals with the resident at the time of transfer, LPN #4 stated, "No." LPN #4 stated that she does not normally document the paperwork that was sent with the resident. LPN #4 stated that a carbon copy of the transfer sheet was usually kept on the clinical record.

The carbon copy of Resident #114's transfer

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sheet could not be found in the clinical record.

On 6/14/18 at approximately 5 p.m., ASM (administrative staff member) #1, the administrator was made aware of the above concerns. No further information was presented prior to exit.

(1) Hyperkalemia is elevated levels of potassium that can induce deadly cardiac arrhythmias. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1413606/.

(2) Hemodialysis is a treatment to filter wastes and water from your blood, as your kidneys did when they were healthy. Hemodialysis helps control blood pressure and balance important minerals, such as potassium, sodium, and calcium, in your blood. This information was obtained from The National Institutes of Health. https://www.niddk.nih.gov/health-information/kidney-disease/kidney-failure/hemodialysis.
3. The facility staff failed to evidence that all required information was provided to the hospital upon Resident #57's transfer to the hospital on 3/19/18.

Resident #57 was admitted to the hospital on 7/9/16 with the diagnoses of but not limited to right hip fracture, manic episodes, osteoporosis, dementia, coronary artery disease, high blood pressure, anxiety disorder, atrial fibrillation, and dysphagia. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 5/26/18. The resident was coded as significantly impaired in ability to make daily life decisions.

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A review of the clinical record revealed the following nurse's notes dated 3/19/18, 10:56 p.m., "Guest sent to (name of hospital) r/t (related to) an acute intertrochanteric femur fracture rp [sic] notified."

The following physician's note dated 3/26/18 at 11:25 a.m., documented, "85 yo (year old) female was re-adm (readmitted) from (name of hospital) (3/20-3/25) after having a fall resulting in L (left) hip fx (fracture)....Good pain control...."

Further review of the clinical record failed to reveal any evidence of what documentation was sent to the hospital with the resident on 3/19/18.

On 6/14/18 at 10:40 a.m., in an interview with LPN #4 (Licensed Practical Nurse), she stated that when a resident is transferred to the hospital, there is a transfer form, with list of meds and code status. LPN #4 stated this form includes the resident's name, type of insurance, social security number, vital signs, why the resident is being transferred, allergies, etc. When asked if the comprehensive care plan and care plan goals, are sent with residents, LPN #4 stated, "No."

A review of a blank copy of this transfer form, titled "Inter-Facility Continuity of Care Report" documented the following areas to be completed for a transfer: Name, gender, last 4 digits of the resident's social security number, guest's (resident/patient) address, date of birth, religion, date and time of transfer, name and address of facility transferring to, physician's information, name and address of facility transferring from, dates of admission and discharge of the facility transferring from, information of the responsible

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party for the resident, diagnoses, reason for transfer, bed hold letter information, advanced directives, code status, vital signs, impairments, allergies, diet, medications and treatments, physician's orders, cognitive status, communication ability, assuasive devices, immunizations, resident assistance levels for transfers / eating / and toileting.

On 6/14/18 at 2:03 p.m., a list of documenters needed from Resident #57's clinical record was provided to the facility. This list included a request for the above transfer form that was completed on 3/19/18 when the resident went to the hospital.

On 6/14/18 at 3:39 p.m., ASM #5 (Administrative Staff Member - Clinical Resource Specialist) stated the completed transfer form for Resident #57 for the hospital transfer of 3/19/18 could not be located, and therefore the facility could not evidence what, if any, required information was provided to the hospital.

On 6/14/18 at approximately 5:00 p.m., the Administrator (ASM #1) was made aware of the concerns. No further information was provided.

4. The facility staff failed to evidence that the comprehensive care plan goals were provided to the hospital upon Resident #115's transfer to the hospital on 6/5/18.

Resident #115 was admitted to the facility on 7/22/14 with the diagnoses of but not limited to high blood pressure, hypothyroidism, bipolar disorder, and polyglandular dysfunction. The

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most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 5/22/18. The resident was coded as cognitively intact in ability to make daily life decisions.

A review of the clinical record revealed the following nurse's notes dated 6/5/18, 9:44 a.m., "Guest was sent to (name of hospital) per N/P (nurse practitioner) order due to Guest being unresponsive, Gurgled breathing, 02 (oxygen) stats [sic] (saturation) 84%, HR (heart rate) 136, Resp (respirations) 28, B/P (blood pressure) 141/79 Guest R/P (responsible party) daughter (name of daughter) notified, messegd [sic] left to R/P (name of another responsible party). bed [sic] hold in place."

A review of the "Inter-Facility Continuity of Care Report" in the clinical record was reviewed. There was no evidence this form included comprehensive care plan goals as required documentation to be provided to the receiving facility. The nurse's notes did not evidence the comprehensive care plan goals were sent to the receiving facility.

On 6/14/18 at 10:40 a.m., in an interview with LPN #4 (Licensed Practical Nurse), she stated that when a resident is transferred to the hospital, there is a transfer form, with list of meds and code status. LPN #4 stated this form includes the resident's name, type of insurance, social security number, vital signs, why the resident is being transferred, allergies, etc. When asked if the comprehensive care plan and care plan goals, are sent with residents, LPN #4 stated, "No."

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On 6/14/18 at approximately 5:00 p.m., the Administrator (ASM #1) was made aware of the concerns. No further information was provided.

5. The facility staff failed to provide the receiving facility with a copy of the resident's care plan goals for Resident #90's facility-initiated transfer on 5/29/18.

Resident #90 was admitted to the facility on 5/9/18 with a recent readmission on 5/29/18 with diagnoses that included but were not limited to: cerebral infarct (area of dead tissue resulting from diminished or stopped blood flow to the tissue area in the brain) (1), high blood pressure, seizures, feeding tube, paralysis on one side, and human immunodeficiency virus (HIV) disease (a virus that causes acquired immunodeficiency syndrome) (2).

The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 5/21/18, coded the resident as having both short and long-term memory difficulties.

The nurse's note dated, 5/29/18 at 4:00 p.m. documented, "Therapy called writer into room and observed guest not verbally responding to them. Guest spoke to me earlier in the day responding appropriately. When writer entered room, guest was not responding to questions, eyes were open, not verbally responding. NP (nurse practitioner) assessed and stated send guest to ER (emergency room). Guest left facility at 12:15 p.m. via ambulance. RP (responsible party) was notified."

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An interview was conducted with LPN (licensed practical nurse) #4 on 6/14/18 at 10:40 a.m. When asked if they provide the comprehensive care plan and comprehensive care plan goals to the receiving hospital, LPN #4 stated, "No." When asked if she documents what documents are sent with the resident, LPN #4 stated, "Only the bed hold policy."

The administrator, ASM (administrative staff member) #1 and ASM #2, director of nursing were made aware of the above concern on 6/14/18 at 2:00 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 296.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 276

6. The facility staff failed to send the comprehensive care plan goals upon Resident #43's facility initiated transfer to the hospital on 3/29/18.

Resident #43 was admitted to the facility on 10/23/17 with most recent readmission on 4/9/18, with diagnoses that included but were not limited to: heart failure, pneumonia, diabetes, chronic obstructive pulmonary disease (a chronic lung disease that makes it hard to breath) (1), high blood pressure, anxiety, and severe obesity.

The most recent MDS (minimum data set) assessment, a significant change assessment,

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with an assessment reference date of 4/16/18, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating she has severe cognitive impairment for daily decision making.

The "Nurses Note" dated 3/29/18 at 8:25 a.m., documented in part, "Guest was noted with labored breathing, O2 (oxygen) sats (saturation) 65 on 3 liters O2, rescue squad called to send to ER (emergency room), son [name] made aware, [Medical Doctor's name] made aware".

On 6/14/18 at 10:41 a.m., an interview was conducted with LPN (licensed practical nurse) #4, when asked if a transfer would be documented in the clinical record, LPN #4 stated that she would document the transfer in a nursing note as well as complete a "Transfer form". When asked what documents were sent with residents during a transfer, LPN #4 stated that nurses will send the transfer sheet, medication listing, advanced directives, any pertinent orders, bed hold information, and any laboratory tests that are pertinent. When asked if the comprehensive care plan and care plan goals are sent with residents to the hospital, LPN #4 stated that they do not send the care plan or care plan goals with the Resident to the hospital.

ASM (administrative staff member) #1, the administrator, and ASM #2 (the director of nursing) were made aware of the above findings on 6/14/18 at 3:00 p.m.

No further information was obtained prior to exit.

(1) This information was obtained from the

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following website:
https://medlineplus.gov/ency/article/000091.htm

7. The facility staff failed to send care the comprehensive plan goals upon Resident #95's facility initiated transfer to the hospital on 3/16/18.

Resident #95 was admitted to the facility on 6/29/16 with recent readmission on 3/20/18, with diagnoses that included but were not limited to: Parkinson's disease (a progressive movement disorder often accompanied by shaking or tremors) (1), high blood pressure, cancer of the bone and prostate, and difficulty swallowing.
.
The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 5/18/18, coded the resident as scoring a "7" on the BIMS (brief interview for mental status) score, indicating he has severe cognitive impairment of daily decision making.

A nursing note, dated 3/16/18 at 1:32 p.m., documented in part, "Guest is very lethargic and hard to arouse, guest doesn't want to eat or get out of bed, md (medical doctor) assessed and stated send out, md and nurse attempted to all rp (responsible party) [name] no answer voicemail left, guest is going to [name] ER (emergency room)."

On 6/14/18 at 10:41 a.m., an interview was conducted with LPN (licensed practical nurse) #4, when asked if a transfer would be documented in the clinical record, LPN #4 stated that she would document the transfer in a nursing note as well as complete a "Transfer form". When asked what

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documents were sent with residents during a transfer, LPN #4 stated that nurses will send the transfer sheet, medication listing, advanced directives, any pertinent orders, bed hold information, and any laboratory tests that are pertinent. When asked if the comprehensive care plan and care plan goals are sent with residents to the hospital, LPN #4 stated that they do not send the care plan or care plan goals with the Resident to the hospital.

ASM (administrative staff member) #1, the administrator, and ASM #2 (the director of nursing) were made aware of the above findings on 6/4/18 at 3:00 p.m.

No further information was obtained prior to exit.

(1) This information was obtained from the following website: https://medlineplus.gov/parkinsonsdisease.html

8. The facility staff failed to send the comprehensive care plan goals upon Resident #117's facility initiated transfer to the hospital on 5/5/18.

Resident #117 was admitted to the facility on 6/22/16 with recent readmission on 5/9/18, with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (a chronic lung disease that makes it hard to breath) (1), a stroke with right sided paralysis, dementia, high blood pressure, and a gastrostomy tube (a tube that is inserted through the wall of the abdomen directly into the stomach in order to give drugs,

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liquids and liquid food to a patient) (2).
.
The most recent MDS (minimum data set) assessment, a 14 day Medicare assessment, with an assessment reference date of 5/23/18, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating he has severe cognitive impairment of daily decision making.

A nursing note, dated 5/5/18 at 10:51 p.m., documented in part, "Guest in bed, head elevated with feeding via peg (percutaneous endoscopic tube or gastrostomy tube) in progress [sic] noted to be foaming through the mouth; guest noted to be diaphorisis [sic], vs (vital signs) was [sic] taken ...called 911 ...RP (responsible party) made aware ...MD (medical doctor) on call made aware".

On 6/14/18 at 10:41 a.m., an interview was conducted with LPN (licensed practical nurse) #4, when asked if a transfer would be documented in the clinical record, LPN #4 stated that she would document the transfer in a nursing note as well as complete a "Transfer form". When asked what documents were sent with residents during a transfer, LPN #4 stated that nurses will send the transfer sheet, medication listing, advanced directives, any pertinent orders, bed hold information, and any laboratory tests that are pertinent. When asked if the comprehensive care plan and care plan goals are sent with residents to the hospital, LPN #4 stated that they do not send the care plan or care plan goals with the Resident to the hospital.

ASM (administrative staff member) #1, the administrator, and ASM #2 (the director of

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nursing) were made aware of the above findings on 6/4/18 at 3:00 p.m.

No further information was obtained prior to exit.

(1) This information was obtained from the following website:
https://medlineplus.gov/ency/article/000091.htm

(2) This information was obtained from the following website:
https://www.cancer.gov/publications/dictionaries/cancer-terms/def/gastrostomy-tube
9a. The facility staff failed to evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer on 03/30/18 and 04/06/18 for Resident # 42.

Resident # 42 was admitted to the facility on 04/23/13 with a readmission of 04/08/18 with diagnoses that included but were not limited to convulsions (1), gastroesophageal reflux disease (2), hydrocephalus (3), hypertension (4) and depression (5).

Resident # 42's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 04/14/18, coded Resident # 42 as scoring a 7 (seven) on the brief interview for mental status (BIMS) of a score of 0 - 15, 7 (seven) - being severely impaired of cognition for making daily decisions.

The nurse's "Progress Notes," dated 03/30/2018. 11:15 (a.m.) for Resident # 42 documented, "At 11:15 a.m. Guest was in the shower room with two shower aides and they were transferring her from the sit to stand lift, to the shower chair and

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guest hands slipped off of machine and she fell in the shower. Guest c/o (complaint of) left leg pain and the leg was red and painful when touched. A pillow was placed under her head for comfort and she was not moved from floor until paramedics came. Emergency ambulance were called to come take guest to the hospital. Guest was transported to (Name of Hospital) at 11:30 a.m. RP (responsible party) notified, MD (medical doctor) notified, DON (director of nursing) notified."

The nurse's "Progress Notes," dated 03/31/2018. 01:58 (1:58 p.m.) for Resident # 42 documented, "Guest returned from hospital at 6:15 p.m. She has a non-displaced tib/fib (tibia/fibula) fracture and needs to be non-weight bearing for the next 6 (six) weeks. No complaints of pain."

The nurse's "Progress Notes," dated 04/06/2018. 21:00 (9:00 p.m.) for Resident # 42 documented, "Call placed to on call MD (medical doctor) around 6:25 p.m. awaiting call back. MD on call returned my call. She was made aware of the x-ray results for right hip and femur. New order to send out for further evaluation."

The nurse's "Progress Notes," dated 04/08/2018 10:59 (a.m.) for Resident # 42 documented, "Received report from (Name of Hospital) that guest will be returning to facility before noon. Guest is returning with right femur fracture and left tib/fib (fibula/fibula) fracture, guest has a current UTI (urinary tract infection) and placed of [sic] antibiotics."

On 06/14/18 at 10:40 a.m., an interview was conducted with LPN (licensed practical nurse) # 4. When asked describe what documentation is

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provided to the receiving facility when a resident is transferred LPN # 4 stated, "Get an order from the physician, call RP (responsible party), call transportation, if emergency call 911, nursing sends the bed hold policy with the resident, transfer form, name, insurance vital, why they are being sent out. When asked if they the comprehensive care plan or care plan goals are sent with residents, LPN # 4 stated, "No."

Review of the facility's transfer form entitled "Inter-Facility Continuity of Care Report" failed to evidence the resident's care plan goals as part of the transfer paperwork.

Review of Resident # 42's clinical record failed to evidence the receiving facility received a copy of Resident # 42's care plan goals.

On 06/14/18 at approximately 6:15 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, and ASM # 5, clinical resource specialist, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: https://medlineplus.gov/ency/article/003200.htm.

(2) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website:

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https://www.nlm.nih.gov/medlineplus/gerd.html.

(3) A buildup of fluid inside the skull that leads to brain swelling. This information was obtained from the website: https://medlineplus.gov/ency/article/001571.htm.

(4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(5) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

9b. The facility staff failed to provide documentation from the physician evidencing the specific needs the facility could not meet, facility's efforts to meet the those needs and the specific needs the receiving facility could provide to meet the needs of Resident # 42 for a facility initiated transfer on 03/30/18 and 04/06/18.

The nurse's "Progress Notes," dated 03/30/2018. 11:15 (a.m.) for Resident # 42 documented, "At 11:15 a.m. Guest was in the shower room with two shower aides and they were transferring her from the sit to stand lift, to the shower chair and guest hands slipped off of machine and she fell in the shower. Guest c/o (complaint of) left leg pain and the leg was red and painful when touched. A

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pillow was placed under her head for comfort and she was not moved from floor until paramedics came. Emergency ambulance were called to come take guest to the hospital. Guest was transported to (Name of Hospital) at 11:30 a.m. RP (responsible party) notified, MD (medical doctor) notified, DON (director of nursing) notified."

The nurse's "Progress Notes," dated 03/31/2018. 01:58 (1:58 p.m.) for Resident # 42 documented, "Guest returned from hospital at 6:15 p.m. She has a non-displaced tib/fib (tibia/fibula) fracture and needs to be non-weight bearing for the next 6 (six) weeks. No complaints of pain."

The nurse's "Progress Notes," dated 04/06/2018. 21:00 (9:00 p.m.) for Resident # 42 documented in part, "Call placed to on call MD (medical doctor) around 6:25 p.m. awaiting call back. MD on call returned my call. She was made aware of the x-ray results for right hip and femur. New order to send out for further evaluation. MD also aware of guest going to the hospital on 3/31/18 for pain. NP (nurse practitioner had been following her. RP (responsible party, Name of Responsible Party) made aware around 6:53 p.m. of the x-ray and the doctor's order to send her to the hospital for evaluations. RP stated that was fine. (Name of Ambulance Service) called awaiting pickup around 7:34 p.m. Guest left the facility around 8:51 p.m ..."

The nurse's "Progress Notes," dated 04/08/2018 10:59 (a.m.) for Resident # 42 documented, "Received report from (Name of Hospital) that guest will be returning to facility before noon. Guest is returning with right femur fracture and left tib/fib (tibia/fibula) fracture, guest has a

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current UTI (urinary tract infection) and placed of [sic] antibiotics. Guest shall keep immobilizer on left leg and use therapy to heal right femur fracture."

Review of the physician's most recent progress notes dated March 2018 through May 2018 failed to evidence documentation of the specific needs the facility could not meet, facility's efforts to meet the those needs and the specific needs the receiving facility could provide to meet the needs of Resident # 42.

On 06/14/18, 11:36 a.m. an interview was conducted with ASM (administrative staff member) # 6, the nurse practitioner. When asked what is documented when a resident is transferred to the hospital, ASM # 6 stated she documents the reason why they are being seen, the findings, and change of condition, why they are being sent out. When asked if she documents why the residents needs can't be met at the facility, ASM # 6 stated, "No. I'm assuming they require a higher level of care and need acute care management." ASM # 6 further stated, "I would not specifically state what the receiving facility would provide."

On 06/14/18 at approximately 6:15 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, and ASM # 5, clinical resource specialist, were made aware of the above findings.

No further information was provided prior to exit.

10a. The facility staff failed to evidence that all required information was provided to the

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receiving provider for a facility-initiated transfer on 06/04/18 for Resident # 60.

Resident # 60 was admitted on 04/06/17 and a readmission on 06/07/18 with diagnoses that included but were not limited to anemia (1) fractured right femur (2), diabetes mellitus (3), hypertension (4) and depressive disorder (5).

Resident # 60's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/27/18 coded Resident # 60 as scoring a 9 (nine) on the brief interview for mental status (BIMS) of a score of 0 (zero) - 15, 9 (nine) being moderately impaired of cognition for making daily decisions.

The nurse's "Progress Notes," dated 06/04/2018 01:00 (1:00 a.m.) for Resident # 60 documented part, "12:50 a.m. resident sent out to (Name of Hospital) for s/s (signs and symptoms) of aspiration."

On 06/14/18 at 10:40 a.m., an interview was conducted with LPN (licensed practical nurse) # 4. When asked describe what documentation is provided to the receiving facility when a resident is transferred LPN # 4 stated, "Get an order from the physician, call RP (responsible party), call transportation, if emergency call 911, nursing sends the bed hold policy with the resident, transfer form, name, insurance vital, why they are being sent out. When asked if they the comprehensive care plan or care plan goals are sent with residents, LPN # 4 stated, "No."

Review of the facility's transfer form entitled "Inter-Facility Continuity of Care Report" failed to

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evidence the resident's care plan goals as part of the transfer paperwork.

Review of Resident # 60's clinical record failed to evidence the receiving facility received a copy of Resident # 60's care plan goals.

On 06/14/18 at approximately 6:15 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, and ASM # 5, clinical resource specialist, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) Low iron. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/anemia.html
.

(2) You had a fracture (break) in the femur in your leg. It is also called the thigh bone. You may have needed surgery to repair the bone. You may have had surgery called an open reduction internal fixation. In this surgery, your surgeon will make a cut to open your fracture. This information was obtained from the website:
https://medlineplus.gov/ency/patientinstructions/000166.htm.

(3) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(4) High blood pressure. This information was obtained from the website:

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https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(5) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(6) Ondansetron is used to prevent nausea and vomiting caused by cancer chemotherapy, radiation therapy, and surgery. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601209.html.

(7) When you're short of breath, it's hard or uncomfortable for you to take in the oxygen your body needs. You may feel as if you're not getting enough air. Sometimes you can have mild breathing problems because of a stuffy nose or intense exercise. But shortness of breath can also be a sign of a serious disease. This information was obtained from the website: https://medlineplus.gov/breathingproblems.html.

10b. The facility staff failed to provide documentation from the physician evidencing the specific needs the facility could not meet, facility's efforts to meet the those needs and the specific needs the receiving facility could provide to meet the needs of Resident # 60 for a facility initiated transfer on 06/04/18.

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The nurse's "Progress Notes," dated 06/04/2018 01:00 (1:00 a.m.) for Resident # 60 documented, "12:50 a.m. resident sent out to (Name of Hospital) for s/s (signs and symptoms) of aspiration. Writer administered PRN (as needed) Zofran (6) for c/o (complaint of) nausea. Guest spit out med (medication) then vomited. Then guest showed s/s of dyspnea (7)."

The nurse's "Progress Notes," dated 06/08/2018 12:07 p.m. for Resident # 60 documented, "Guest seen by wound MD (medical doctor) for evaluation of wounds on 6/7/2018 with readmission. Clarification of wounds; right ankle is an arterial wound not pressure ulcer."

Review of the physician's most recent progress notes dated May 2018 and June 2018 failed to evidence documentation of the specific needs the facility could not meet, facility's efforts to meet the those needs and the specific needs the receiving facility could provide to meet the needs of Resident # 60.

On 06/14/18 11:36 a.m. an interview was conducted with ASM (administrative staff member) # 6, the nurse practitioner. When asked what is documented when a resident is transferred to the hospital ASM # 6 stated she documents the reason why they are being seen, the findings, change of condition, why they are being sent out. When asked if she documents why the resident's needs can't be met at the facility ASM # 6 stated, "No. I'm assuming they require a higher level of care and need acute care management." ASM # 6 further stated, "I would not specifically state what the receiving facility would provide."

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On 06/14/18 at approximately 6:15 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, and ASM # 5, clinical resource specialist, were made aware of the above findings.

No further information was provided prior to exit.

11a. The facility staff failed to evidence that all required information was provided to the receiving provider for a facility-initiated transfer on 03/03/18 and 03/19/18 for Resident # 28.

Resident # 28 was admitted on 05/19/17 and a readmission on 03/23/18 with diagnoses that included but were not limited to cerebral infarction (1) sepsis (2) and schizophrenia (3).

Resident # 28's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 03/30/18 coded Resident # 28 as scoring a 0 (zero) on the brief interview for mental status (BIMS) of a score of 0 (zero) - 15, 0 (zero) being severely impaired of cognition for making daily decisions.

The nurse's "Progress Notes," dated 03/03/20 15:54 (3:54 p.m.) for Resident # 28 documented, "Guest noted with s/s (signs and symptoms) of distress, labored breathing, rsp (respiration) 28, temp (temperature) of 102, bp (blood pressure) 106/70, pulse 134, O2 (oxygen) 90%, on 3l (three liters) of O2 via (by) nasal cannula, diaphoretic skin. Guest was given neb (nebulizer) treatment and Tylenol given. Md (medical doctor) notified ordered to send guest to hospital (Name of First Hospital). Ambulance service sent guest to (Name of Second Hospital) which was the closest

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for guest condition, refused to transport to (Name of First Hospital) r/t (related to) distress. RP (responsibility party) was called an [sic] no answer, left message to call facility back, bed hold policy sent with guest."

The nurse's "Progress Notes," dated 03/19/2018 16:19 (4:19 p.m.) for Resident # 28 documented, "Guest sent out via (by) 911 at 3:05 p.m. MD (medical doctor) notified, RP (responsible party) notified."

On 06/14/18 at 10:40 a.m., an interview was conducted with LPN (licensed practical nurse) # 4. When asked describe what documentation is provided to the receiving facility when a resident is transferred LPN # 4 stated, "Get an order from the physician, call RP (responsible party), call transportation, if emergency call 911, nursing sends the bed hold policy with the resident, transfer form, name, insurance vital, why they are being sent out. When asked if they the comprehensive care plan or care plan goals are sent with residents, LPN # 4 stated, "No."

Review of the facility's transfer form entitled "Inter-Facility Continuity of Care Report" failed to evidence the resident's care plan goals as part of the transfer paperwork.

Review of Resident # 28's clinical record failed to evidence the receiving facility received a copy of Resident # 28's comprehensive care plan goals on 3/3/18 and 3/19/18.

On 06/14/18 at approximately 6:15 p.m., ASM (administrative staff member) # 1, administrator,

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ASM # 2, director of nursing, and ASM # 5, clinical resource specialist, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website:
https://medlineplus.gov/ency/article/000726.htm .

(2) Sepsis is an illness in which the body has a severe, inflammatory response to bacteria or other germs. The symptoms of sepsis are not caused by the germs themselves. Instead, chemicals the body releases cause the response. This information was obtained from the website:
https://medlineplus.gov/ency/article/000666.htm.

(3) A mental disorder that makes it hard to tell the difference between what is real and not real. This information was obtained from the website:
https://medlineplus.gov/ency/article/000928.htm.
scoliosis (a sideways curve of your backbone, or spine.) This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/scoliosis.html.

11b. The facility staff failed to provide documentation from the physician evidencing the specific needs the facility could not meet, facility's efforts to meet the those needs and the specific needs the receiving facility could provide to meet

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the needs of Resident # 28 for a facility initiated transfer on 03/03/18 and 03/19/18.

The nurse's "Progress Notes," dated 03/03/20 15:54 (3:54 p.m.) for Resident # 28 documented, "Guest noted with s/s (signs and symptoms) of distress, labored breathing, rsp (respiration) 28, temp (temperature) of 102, bp (blood pressure) 106/70, pulse 134, O2 (oxygen) 90%, on 3l (three liters) of O2 via (by) nasal cannula, diaphoretic skin. Guest was given neb (nebulizer) treatment and Tylenol given. Md (medical doctor) notified ordered to send guest to hospital (Name of First Hospital). Ambulance service sent guest to (Name of Second Hospital) which was the closest for guest condition, refused to transport to (Name of First Hospital) r/t (related to) distress. RP (responsibility party) was called an [sic] no answer, left message to call facility back, bed hold policy sent with guest."

The nurse's "Progress Notes," dated 03/19/2018, 16:19 (4:19 p.m.) for Resident # 28 documented, "Guest sent out via (by) 911 at 3:05 p.m. MD (medical doctor) notified, RP (responsible party) notified."

The nurse's "Progress Notes," dated 03/24/20 01:17 (1:17 a.m.) for Resident # 28 documented in part, "Guest returned from hospital this evening."

Review of the physician's most recent progress notes dated March 2018 and April 2018 failed to evidence documentation of the specific needs the facility could not meet, facility's efforts to meet the those needs and the specific needs the receiving facility could provide to meet the needs of

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F 622	Continued From page 64 Resident # 28 on 3/3/18 and 3/19/18. On 06/14/18, 11:36 a.m. an interview was conducted with ASM (administrative staff member) # 6, the nurse practitioner. When asked what is documented when a resident is transferred to the hospital ASM # 6 stated she documents the reason why they are being seen, the findings, change of condition, why they are being sent out. When asked if she documents why the resident's needs can't be met at the facility ASM # 6 stated, "No. I'm assuming they require a higher level of care and need acute care management." ASM # 6 further stated, "I would not specifically state what the receiving facility would provide." On 06/14/18 at approximately 6:15 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, and ASM # 5, clinical resource specialist, were made aware of the above findings. No further information was provided prior to exit.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or	F 623		7/27/18

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discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email),

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and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

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

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of

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F 623	Continued From page 67 the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide written notification to the resident representative of a facility initiated transfer to the hospital for ten of 50 residents, Resident #15, #114, #57, #90, #43, #95, #117, #42, #60, #28. 1. The facility staff failed to provide written notification to Resident #15's responsible party for a transfer to the hospital on 2/27/18. 2. The facility staff failed to provide written notification to Resident #114's responsible party for a transfer to the hospital on 1/24/18. 3. The facility staff failed to evidence that Resident #57's responsible party was provided with written notification of the hospital transfer of 3/17/18. 4. The facility staff failed to provide written documentation to the resident and/or resident representative for a facility initiated transfer for Resident #90 on 5/29/18. 5. The facility staff failed to provide required written notification to the resident or responsible representative for a facility initiated transfer to the hospital for Resident #43. 6. The facility staff failed to provide required written notification to the resident or responsible	F 623	Ftag 623 Resident # 15: Has returned to the facility. No negative outcome has occurred from this practice. Resident #114: Has returned to the facility. No negative outcome has occurred from this practice. Resident #57: Has returned to the facility. No negative outcome has occurred from this practice. Resident # 90: Has returned to the facility. No negative outcome has occurred from this practice. Resident #43: Has returned to the facility. No negative outcome has occurred from this practice. Resident #95: Has returned to the facility. No negative outcome has occurred from this practice. Resident #117: Has returned to the facility. No negative outcome has occurred from this practice. Resident #42: Has returned to the facility. No negative outcome has occurred from this practice.	

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F 623	Continued From page 68 representative for a facility initiated transfer to the hospital for Resident #95. 7. The facility staff failed to provide required written notification to the resident or responsible representative for a facility initiated transfer to the hospital for Resident #117. 8. The facility staff failed to provide written notification to the resident and responsible party (RP) and of a facility initiated transfer to the hospital on 03/30/18 and 04/06/18 for Resident # 42. 9. The facility staff failed to provide written notification to the resident and responsible party (RP) and of a facility initiated transfer to the hospital on 06/04/18 for Resident # 60. 10. The facility staff failed to provide written notification to the resident and responsible party (RP) and of a facility initiated transfer to the hospital on 02/06/18 and 03/03/18 for Resident # 28. The findings include: 1. Resident #15 was admitted to the facility on 6/22/15 and readmitted on 3/3/18 with diagnoses that included but were not limited to COPD (chronic obstructive pulmonary disease), osteoporosis, muscle weakness and cognitive communication deficit. Resident #15's most recent MDS (minimum data set) assessment was a 14 day scheduled assessment with an ARD (assessment reference date) of 3/17/18. Resident #15 was coded as being severely impaired in cognitive function scoring 03 out of 15	F 623	Resident # 60: Has returned to the facility. No negative outcome has occurred from this practice. Resident #28: Has returned to the facility. No negative outcome has occurred from this practice. All residents have the potential to be affected. The facility has created a written notice to be used for hospital transfers. The DON or designee will educate licensed nursing staff on completing the notice and, sending it with the resident. Medical Records or designee will be educated on the process of mailing the written notice to the resident representative. The DON or designee will audit the last 14 days of hospital transfers. Nursing administration will monitor hospital transfers 5 times a week for 4 weeks for appropriate documentation and evidence a notice of transfer has been given. Checking hospital transfers will remain a process of the clinical meeting. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee. Continued compliance will be monitored through the facility□s quality assurance program. Additional education and monitoring will be initiated for any	

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F 623	Continued From page 69 on the BIMS (Brief Interview for Mental Status) exam. Resident #15 was coded as requiring extensive assistance from one staff member with most ADLS (activities of daily living). Review of Resident #15's clinical record revealed that she had been transferred to the hospital on 2/27/18. The following nursing note was documented: "guest sent to (Name of hospital), due to abnormal mood and behavior, vs (vital signs) were stable, guest has shown no interest in eating or doing normal activities (going out of room) etc. md (medical doctor) notified, rp (responsible party) (name of RP) notified as well." The following nurse practitioner note was documented on 2/27/18: "...f/u (follow up) on her productive cough and feeling fatigued x 5 days now. She reports that her nausea and vomiting has resolved. Patient reports not feeling well. She is in bed again today. She denies CP (chest pain), shortness of breath, or edema. Advised her nurse to send patient to ER (emergency room) for evaluation and treatment as all labs are negative." Further review of the clinical record revealed Resident #15 was admitted back to the facility on 3/5/18 with diagnoses of encephalopathy (1) related to acute kidney failure (2) and L3 osteoporotic compression fracture (3). Review of Resident #15's clinical record failed to evidence that the RP (responsible party) was notified in writing for her reason for transfer On 6/14/18 at 10:42 a.m., an interview was conducted with LPN (licensed practical nurse) #4. When asked the process when a resident is sent	F 623	identified concerns. Completion Date: July 27, 2018	

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out to the hospital, LPN #4 stated that she would notify the medical doctor to make them aware, obtain an order to send the resident out, and then call the responsible party. LPN #4 stated that if the transfer was approved by the responsible party, she would then call the ambulance service. When asked if nurses provided written notification to the RP and resident, documenting the reason for hospital transfer, LPN #4 stated that she only notifies the RP and resident verbally. LPN #4 stated that written notification is not provided by nursing.

On 6/14/18 at approximately 5 p.m., ASM (administrative staff member) #1, the administrator was made aware of the above concerns.

Facility policy titled, "Discharge of Guest," did not address the above concerns.

(1) Encephalopathy is a term for any diffuse disease of the brain that alters brain function or structure. Encephalopathy may be caused by infectious agent (bacteria, virus, or prion), metabolic or mitochondrial dysfunction, brain tumor or increased pressure in the skull, prolonged exposure to toxic elements (including solvents, drugs, radiation, paints, industrial chemicals, and certain metals), chronic progressive trauma, poor nutrition, or lack of oxygen or blood flow to the brain. The hallmark of encephalopathy is an altered mental state." This information was obtained from The National Institutes of Health. https://www.ninds.nih.gov/Disorders/All-Disorders/Encephalopathy-Information-Page.

(2) Acute Kidney Failure is a potentially reversible

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reduction in the capacity of the kidney to excrete nitrogenous wastes and maintain fluid and electrolyte homoeostasis, which usually occurs over hours to days. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2596697/.

(3) L3 osteoporotic compression fracture-fracture of the vertebrae related to osteoporosis. Vertebral compression fractures are a prevalent disease affecting osteoporotic patients. The risk of developing a vertebral fracture is strongly associated with decreasing bone density. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3693826/.

2. The facility staff failed to provide written notification to Resident #114's responsible party for a transfer to the hospital on 1/24/18.

Resident #114 was admitted to the facility on 12/18/17 and readmitted on 3/6/18 with diagnoses that included but were not limited to peripheral vascular disease, muscle weakness, schizophrenia, and end stage renal disease. Resident #114's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 5/22/18. Resident #114 was coded as being intact in cognitive function scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status exam. Resident #114 was coded as requiring extensive assistance from one staff member with bed mobility, dressing, personal hygiene, and transfers; limited assistance from one staff member with walking, and toileting; and total

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dependence on one staff member with bathing.

Review of Resident #114's clinical record revealed that she had been sent out to the hospital on 1/24/18 due to altered mental status. The nursing note dated 1/24/18, documented that the RP had been made aware.

The following note was documented by the physician on 1/31/18: "Pt (patient) was readmitted from (Name of hospital) (1/24-1/30) due to AMS (altered mental status) due to severe hyperkalemia (1) due to missed HD (hemodiaylsis) (2)...

Further review of the clinical record revealed that Resident #114 often refused dialysis appointments.

Review of Resident #114's clinical record failed to evidence that the RP (responsible party) was notified in writing for her reason for transfer

On 6/14/18 at 10:42 a.m., an interview was conducted with LPN (licensed practical nurse) #4. When asked the process when a resident is sent out to the hospital, LPN #4 stated that she would notify the medical doctor to make them aware, obtain an order to send the resident out, and then call the responsible party. LPN #4 stated that if the transfer was approved by the responsible party, she would then call the ambulance service. When asked if nurses provided written notification to the RP and resident, documenting the reason for hospital transfer, LPN #4 stated that she only notifies the RP and resident verbally. LPN #4 stated that written notification is not provided by nursing.

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On 6/14/18 at 11:51 a.m., an interview was conducted with OSM (other staff member) #8, the Director of Social Work. OSM #8 stated that she was not involved with hospital transfers.

On 6/14/18 at approximately 5 p.m., ASM (administrative staff member) #1, the administrator was made aware of the above concerns. No further information was presented prior to exit.

(1) Hyperkalemia is elevated levels of potassium that can induce deadly cardiac arrhythmias. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1413606/.

(2) Hemodialysis is a treatment to filter wastes and water from your blood, as your kidneys did when they were healthy. Hemodialysis helps control blood pressure and balance important minerals, such as potassium, sodium, and calcium, in your blood. This information was obtained from The National Institutes of Health. https://www.niddk.nih.gov/health-information/kidney-disease/kidney-failure/hemodialysis.

3. The facility staff failed to evidence that Resident #57's responsible party was provided with written notification of the hospital transfer of 3/17/18.

Resident #57 was admitted to the hospital on 7/9/16 with the diagnoses of but not limited to right hip fracture, manic episodes, osteoporosis, dementia, coronary artery disease, high blood

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pressure, anxiety disorder, atrial fibrillation, and dysphagia. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 5/26/18. The resident was coded as significantly impaired in ability to make daily life decisions.

A review of the clinical record revealed the following nurse's notes dated 3/19/18, 10:56 p.m., "Guest sent to (name of hospital) r/t (related to) an acute intertrochanteric femur fracture rp [sic] notified."

The following physician's note dated 3/26/18 at 11:25 a.m., documented, "85 yo (year old) female was re-adm (readmitted) from (name of hospital) (3/20-3/25) after having a fall resulting in L (left) hip fx (fracture)....Good pain control...."

Further review of the clinical record failed to reveal any evidence that the responsible party was provided with written notification of the transfer.

On 6/14/18 at 10:40 a.m., in an interview with LPN #4 (Licensed Practical Nurse), when asked, if a written notification of the transfer is provided the RP (responsible party) and resident, LPN #4 stated, "No. Just notify by phone."

On 6/14/18 at 11:51 a.m., OSM #8 (Other Staff Member, director of social services) stated that she is not involved with hospital transfers.

On 6/14/18 at approximately 5:00 p.m., the Administrator, ASM (administrative staff member) #1 was made aware of the concerns. No further information was provided.
4. The facility staff failed to provide written

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documentation to the resident and/or resident representative for a facility initiated transfer for Resident #90 on 5/29/18.

Resident #90 was admitted to the facility on 5/9/18 with a recent readmission on 5/29/18 with diagnoses that included but were not limited to: cerebral infarct (area of dead tissue resulting from diminished or stopped blood flow to the tissue area in the brain) (1), high blood pressure, seizures, feeding tube, paralysis on one side, and human immunodeficiency virus (HIV) disease (a virus that causes acquired immunodeficiency syndrome) (2).

The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 5/21/18, coded the resident as having both short and long-term memory difficulties.

The nurse's note dated, 5/29/18 at 4:00 p.m. documented, "Therapy called writer into room and observed guest not verbally responding to them. Guest spoke to me earlier in the day responding appropriately. When writer entered room, guest was not responding to questions, eyes were open, not verbally responding. NP (nurse practitioner) assessed and stated send guest to ER (emergency room). Guest left facility at 12:15 p.m. via ambulance. RP (responsible party) was notified."

Further review of the clinical record failed to reveal any evidence that the resident or the responsible party was provided with written notification of the transfer.

An interview was conducted with LPN (licensed

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practical nurse) #4 on 6/14/18 at 10:40 a.m. When asked if the resident and/or resident representative anything in writing related to the reason the resident is being transferred, LPN #4 stated, "No, we call them and tell them we are sending the guest out."

On 6/14/18 at 11:51 a.m., OSM #8 (Other Staff Member, director of social services) stated that she is not involved with hospital transfers.

The administrator, ASM (administrative staff member) #1 and ASM #2, director of nursing were made aware of the above concern on 6/14/18 at 2:00 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 296.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 276
5. The facility staff failed to provide required written notification to the resident or responsible representative for a facility initiated transfer to the hospital for Resident #43.

Resident #43 was admitted to the facility on 10/23/17 with most recent readmission on 4/9/18, with diagnoses that included but were not limited to: heart failure, pneumonia, diabetes, chronic obstructive pulmonary disease (a chronic lung disease that makes it hard to breath) (1), high blood pressure, anxiety, and severe obesity.

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The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 4/16/18, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating she has severe cognitive impairment for daily decision making.

The "Nurses Note" dated 3/29/18 at 8:25 a.m., documented in part, "Guest was noted with labored breathing, O2 (oxygen) sats (saturation) 65 on 3 liters O2, rescue squad called to send to ER (emergency room), son [name] made aware, [Medical Doctor's name] made aware".

On 6/14/18 at 10:41 a.m., an interview was conducted with LPN (licensed practical nurse) #4, regarding the process when residents are sent out to the hospital. LPN #4 stated that she would call the Resident's responsible representative and EMS (emergency medical services) to transport the Resident. When asked if the resident or responsible representative received anything in writing regarding the transfer to the hospital, LPN #4 stated "No. Calls are made, there is nothing in writing".

On 6/14/18 at 11:51 a.m., OSM #8 (Other Staff Member, director of social services) stated that she is not involved with hospital transfers.

ASM (administrative staff member) #1, the administrator, and ASM #2 (the director of nursing) were made aware of the above findings on 6/14/18 at 3:00 p.m.

No further information was obtained prior to exit.

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(1) This information was obtained from the following website: https://medlineplus.gov/ency/article/000091.htm

6. The facility staff failed to provide required written notification to the resident or responsible representative for a facility initiated transfer to the hospital for Resident #95.

Resident #95 was admitted to the facility on 6/29/16 with recent readmission on 3/20/18, with diagnoses that included but were not limited to: Parkinson's disease (a progressive movement disorder often accompanied by shaking or tremors) (1), high blood pressure, cancer of the bone and prostate, and difficulty swallowing.
.
The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 5/18/18, coded the resident as scoring a "7" on the BIMS (brief interview for mental status) score, indicating he has severe cognitive impairment of daily decision making.

A nursing note, dated 3/16/18 at 1:32 p.m., documented in part, "Guest is very lethargic and hard to arouse, guest doesn't want to eat or get out of bed, md (medical doctor) assessed and stated send out, md and nurse attempted to all rp (responsible party) [name] no answer voicemail left, guest is going to [name] ER (emergency room)."

On 6/14/18 at 10:41 a.m., an interview was conducted with LPN (licensed practical nurse) #4, regarding the process when residents are sent out to the hospital. LPN #4 stated that she would

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call the Resident's responsible representative and EMS (emergency medical services) to transport the Resident. When asked if the resident or responsible representative received anything in writing regarding the transfer to the hospital, LPN #4 stated "No. Calls are made, there is nothing in writing".

On 6/14/18 at 11:51 a.m., OSM #8 (Other Staff Member, director of social services) stated that she is not involved with hospital transfers.

ASM (administrative staff member) #1, the administrator, and ASM #2 (the director of nursing) were made aware of the above findings on 6/14/18 at 3:00 p.m.

No further information was obtained prior to exit.

(1) This information was obtained from the following website: https://medlineplus.gov/parkinsonsdisease.html

7. The facility staff failed to provide required written notification to the resident or responsible representative for a facility initiated transfer to the hospital for Resident #117.

Resident #117 was admitted to the facility on 6/22/16 with recent readmission on 5/9/18, with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (a chronic lung disease that makes it hard to breath) (1), a stroke with right sided paralysis, dementia, high blood pressure, and a gastrostomy tube (a tube that is inserted through the wall of the abdomen directly into the stomach in order to give drugs,

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liquids and liquid food to a patient) (2).
.
The most recent MDS (minimum data set) assessment, a 14 day Medicare assessment, with an assessment reference date of 5/23/18, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating he has severe cognitive impairment of daily decision making.

A nursing note, dated 5/5/18 at 10:51 p.m., documented in part, "Guest in bed, head elevated with feeding via peg (percutaneous endoscopic tube or gastrostomy tube) in progress [sic] noted to be foaming through the mouth; guest noted to be diaphorisis [sic], vs (vital signs) was [sic] taken ...called 911 ...RP (responsible party) made aware ...MD (medical doctor) on call made aware".

On 6/14/18 at 10:41 a.m., an interview was conducted with LPN (licensed practical nurse) #4, regarding the process when residents are sent out to the hospital. LPN #4 stated that she would call the Resident's responsible representative and EMS (emergency medical services) to transport the Resident. When asked if the resident or responsible representative received anything in writing regarding the transfer to the hospital, LPN #4 stated "No. Calls are made, there is nothing in writing".

On 6/14/18 at 11:51 a.m., OSM #8 (Other Staff Member, director of social services) stated that she is not involved with hospital transfers.

ASM (administrative staff member) #1, the administrator, and ASM #2 (the director of

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nursing) were made aware of the above findings on 6/14/18 at 3:00 p.m.

No further information was obtained prior to exit.

(1) This information was obtained from the following website: https://medlineplus.gov/ency/article/000091.htm

(2) This information was obtained from the following website: https://www.cancer.gov/publications/dictionaries/cancer-terms/def/gastrostomy-tube

8. The facility staff failed to provide written notification to the resident and responsible party (RP) and of a facility initiated transfer to the hospital on 03/30/18 and 04/06/18 for Resident # 42.

Resident # 42 was admitted to the facility on 04/23/13 with a readmission of 04/08/18 with diagnoses that included but were not limited to convulsions (1), gastroesophageal reflux disease (2), hydrocephalus (3), hypertension (4) and depression (5).

Resident # 42's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 04/14/18, coded Resident # 42 as scoring a 7 (seven) on the brief interview for mental status (BIMS) of a score of 0 - 15, 7 (seven) - being severely impaired of cognition for making daily decisions. Resident # 42 was coded as requiring extensive assistance of one staff member for activities of daily living.

The nurse's "Progress Notes," dated 03/30/2018. 11:15 (a.m.) for Resident # 42 documented, "At

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11:15 a.m. Guest was in the shower room with two shower aides and they were transferring her from the sit to stand lift, to the shower chair and guest hands slipped off of machine and she fell in the shower. Guest c/o (complaint of) left leg pain and the leg was red and painful when touched. A pillow was placed under her head for comfort and she was not moved from floor until paramedics came. Emergency ambulance were called to come take guest to the hospital. Guest was transported to (Name of Hospital) at 11:30 a.m. RP (responsible party) notified, MD (medical doctor) notified, DON (director of nursing) notified."

The nurse's "Progress Notes," dated 03/31/2018. 01:58 (1:58 p.m.) for Resident # 42 documented, "Guest returned from hospital at 6:15 p.m. She has a non-displaced tib/fib (tibia/fibula) fracture and needs to be non-weight bearing for the next 6 (six) weeks. No complaints of pain."

The nurse's "Progress Notes," dated 04/06/2018. 21:00 (9:00 p.m.) for Resident # 42 documented, "Call placed to on call MD (medical doctor) around 6:25 p.m. awaiting call back. MD on call returned my call. She was made aware of the x-ray results for right hip and femur. New order to send out for further evaluation. MD also aware of guest going to the hospital on 3/31/18 for pain. NP (nurse practitioner had been following her. RP (responsible party, Name of Responsible Party) made aware around 6:53 p.m. of the x-ray and the doctor's order to send her to the hospital for evaluations. RP stated that was fine. (Name of Ambulance Service) called awaiting pickup around 7:34 p.m. Guest left the facility around 8:51 p.m.. Bed hold policy and DNR (do not resuscitate) was sent along. Skin assessment

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completed to observe bruising and redness to left lower leg with plus 3 (three) edema. Splint in place to LLE (left lower extremity."

The nurse's "Progress Notes," dated 04/08/2018 10:59 (a.m.) for Resident # 42 documented, "Received report from (Name of Hospital) that guest will be returning to facility before noon. Guest is returning with right femur fracture and left tib/fib fracture, guest has a current UTI (urinary tract infection) and placed of [sic] antibiotics. Guest shall keep immobilizer on left leg and use therapy to heal right femur fracture. Guest remains a DNR (no not resuscitate), guest has no other issues, md (medical doctor) is aware, don (director of nursing), admin (administrator) and rp (responsible party) aware."

Review of Resident # 42's clinical record failed to evidence written notification to Resident # 42 and Resident # 42's responsible party.

On 06/14/18 at 10:40 a.m., an interview was conducted with LPN (licensed practical nurse) # 4. When asked if the give the responsible party and/or the resident written notification of the transfer, LPN # 4 stated, "No."

Review of Resident # 42's clinical record failed to evidence written notification to Resident # 42 and Resident # 42's responsible party.

On 6/14/18 at 11:51 a.m., OSM #8 (Other Staff Member, director of social services) stated that she is not involved with hospital transfers.

On 06/14/18 at approximately 6:15 p.m., ASM (administrative staff member) # 1, administrator,

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ASM # 2, director of nursing, and ASM # 5, clinical resource specialist, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: https://medlineplus.gov/ency/article/003200.htm.

(2) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(3) A buildup of fluid inside the skull that leads to brain swelling. This information was obtained from the website: https://medlineplus.gov/ency/article/001571.htm.

(4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(5) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

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9. The facility staff failed to provide written notification to the resident and responsible party (RP) and of a facility initiated transfer to the hospital on 06/04/18 for Resident # 60.

Resident # 60 was admitted on 04/06/17 and a readmission on 06/07/18 with diagnoses that included but were not limited to anemia (1) fractured right femur (2), diabetes mellitus (3), hypertension (4) and depressive disorder (5).

Resident # 60's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/27/18 coded Resident # 60 as scoring a 9 (nine) on the brief interview for mental status (BIMS) of a score of 0 (zero) - 15, 9 (nine) being moderately impaired of cognition for making daily decisions.

The nurse's "Progress Notes," dated 06/04/2018 01:00 (1:00 a.m.) for Resident # 60 documented, "12:50 a.m. resident sent out to (Name of Hospital) for s/s (signs and symptoms) of aspiration. Writer administered PRN (as needed) Zofran (6) for c/o (complaint of) nausea. Guest spit out med (medication) then vomited. Then guest showed s/s of dyspnea (7)."

Review of Resident # 60's clinical record failed to evidence written notification to Resident # 60 and Resident # 60's responsible party.

On 06/14/18 at 10:40 a.m., an interview was conducted with LPN (licensed practical nurse) # 4. When asked if the give the responsible party and/or the resident written notification of the transfer, LPN # 4 stated, "No."

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On 6/14/18 at 11:51 a.m., OSM #8 (Other Staff Member, director of social services) stated that she is not involved with hospital transfers.

On 06/14/18 at approximately 6:15 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, and ASM # 5, clinical resource specialist, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) Low iron. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/anemia.html
.

(2) You had a fracture (break) in the femur in your leg. It is also called the thigh bone. You may have needed surgery to repair the bone. You may have had surgery called an open reduction internal fixation. In this surgery, your surgeon will make a cut to open your fracture. This information was obtained from the website:
https://medlineplus.gov/ency/patientinstructions/000166.htm.

(3) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(4) High blood pressure. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/highbloodpr

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essure.html.

(5) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(6) Ondansetron is used to prevent nausea and vomiting caused by cancer chemotherapy, radiation therapy, and surgery. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601209.html.

(7) When you're short of breath, it's hard or uncomfortable for you to take in the oxygen your body needs. You may feel as if you're not getting enough air. Sometimes you can have mild breathing problems because of a stuffy nose or intense exercise. But shortness of breath can also be a sign of a serious disease. This information was obtained from the website: https://medlineplus.gov/breathingproblems.html.

10. The facility staff failed to provide written notification to the resident and responsible party (RP) and of a facility initiated transfer to the hospital on 03/03/18 and 03/19/18 for Resident # 28.

Resident # 28 was admitted on 05/19/17 and a readmission on 03/23/18 with diagnoses that included but were not limited to cerebral infarction (1) sepsis (2) and schizophrenia (3).

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Resident # 28's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 03/30/18 coded Resident # 28 as scoring a 0 (zero) on the brief interview for mental status (BIMS) of a score of 0 (zero) - 15, 0 (zero) being severely impaired of cognition for making daily decisions.

The nurse's "Progress Notes," dated 03/03/20 15:54 (3:54 p.m.) for Resident # 28 documented, "Guest noted with s/s (signs and symptoms) of distress, labored breathing, rsp (respiration) 28, temp (temperature) of 102, bp (blood pressure) 106/70, pulse 134, O2 (oxygen) 90%, on 3l (three liters) of O2 via (by) nasal cannula, diaphoretic skin. Guest was given neb (nebulizer) treatment and Tylenol given. Md (medical doctor) notified ordered to send guest to hospital (Name of First Hospital). Ambulance service sent guest to (Name of Second Hospital) which was the closest for guest condition, refused to transport to (Name of First Hospital) r/t (related to) distress. RP (responsibility party) was called an [sic] no answer, left message to call facility back, bed hold policy sent with guest."

The nurse's "Progress Notes," dated 03/19/2018, 16:19 (4:19 p.m.) for Resident # 28 documented, "Guest sent out via (by) 911 at 3:05 p.m. MD (medical doctor) notified, RP (responsible party) notified."

The nurse's "Progress Notes," dated 03/24/20 01:17 (1:17 a.m.) for Resident # 28 documented in part, "Guest returned from hospital this evening."

Review of Resident # 28's clinical record failed to

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evidence written notification to Resident # 28 and Resident # 28's responsible party.

On 06/14/18 at 10:40 a.m., an interview was conducted with LPN (licensed practical nurse) # 4. When asked if the give the responsible party and/or the resident written notification of the transfer, LPN # 4 stated, "No."

On 6/14/18 at 11:51 a.m., OSM #8 (Other Staff Member, director of social services) stated that she is not involved with hospital transfers.

On 06/14/18 at approximately 6:15 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, and ASM # 5, clinical resource specialist, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website:
https://medlineplus.gov/ency/article/000726.htm .

(2) Sepsis is an illness in which the body has a severe, inflammatory response to bacteria or other germs. The symptoms of sepsis are not caused by the germs themselves. Instead, chemicals the body releases cause the response. This information was obtained from the website:
https://medlineplus.gov/ency/article/000666.htm.

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F 623	Continued From page 90 (3) A mental disorder that makes it hard to tell the difference between what is real and not real. This information was obtained from the website: https://medlineplus.gov/ency/article/000928.htm. scoliosis (a sideways curve of your backbone, or spine.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/scoliosis.html.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the	F 625		7/27/18

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F 625	Continued From page 91 resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide the written bed hold notification for a facility-initiated transfer for four of 50 residents in the survey sample, Resident #15, #114, #95, #117. 1. The facility staff failed to provide written documentation of bed hold to the Resident/Responsible Representative upon transfer to hospital for Resident #15 on 2/27/18. 2. The facility staff failed to provide written documentation of bed hold to the Resident/Responsible Representative upon transfer to hospital for Resident #114 on 1/24/18. 3. The facility staff failed to provide the written bed hold information to a resident or responsible representative upon a facility initiated transfer to the hospital for Resident #95. 4. The facility staff failed to provide the written bed hold information to a resident or responsible representative upon a facility initiated transfer to the hospital for Resident #95. 5. Facility staff failed to provide the written bed hold information to a resident or responsible representative upon a facility initiated transfer to the hospital for Resident #117. The finding include:	F 625	Ftag 625 Resident #15: Has returned to the facility. No negative outcome has occurred from this practice. Resident #95: Has returned to the facility. No negative outcome has occurred from this practice. Resident #114: Has returned to the facility. No negative outcome has occurred from this practice. Resident #117: Has returned to the facility. No negative outcome has occurred from this practice. All residents have the potential to be affected The facility has created a written notice to be used for hospital transfers. The notice includes information about bed hold. The DON or designee will educate licensed nursing staff on completing the notice and sending it with the resident. Medical Records or designee will be educated on the process of mailing the written notice, including bed hold to the resident representative as appropriate. The DON or designee will audit the last 14 days of hospital transfers for bed hold	

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F 625	Continued From page 92 1. Resident #15 was admitted to the facility on 6/22/15 and readmitted on 3/3/18 with diagnoses that included but were not limited to COPD (chronic obstructive pulmonary disease), osteoporosis, muscle weakness and cognitive communication deficit. Resident #15's most recent MDS (minimum data set) assessment was a 14 day scheduled assessment with an ARD (assessment reference date) of 3/17/18. Resident #15 was coded as being severely impaired in cognitive function scoring 03 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #15's clinical record revealed that she had been transferred to the hospital on 2/27/18. The following nursing note was documented: "guest sent to (Name of hospital), due to abnormal mood and behavior, vs (vital signs) were stable, guest has shown no interest in eating or doing normal activities (going out of room) etc. md (medical doctor) notified, rp (responsible party) (name of RP) notified as well." The following nurse practitioner note was documented on 2/27/18: "...f/u (follow up) on her productive cough and feeling fatigued x 5 days now. She reports that her nausea and vomiting has resolved. Patient reports not feeling well. She is in bed again today. She denies CP (chest pain), shortness of breath, or edema. Advised her nurse to send patient to ER (emergency room) for evaluation and treatment as all labs are negative." Further review of the clinical record revealed Resident #15 was admitted back to the facility on 3/5/18 with diagnoses of encephalopathy (1)	F 625	policy documentation. Nursing administration will monitor hospital transfers five times a week for four weeks for appropriate documentation and evidence that bed hold has been given and reviewed. Checking hospital transfers will remain a process of the clinical meeting. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee. Continued compliance will be monitored through the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: July 27, 2018	

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related to acute kidney failure (2) and an L3 osteoporotic compression fracture (3).

There was no evidence of written documentation the bed hold policy was provided the Resident/Responsible Representative upon transfer to the hospital on 2/27/18.

On 6/14/18 at 10:42 a.m., an interview was conducted with LPN (licensed practical nurse) #4. When asked if written documentation of the bed hold policy was offered to the resident and the responsible party at the time of transfer, LPN #4 stated that the bed hold policy was sent with the resident at the time of transfer. LPN #4 stated that the transfer forms that were sent with each resident during a hospital transfer also had a place to check that the bed hold policy was provided to the resident. LPN #4 stated that a carbon copy of the transfer form should be located in the resident's clinical record.

The transfer form and any evidence of written bed hold notification for Resident #15 was requested from administration on 6/14/18. This information could not be provided.

On 6/14/18 at approximately 5 p.m., ASM (administrative staff member) #1, the administrator was made aware of the above concerns.

The facility policy titled," Bed Hold and Return to Facility," documents in part, the following: "The Facility will provide written information to the guest or guests representative of this bed hold policy upon leaving for hospitalization or therapeutic leave. 1. Should a guest wish to return to the facility and hold a bed after a

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hospitalization, the guest personally pays for the room charge for the days while he/she is away. 2. Bed hold are prepaid at the beginning of the bed hold stay. These arrangements should be made with the facility business office. 3. Medicare does not pay for the bed during a hospitalization..."

No further information was presented prior to exit.

(1) Encephalopathy is a term for any diffuse disease of the brain that alters brain function or structure. Encephalopathy may be caused by infectious agent (bacteria, virus, or prion), metabolic or mitochondrial dysfunction, brain tumor or increased pressure in the skull, prolonged exposure to toxic elements (including solvents, drugs, radiation, paints, industrial chemicals, and certain metals), chronic progressive trauma, poor nutrition, or lack of oxygen or blood flow to the brain. The hallmark of encephalopathy is an altered mental state." This information was obtained from The National Institutes of Health. https://www.ninds.nih.gov/Disorders/All-Disorders/Encephalopathy-Information-Page.

(2) Acute Kidney Failure is a potentially reversible reduction in the capacity of the kidney to excrete nitrogenous wastes and maintain fluid and electrolyte homoeostasis, which usually occurs over hours to days. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2596697/.

(3) L3 osteoporotic compression fracture-fracture of the vertebrae related to osteoporosis. Vertebral compression fractures are a prevalent disease affecting osteoporotic patients. The risk

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of developing a vertebral fracture is strongly associated with decreasing bone density. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3693826/.

2. The facility staff failed to provide written documentation of bed hold to the Resident/Responsible Representative upon transfer to hospital for Resident #114 on 1/24/18.

Resident #114 was admitted to the facility on 12/18/17 and readmitted on 3/6/18 with diagnoses that included but were not limited to peripheral vascular disease, muscle weakness, schizophrenia, and end stage renal disease. Resident #114's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 5/22/18. Resident #114 was coded as being intact in cognitive function scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status exam.

Review of Resident #114's clinical record revealed that she had been sent out to the hospital on 1/24/18 due to altered mental status. The physician documented the following note on 1/31/18: "Pt (patient) was readmitted from (Name of hospital) (1/24-1/30) due to AMS (altered mental status) due to severe hyperkalemia (1) due to missed HD (hemodialysis) (2)...

Further review of the clinical record revealed that Resident #114 often refused dialysis appointments.

There was no evidence of written documentation

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of a bed hold policy to the Resident/Responsible Representative upon transfer to the hospital on 1/24/18.

On 6/14/18 at 10:42 a.m., an interview was conducted with LPN (licensed practical nurse) #4. When asked if written documentation of the bed hold policy was offered to the resident and the responsible party at the time of transfer, LPN #4 stated that the bed hold policy was sent with the resident at the time of transfer. LPN #4 stated that the transfer forms that were sent with each resident during a hospital transfer also had a place to check that the bed hold policy was provided to the resident. LPN #4 stated that a carbon copy of the transfer form should be located in the resident's clinical record.

On 6/14/18 at approximately 3:00 p.m., an interview was conducted with Resident #114. Resident #114 could not remember if she was provided the bed hold policy at the time of her 1/24/18 transfer.

The transfer form and any evidence of written bed hold notification for Resident #114 was requested from administration on 6/14/18. This information could not be provided.

On 6/14/18 at approximately 5 p.m., ASM (administrative staff member) #1, the administrator was made aware of the above concerns. No further information was presented prior to exit

(1) Hyperkalemia is elevated levels of potassium that can induce deadly cardiac arrhythmias. This information was obtained from The National

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Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1413606/.

(2) Hemodialysis is a treatment to filter wastes and water from your blood, as your kidneys did when they were healthy. Hemodialysis helps control blood pressure and balance important minerals, such as potassium, sodium, and calcium, in your blood. This information was obtained from The National Institutes of Health. https://www.niddk.nih.gov/health-information/kidney-disease/kidney-failure/hemodialysis.

3. The facility staff failed to provide the written bed hold information to a resident or responsible representative upon a facility initiated transfer to the hospital for Resident #95.

Resident #57 was admitted to the hospital on 7/9/16 with the diagnoses of but not limited to right hip fracture, manic episodes, osteoporosis, dementia, coronary artery disease, high blood pressure, anxiety disorder, atrial fibrillation, and dysphagia. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 5/26/18. The resident was significantly impaired in ability to make daily life decisions.

A review of the clinical record revealed the following nurse's notes dated 3/19/18, 7:24 p.m., "writer [sic] was notified by aide that guest was found on the floor. Guest was noted left sidelying [sic] at the foot of the bed a [sic] wheelchair next to bed. Guest was last seen by aide lying in bed. Guest screaming in pain to her left hip. no [sic] open or bruised area noted. guest [sic]

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medicated for pain, with positive effect Guest [sic] stated "she fell out of bed" md/rp [sic] (medical doctor/responsible party) notified. ordered [sic] STAT (immediately) xray to pelvis and left hip. awaiting [sic] results. guest [sic] denies abuse or mistreatment." 10:56 p.m., "Guest sent to (name of hospital) r/t (related to) an acute intertrochanteric femur fracture rp [sic] notified."

There was no evidence of written documentation of a bed hold policy to the Resident/Responsible Representative upon transfer to the hospital on 3/19/18.

On 6/14/18 at 10:42 a.m., an interview was conducted with LPN (licensed practical nurse) #4. When asked if written documentation of the bed hold policy was offered to the resident and the responsible party at the time of transfer, LPN #4 stated that the bed hold policy was sent with the resident at the time of transfer. LPN #4 stated that the transfer forms that were sent with each resident during a hospital transfer also had a place to check that the bed hold policy was provided to the resident. LPN #4 stated that a carbon copy of the transfer form should be located in the resident's clinical record.

On 6/14/18 at 2:03 p.m., a list of documenters needed from Resident #57's clinical record was provided to the facility. This list included a request for the transfer form that was completed on 3/19/18 when the resident went to the hospital, as it included a spot for documenting the bed hold was sent.

On 6/14/18 at 3:39 p.m., ASM #5 (Administrative Staff Member - Clinical Resource Specialist)

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stated the completed transfer form for Resident #57 for the hospital transfer of 3/19/18 could not be located, and therefore the facility could not evidence that the written bed hold policy was provided, as it was also not in a nurse's note either.

On 6/14/18 at approximately 5:00 PM, the Administrator was made aware of the concerns. No further information was provided.

4. The facility staff failed to provide the written bed hold information to a resident or responsible representative upon a facility initiated transfer to the hospital for Resident #117.

Resident #117 was admitted to the facility on 6/22/16 with recent readmission on 5/9/18, with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (a chronic lung disease that makes it hard to breath) (1), a stroke with right sided paralysis, dementia, high blood pressure, and a gastrostomy tube (a tube that is inserted through the wall of the abdomen directly into the stomach in order to give drugs, liquids and liquid food to a patient) (2).

The most recent MDS (minimum data set) assessment, a 14 day Medicare assessment, with an assessment reference date of 5/23/18, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating he has severe cognitive impairment of daily decision making.

A nursing note, dated 5/5/18 at 10:51 p.m., documented in part, "Guest in bed, head elevated with feeding via peg (percutaneous endoscopic tube or gastrostomy tube (3)) in progress [sic]

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noted to be foaming through the mouth; guest noted to be diaphorisis [sic], vs (vital signs) was [sic] taken ...called 911 ...RP (responsible party) made aware ...MD (medical doctor) on call made aware".

On 6/14/18 at 10:41 a.m., an interview was conducted with LPN (licensed practical nurse) #4. When asked how the resident or responsible representative are made aware of the bed hold policy upon transfer to the hospital, LPN #117 stated that it is documented on the transfer form.

A blank copy of the facility's transfer form titled "Inter-facility Continuity of Care Report was provided. The form does provide an area to document that the "Bed Hold Letter was sent".

A review of Resident #117's medical record failed to provide evidence of this transfer form.

ASM (administrative staff member) #1, the administrator, and ASM #2 (the director of nursing) were made aware of the above findings on 6/14/18 at 3:00 p.m.

No further information was obtained prior to exit.

(1) This information was obtained from the following website:
https://medlineplus.gov/ency/article/000091.htm

(2) This information was obtained from the following website:
https://www.cancer.gov/publications/dictionaries/cancer-terms/def/gastrostomy-tube

(3) This information was obtained from the website:

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F 625	Continued From page 101 https://medlineplus.gov/ency/article/002937.htm	F 625		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:	F 655		7/27/18

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F 655	Continued From page 102 (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that facility staff failed to develop a baseline care plan for three of 50 residents in the survey sample, Resident #336, #85 and #96. 1. The facility staff failed to develop a baseline care plan to address Resident # 336's dialysis. 2. The facility staff failed to evidence that a baseline care plan was developed within 48 hours of admission, Resident #85 was originally admitted on 5/1/18, and that the resident or resident representative was provided with a summary of the baseline care plan goals. 3. The facility staff failed to evidence that a baseline care plan was developed within 48 hours of admission, Resident #96 was originally admitted on 1/5/18, and that the resident or resident representative was provided with a summary of the baseline care plan goals. The findings include: 1. The facility staff failed to develop a baseline care plan to address Resident # 336's dialysis. Resident # 336 was admitted to the facility on	F 655	Ftag 655 Resident # 336: The care plan has been updated to reflect dialysis and a copy given to the resident. No negative outcome occurred from this practice. Resident #85: A copy of the care plan has been given to the resident. No negative outcome occurred from this practice. Resident # 96: The care plan has been updated and a copy given to the resident. No negative outcome occurred from this practice. All residents have the potential to be affected. DON or designee will educate licensed nursing staff on ensuring that dialysis is reflected in the baseline care plan upon admission. NHA or designee will educate the administrative team on the process of providing a copy of the baseline care plan to the resident for new admissions and readmissions.	

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F 655	Continued From page 103 06/06/18 with diagnoses that included but were not limited to: end stage renal disease (1), diabetes mellitus (2), depressive disorder (3), gastroesophageal reflux disease (4), and hypertension (5). Resident # 336's admission MDS (minimum data set) assessment was not due at the time of the survey. The "Admission Assessment" for Resident # 336 dated 06/07/18 documented she was oriented to person, place and time. Under the heading "Genitourinary" it documented, "5. Dialysis: Hemodialysis." The POS (physician's order sheet) dated June 2018 for Resident # 336 documented, "Hemodialysis Monday, Wednesday, Friday @ (at) (name of Dialysis Center). Order Date: 06/06/2018." Review of the facility's "Baseline Care Plan" dated 06/06/18 for Resident # 336 failed to evidence documentation of Resident # 336's dialysis. On 06/15/18 at 8:40 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked to describe the process to develop a baseline care plan ASM # 2 stated, "The baseline care plan is developed according to the resident's history and physical, and discharge instructions from the hospital, physician's orders and any observations or changes prior to the comprehensive care plan. After reviewing the baseline care plan dated 06/06/18 for Resident # 336 ASM # 2 stated, "The care plan was not checked for Resident # 336's dialysis." The facility's policy "Interdisciplinary Care Plan"	F 655	The DON or designee will audit the last 30 days of admissions to 1. Ensure dialysis is reflected on the care plan for residents receiving these services and 2. Ensure that a copy of the baseline care plan has been given to the resident or the resident representative. The DON or designee will conduct a review 5 times a week for 4 weeks of new admissions and baseline care plans. A tracking log will be developed for continued monitoring of completion. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee. Continued compliance will be monitored though the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: July 27, 2018	

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documented, "5. The preliminary care plan is developed upon the guest's admission. The preliminary care plan is used only until the comprehensive care plan has been developed."

On 06/14/18 at approximately 6:15 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, and ASM # 5, clinical resource specialist, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/000500.htm.

(2) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(3) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(4) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website:

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https://www.nlm.nih.gov/medlineplus/gerd.html.

(5) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

2. The facility staff failed to evidence that a baseline care plan was developed within 48 hours of admission, Resident #85 was originally admitted on 5/1/18, and that the resident or resident representative, was provided with a summary of the baseline care plan goals.

Resident #85 was admitted to the facility on 5/1/18 (discharged to hospital on 5/5/18) and readmitted on 5/8/18 with the diagnoses of but not limited to emphysema, high blood pressure, neoplasm of the spinal cord, trachea, bronchus and lung, and other sites, history of malignant neoplasm of the breast, alcohol abuse, pneumonia, and paraplegia. The most recent MDS (Minimum Data Sheet) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 5/15/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, and toileting; supervision for hygiene and eating; and as incontinent of bowel and bladder.

A review of the clinical record revealed a baseline care plan dated for the 5/8/18 readmission. There was no evidence a baseline care plan was developed for the initial admission of 5/1/18.

On 6/13/18 at approximately 3:00 p.m., in an interview with OSM #7 (Other Staff Member, the

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social worker) she stated that the baseline care plan is provided at a "72 hour meeting" conducted with the facility and resident / resident representative. When asked about evidence that the baseline care plan was provided to the resident or resident representative for Resident #85, OSM #7 was not able to locate the evidence, and stated that she would search for other documentation.

On 6/14/18 at 2:03 p.m., a list of documents needed from Resident #85's clinical record was provided to the facility. On this list was included a request for a copy of the baseline care plan for the 5/1/18 admission. It was not provided.

On 6/14/18 05:06 p.m., in an interview with ASM #5 (Administrative Staff Member - the clinical resource specialist), ASM #5 was asked about the baseline care plan for Resident #85. ASM #5 stated that the facility did not have a baseline care plan for the 5/1/18 admission, and did not have evidence of the 72-hour meeting sheet that was supposed to be completed which should have documented that a baseline care plan summary was provided to the resident or resident representative.

On 6/14/18 at 5:08 p.m., the administrator (ASM #1) was notified about the baseline care plan. ASM #1 stated that there wasn't one developed; and that by extension, it also could not be provided to the resident or resident representative.

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

According to "Fundamentals of Nursing Made

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Incredibly Easy" Lippincott Williams and Wilkins, Philadelphia PA page 56: "The first step in the nursing process--assessment--begins when you first see the patient. According to the American Nurses Association guidelines, data should accurately reflect the patient's life experiences, and his patterns of living...during the assessment you collect relevant information from various sources and analyze it to form a complete picture of your patient...it guides you through the rest of the nursing process, helping you formulate nursing diagnoses, expected outcomes, and nursing interventions. It serves as a vital communication tool for other team members- as a baseline for evaluating a patient's progress and for use as legal documentation...the initial assessment helps you determine what care the patient needs and sets the stage for further assessments...the history of the patient as well as medical problems are of great importance..." and on page 65, "A written care plan serves as a communication tool among health care team members that helps ensure the continuity of care...the care plan is developed on admission and includes the most significant problems and is reviewed and revised as necessary..."

3. The facility staff failed to evidence that a baseline care plan was developed within 48 hours of admission, Resident #96 was originally admitted on 1/5/18, and that the resident or resident representative was provided with a summary of the baseline care plan goals.

Resident #96 was admitted to the facility on 1/5/18 with the diagnoses of but not limited to left leg amputation, chronic kidney disease,

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congestive heart failure, diabetes, high cholesterol, stroke, obstructive uropathy, benign prostatic hyperplasia, heart attack, and Fournier Gangrene {1} (a type of gangrene specific to the genitals, usually of men). The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 5/9/18. The resident was cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive care for transfers, dressing, toileting and hygiene; supervision for eating; and as incontinent of bowel and as having an indwelling catheter for bladder.

A review of the clinical record revealed Resident #96 was admitted on 1/5/18, discharged to the hospital on 3/9/18 and readmitted on 3/13/18. Further review revealed a baseline care plan that was developed upon the resident's 3/13/18 readmission after the brief hospitalization. However, there was no evidence a baseline care plan was developed within 48 hours of the initial admission on 1/5/18.

On 6/13/18 at approximately 3:00 p.m., in an interview with OSM #7 (Other Staff Member, the social worker) she stated that the baseline care plan is provided at a "72 hour meeting" conducted with the facility and resident / resident representative. When asked about evidence that the baseline care plan was provided to the resident or resident representative for Resident #96, OSM #7 was not able to locate the evidence, and stated that she would search for other documentation.

On 6/14/18 at 2:03 p.m., a list of documents needed from Resident #96's clinical record was

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provided to the facility. On this list was included a request for a copy of the baseline care plan for the 1/5/18 admission. It was not provided.

On 6/14/18 05:06 p.m., in an interview with ASM #5 (Administrative Staff Member - the clinical resource specialist), ASM #5 was asked about the baseline care plan for Resident #96. ASM #5 stated that the facility did not have a baseline care plan for the 5/1/18 admission, and did not have evidence of the 72-hour meeting sheet that was supposed to be completed which should have documented that a baseline care plan summary was provided to the resident or resident representative.

On 6/14/18 at 5:08 p.m., the administrator (ASM #1) was notified about the baseline care plan. ASM #1 stated that there wasn't one developed; and that by extension, it also could not be provided to the resident or resident representative.

A review of the facility policy, "Admission Baseline Care Plan" documented, "The facility will initiate a baseline care plan within 24 hours of admission and complete it within 48 hours of admission....Procedure: 3. The care plan will be summarized with the guest and/or responsible party at the 72-hour guest / family conference."

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

{1} Information obtained from https://www.mayoclinic.org/diseases-conditions/gangrene/symptoms-causes/syc-20352567?p=1

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F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		7/27/18

§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate

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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 656	Continued From page 111 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to develop and implement the comprehensive care plan for nine of 50 residents in the survey sample, Residents #106, #83, #238, #24, #43, #99, #117, #121, and #60. 1. The facility staff failed to implement Resident #106's care plan for wound treatment on multiple dates in May 2018 and June 2018. 2. The facility staff failed to implement Resident #83's comprehensive care plan for the administration of oxygen 3. The facility staff failed to develop a comprehensive care plan to address Resident #238's risk for elopement. 4. The facility staff failed to implement Resident #24's comprehensive care plan for fall prevention. Resident #24 was observed in bed without a fall mat on the floor as ordered by the physician and per the comprehensive care plan. 5.a. The facility staff failed to implement Resident #43's comprehensive care plan for the administration of oxygen. 5b. For Resident #43, the facility staff failed to follow the comprehensive care plan for diabetic	F 656	Ftag 656 Resident#106: No negative outcome resulted from this practice. Resident is currently receiving appropriate wound care treatment. Resident # 83: Oxygen was corrected to the ordered setting. No negative outcome resulted from this practice. Resident #238: The care plan was reviewed and updated. No negative outcome resulted from this practice. Resident # 24: Fall mat was put in place while the resident was in bed. No negative outcome resulted from this practice. Resident #43: Oxygen was corrected to the ordered setting. Guest was placed on the podiatrists list for toenail services. No negative outcome resulted from these practices. Resident # 99: Resident no longer resides at the facility Resident#117: Oxygen was corrected to the ordered setting. No negative outcome resulted from this practice.	

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F 656	Continued From page 112 foot care. 6. The facility staff failed to follow Resident #99's comprehensive care plan for the administration of oxygen. 7. The facility staff failed to follow Resident #117's comprehensive care plan for the administration of oxygen. 8. The facility staff failed to implement Resident # 121's comprehensive care plan for pain. 9. The facility staff failed to implement Resident # 60's comprehensive care plan for blood sugar monitoring. The findings include: 1. The facility staff failed to implement Resident #106's care plan for wound treatment on multiple dates in May 2018 and June 2018. Resident #106 was admitted to the facility on 4/23/18. Resident #106's diagnoses included but were not limited to congestive heart failure, chronic kidney disease and urinary tract infection. Resident #106's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/20/18, coded the resident as being cognitively intact. Section M coded Resident #106 as having a stage I pressure injury (2). Review of Resident #106's clinical record revealed a Braden scale for predicting pressure sore (injury) risk dated 4/23/18 that documented the resident's sensory perception was slightly limited, mobility was slightly limited, nutrition was	F 656	Resident # 121: No negative outcome resulted from this practice. Resident #60: Blood sugar parameters have been reviewed by the physician. No negative outcome resulted from this practice. All residents have the potential to be affected DON or designee will educate licensed nursing staff on following the care plan and interventions, accurate documentation on wound care provided, checking oxygen settings with physician□s orders, capturing elopement risk and wanderguards on the care plan, following blood sugar parameters as ordered, and following interventions for non pharmacological approaches for pain. The DON or designee will educate licensed nursing staff on following interventions on resident care plans. This will also include education on ensuring 02 settings match orders as care planned, residents at risk for elopement are care planned, care plans are followed for blood sugar management, and followed for non pharmacological approaches, and that fall interventions on the care plan are being followed. The DON or designee will audit: 1. Current residents on 02 and their settings 2. Current residents with pressure ulcers, treatment records for missing documentation. 3. Current residents with	

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F 656	Continued From page 113 adequate and a potential problem with friction and shear. A wound/skin healing record with an effective date of 4/24/18 documented excoriation on Resident #106's sacrum. A physician's order dated 4/30/18 documented an order for triad hydrophilic wound dressing paste (3) to the sacrum every shift for excoriation. A wound/skin healing record with an effective date of 5/19/18 documented a stage I pressure injury on Resident #106's sacrum. Resident #106's May 2018 and June 2018 TARs (treatment administration records) failed to reveal documented evidence that triad was applied to the resident's sacrum every shift on 5/19/18, 5/20/18, 5/25/18, 5/27/18, 5/30/18, 6/1/18, 6/4/18 and 6/5/18 (as evidenced by blank spaces on the TAR). A wound/skin healing record with an effective date of 6/6/18 documented a stage II pressure injury (4) on Resident #106's sacrum. Resident #106's care plan dated 4/23/18 and revised on 6/8/18 documented, "Actual impaired skin integrity related to skin tear to left 2nd finger, Shearing wounds left posterior (back) heel. stage 2 to sacrum, skin tear to back of right arm...Treatment as ordered..." On 6/13/18 at 3:54 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked the purpose of the care plan. RN #1 stated, "A care plan is to notify staff. It directs the care of the residents so the staff can see what	F 656	wanderguards and their care plans 4. Current insulin dependent residents and their parameters 5. Residents who have fallen in the last 30 days, for interventions care planned and in place. 6. Residents who have triggered for pain on the MDS in the last 30 days, care plan interventions and documented non pharmacological interventions. Nursing administration will: 1. Monitor oxygen settings weekly for four weeks. 2. Monitor treatment records 5 days a week for 4 weeks. 3. Monitor for new orders for wander guard placement 5 days a week for 4 weeks. 4. New insulin orders will be reviewed for parameters and documentation for physician notification will be monitored 5 times a week for 4 weeks. 5. Department managers will conduct room rounds 2 times a week for 4 weeks to ensure fall interventions are in place. 6. New triggers for pain on the MDS- MARs will be reviewed for non pharmacological approaches weekly for four weeks. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee. Continued compliance will be monitored though the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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interventions are there and any kind of care we are giving. RN #1 was asked the facility process for following the care plan. RN #1 stated, "They read the care plan."

On 6/14/18 at 10:02 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked how nurse's evidence treatments are done. LPN #1 stated the treatments are signed off on the TAR. LPN #1 was asked what a blank space on the TAR meant. LPN #1 stated, "You can't prove whether or not it was or wasn't done." LPN #1 was shown Resident #106's May 2018 and June 2018 TARs and asked how she would know if the treatment was done on the dates of the blank spaces. LPN #1 stated, "Unless I saw the nurse do it or unless I did it myself, I don't."

On 6/14/18 at 6:14 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility document titled, "INTERDISCIPLINARY CARE PLAN" documented, "It is the policy of this facility to develop an interdisciplinary care plan for each guest that includes measurable goals and time frames directed toward achieving and maintaining each guest's optimal medical, physical, mental and psychosocial needs."

No further information was presented prior to exit.

(1) "The sacrum is a shield-shaped bony structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis. The sacrum forms the posterior pelvic wall and

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strengthens and stabilizes the pelvis." This information was obtained from the website: https://medlineplus.gov/ency/imagepages/19464.htm

(2) "Pressure Injury:
A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.
Stage 1 Pressure Injury: Non-blanchable erythema of intact skin
Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury." This information was obtained from the website: http://www.npuap.org/national-pressure-ulcer-advisory-panel-npuap-announces-a-change-in-terminology-from-pressure-ulcer-to-pressure-injury-and-updates-the-stages-of-pressure-injury/

(3) Triad hydrophilic wound dressing paste is "zinc-oxide based hydrophilic paste for light-to-moderate levels of wound exudates. Helps maintain an optimal wound healing environment to facilitate natural autolytic debridement." This information was obtained from the website:

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https://www.coloplast.us/triad-hydrophilic-wound-dressing-en-us.aspx#section=product-description_3

(4) "Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).:" This information was obtained from the website: http://www.npuap.org/national-pressure-ulcer-advisory-panel-npuap-announces-a-change-in-terminology-from-pressure-ulcer-to-pressure-injury-and-updates-the-stages-of-pressure-injury/

2. The facility staff failed to implement Resident #83's comprehensive care plan for the administration of oxygen.

Resident #83 was admitted on 5/12/11 and readmitted on 10/19/17 with the diagnoses of but not limited to heart failure, high blood pressure, respiratory failure, Hepatitis C, thyrotoxicosis, pressure ulcer, stroke, anxiety disorder, osteomyelitis, and pneumonia. The most recent MDS (Minimum Data Set) was a quarterly

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assessment with an ARD (Assessment Reference Date) of 5/11/18. The resident was cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for hygiene, toileting, dressing, and transfers; supervision for eating; and as incontinent of bowel and bladder.

A review of the clinical record revealed a physician's order dated 5/8/18 for "O2 (oxygen {1}) 2 liters continuous per nasal cannula every shift for CHF (congestive heart failure) Call Dr (doctor) if pulse ox (oxygen saturation) 89% or below."

Observations were made of Resident #83 on 6/12/18 at 12:53 p.m., 6/12/18 at 4:32 p.m., 6/13/18 at 8:30 a.m., and 6/13/18 at 12:42 p.m.. At each observation, the resident's oxygen concentrator rate was set at 1.5 liters and not the physician ordered 2 liters.

On 6/13/18 at 12:43 p.m., LPN #5 (Licensed Practical Nurse) was asked to look at Resident #83's oxygen concentrator. When asked to verify the level the concentrator was set at, LPN #5 stated "about 1.5 maybe a little more but certainly not at 2" (liters as ordered.)

A review of the care plan for Resident #83 revealed one for "Cardiac: At risk for decreased Cardiac output R/T (related to): HTN (hypertension - high blood pressure), CHF (congestive heart failure) w/ (with) O2 (oxygen) usage, Hx (history) of CVA (cerebral vascular accident - stroke)." This care plan was dated 10/20/17. The interventions included one dated 10/20/17 for "O2 via as ordered."

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On 6/14/18 at 12:38 p.m., in an interview with LPN #4, when asked if the care plan for oxygen was being followed if the ordered rate was for 2 liters but the concentrator was set at 1.5 liters, and the care plan specified to administer oxygen as ordered, she stated, "no, the care plan is not being followed."

A review of the facility policy, "Medication Administration" documented, "All medications and treatments shall be initiated, administered, and/or discontinued in accordance with written physician orders...Procedure: 2. Compare the medication package/container to the guest's Medication Administration Record (MAR) to validate the correct medication, dosage, route, and time of administration...."

A review of the manufacturer's instructions on the oxygen concentrator documented, "To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the knob until the ball rises to the line. Now, center the ball on the L/min (liters per minute) line prescribed."

A review of the facility policy, "Interdisciplinary Care Plan" did not include any direction for the requirement of staff to follow the care plan.

On 6/14/18 at approximately 5:00 p.m., the administrator, ASM (administrative staff member) #1, was made aware of the concerns. No further information was provided.

According to "Fundamentals of Nursing Made Incredibly Easy" Lippincott Williams and Wilkins, Philadelphia PA page 56: "The first step in the nursing process--assessment--begins when you first see the patient. According to the American

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Nurses Association guidelines, data should accurately reflect the patient's life experiences, and his patterns of living...during the assessment you collect relevant information from various sources and analyze it to form a complete picture of your patient...it guides you through the rest of the nursing process, helping you formulate nursing diagnoses, expected outcomes, and nursing interventions. It serves as a vital communication tool for other team members- as a baseline for evaluating a patient's progress and for use as legal documentation...the initial assessment helps you determine what care the patient needs and sets the stage for further assessments...the history of the patient as well as medical problems are of great importance..." and on page 65, "A written care plan serves as a communication tool among health care team members that helps ensure the continuity of care...the care plan is developed on admission and includes the most significant problems and is reviewed and revised as necessary..."

{1} According to Fundamentals of Nursing, Fifth Edition, Lippincott Williams & Wilkins, 2007, page 851, "Because oxygen is a drug, its use requires a prescription. Policies and standing orders often permit the nurse to administer oxygen in emergency situations if the physician is not immediately available to write an order. Although oxygen is generally safe when used properly, certain precautions must be observed. As with all drugs, the potential exists for causing harm with misuse." On page 852, Procedure 36-5, "3. Identify client and proceed with 5 rights of medication administration...Rationale: Oxygen is a drug and administering using the 5 rights avoids potential errors....10. Monitor continuous therapy

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by assessing for pressure areas on the skin and nares every 2 hours and rechecking flow rate every 4 to 8 hours. Rationale: Permit early detection of skin breakdown or inadequate flow rate."

3. The facility staff failed to develop a comprehensive care plan to address Resident #238's risk for elopement.

Resident #238 was admitted to the facility on 5/25/18 with diagnoses that included but were not limited to: Squamous cell cancer of the skin of the scalp, dementia, repeated falls, and a fracture of the humerus (bone in the upper arm).

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 6/1/18 coded the resident as scoring a "4" on the BIMS (brief interview for mental status) score, indicating he was severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one staff member for moving in the bed, transfers, dressing, toilet use, personal hygiene and bathing. The resident was coded as requiring supervision for moving on and off the unit and eating.

The physician order dated, 5/27/18, documented, "Check wander guard bracelet placement every shift."

Review of the comprehensive care plan dated, 6/4/18, failed to evidence documentation of the resident's risk for elopement and needing a wander guard bracelet.

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The "Behavior Data and Analysis" dated, 6/6/18, documented in part, "Behavior 1: pulls wound vac (vacuum) tubing." The "Analysis documented, "Guest has a dx (diagnosis) of dementia without behavioral disturbance. Guest pulls at his wound vac tubing. Guest can be hard to redirect. Guest has a wander guard due be at risk for elopement."

An interview was conducted with RN (registered nurse) #2, on 6/13/18 at 5:05 p.m. When asked if Resident #238 wanders, RN #2 stated, "He does get up and walk around but he's not steady." When asked if a resident is wearing a wander guard because they are at risk for elopement, should that be on the care plan, RN #2 stated, "Yes, it should be." RN #2 was asked to review the care plan for Resident #238. Once reviewed RN #2 stated, "I did not see it care planned."

The administrator, ASM (administrative staff member) #1 and director of nursing, ASM #2, were made aware of the above findings on 6/13/18 at 6:15 p.m.

No further information was provided prior to exit.

4. The facility staff failed to implement Resident #24's comprehensive care plan for fall prevention. Resident #24 was observed in bed without a fall mat on the floor as ordered by the physician and per the comprehensive care plan.

Resident #24 was admitted to the facility on 3/30/18 with diagnoses that included but were not limited to: cancer of the brain, anxiety disorder, history of breast cancer, high blood pressure, paralysis on one side, and encephalopathy (any

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brain disorder or disease) (1).

The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 4/27/18 coded Resident #24 as being rarely understood and rarely understanding others. The resident was coded as having both short and long-term memory difficulties and being severely impaired to make daily cognitive decisions. Resident # 24 was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living.

The comprehensive care plan dated, 3/30/18 documented in part, "Focus: At risk for fall related injury R/T (related to) impaired mobility, psychotropic drug use, history of falls, cognitive deficit, Hx (history of) Craniotomy r/t glioblastoma (surgery related to the brain tumor) (2). The "Interventions" documented in part, "Mat to floor next to bed as ordered."

The physician orders dated, 5/10/18, documented, "Floor mat to side of bed while guest in bed every shift for prevention."

Observation was made of Resident #24 on 6/13/18 at 8:36 a.m., 11:29 a.m. 1:23 p.m., 1:47 p.m. and 2:12 p.m. in bed. The bed was up against the wall on the resident's right side. There was no fall mat down on the resident's left side of the bed. The fall mat was observed folded up at the foot of the bed, leaving against the closet.

An interview was conducted with LPN (licensed practical nurse) #6 on 6/13/18 at 2:26 p.m. When asked the purpose of the care plan, LPN #6 stated, "It's to monitor what the resident's goals

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are. It is a guide to how to care for the resident.

An interview was conducted with LPN #1 on 6/13/18 at 2:52 p.m. When asked the purpose of the care plan, LPN #1 stated, "It's the way to communicate patient specific information throughout the disciplines or to their families." When asked who has access to the care plan, LPN #1 stated, "Now that we are computerized, every discipline has access to the care plan." When asked if the CNAs have access to the care plan, LPN #1 stated, the CNAs do not have access but have a kardex to follow."

The administrator and director of nursing were made aware of the above finding on 6/13/18 at 6:15 p.m.

No further information was obtained prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 192.
(2) This information was obtained from the following website: https://www.cancer.gov/publications/dictionaries/cancer-terms/def/glioblastoma-multiforme

5.a. The facility staff failed to implement Resident #43's comprehensive care plan for the administration of oxygen.

Resident #43 was admitted to the facility on 10/23/17 with a most recent readmission on 4/9/18, with diagnoses that included but were not limited to: heart failure, pneumonia, diabetes, chronic obstructive pulmonary disease (a chronic lung disease that makes it hard to breath) (1),

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high blood pressure, anxiety, and severe obesity.

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 4/16/18, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating she has severe cognitive impairment for daily decision making. The resident was coded as requiring extensive assistance of at least two or more staff members for bed mobility and transfers, and at least one person physical assist for dressing, toileting, eating and personal hygiene.

A review of the comprehensive care plan dated 10/23/17, with a most recent revision on 4/9/18, documented in part, "Need: difficulty breathing". In the Interventions section of this focus it is documented in part, "Administer treatments per physician order ...O2 (oxygen) as ordered".

A review of Resident #43's clinical record documented the physician order stating "oxygen 3 liters/min (minute) via nasal cannula continuously every shift for SOB (shortness of breath)".

Observation on 6/12/18 at 8:35 a.m., 10:30 a.m., and 2:00 p.m. noted Resident # 43 reclining in her bed with oxygen on via nasal cannula (a plastic tube with two prong that are inserted just inside the nose) connected to an oxygen concentrator that was set at between 4.5-5 L/min.

On 6/14/18 at 8:12 a.m., RN (registered nurse) #1 was asked to review MD's oxygen orders for Resident #43. RN #1 confirmed the order documented a rate of 3 L/min. RN #1 was asked

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to assess Resident #43's current flow rate. She confirmed it was at 4.5-5 L/min. She then set the oxygen flowmeter to the ordered rate of 3 L/min. RN (registered nurse) #1 was asked what the purpose of the care plan is. She stated to communicate the individual needs of each resident.

On 6/14/18 at 10:15 a.m., LPN (licensed practical nurse) #1 was asked to describe the purpose of a Resident's care plan. She stated that it communicates each resident's different needs.

ASM (administrative staff member) #1, the administrator and ASM #2, director of nursing, where made aware of the above concerns on 6/14/18 at 3:00 p.m.

No further information was provided prior to exit.

5b. For Resident #43, the facility staff failed to follow the comprehensive care plan for diabetic foot care.

During the initial tour on 6/11/18 at 2:58 p.m., Resident #43 was noted to have long, thickened, and discolored big toenails.

A review of the comprehensive care plan dated 11/3/17, documented in part, "Need: At risk for fluctuation of blood sugars R/T (related to) Diabetes". In the Interventions section of this need was documented in part, "Provide proper foot care prn. Schedule podiatry consult pr[sic: prn or as needed]".

On 6/13/18 at 2:18 p.m., RN (registered nurse) #1 was asked who is responsible for initiating a

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podiatric consult. She stated that the social workers handle those consults.

On 6/13/18 at 2:55 p.m., CNA (certified nursing assistant) #6 was asked to come and confirm condition of Resident #43's toenails. CNA #6 agreed the big toenails were thickened and discolored on both feet, extending approximately 1.5-2 centimeters beyond the toe. CNA #6 stated that Resident #43 was diabetic and that only a podiatrist can provide the nail care.

On 6/13/18 at 3:20 p.m., an interview was conducted with OSM (other staff member) #7, a social worker, who stated when a resident requires podiatric services; their name is added to a list, which is faxed to a podiatrist who visits the facility one to two times a month. When asked if Resident #43 was on this list, OSM #7 stated she believed she had been added but she would check.

On 6/14/18 at 08:10 a.m., OSM #6 stated that Resident #43 was added to the podiatric consult list on 6/13/18 at 4:02 p.m.

ASM (administrative staff member) #1, the administrator and ASM #2, director of nursing, where made aware of the above concerns on 6/14/18 at 3:00 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://medlineplus.gov/ency/article/000091.htm

6. The facility staff failed to follow Resident #99's

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comprehensive care plan for the administration of oxygen.

Resident #99 was admitted to the facility on 5/8/17 with a most recent readmission of 5/29/17 with diagnoses that included but were not limited to: ALS (amyotrophic lateral sclerosis) (a disease of the nerve cells in the brain, brain stem and spinal cord that control voluntary muscle movement) (1), difficulty swallowing, diabetes, high blood pressure, and generalized muscle weakness.

The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 5/15/18, coded the resident as scoring a "9" on the BIMS (brief interview for mental status) score, indicating she has moderate cognitive impairment for daily decision making. The resident was coded as requiring extensive assistance of at one staff member physical assist for bed mobility, transfers, dressing, toileting, eating and personal hygiene. In Section O - Special Treatments, the resident was coded as using oxygen during the look back period.

A review of the comprehensive care plan dated 11/28/17, with a most recent revision on 2/27/18, documented in part, "Need: Potential difficulty breathing". In the Interventions section of this focus it is documented in part, "Administer treatments per physician order".

A review of Resident #99's clinical record documented the physicians order stating "O2 (oxygen) via NC (nasal cannula) (a plastic tube with two prong that are inserted just inside the nose) continuous at 2 LPM (liters/minute) every

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shift for low O2 saturation".

Observation on 6/12/18 at 8:32 a.m., 10:45 a.m., and 2:14 p.m., noted Resident #99 was reclining in her bed with oxygen on via nasal cannula connected to an oxygen concentrator set at between 2.5-3 L/min.

On 6/14/18 at 8:12 a.m., RN (registered nurse) #1 was asked to review MD's oxygen orders for Resident #99. RN #1 confirmed the order documented a rate of 2 L/min. Asked RN #1 to assess Resident #99's current flow rate. She confirmed it was at 2.5-3 L/min. She then set the oxygen flowmeter to the ordered rate of 2 L/min. RN (registered nurse) #1 was asked what the purpose of the care plan is. She stated to communicate the individual needs of each resident.

On 6/14/18 at 10:15 a.m., LPN (licensed practical nurse) #1 was asked to describe the purpose of a Resident's care plan. She stated that it communicates each resident's different needs.

ASM (administrative staff member) #1, the administrator and ASM #2, director of nursing, where made aware of the above concerns on 6/14/18 at 3:00 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://medlineplus.gov/ency/article/000688.htm

7. The facility staff failed to follow Resident #117's comprehensive care plan for the

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administration of oxygen.

Resident #117 was admitted to the facility on 6/22/16 with recent readmission on 5/9/18, with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (a chronic lung disease that makes it hard to breath) (1), a stroke with right sided paralysis, dementia, high blood pressure, and a gastrostomy tube (a tube that is inserted through the wall of the abdomen directly into the stomach in order to give drugs, liquids and liquid food to a patient) (2).

The most recent MDS (minimum data set) assessment, a 14 day Medicare assessment, with an assessment reference date of 5/23/18, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating he has severe cognitive impairment of daily decision making. The resident was coded as requiring extensive assistance of at least one staff member for bed mobility, transferring, dressing, eating, toilet use and personal hygiene. In Section O - Special Treatments, the resident was coded as using oxygen during the look back period.

A review of the comprehensive care plan dated 11/28/17, with a most recent revision on 2/27/18, documented in part, "Need: Potential difficulty breathing". In the Interventions section of this focus it is documented in part, "Administer treatments per physician order".

A review of Resident #117's clinical record documented the MD (medical doctor) order stating "Oxygen 2 L/min (liters/minute) via NC (nasal cannula) every shift for sob (shortness of breath)".

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Observation on 6/12/18 at 8:49 a.m., 11:10 a.m., and 4:16 p.m., noted Resident #117 reclining in his bed with oxygen on via nasal cannula (a plastic tube with two prong that are inserted just inside the nose) connected to an oxygen concentrator set at 1.5 L/min.

On 6/14/18 at 8:12 a.m., RN (registered nurse) #1 was asked to review MD's oxygen orders for Resident #117. RN #1 confirmed the order documented a rate of 2 L/min. Asked RN #1 to assess Resident #117's current flow rate. She confirmed it was at 1.5 L/min. She then set the oxygen flowmeter to the ordered rate of 2 L/min. RN (registered nurse) #1 was asked what the purpose of the care plan is. She stated to communicate the individual needs of each resident.

On 6/14/18 at 10:15 a.m., LPN (licensed practical nurse) #1 was asked to describe the purpose of a Resident's care plan. She stated that it communicates each resident's different needs.

ASM (administrative staff member) #1, the administrator and ASM #2, director of nursing, where made aware of the above concerns on 6/14/18 at 3:00 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website:
https://medlineplus.gov/ency/article/000091.htm

(2) This information was obtained from the following website:

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https://www.cancer.gov/publications/dictionaries/cancer-terms/def/gastrostomy-tube

8. The facility staff failed to implement Resident # 121's comprehensive care plan for pain.

Resident # 121 was admitted to the facility on 04/04/17 with a readmission of 05/16/18 with diagnoses that included but were not limited to hypertension (1), gastroesophageal reflux disease (2), diabetes mellitus (3), depression (4) and chronic obstructive pulmonary disease (5).

Resident # 121's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/23/18, coded Resident # 121 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 121 was coded as requiring extensive assistance of one staff member for activities of daily living. Section "J0300 Pain Presence" coded Resident # 121 as having pain frequently with a pain level of 10.

The physician's orders dated June 2018 for Resident # 121 documented, "MAPAP (Acetaminophen) [6] 500 MG (milligram). Give 1 (one) tablet by mouth every 8 (eight) hours a needed for Pain. Start Date: 05/16/18."
"Tramadol (7) 50 MG. Give 1 (one) tablet by mouth every 8 (eight) hours a needed for Pain. Start Date: 05/16/18."
"Tramadol 50 MG. Give 2 (two) tablets by mouth every 8 (eight) hours a needed for Pain. Start Date: 05/16/18."

The eMAR (electronic medication administration record) dated May 2018 documented,

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"MAPAP (Acetaminophen) 500 MG (milligram). Give 1 (one) tablet by mouth every 8 (eight) hours a needed for Pain. Start Date: 05/16/18."
"Tramadol 50 MG. Give 1 (one) tablet by mouth every 8 (eight) hours a needed for Pain. Start Date: 05/16/18."
"Tramadol 50 MG. Give 2 (two) tablets by mouth every 8 (eight) hours a needed for Pain. Start Date: 05/16/18."

Review of the May 2018 eMAR revealed tramadol 50 mg one tablet was administered to Resident # 121:
On 05/17/18 at 2047 (8:47 p.m.) with a pain level of 4 (four).
On 05/26/18 at 2002 (8:02 p.m.) with a pain level of 4 (four).
On 05/29/18 at 1529 (3:29 p.m.) with a pain level of 4 (four).
On 05/30/18 at 2230 (10:30 p.m.) with a pain level of 5 (five).
On 05/31/18 at 2312 (11:12 p.m.) with a pain level of 4 (four).

Review of the May 2018 eMAR revealed tramadol 50 mg two tablets were administered to Resident # 121:
On 05/07/18 at 2245 (10:45 p.m.) with a pain level of 5 (five).
On 05/11/18 at 1134 (11:34 a.m.) with a pain level of 4 (four).

Review of the May 2018 eMAR revealed MAPAP 500 mg was administered to Resident # 121 on 05/31/18 at 0957 (9:57 a.m.) with a pain level of 6 (six).

The eMAR (electronic medication administration record) dated June 2018 documented,

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"MAPAP (Acetaminophen) 500 MG (milligram). Give 1 (one) tablet by mouth every 8 (eight) hours a needed for Pain. Start Date: 05/16/18."
"Tramadol 50 MG. Give 1 (one) tablet by mouth every 8 (eight) hours a needed for Pain. Start Date: 05/16/18."

Review of the June 2018 eMAR revealed tramadol 50 mg one tablet was administered to Resident # 121:
On 06/05/18 at 1339 (1:39 p.m.) with a pain level of 7 (seven).
On 06/06/18 at 1525 (3:25 p.m.) with a pain level of 5 (five).
On 06/11/18 at 1324 (1:24 p.m.) with a pain level of 5 (five).
On 06/12/18 at 1330 (1:30 p.m.) with a pain level of 5 (five).

Review of the June 2018 eMAR revealed MAPAP 500 mg one tablet was administered to Resident # 121:
On 06/01/18 at 1700 (5:00 p.m.) with a pain level of 2 (two).
On 06/02/18 at 1646 (4:46 p.m.) with a pain level of 5 (five).

The comprehensive pain care plan for Resident # 121 dated, 01/04/18 documented, "Need. Pain-chronic related to Fibromyalgia (8) & (and) restless leg syndrome, muscle spasms, pressure injury. Date Initiated 01/04/18. Revision on 05/24/18." Under "Interventions/Tasks" it documented, "Assist to position for comfort with physical support as necessary. Date initiated 01/04/18" and "Instruct in relaxation techniques as needed and offer comfort measures such as: distraction, back rubs, slow breathing, change of position, etc. Date initiated: 01/04/18."

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Review of the Nurse's "Progress Notes" dated 05/16/18 through 06/13/18 failed to evidence documentation of non- pharmacological interventions prior to the administration of tramadol and MAPAP.

On 06/14/18 at 10:52 a.m., an interview was conducted with LPN (licensed practical nurse) # 4. When asked to describe the purpose of the care plan LPN # 4 stated, "To give individualized treatment to each resident. Each patient has different goal." When asked if the care plan should be followed, LPN # 4 stated, "Yes." LPN # 4 stated, "If it isn't documented it wasn't done and the care plan was not followed." After review the May and June 2018 eMARS and nurse's notes dated 05/16/18 through 06/13/18 for Resident # 121, LPN # 4 was asked if non-pharmacological interventions were attempted prior to prn (as needed) pain medication being administered to Resident # 121. LPN # 4 stated, "I can't say the non-pharmacological interventions were attempted. After reviewing Resident # 121's care plan, LPN # 4 stated the care plan was not followed for the use of non-pharmacological interventions.

On 06/15/18 at 8:40 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked to describe the purpose of the care plan ASM # 2 stated, "It guides the treatment and care. If it is documented on the care plan it should be followed." After review the May and June 2018 eMARS and nurse's notes dated 05/16/18 through 06/13/18 ASM # 2 was asked if non-pharmacological interventions were attempted prior to prn (as needed) pain

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medication being administered to Resident # 121. ASM # 2 stated the care plan was not followed for the use of non-pharmacological interventions.

On 06/14/18 at approximately 6:15 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, and ASM # 5, clinical resource specialist, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(2) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(3) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(4) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

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(5) Disease that makes it difficult to breath that can lead to shortness of breath) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

(6) Acetaminophen is used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a681004.html.

(7) Tramadol is used to relieve moderate to moderately severe pain. Tramadol extended-release tablets and capsules are only used by people who are expected to need medication to relieve pain around-the-clock. Tramadol is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695011.html.

(8) A common syndrome in which a person has long-term pain that is spread throughout the body. The pain is most often linked to fatigue, sleep problems, headaches, depression, and anxiety. People with fibromyalgia may also have

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tenderness in the joints, muscles, tendons, and other soft tissues. This information was obtained from the website: https: https://medlineplus.gov/ency/article/000427.htm.

9. The facility staff failed to implement Resident # 60's comprehensive care plan for blood sugar monitoring.

Resident # 60 was admitted on 04/06/17 and a readmission on 06/07/18 with diagnoses that included but were not limited to anemia (1) fractured right femur (2), diabetes mellitus (3), hypertension (4) and depressive disorder (5).

Resident # 60's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/27/18, coded Resident # 60 as scoring a 9 (nine) on the brief interview for mental status (BIMS) of a score of 0 (zero) - 15, 9 (nine) being moderately impaired of cognition for making daily decisions. Resident # 60 was coded as being totally dependent of one staff member for activities for ADLs (activities of daily living) and supervision with eating.

The physician's order for Resident # 60 dated 06/13/2018, documented, "Accu-checks (brand of glucometer used to obtain blood sugar readings) AC (before meals) and HS (hour of sleep, bedtime) before meals and at bedtime for DM (diabetes mellitus). Notify MD (medical doctor) if BS (blood sugar) < (less than) 70 or > (greater than) 250. Start Date: 05/18/2018."

The eMAR (electronic medication administration record) dated "May 2018" for Resident # 60 documented, "Accu-checks AC (before meals)

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and HS before meals and at bedtime for DM (diabetes mellitus). Notify MD (medical doctor) if BS (blood sugar) < (lees than) 70 or > (greater than) 250. Start Date: 05/18/2018." Further review of the eMAR documented the following blood sugars greater than 250:
On 05/18/18 at 9:00 p.m. BS (blood sugar) 348.
On 05/19/18 at 4:30 p.m. BS 431 and at 9:00 p.m. 430.
On 05/20/18 at 6:30 a.m. BS 391 and at 11:30 a.m. BS 291.
On 05/21/18 at 4:30 p.m. BS 391 and at 9:00 p.m. BS 510.
On 05/22/18 at 6:30 a.m. BS 283, at 4:30 p.m. BS 471 and at 9:00 p.m. BS 418.
On 05/23/18 at 11:30 a.m. BS 370.
On 05/25/18 at 11:30 a.m. BS 256 and at 4:30 p.m. BS 257.
On 05/26/18 at 4:30 p.m. BS 363 and at 9:00 p.m. BS 376.
On 05/29/18 at 9:00 p.m. BS 291.
On 05/30/18 at 11:30 a.m. BS 271 and at 9:00 p.m. BS 324.
On 05/31/18 at 9:00 p.m. BS 266.

The eMAR (electronic medication administration record) dated "June 2018" for Resident # 60 documented, "Accu-checks AC (before meals) and HS before meals and at bedtime for DM (diabetes mellitus). Notify MD (medical doctor) if BS (blood sugar) < (less than) 70 or > (greater than) 250. Start Date: 05/18/2018." Further review of the eMAR documented the following blood sugars greater than 250:
On 06/03/18 at 4:30 p.m. BS (blood sugar) 299.
On 06/09/18 at 6:30 a.m. BS 251.
On 06/11/18 at 11:30 a.m. BS 317, 4:30 p.m. BS 326 and at 9:00 p.m. BS 312.
On 06/12/18 at 9:00 a.m. BS 327.

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The comprehensive care plan dated 02/21/18 for Resident # 60 documented, "Need. BLOOD SU (sugar): At risk for fluctuation blood sugars R/T (related to): Diabetes. Date initiated: 02/21/2018." Under "Interventions" it documented, "Observe and document s/sx (signs and symptoms) of complications from fluctuating blood sugar. Report abnormal findings to physician. Date initiated: 02/21/2018."

Review of the facility's nursing "Progress Notes" dated 05/18/18 through 06/12/18 failed to evidence documentation of physician notification of Resident # 60's blood sugars over 250.

On 06/14/18 at 10:52 a.m., an interview was conducted with LPN (licensed practical nurse) # 4. When asked to describe the purpose of the care plan LPN # 4 stated, "To give individualized treatment to each resident. Each patient has different goal." When asked if the care plan, should it be followed, LPN # 4 stated, "Yes." LPN # 4 stated, "If it isn't documented it wasn't done and the care plan was not followed." After reviewing the May and June 2018 eMARS and nurse's notes dated 05/18/18 through 06/12/18 for resident #60, LPN # 4 was asked if the care plan was followed for the reporting of Resident # 60 blood sugars over 250 to the physician. LPN # 4 stated, "I can't say the physician was notified. After reviewing Resident #60's care plan, LPN # 4 stated that that the care plan was not followed.

On 06/15/18 at 8:40 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked to describe the purpose of the care plan, ASM # 2 stated, "It guides the treatment and care. If it is

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documented on the care plan it should be followed." After reviewing the May and June 2018 eMARS and nurse's notes dated 05/18/18 through 06/12/18 for Resident # 60, ASM # 2 was asked if the care plan was followed for the reporting of Resident # 60 blood sugars over 250 to the physician. ASM # 2 stated, "I can't say the physician was notified. After reviewing Resident #60's care plan, ASM # 2 stated that that the care plan was not followed.

On 06/14/18 at approximately 6:15 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, and ASM # 5, clinical resource specialist, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) Low iron. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/anemia.html
.

(2) You had a fracture (break) in the femur in your leg. It is also called the thigh bone. You may have needed surgery to repair the bone. You may have had surgery called an open reduction internal fixation. In this surgery, your surgeon will make a cut to open your fracture. This information was obtained from the website:
https://medlineplus.gov/ency/patientinstructions/000166.htm.

(3) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/ency/article/

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F 656	Continued From page 141 001214.htm. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (5) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to follow professional standards of practice for three of 50 residents in the survey sample, Residents #24, 43, and 69. 1. The facility staff failed to clarify the physician orders for the administration of Ativan for Resident #24. 2. The facility staff failed to clarify the physician's orders for pain medication for Resident #43.	F 658	Ftag 658 Resident #24: Ativan order was clarified. No negative outcome occurred as a result of this practice. Resident #43: Pain medication order was clarified. No negative outcome occurred as a result of this practice. Resident#69: Medication is available and guest is receiving it as ordered. No	7/27/18

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F 658	Continued From page 142 3. The facility staff failed to accurately document Resident #69's medication Isometheptene-caffeine-acetaminophen (1) was held on multiple dates in April 2018. The facility staff documented the medication was administered when the medication was not available. The findings include: 1. Resident #24 was admitted to the facility on 3/30/18 with diagnoses that included but were not limited to: cancer of the brain, anxiety disorder, history of breast cancer, high blood pressure, paralysis on one side, and encephalopathy (any brain disorder or disease) (1). The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 4/27/18 coded the resident as being rarely understood and rarely understanding others. The resident was coded as having both short and long-term memory difficulties and being severely impaired to make daily cognitive decisions. Resident # 24 was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living. The physician orders dated, 5/25/18, documented, "Lorazepam (Ativan) (used to treat anxiety)(2) Concentrate 2 mg/ml (milligrams/milliliters) give 0.25 ml sublingually (under the tongue) every 6 hours as needed for anxiety. Lorazepam solution 2 mg/ml, give 0.25 ml sublingually every 3 hours as needed for anxiety."	F 658	negative outcome occurred as a result of this practice. All residents have the potential to be affected The DON or designee will educate licensed nursing staff and physicians on PRN Ativan orders and clarification with the physician. They will also be educated on obtaining parameters for residents with multiple pain medication orders. Education will be provided on proper documentation of the MAR. The DON or designee will audit current residents with PRN Ativan orders and will seek physician clarification as needed. An audit will be conducted on residents with more than one PRN pain medication order. Medication Carts will be audited for medication availability. Nursing administration will monitor new PRN Ativan orders and new PRN pain medication orders for 5 times a week for 4 weeks. The medication carts will be audited weekly for four weeks. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee. Continued compliance will be monitored though the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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The May 2018 MAR (medication administration record) documented the above physician orders. The Ativan was documented as having been administered on 5/28/18 at 9:17 a.m. and 5/29/18 at 5:34 p.m.

The June 2018 MAR documented the above physician order. The Ativan was documented as having been administered on 6/2/18 at 7:05 p.m., 6/4/18 at 5:27 a.m. and 11:10 a.m., on 6/11/18 at 12:04 a.m., 4:18 a.m. and 9:42 p.m., on 6/12/18 at 8:45 a.m. and on 6/13/18 at 12:17 a.m.

The comprehensive care plan dated, 6/5/18, documented in part, "Focus: At risk for increased anxiety related to dx (diagnosis) and history of anxiety disorder." The "Interventions" documented in part, "Administer anti-anxiety medications per physician order. Observe or ineffectiveness/side effects, report abnormal findings to the physician."

An interview was conducted with LPN (licensed practical nurse) #5 and LPN #12 on 6/13/18 at 3:26 p.m. LPN #5 and LPN #12 were asked to review the physician orders for Ativan above. Once reviewed the LPNs were asked how a nurse would know which order to follow, LPN #12 stated, "That order needs to be clarified." LPN #5 agreed with LPN #12. Both nurses stated the order needed to be clarified with the physician for how often it can be given.

The administrator, ASM (administrative staff member) #1 and the director of nursing, ASM #2 were made aware of the above findings on 6/13/18 at 6:15 p.m. The director of nursing was asked what standard of practice they follow, the director of nursing stated they follow Lippincott

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and their policies.

"Always clarify with the prescriber any medication order that is unclear or seems in appropriate." Fundamentals of Nursing 5th edition, Lippincott, Williams & Wilkins, page 553.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 192.
(2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010988/?report=details

2. The facility staff failed to clarify the physician's orders for pain medication for Resident #43.

Resident #43 was admitted to the facility on 10/23/17 with a most recent readmission on 4/9/18, with diagnoses that included but were not limited to: heart failure, pneumonia, diabetes, chronic obstructive pulmonary disease (a chronic lung disease that makes it hard to breath) (1), high blood pressure, anxiety, and severe obesity.

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 4/16/18, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating she has severe cognitive impairment for daily decision making. The resident was coded as requiring extensive assistance of at least two or more staff members for bed mobility and transfers, and at least one person physical assist for dressing, toileting, eating and personal

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hygiene. In Section N - Medications, the resident was coded as using opioids during the look back period. In Section O - Special Treatments, The resident is coded as using hospice services during the look back period.

The physician order dated, 4/10/18, documented, "Acetaminophen (used to treat mild to moderate pain) (2) suppository 650 mg: Insert 1 suppository rectally every 4 hours as needed for pain ...Morphine Sulfate (used to treat moderate to severe pain) (3) (Concentrate) Solution 20 mg/ml (milligrams per milliliter): Give 0.25 ml (milliliters) every 4 hours as needed for pain, sob (shortness of breath)." Neither order had documented which pain medication should be used based on the resident's pain level.

The May 2018 MAR (medication administration record) documented the above physician orders. The Morphine was documented as having been administered on 5/1/18 at 5:43 a.m. for a pain level of 5; on 5/1/18 at 11:30 p.m. for a pain level of 6; on 5/8/18 at 3:33 a.m. for a pain level of 5; on 5/23/18 at 3:32 a.m. for a pain level of 5; and on 5/24/18 at 5:54 p.m. for a pain level of 6. There is no documentation indicating that the Acetaminophen suppository was offered or given for complaints of pain.

The June 2018 MAR documented the above physician order. The Morphine was documented as having been administered on 6/11/18 at 1:57 a.m. for a pain level of 7. There is no documentation indicating that the Acetaminophen suppository was offered or given for complaints of pain.

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The comprehensive care plan dated 10/23/17, with a most recent revision date of 4/26/18, documented in part, "Need: Pain risk related to GERD (gastroesophageal reflux disease), COPD (chronic obstructive pulmonary disease), CHF (congestive heart failure)." The "Interventions" documented in part, "Administer medication for pain and observe for effectiveness/side effects and report ineffectiveness to physician".

An interview was conducted with RN (registered nurse) #1 on 6/14/18 at 2:20 p.m. When asked how it is determined which pain medication is given to a resident when the resident has multiple orders for pain medications, RN #1 stated, "We ask them the pain level or to number the pain they are having. Then we ask the resident which pain medicine they want". When asked how they determine which pain medication to give a cognitively impaired resident, RN #1 stated, "We assess for facial grimacing, restlessness, and any moaning". When informed of the above order for Morphine and Acetaminophen that was written on 4/10/18, RN #1 stated, "We need to ask the doctor to clarify which level of pain requires which pain medication."

A review of the facility's "Medication Administration" policy failed to evidence the clarification of medication orders.

Fundamentals of Nursing" 8th edition, 2013: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 983. "Box 43-13 Nursing Principles for Administering Analgesics" documents in part, "Select proper medications when more than one is ordered: Use non-opioid analgesics for mild to moderate pain".

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ASM (administrative staff member) #1, the administrator and ASM #2, director of nursing, where made aware of the above concerns on 6/14/18 at 3:00 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://medlineplus.gov/ency/article/000091.htm

(2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a681004.html

(3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682133.html

3. The facility staff failed to accurately document Resident #69's medication Isometheptene-caffeine-acetaminophen (1) was held on multiple dates in April 2018. The facility staff documented the medication was administered when the medication was not available.

Resident #69 was admitted to the facility on 5/10/17 and 4/2/18. Resident #69's diagnoses included but were not limited to pneumonia, diabetes and seizures. Resident #69's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 4/29/18, coded the resident's cognition as moderately impaired.

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THE LAURELS OF UNIVERSITY PARK	2420 PEMBERTON RD RICHMOND, VA 23233

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Review of Resident #69's clinical record revealed a physician's order dated 4/2/18 for Isometheptene-caffeine-acetaminophen 65/100/325 mg (milligrams) - one capsule by mouth every six hours for headache.

Review of Resident #69's care plan dated 12/28/17 failed to reveal documentation regarding administration of Isometheptene-caffeine-acetaminophen.

Review of Resident #69's April 2018 MAR (medication administration record) revealed Isometheptene-caffeine-acetaminophen 65/100/325 mg was not administered (as evidenced by documentation of the code "5=Hold/See Nurse Notes") on the following dates and times:
-4/14/18 at 6:00 p.m.
-4/15/18 at 12:00 a.m., 6:00 a.m. and 6:00 p.m.
-4/16/18 at 12:00 a.m., 6:00 a.m. and 6:00 p.m.
-4/17/18 at 12:00 a.m. and 6:00 a.m.
-4/18/18 at 6:00 a.m.
-4/19/18 at 12:00 a.m. and 6:00 a.m.

Further review of Resident #69's April 2018 MAR revealed Isometheptene-caffeine-APAP was documented as being administered as evidenced by a check mark and nurses' initials on the following dates and times:
-4/15/18 at 12:00 p.m.
-4/16/18 at 12:00 p.m.
-4/17/18 at 12:00 p.m. and 6:00 p.m.
-4/18/18 at 12:00 a.m., 12:00 p.m. and 6:00 p.m.
-4/19/18 at 12:00 p.m.

A nurse's note dated 4/14/18 at 6:06 p.m. documented, "Isometheptene-caffeine-APAP (acetaminophen) Capsule 65-100-325 MG

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(milligrams) Give 1 capsule by mouth every 6 hours for headache On call awared (sic) that med (medication) is not in the building. If he could please reorder it because it is scheduled every six hours. He stated that the facility doctor can do the reordering. This writer made he (sic) aware there is a PRN (as needed) fiorcet (2). We could probably use that this weekend."

A nurse's note dated 4/15/18 at 3:56 a.m. documented, "Isometheptene-caffeine-APAP Capsule 65-100-325 MG Give 1 capsule by mouth every 6 hours for headache MD (medical doctor) aware."

A nurse's note dated 4/15/18 at 6:07 a.m. documented, "Isometheptene-caffeine-APAP Capsule 65-100-325 MG Give 1 capsule by mouth every 6 hours for headache Awaiting MD aware."

A nurse's note dated 4/15/18 at 7:10 p.m. documented, "Isometheptene-caffeine-APAP Capsule 65-100-325 MG Give 1 capsule by mouth every 6 hours for headache md aware."

A nurse's note dated 4/16/18 at 6:39 a.m. documented, "Isometheptene-caffeine-APAP Capsule 65-100-325 MG Give 1 capsule by mouth every 6 hours for headache awaiting, md aware."

A nurse's note dated 4/16/18 at 11:54 p.m. documented, "Isometheptene-caffeine-APAP Capsule 65-100-325 MG Give 1 capsule by mouth every 6 hours for headache Med not given signed order 4/16/18 faxed to pharmacy, MD aware."

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A nurse's note dated 4/17/18 at 7:50 a.m. documented, "Isometheptene-caffeine-APAP Capsule 65-100-325 MG Give 1 capsule by mouth every 6 hours for headache Awaiting MD aware."

A nurse's note dated 4/18/18 at 6:05 a.m. documented, "Isometheptene-caffeine-APAP Capsule 65-100-325 MG Give 1 capsule by mouth every 6 hours for headache not available pharm (pharmacy) aware."

A nurse's note dated 4/19/18 at 8:11 a.m. documented, "Isometheptene-caffeine-APAP Capsule 65-100-325 MG Give 1 capsule by mouth every 6 hours for headache MD aware."

A nurse practitioner's note dated 4/19/18 at 8:05 p.m. documented, "Headaches: controlled. Pharmacist requests D/C Midrin (Isometheptene-caffeine-APAP) as it is off the market. Will switch to Prodrin..."

Review of pharmacy documentation dated 4/18/18 at 10:48 a.m. revealed Isometheptene-caffeine-APAP was not available from the manufacturer. Review of a FDA (federal drug administration) notification regarding Isometheptene-caffeine-APAP revealed the FDA notified manufacturers to stop distributing the medication because it was considered an unapproved new drug.

On 6/13/18 at 1:48 p.m., an interview was conducted with LPN (licensed practical nurse) #3 (the nurse who documented administration of the noon dose of Isometheptene-caffeine-APAP to Resident #69 on 4/15/18 through 4/19/18). LPN #3 confirmed she documented administration of

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the noon dose of Resident #69's Isometheptene-caffeine-APAP on 4/15/18 through 4/19/18 by documenting a check mark and initials. LPN #3 was made aware other nurses had documented the medication was not available on those dates and asked how she was able to administer the medication. LPN #3 stated she did not document that she administered the medication and she did not know why the check marks were documented. LPN #3 stated she did not know what the check marks were for and how they were used.

On 6/13/18 at 2:01 p.m., an interview was conducted with LPN #1. LPN #1 confirmed a check mark and nurse's initials on the MAR indicates the medication was given. LPN #1 was made aware of the above documentation and asked how one nurse could have administered the medication on those same dates when other nurses documented the medication was not available and according to pharmacy documentation, the medication was not available. LPN #1 stated, "Unless it was still in the Omni cell (a machine in the facility that contains various medications), I'm not sure how."

Review of the Omni cell list revealed Isometheptene-caffeine-APAP was not available in the machine.

On 6/13/18 at 6:12 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing were made aware of the above findings.

The facility document titled, "MEDICATION ADMINISTRATION" documented, "10. Initial the guest's Medication Administration Record (MAR)

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F 658	Continued From page 152 immediately following administration. 11. Record any medication omissions including date, time, and reason on the back of the Medication Administration Record (MAR)..." No further information was presented prior to exit. (1) Isometheptene-caffeine-acetaminophen is used to treat headaches. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/medgen/741144 (2) Fiorcet is used to treat headaches. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009376/?report=details	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide ADL (activities of daily living) care for one of 50 residents in the survey sample, Resident #5. The facility staff failed to trim Resident #5's fingernails. Resident #5's fingernails were long and a brown substance was observed under the resident's right hand fingernails. The findings include:	F 677	Ftag 677 Resident #5: Nails were cleaned and trimmed. No negative outcomes occurred as a result of this practice. All residents have the potential to be affected. The DON or designee will educate licensed staff on providing nail care. Department managers will be educated on observation of appropriate nail care.	7/27/18

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F 677	Continued From page 153 Resident #5 was admitted to the facility on 10/4/16. Resident #5's diagnoses included but were not limited to Alzheimer's disease (1), irritable bowel syndrome (2) and major depressive disorder. Resident #5's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/9/18, coded the resident's cognition as severely impaired. Section G coded Resident #5 as requiring extensive assistance of one staff with personal hygiene. On 6/12/18 at 1:14 p.m., Resident #5 was sitting up in bed feeding herself a slice of pie with her right hand. The resident's fingernails were long and a brown substance was observed under the resident's right hand fingernails. On 6/13/18 at 2:58 p.m., Resident #5 was lying in bed. The resident's fingernails were long and a brown substance was observed under the resident's right hand fingernails. On 6/13/18 at 3:35 p.m., an interview was conducted with CNA (certified nursing assistant) #4 (a CNA who routinely cared for Resident #5 on the 3:00 p.m. to 11:00 p.m. shift). CNA #4 was asked the facility process for fingernail care. CNA #4 stated, "I'm not too sure. If a resident asks, we provide it. That's as far as I know." When asked if she ever periodically trims residents' fingernails, CNA #4 stated she only does so if a resident asks for it or if a resident's nails are extremely shabby looking. When asked to describe the word "shabby," CNA #4 stated, "long and uneven." When asked if she has ever provided nail care for Resident #5, CNA #4 stated	F 677	Department managers will round on residents to check for clean and trimmed fingernails. Department managers will round weekly for four weeks on fingernails. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee. Continued compliance will be monitored though the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: July 27, 2018	

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on those occasions, Resident #5 played in her stool so she (CNA #4) soaked the resident's hands and removed stool from under her nails. When asked if she had ever trimmed Resident #5's fingernails, CNA #4 stated, "Not to my recollection."

On 6/13/18 at 3:54 p.m., an interview was conducted with RN (registered nurse) #1 (Resident #5's unit manager). RN #1 was asked the facility process for fingernail care. RN #1 stated residents' fingernails are supposed to be trimmed when residents are given showers and the CNAs can report to the nurses if they feel they cannot trim residents' nails or if the residents are diabetic so the nurses can trim the nails. RN #1 was asked if she had recently observed Resident #5's fingernails. RN #1 stated she had not. On 6/13/18 at 4:05 p.m., Resident #5's fingernails were observed with RN #1. RN #1 confirmed a brown substance was under the fingernails on Resident #5's right hand. RN #1 was asked to describe the length of Resident #5's fingernails. RN #1 stated the nails on the resident's right hand were approximately one centimeter past the tip of the resident's fingers and the nails on the resident's left hand were approximately one to one and a half centimeters past the tip of the resident's fingers.

On 6/13/18 at 6:12 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

The facility document titled, "NAIL CARE-FINGERS, TOES, & DIABETIC" documented, "Nail and foot care will be provided to the guest by nursing staff, at least twice a week with the

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F 677	Continued From page 155 guest's bath or shower. Fingernails and toenails will be observed and cleaned, as well as trimmed when necessary..." No further information was presented prior to exit. (1) "Alzheimer's disease (AD) is the most common form of dementia among older people. Dementia is a brain disorder that seriously affects a person's ability to carry out daily activities." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=alzheimers+disease&_ga=2.143186225.545294603.1529491200-139120270.1477942321 (2) "Irritable bowel syndrome (IBS) is a problem that affects the large intestine. It can cause abdominal cramping, bloating, and a change in bowel habits. Some people with the disorder have constipation. Some have diarrhea. Others go back and forth between the two. Although IBS can cause a great deal of discomfort, it does not harm the intestines." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=irritable+bowel+syndrome	F 677		
F 684 SS=D	Quality of Care 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	F 684		7/27/18

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F 684	Continued From page 156 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, it was determined the facility staff failed to ensure residents received treatment and care in accordance with professional standards of practice and the comprehensive person centered care plan for three of 50 residents in the survey sample, Resident #s 60, 336 and 90. 1. The facility staff failed to follow physician's orders for the monitoring Resident #60's blood sugars. 2. The facility staff failed to monitor Resident # 336's dialysis catheter for infection and monitor the bruit and thrill on four occasions in June 2018. 3. The facility staff failed to administer medications per the physician order for Resident #90. The findings include: 1. The facility staff failed to follow physician's orders for the monitoring Resident #60's blood sugars. Resident # 60 was admitted on 04/06/17 and a readmission on 06/07/18 with diagnoses that included but were not limited to anemia (1) fractured right femur (2), diabetes mellitus (3), hypertension (4) and depressive disorder (5). Resident # 60's most recent MDS (minimum data	F 684	Ftag 684 Resident #60: No negative outcome has occurred as a result of this practice. Parameters have been reviewed by the physician. Resident #336: No negative outcome has occurred as a result of this practice. Resident# 90: Medications are in stock in the facility. No negative outcomes have occurred as a result of this practice. All residents have the potential to be affected. The DON or designee will educate licensed nursing staff on following blood sugar parameters for physician notification. Education will also be provided for checking bruit and thrill on dialysis residents. documenting this occurred. Education to be provided on what to do if a medication is not available. The DON or designee will audit MAR□s for current insulin dependent residents for compliance with physician notification. Documentation for bruit and thrill will be audited on the TAR. Medication Cart audits will occur to identify medications not available at the facility.	

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F 684	Continued From page 157 set), a quarterly assessment with an ARD (assessment reference date) of 04/27/18 coded Resident # 60 as scoring a 9 (nine) on the brief interview for mental status (BIMS) of a score of 0 (zero) - 15, 9 (nine) being moderately impaired of cognition for making daily decisions. Resident # 60 was coded as being totally dependent of one staff member for activities for ADLs (activities of daily living) and supervision with eating. The physician's order for Resident # 60 dated 06/13/2018 documented, "Accu-checks AC (before meals) and HS before meals and at bedtime for DM (diabetes mellitus). Notify MD (medical doctor) if BS (blood sugar) < (less than) 70 or > (greater than) 250. Start Date: 05/18/2018." The eMAR (electronic medication administration record) dated "May 2018" for Resident # 60 documented, "Accu-checks AC (before meals) and HS (before meals and at bedtime) for DM (diabetes mellitus). Notify MD (medical doctor) if BS (blood sugar) < (less than) 70 or > (greater than) 250. Start Date: 05/18/2018." Further review of the eMAR documented the following blood sugars greater than 250: On 05/18/18 at 9:00 p.m. BS (blood sugar) 348. On 05/19/18 at 4:30 p.m. BS 431 and at 9:00 p.m. 430. On 05/20/18 at 6:30 a.m. BS 391 and at 11:30 a.m. BS 291. On 05/21/18 at 4:30 p.m. BS 391 and at 9:00 p.m. BS 510. On 05/22/18 at 6:30 a.m. BS 283, at 4:30 p.m. BS 471 and at 9:00 p.m. BS 418. On 05/23/18 at 11:30 a.m. BS 370. On 05/25/18 at 11:30 a.m. BS 256 and at 4:30 p.m. BS 257.	F 684	Nursing administration will monitor new insulin orders 5 times a week for 4 weeks for appropriate physician notification. Residents receiving dialysis will have their TAR□s monitored 5 days a week for 4 weeks for documentation of bruit and thrill. Medication Carts will be audited weekly for four weeks for any medications not available at the facility. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee. Continued compliance will be monitored though the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion date: July 27, 2018	

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On 05/26/18 at 4:30 p.m. BS 363 and at 9:00 p.m. BS 376.
On 05/29/18 at 9:00 p.m. BS 291.
On 05/30/18 at 11:30 a.m. BS 271 and at 9:00 p.m. BS 324.
On 05/31/18 at 9:00 p.m. BS 266.

The eMAR (electronic medication administration record) dated "June 2018" for Resident # 60 documented, "Accu-checks (brand of glucometer used to check blood sugars) AC (before meals) and HS before meals and at bedtime for DM (diabetes mellitus). Notify MD (medical doctor) if BS (blood sugar) < (less than) 70 or > (greater than) 250. Start Date: 05/18/2018." Further review of the eMAR documented the following blood sugars greater than 250:
On 06/03/18 at 4:30 p.m. BS (blood sugar) 299.
On 06/09/18 at 6:30 a.m. BS 251.
On 06/11/18 at 11:30 a.m. BS 317, 4:30 p.m. BS 326 and at 9:00 p.m. BS 312.
On 06/12/18 at 9:00 a.m. BS 327.

The comprehensive care plan dated 02/21/18 for Resident # 60 documented, "Need. BLOOD SU (sugar): At risk for fluctuation blood sugars R/T (related to): Diabetes. Date initiated: 02/21/2018." Under "Interventions" it documented, "Observe and document s/sx (signs and symptoms) of complications from fluctuating blood sugar. Report abnormal findings to physician. Date initiated: 02/21/2018."

Review of the facility's nursing "Progress Notes" dated 05/18/18 through 06/12/18 failed to evidence documentation of physician notification of Resident # 60's blood sugars over 250.

On 06/14/18 at 10:52 a.m. an interview was

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conducted with LPN (licensed practical nurse) # 4 regarding Resident # 60's blood sugars. After reviewing the physician's order for notification if blood sugars over 250, the May and June eMARs and the progress notes dated 05/18/18 through 06/12/18, LPN # 4 was asked if the physician was notified for the dates Resident # 60's blood sugars were above 250. LPN # 4 stated, "No. The physician should have been notified for the blood sugar over 250. When asked how she would you notify the physician LPN # 4 stated, "I would notify by phone or in person if they are in the building." When asked where it would documented that the physician was notified, LPN # 4 stated, "In the nurse's note if it was abnormally high or low."

On 06/15/18 at 8:40 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing regarding Resident # 60's blood sugars. After reviewing the physician's order for notification if blood sugars were over 250, the May and June eMARs and the progress notes dated 05/18/18 through 06/12/18, ASM # 2 was asked if the physician was notified for the dates Resident # 60's blood sugars were above 250. ASM # 2 stated, "No. Notification should have been documented in the progress notes." ASM # 2 further stated, "The order should have been clarified to be blood sugars less than 60 or greater than 400, but regardless the order should have been followed.

On 06/14/18 at approximately 6:15 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, and ASM # 5, clinical resource specialist, were made aware of the above findings.

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No further information was provided prior to exit.

References:
(1) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .

(2) You had a fracture (break) in the femur in your leg. It is also called the thigh bone. You may have needed surgery to repair the bone. You may have had surgery called an open reduction internal fixation. In this surgery, your surgeon will make a cut to open your fracture. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000166.htm.

(3) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(5) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

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2. The facility staff failed to monitor Resident # 336's dialysis catheter for infection and monitor the bruit and thrill on four occasions in June 2018.

Resident # 336 was admitted to the facility on 06/06/18 with diagnoses that included but were not limited to: end stage renal disease (2), diabetes mellitus (3), depressive disorder (4), gastroesophageal reflux disease (5), and hypertension (6).

Resident # 336's admission MDS (minimum data set) assessment was not due at the time of the survey. The "Admission Assessment" for Resident # 336 dated 06/07/18 documented she was oriented to person, place and time. Under the heading "Genitourinary" it documented, "5. Dialysis: Hemodialysis. 6. Type of dialysis Access: AV Shunt."

The physician's order for Resident # 336 dated 06/13/2018 documented,
"Check bruit and thrill every shift. Start Date: 06/06/18."
"Monitor dialysis catheter for s/s (signs/symptoms) infection every shift. Start date: 06/06/18."

The eMAR (electronic medication administration record) dated "June 2018" for Resident # 336 documented,
"Check bruit and thrill every shift. Start Date: 06/06/18." Further review of the eMAR revealed blanks for the dates of 06/08/18, 06/09/18, 06/10/18, and 06/13/18 indicating the bruit and thrill was not checked.
"Monitor dialysis catheter for s/s (signs/symptoms) infection every shift. Start

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date: 06/06/18." Further review of the eMAR revealed blanks for the dates of 06/08/18, 06/09/18, 06/10/18, and 06/13/18 indicating the the dialysis catheter was not checked.

Review of the facility's nursing "Progress Notes" dated 06/06/18 through 06/13/18 failed to evidence documentation of the bruit and thrill and monitoring of the dialysis catheter was being completed as ordered.

On 06/15/18 at 8:40 a.m. an interview was conducted with ASM (administrative staff member) # 2, director of nursing regarding Resident # 336's bruit and thrill and monitoring of the dialysis catheter for infection. ASM #2 completed review of the eMAR, physician's orders, and progress dated 06/06/18 through 06/13/18, and agreed the physician's orders were not followed for the monitoring of infection and the bruit and thrill. ASM # 2 stated, "The physician's order should have been followed. Since there is no documentation the bruit and thrill and catheter were monitor and checked I can't say it was done."

Medical Surgical Nursing made Incredibly Easy, Lippincott Williams & Wilkins copyright 2004 page 565 "Dialysis Monitoring and Aftercare: After completion of hemodialysis, monitor the vascular access site for bleeding. If bleeding is excessive, maintain pressure on the sited and notify the doctor. To prevent clotting or other problems with blood flow, make sure that the arm used for vascular access isn't used for any other procedure, including I.V. line insertion, blood pressure monitoring, and venipuncture. At least four times per day, assess circulation at the access site by auscultating for the presence of

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bruits and palpating for thrills. Unlike most other circulatory assessments, bruits and thrills should be present here. Lack of a bruit at a venous access site for dialysis may indicate a blood clot requiring immediate surgical attention."

On 06/14/18 at approximately 6:15 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, and ASM # 5, clinical resource specialist, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) A bruit is an audible vascular sound associated with turbulent blood flow. Although usually heard with the stethoscope, such sounds may occasionally also be palpated as a thrill. In the head and neck, these auscultatory sounds may originate in the heart (cardiac valvular murmurs radiating to the neck), the cervical arteries (carotid artery bruits), the cervical veins (cervical venous hum), or arteriovenous (AV) connections (intracranial AV malformations). These sounds may be normal, innocent findings (i.e., a venous hum in a child) or may point to underlying pathology (i.e., a carotid artery bruit caused by atherosclerotic stenosis in an adult). Head and neck bruits loom especially important today because physicians encounter arterial occlusive disease more frequently as a greater proportion of our population lives longer. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/books/NBK289/

(2) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html

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(3) You had a fracture (break) in the femur in your leg. It is also called the thigh bone. You may have needed surgery to repair the bone. You may have had surgery called an open reduction internal fixation. In this surgery, your surgeon will make a cut to open your fracture. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000166.htm.

(4) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(5) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(6) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

3. The facility staff failed to administer medications per the physician order for Resident #90.

Resident #90 was admitted to the facility on 5/9/18 with a recent readmission on 5/29/18 with

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diagnoses that included but were not limited to: cerebral infarct (area of dead tissue resulting from diminished or stopped blood flow to the tissue area in the brain) (1), high blood pressure, seizures, feeding tube, paralysis on one side, and human immunodeficiency virus (HIV) disease (a virus that causes acquired immunodeficiency syndrome) (2).

The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 5/21/18, coded the resident as having both short and long-term memory difficulties. The resident was coded as being severely impaired to make daily cognitive decisions. Resident #90 was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living.

The physician orders dated, 5/9/18, documented the following medication orders:
-"Lexiva Suspension 50 mg/ml (milligrams/milliliter), Give 700 mg via Peg-Tube (feeding tube) two times a day for HIV." (LEXIVA is indicated in combination with other antiretroviral agents for the treatment of human immunodeficiency virus infection). (3)
- Norvir Solution 80 mg/ml, Give 1.25 ml by mouth two times a day for HIV, give with meals. (Norvir is used in combination with other drugs to treat the infection caused by HIV) (4)
- Prezista Suspension, give 600 mg via Peg-tube two times a day for HIV. (Prezista is used in combination with of other drugs to treat HIV). (5)
- Tivicay Tablet 50 mg, give 1 tablet by mouth two times a day for HIV."(Tivicay is used in combination with other drugs to treat the infection caused by HIV) (6).

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The May 2018 MAR (medication administration record) documented the above medications. The MAR documented the Lexiva Suspension was not administered on 5/10/18 at 9:00 a.m. and 5:00 p.m., on 5/11/18 at 9:00 a.m. and 5:00 p.m. and on 5/12/18 at 9:00 a.m.

The eMAR (electronic medication administration record) notes documented the following:
5/10/18 at 2:47 p.m. - Lexiva suspension - order to be clarified.
5/10/18 at 8:05 p.m. - Lexiva suspension - awaiting approval from administration.
5/11/18 at 12:05 p.m. - Lexiva suspension - Not available from pharmacy - MD (medical doctor) aware.
5/11/18 at 9:25 p.m. - Lexiva suspension - awaiting pharm (pharmacy)
5/12/18 at 9:35 a.m. - Lexiva suspension - not available.

The May 2018 MAR documented the Norvir suspension was not administered on 5/10/18 at 9:00 a.m. and 5:00 p.m.

The eMAR notes documented the following:
5/10/18 at 2:49 p.m., - Norvir suspension - clarification needed.
5/10/18 at 8:00 p.m. - Norvir suspension - awaiting approval from administration.

The May 2018 MAR documented the Prezista suspension was not administered on 5/10/18 at 9:00 a.m. and 5:00 p.m., 5/11/18 at 9:00 a.m. and 5:00 p.m. and on 5/12/18 at 9:00 a.m. and 5:00 p.m.

The eMAR notes documented the following:

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5/10/18 at 2:50 p.m., - Prezista suspension - clarification needed.
5/10/18 at 8:07 p.m. - Prezista suspension - awaiting approval from administration.
5/11/18 at 12:05 p.m. - Prezista suspension - Will give upon arrival
5/11/18 at 9:26 p.m. - Prezista suspension - no explanation as to why it was not given.
5/12/18 at 9:36 a.m. - Prezista suspension - will give upon arrival.
5/12/18 at 9:44 p.m. - Prezista suspension - awaiting approval from management.

The May 2018 MAR documented the Tivicay was not administered on 5/9/18 at 5:00 p.m.

The eMAR notes documented the following:
5/9/18 at 10:53 p.m. - Tivicay - awaiting pharmacy.

The comprehensive care plan dated, 5/22/18, failed to evidence a care plan to address the administration of the HIV medications. The diagnosis of HIV was throughout the care plan but did not include a specific care plan to address the medications.

An interview was conducted with LPN (licensed practical nurse) #9 on 6/14/18 at 10:07 a.m., regarding the process for obtaining medications when a resident is admitted. LPN #9 stated, "We put the medication orders into the computer. We print out the orders, face sheet, and fax it to the pharmacy. We follow that up with a phone call." When asked what process the staff follows when scheduled medications are not in the cart at the scheduled time of administration, LPN #9 stated, "We check the (name of back up drug system in the facility)." LPN #9 stated, "I call the doctor and

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tell them the meds (medications) aren't here and then call the pharmacy and have it sent stat (right away). Usually the medications are here in four hours."

An interview was conducted with RN (registered nurse) #2, on 6/14/18 at 10:19 a.m. regarding the process staff follows for obtaining medications upon admission. RN #2 stated, "(Name of nurse who does admission paperwork) puts them in the computer, copies the orders, sends them to the pharmacy and follows up with a phone call." When asked about the process followed when a medication is not available at the scheduled time of administration, RN #2 stated, "We check the (name of back up drug system in facility) and or call the pharmacy and notify the doctor that it's not available." When shown the eMAR notes above, RN #2 stated, "I was not involved in any of this."

An interview was conducted with ASM (administrative staff member) #1, the administrator, on 6/14/18 at 2:00 p.m. When asked about her involvement with the above medications, AM #1 stated, "I was aware the resident was coming on the medications. I had given the former director of nursing, the authority to get the medications needed." When asked if she was aware of the multiple doses of medications the resident missed, ASM #1 stated, "I didn't know that." ASM #1 was made aware of the above concern.

No further information was obtained prior to exit.

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

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F 684	Continued From page 169 Chapman, page 296. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 276. (3) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=24feb9be-32a6-45fd-a896-f3e202edd8a9 (4) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012017/?report=details. (5) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009822/?report=details. (6) This information was obtained from the following website: https://aidsinfo.nih.gov/drugs/560/descovy/0/patient	F 684		
F 686 SS=D	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 new ulcers from developing.	F 686		7/27/18

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F 686	Continued From page 170 This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide treatment to promote the healing of a pressure injury for one of 50 residents in the survey sample, Resident 106. The facility staff failed to provide physician prescribed treatment to a pressure injury on Resident #106's sacrum (1) on multiple dates in May 2018 and June 2018. The findings include: Resident #106 was admitted to the facility on 4/23/18. Resident #106's diagnoses included but were not limited to congestive heart failure, chronic kidney disease and urinary tract infection. Resident #106's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/20/18, coded the resident as being cognitively intact. Section M coded Resident #106 as having a stage I pressure injury (2). Review of Resident #106's clinical record revealed a Braden scale for predicting pressure sore (injury) risk dated 4/23/18 that documented the resident's sensory perception was slightly limited, mobility was slightly limited, nutrition was adequate and a potential problem with friction and shear. A wound/skin healing record with an effective date of 4/24/18 documented excoriation on Resident #106's sacrum.	F 686	Ftag 686 Resident #106: No negative outcome occurred as a result of this practice. Residents with pressure injuries have the potential to be affected. The DON or designee will provide education to licensed nursing staff on treatment documentation for pressure injuries. The DON or designee will audit TARs for all current residents with pressure injuries. Nursing administration will review TARs for residents 5 with pressure injuries 5 times a week for 4 weeks. Continued compliance will be monitored though the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion date: July 27, 2018	

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A physician's order dated 4/30/18 documented an order for triad hydrophilic wound dressing paste (3) to the sacrum every shift for excoriation.

A wound/skin healing record with an effective date of 5/19/18 documented a stage I pressure injury on Resident #106's sacrum.

Resident #106's May 2018 and June 2018 TARs (treatment administration records) failed to reveal evidence that triad was applied to the resident's sacrum every shift on 5/19/18, 5/20/18, 5/25/18, 5/27/18, 5/30/18, 6/1/18, 6/4/18 and 6/5/18 (as evidenced by blank spaces on the TAR).

A wound/skin healing record with an effective date of 6/6/18 documented a stage II pressure injury (4) on Resident #106's sacrum.

Resident #106's care plan dated 4/23/18 and revised on 6/8/18 documented, "Actual impaired skin integrity related to skin tear to left 2nd finger, Shearing wounds left posterior (back) heel. stage 2 to sacrum, skin tear to back of right arm...Treatment as ordered..."

On 6/14/18 at 10:02 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked how nurses evidence treatments are done. LPN #1 stated the treatments are signed off on the TAR. LPN #1 was asked what a blank space on the TAR meant. LPN #1 stated, "You can't prove whether or not it was or wasn't done." LPN #1 was shown Resident #106's May 2018 and June 2018 TARs and asked how she would know if the treatment was done on the dates of the blank spaces. LPN #1 stated, "Unless I saw the nurse do it or unless I did it myself, I don't."

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F 686	Continued From page 172 On 6/14/18 at 6:14 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility document titled, "Wound and Skin Management Program" documented, "B. Maintain skin integrity; improve skin strength and tolerance to pressure. The goal of skin management is to keep the skin intact. Adequate nutrition and hydration will promote this goal. In addition, preventative products are to be used..." No further information was presented prior to exit. (1) "The sacrum is a shield-shaped bony structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis. The sacrum forms the posterior pelvic wall and strengthens and stabilizes the pelvis." This information was obtained from the website: https://medlineplus.gov/ency/imagepages/19464.htm (2) "Pressure Injury: A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. Stage 1 Pressure Injury: Non-blanchable erythema of intact skin	F 686		

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Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury." This information was obtained from the website: http://www.npuap.org/national-pressure-ulcer-advisory-panel-npuap-announces-a-change-in-terminology-from-pressure-ulcer-to-pressure-injury-and-updates-the-stages-of-pressure-injury/

(3) Triad hydrophilic wound dressing paste is "zinc-oxide based hydrophilic paste for light-to-moderate levels of wound exudates. Helps maintain an optimal wound healing environment to facilitate natural autolytic debridement." This information was obtained from the website: https://www.coloplast.us/triad-hydrophilic-wound-dressing-en-us.aspx#section=product-description_3

(4) "Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive

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F 686	Continued From page 174 related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).:" This information was obtained from the website: http://www.npuap.org/national-pressure-ulcer-advisory-panel-npuap-announces-a-change-in-terminology-from-pressure-ulcer-to-pressure-injury-and-updates-the-stages-of-pressure-injury/	F 686		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review it was determined that the facility staff failed to provide foot care and services for one of 50 residents in the survey sample. Resident 43. The facility staff failed to ensure a diabetic resident, Resident #43, received appropriate toenail care and services. The findings include: Resident #43 was admitted to the facility on	F 687	Ftag 687 Resident #43: Resident was placed on the podiatry list for the next scheduled visit. No negative outcome occurred from this practice. All diabetic residents have the potential to be affected. The DON or designee will educate licensed staff on toenail care for diabetics and the process of coordinating and communicating podiatry services at the	7/27/18

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F 687	Continued From page 175 10/23/17, with a most recent readmission on 4/9/18, with diagnoses that included but were not limited to: heart failure, pneumonia, diabetes, chronic obstructive pulmonary disease (a chronic lung disease that makes it hard to breath) (1), high blood pressure, anxiety, and severe obesity. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 4/16/18, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating she has severe cognitive impairment for daily decision making. The resident was coded as requiring extensive assistance of at least two or more staff members for bed mobility and transfers, and at least one person physical assist for dressing, toileting, eating and personal hygiene. During the initial tour on 6/11/18, at 2:58 p.m., Resident #43 was noted to have long, thickened, and discolored toenails on both of her big toes. A review of the comprehensive care plan dated 11/3/17, documented in part, "Need: At risk for fluctuation of blood sugars R/T (related to) Diabetes". In the Interventions section of this need is documented in part, "Provide proper foot care prn. Schedule podiatry consult pr [sic: prn]". On 6/13/18 at 2:18 p.m., RN (registered nurse) #1 was asked who is responsible for initiating a podiatric consult. RN #1 stated that the social workers handle those consults. On 6/13/18 at 2:55 p.m., CNA (certified nursing assistant) #6 was asked to come and confirm condition of Resident #43's toenails. CNA #6	F 687	facility. The DON or designee will assess diabetic residents toenails and referrals to the podiatrist will be made as needed. Nursing administration will round on toenails of diabetic residents weekly for four weeks and podiatry referrals will be made as needed. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee. Continued compliance will be monitored though the facility s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: July 27, 2018	

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agreed the big toenails were thickened and discolored on both feet, extending approximately 1.5-2 centimeters beyond the toe. CNA #6 stated that Resident 43 was diabetic and that only a podiatrist can provide the nail care.

On 6/13/18 at 3:20 p.m., an interview was conducted with OSM (other staff member) #7, a social worker, who stated when a resident requires podiatric services; their name is added to a list, which is faxed to a podiatrist who visits the facility one to two times a month. When asked if Resident #43 was on this list, OSM #7 stated she believed she had been added but she would check.

On 6/14/18 at 08:10 a.m., OSM #6 stated that Resident #43 was added to the podiatric consult list on 6/13/18 at 4:02 p.m.

A review of the facility's policy "Nail Care-Fingers, Toes, & Diabetics" was provided for review. Under "Special Considerations" it is documented in part "Before completing nail and/or foot care, the licensed nurse should consult the physician for guests with ...thick mycotic nails (Mycotic nails are nails that are infected with a fungus. The nail may be discolored, yellowish-brown or opaque, thick, brittle and separated from the nail bed) (2) ...Make a referral to the podiatrist at the direction of a physician's order".

ASM (administrative staff member) #1, the administrator and ASM #2, director of nursing, where made aware of the above concerns on 6/14/18 at 3:00 p.m.

No further information was provided prior to exit.

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F 687	Continued From page 177 (1) This information was obtained from the following website: https://medlineplus.gov/ency/article/000091.htm (2) This information was obtained from the following website: https://my.clevelandclinic.org/health/diseases/17253-mycotic-nails	F 687		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review it was determined that the facility staff failed to provide and implement interventions /assistive devices to prevent accidents for two of 50 residents in the survey sample, Resident #42 and #24. 1. The facility staff failed to ensure a safe transfer to prevent injury for Resident #42, who was assessed by PT (physical therapy) on 1/12/18, as non-ambulatory and as requiring Hoyer transfer. On 3/30/18, two CNA's (certified nursing assistants) transferred Resident #42 using a sit to stand lift, the resident fell and sustained *acute left proximal tibia and fibula shaft fractures, resulting in harm.	F 689	Ftag 689 Resident #42: An action plan was completed on mechanical lift transfers after the initial fall with fracture. Staff was educated on transfer status, use of mechanical lifts, and therapy communication. No further falls related to mechanical lifts have occurred in the facility. Resident #24: The fall mat was put in place. No negative outcome occurred from this practice. All residents have the potential to be affected.	7/27/18

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F 689	Continued From page 178 *(Acute- having a rapid onset. Proximal situated nearer to the center of the body or the point of attachment. Tibia is the medial and larger of the two bones of the lower leg, articulating with the femur, Synonym(s): shinbone. Fibula is the lateral and smaller of the two lower bones of the leg. Shaft is long slender part, such as the diaphysis [shaft or central part] of a long bone). (1) 2. The facility staff failed to put a fall mat down while the resident was in bed per the physician orders and the comprehensive care plan for Resident #24. The findings include: 1. Resident # 42 was admitted to the facility on 04/23/13 with a readmission of 04/08/18 with diagnoses that included but were not limited to convulsions (2), gastroesophageal reflux disease (3), hydrocephalus (4), hypertension (5) and depression (6). Resident # 42's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/07/18, coded Resident # 42 as scoring a 6 (six) on the brief interview for mental status (BIMS) of a score of 0 - 15, 6 (six) - being severely impaired of cognition for making daily decisions. Resident # 42 was coded as requiring extensive assistance of one staff member for activities of daily living. Under "G0120 Bathing" Resident # 42 was coded as totally dependent of two staff members. Resident # 42 was coded as requiring extensive assistance of two staff members for transfers- (how the resident moves between surfaces including to or from bed, chair, wheelchair, standing position). Under section "G0300 Balance During Transitions	F 689	The DON or designee will educate 100% of licensed nursing staff on transfer status, use of mechanical lifts and therapy communication. The RSD or designee will educate 100% of the therapy department on communication of transfer status changes to the nursing department. Licensed nursing staff and department managers will be educated on the importance of fall interventions and ensuring that they are in place as care planned. The RSD or designee will audit all residents to ensure the transfer status is appropriate. Updates will be communicated to licensed nursing staff immediately upon any findings. The DON or designee will audit all fall interventions to ensure accuracy. Nursing administration will review new occurrences of falls 5 times a week in the clinical operations meeting. Department managers will conduct rounds 5 times a week for 4 weeks to ensure appropriate fall interventions are in place. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee Continued compliance will be monitored though the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	

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and Walking" Resident # 42 was coded as "2 (two) - Not steady, only able to stabilize with staff assistance" for "E. Surface-to-surface transfer (transfer between bed and chair or wheelchair.)" Under "G0400 Functional Limitations in Range of Motion" Resident # 42 was coded, "Impairment on both sides of lower extremity (hip, knee, ankle, foot."

Resident # 42's MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 04/14/18, coded Resident # 42 as scoring a 7 (seven) on the brief interview for mental status (BIMS) of a score of 0 - 15, 7 (seven) - being severely impaired of cognition for making daily decisions. Resident # 42 was coded as requiring extensive assistance of one staff member for activities of daily living. Under "Section J1800 Any Falls Since Admission/Entry or Reentry or Prior Assessment" documented, "Yes." Under "J1900 Number of Falls Since Admission/Entry or Reentry or Prior Assessment" documented, "1 (one) C. Major injury - bone fracture, joint dislocation, closed head injuries with altered consciousness, subdural hematoma."

The "Physical Therapy Evaluation and Plan of Treatment" dated 01/21/18 for Resident # 42 documented, "Current Referral: Reason for Referral/Current Illness: Pt (patient) referred to skilled PT (physical therapy) to assess need for RNP (restorative nursing program) and program development. Musculoskeletal System Assessment: RLE (right lower extremity) = impaired. LLE (left lower extremity) = impaired. General RLE Strength = Hip = impaired; Knee =

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impaired; Ankle = impaired. General LLE Strength = Hip = impaired; Knee = impaired; Ankle = impaired." Under "Functional Mobility Assessment" it documented, "Transfers = Hoyer transfer. PT (patient) unable to amb (ambulate)." Under "Assessment Summary", it documented, "Clinical Impressions: Pt is TD (totally dependent) with functional mobility and positioning. Pt was previously on RNP and needs a new program to maintain ROM (range of motion) for proper position and skin integrity." Under "Reason for Therapy", it documented, "Reason for Skilled Services: Pt is not being picked up by skilled services due to no indication to expect a positive functional change."

The physician's note dated "March 23, 2018" and signed by the nurse practitioner on March 23, 2018 documented, "Home/Environment Assessment. Living Situation: Other. Home type: Nursing Home. Skilled Nursing Facility: (Name of Nursing Home). Home equipment: Hoyer lift, Wheelchair."

The facility's "Quarterly Pain/Braden/Falls" form for Resident # 42 dated 03/27/2018 documented, "1. Activity: 3. Degree of physical activity; Chairfast (sic.) - Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted to chair or wheelchair. 4. Mobility: Ability to change and control body position. Very limited - Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently." Under "Fall Risk" it documented, "III. Ambulation/Elimination. 1. Resident's ambulation/elimination status. Chair bound/assist with elimination. Gait N/A (non-applicable) - not able to perform function."

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The comprehensive care plan for Resident # 42 dated,"03/13/18 documented, "Need. FALLS: At risk for fall related injury R/T (related to) Impaired vision, impaired mobility, Incont (incontinence) psychotropic drug use, antidepressant medication for depression and insomnia, history of falls, anticonvulsant usage, DX (diagnoses) Osteoporosis, anemia, foot drop, and seizures. Date Initiated: 03/13/2018." Under "Interventions", it documented in part, "Encourage guest to wear non-skid foot wear when out of bed. Assist guest as needed. Date Initiated: 03/13/2018" and "Lock wheel on wheelchair prior to transfers. Date Initiated: 03/13/2018." Further review of the care plan failed to evidence Hoyer transfer as documented in the 01/21/18 physical therapy evaluation.

The nurse's "Progress Notes," dated 03/30/2018. 11:15 (a.m.) for Resident # 42 documented, "At 11:15 a.m. Guest was in the shower room with two shower aides and they were transferring her from the sit to stand lift, to the shower chair and guest hands slipped off of machine and she fell in the shower. Guest c/o (complaint of) left leg pain and the leg was red and painful when touched. A pillow was placed under her head for comfort and she was not moved from floor until paramedics came. Emergency ambulance were called to come take guest to the hospital. Guest was transported to (Name of Hospital) at 11:30 a.m. RP (responsible party) notified, MD (medical doctor) notified, DON (director of nursing) notified."

The nurse's "Progress Notes" dated 03/31/2018. 01:58 (1:58 p.m.) for Resident # 42 documented,

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"Guest returned from hospital at 6:15 p.m. She has a non-displaced tib/fib (tibia/fibula) fracture and needs to be non-weight bearing for the next 6 (six) weeks. No complaints of pain."

The "User Manual" for the "Stand Up Patient Lift" documented, "The standup lift may be operated by one healthcare professional for all lifting preparation, transferring from and transferring to procedures with a cooperative, partial, weight-bearing patient. However, since medical conditions vary (Name of Company) recommends that the healthcare professional evaluate the need for assistance and determine whether more than one assistant is appropriate in each case to safely perform the transfer."

On 06/14/18 at approximately 2:00 p.m., the facility's "Incident Report" was reviewed. The "Incident Report" documented, "Resident: Resident # 42) Date of Incident 3/30/18; Time of Incident: 11:15 a.m. Type of Occurrence: Witnessed fall. Type of Injury: Left leg discomfort, pain redness. Location: shower room. Was Guest Taken to Hospital? Yes. By Whom? Ambulance - 911 to (Name of Hospital). Equipment Involved, If so, specify: sit to stand. Family and Physician notified on 3/30/18."

On 06/14/18 at approximately 2:00 p.m., the facility's "Post Fall Report" was reviewed. The "Post Fall Report" was undated and was signed by LPN (licensed practical nurse) # 13. The form documented "Incident Date 3/30/18; Time: 11:15; Location: Shower room. Circumstances of Fall: Indicate by circling correct answer for each and explain as indicated: Guest activity: Transferring. Was the guest using assistive device? Yes. Type: Sit to stand. What did the guest say about

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the event? Guest said her hands slipped off of mechanical device and she fell. Physical Handling. Was staff assisting with transfer or ambulation at the time of the fall? Yes. If yes, describe the situation and assistance being provided: Guest was being transferred from sit to stand to the shower chair and her hands slipped off of the machine and she fell in [sic] the floor because she is unable to bear weight."

The "Name of Hospital) Orthopedic note dated 03/30/2018 for Resident # 42 documented, "Plan: Acute left proximal tibia and fibula shaft fractures - patient is minimally ambulatory at baseline and fractures have minimal displacement so will proceed with non-operative conservative management. Placed in knee immobilizer to accommodate her knee valgus (knee deformity). Needs to remain NWB (non-weight bearing) through left leg for at least 6 wks (six weeks). Bed to chair transfers or transfers with NWB with PT/OT (physical therapy/occupational therapy). OK to discharge back to her regular facility if appropriate for her level of care otherwise will need to be admitted for placement."

On 06/14/18 at 2:41 p.m., an interview was conducted with ASM (administrative staff member) # 1, administrator. When asked about the use of the sit to stand lift for transferring Resident # 42, ASM # 1 stated, "It probably was not the best choice."

On 06/14/18 at 3:08 p.m., an interview was conducted with OSM (other staff member) # 6, director of rehabilitation services. OSM #6 asked was asked the rehabilitation department's role in assessing a resident for the use of a mechanical

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lift. OSM # 6 stated, "Currently when a resident is coming off rehab (rehabilitation) and if there is any change in the resident's care needs, functional mobility, transfer status, a form is completed. A copy is brought to the floor for the staff, and it is brought to the clinical meeting every day and reviewed and discussed, and therapy is conducting in-services and education on the last day of treatment regarding the changes for the resident." When asked about Resident # 42's fall on 03/30/18, OSM # 6 stated, "My understanding that it was determined that we should have been using a different lift. When the Regional clinical coordinator reviewed this incident we put a plan into place after reviewing the incident."

On 06/14/18 at 4:55 p.m., this surveyor informed, ASM (administrative staff member) # 1, the administrator, of the concern for harm to Resident #42.

On 06/15/18 at 8:35 a.m. an interview was conducted with ASM # 1, administrator. ASM # 1 was asked to describe the process the facility used for communicating the recommendations from the rehabilitation department to nursing prior to Resident # 42's fall. ASM # 1 stated, "It was a scattered process, no consistency or checks and balances. One can assume that that when the therapist discharged a resident from therapy, they informed the resident's nurse of their recommendations and that it (recommended transfer status) was communicated. I think it is fair to say that both parties (nursing and rehabilitation) had a part in the break down. There was no formal approach. The new approach is, when a resident is coming off rehab

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(rehabilitation) and if there is any change in the resident's care needs, functional mobility, transfer status the form is completed. A copy is brought to the floor for the staff, and brought to the clinical meeting every day and reviewed and discussed, and therapy is conducting in-services/education on the last day of treatment regarding the changes for the resident."

On 06/15/18 at 9:12 a.m., an interview was conducted with ASM (administrative staff member) # 1, administrator. When asked to describe the process for determining what type of mechanical lift was needed for a resident prior to Resident # 42's fall, ASM # 1stated, "Upon admission we would use the weight bearing status that was provided in the discharge paperwork from the hospital or a previous facility. If they were admitted from home use the information provided by the family. The problem we had was a lack of communication between therapy and nursing, staff didn't always know the correct transfer procedure or lift to use for a resident."

On 06/15/18 at approximately 9:20 a.m., an interview was conducted with OSM # 6, director of rehabilitation services. OSM # 6 reviewed the physical therapy evaluation dated 01/21/18 for Resident # 42. OSM # 6 stated Resident # 42 was evaluated for the restorative nursing program but was not picked up because there wouldn't be a positive functional change. When asked about the "Functional Mobility Assessment" section of the PT evaluation that documented the use of a "Hoyer transfer" OSM # 6, stated, "They should have used a Hoyer lift." OSM # 6 also verbally concurred with ASM # 1's statements regarding the process the facility used for communicating

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the recommendations from the rehabilitation department to nursing prior to Resident # 42's fall. OSM # 6 further stated that when a resident was discharged from therapy (including evaluation for restorative), the therapist would tell a staff member what or if there were any changes. We assumed the staff (nursing) would pass the information along.

On 06/14/18 and 06/15/18 attempts were made to contact and interview CNA (certified nursing assistant) # 11, by telephone, one of the two CNAs who transferred Resident # 42 using the sit to stand lift on 03/30/18. CNA # 11 failed to return the telephone calls.

CNA (certified nursing assistant) # 12, one of the other two CNAs who transferred Resident # 42 using the sit to stand lift on 03/30/18 was on emergency leave and could not be interviewed.

LPN (licensed practical nurse) # 13 who completed the facility's "Post Fall Report" was not available for interview, as she was no longer employed with the facility at the time of the survey.

On 06/15/18 at 8:09 a.m., an interview was conducted with CNA # 1. When asked how they determine which mechanical lift should be used to transfer a resident CNA # 1 stated, "If the patient can tell us and is able to voice how they transfer that is how we know or their care cards on the inside of their closet in their room." When asked how the lift status is communicated from the rehabilitation department, CNA # 1 stated, "Somebody from therapy will meet up with me and tell me."

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On 06/15/18 at 8:11 a.m., an interview was conducted with RN (registered nurse) # 1. When asked how they determine which mechanical lift should be used to transfer a resident, RN # 1 stated, "If they can stand a little bit then they can use sit to stand. If totally dependent then they use the Hoyer." When asked how it is communicated to staff RN # 1 stated, "It's on the care card and communicated in report especially if anything new has come along." RN # 1 further stated, "The resident's care card is confirmed and updated with lift status and updated using pencil and eraser, therefore the current status on the care card may not reflect the past on the care card." When asked how the lift status is communicated from the rehabilitation department RN # 1 stated, "They tell us then we put that in the care card and care plan." (*Noted there was no documented evidence therapy had notified the nursing staff of the need to Hoyer transfer Resident #42 as documented in physical therapy evaluation dated, 01/21/18.)

The facility's policy "Lift - Hydraulic" documented, "Policy: A hydraulic lift may be used at the direction of a physician's order or as a nursing measure to lift and move guests who are contracted, spastic, heavy, or totally dependent on staff for bed mobility and transfer. At least two staff members are to be present and assist in the use of the hydraulic lift when transferring a guest."

The facility's policy "Lift Sit-To-Stand" documented, "Policy: A sit-to-stand lift may be used at the direction of a physician's order or as a nursing measure to lift and move guests who are able to support the majority of their own weight in accordance with the guest's individual care plan

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needs.

On 06/14/18 at approximately 6:15 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, and ASM # 5, clinical resource specialist, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) This information was obtained from the website:
http://medical-dictionary.thefreedictionary.com/

(2) The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website:
https://medlineplus.gov/ency/article/003200.htm.

(3) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/gerd.html.

(4) A buildup of fluid inside the skull that leads to brain swelling. This information was obtained from the website:
https://medlineplus.gov/ency/article/001571.htm.

(5) High blood pressure. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(6) Depression may be described as feeling sad,

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blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

2. The facility staff failed to put a fall mat down while the resident was in bed per the physician orders and the comprehensive care plan for Resident #24.

Resident #24 was admitted to the facility on 3/30/18 with diagnoses that included but were not limited to: cancer of the brain, anxiety disorder, history of breast cancer, high blood pressure, paralysis on one side, and encephalopathy (any brain disorder or disease) (1).

The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 4/27/18, coded the resident as rarely understood and rarely understanding others. The resident was coded as having both short and long-term memory difficulties and being severely impaired to make daily cognitive decisions. Resident # 24 was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living.

Observation was made on 6/13/18 at 8:36 a.m., 11:29 a.m. 1:23 p.m., 1:47 p.m. and 2:12 p.m., of Resident #24 in bed. The bed was up against the wall on the resident's right side. There was no fall mat down on the resident's left side of the bed. The fall mat was observed folded up at the foot of

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the bed, leaning against the closet.

The physician orders dated, 5/10/18, documented, "Floor mat to side of bed while guest in bed every shift for prevention."

The comprehensive care plan dated, 3/30/18 documented in part, "Focus: At risk for fall related injury R/T (related to) impaired mobility, psychotropic drug use, history of falls, cognitive deficit, Hx (history of) Craniotomy r/t glioblastoma (surgery related to the brain tumor) (2). The "Interventions" documented in part, "Mat to floor next to bed as ordered."

An interview was conducted with CNA (certified nursing assistant) #7 on 6/13/18 at 2:12 p.m., the CNA assigned to Resident #24 on 6/13/18. When asked how a CNA knows what assistive devices a resident needs, CNA #7 stated it depends on their diagnosis that they have. If the resident has pressure ulcers you need pillows for positioning. There is a kardex in each of the closet doors.

CNA #7 pulled the kardex for Resident #24 out of the closet. The kardex documented a check mark next to "Bed against wall and Mat to floor." The above observations of Resident #24 in bed without a fall mat on the floor as noted above were shared with CNA #7.

An interview was conducted with LPN (licensed practical nurse) #1 on 6/13/18 at 2:52 p.m. When asked how a CNA knows what assistive devices a resident uses, LPN #1 stated the CNAs use the care card of shift to shift verbal report. Resident #24's kardex was reviewed with LPN #1. When asked what should be done if the kardex documents a fall mat while resident in bed, LPN

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F 689	Continued From page 191 #1 stated, "When the resident is in bed the fall mat should be down." The above observations were shared with LPN #1. The administrator and director of nursing were made aware of the above finding on 6/13/18 at 6:15 p.m. No further information was obtained prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 192. (2) This information was obtained from the following website: https://www.cancer.gov/publications/dictionaries/cancer-terms/def/glioblastoma-multiforme	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills	F 693		7/27/18

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F 693	Continued From page 192 and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review it was determined that the facility staff failed to provide tube feeding care and services for one of 50 residents in the survey sample, Resident #117. The facility staff failed to label the tube feeding bag indicating what was infusing into Resident #117 via his gastrostomy tube. The findings include: Resident #117 was admitted to the facility on 6/22/16 with recent readmission on 5/9/18, with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (a chronic lung disease that makes it hard to breath) (1), a stroke with right sided paralysis, dementia, high blood pressure, and a gastrostomy tube (a tube that is inserted through the wall of the abdomen directly into the stomach in order to give drugs, liquids and liquid food to a patient) (2). . The most recent MDS (minimum data set) assessment, a 14 day Medicare assessment, with an assessment reference date of 5/23/18, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating he has severe cognitive impairment of daily decision making. The resident was coded as requiring extensive assistance of at least one staff member for bed mobility, transferring, dressing, toilet use and personal hygiene. The	F 693	Ftag 693 Resident #117: Tube feeding was labeled. No negative outcome occurred from this practice. Residents receiving tube feedings have the potential to be affected. The DON or designee will educate the staff on properly labeling tube feedings. The DON or designee will audit all current tube feeders for accurate tube feeding labels. Nursing administration will round on residents receiving tube feedings weekly for four weeks. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee. Continued compliance will be monitored though the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: July 27, 2018	

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resident was coded as totally dependent on staff for eating.

Observation on 6/13/18 at 2:45 p.m. noted that the bag of liquid infusing into Resident #117's abdomen via his gastrostomy tube was unlabeled.

On 6/13/18 at 2:48 p.m., an interview was conducted with LPN (licensed practical nurse) #3. She confirmed that she had hung the tube feeding bag and that the bag was not labeled with any description of the liquid content. At that point, she pulled out a permanent marker and wrote "Jevity" on the bag. She then stated she would be right back, as she needed to double check the order. She then returned and wrote "1.5" next to "Jevity". LPN #3 was asked why the bag had been unlabeled. She stated that they were usually labeled but it had been a "Busy day". When asked why the bags should be labeled, LPN #3 stated, "So everyone knows what it is".

On 6/14/18 at 8:12 a.m., RN (registered nurse) #1 was made aware of the findings of the unlabeled bag. RN #1 was asked what the purpose of labeling tube feeding bags was. She stated that the purpose was to let the "Staff and the next shift know what is hanging".

A review of the physician's orders confirmed that Resident #117's was to receive Jevity 1.5 Cal (calorie) Liquid (nutritional supplement).

Fundamentals of Nursing" 8th edition, 2013: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 1026. "Safety Guidelines for Nursing Skills" documents in part, "Label enteral equipment with patient name, room, formula

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F 693	Continued From page 194 name, rate, date, time of initiation, and nurse initials". ASM (administrative staff member) #1, the administrator, and ASM #2 (the director of nursing) were made aware of the above findings on 6/14/18 at 3:00 p.m. No further information was obtained prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/ency/article/000091.htm (2) This information was obtained from the following website: https://www.cancer.gov/publications/dictionaries/cancer-terms/def/gastrostomy-tube	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review it was determined that the facility staff failed to provide respiratory care and services for seven of 50 residents in the survey sample. Residents # 43, 99, 117, 83, 338, 336, and 98.	F 695	Ftag 695 Resident #43: Oxygen was corrected to the ordered setting. No negative outcome resulted from this practice	7/27/18

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F 695	Continued From page 195 1. The facility staff failed to administer Resident # 43's oxygen according to the physician's orders. 2. The facility staff failed to administer Resident # 99's oxygen according to the physician's orders. 3. The facility staff failed to administer Resident # 117's oxygen according to the physician's orders. 4. The facility staff failed to administer oxygen to Resident #83 at the physician ordered rate. 5. The facility staff failed to administer Resident # 338's oxygen according to the physician's orders. 6. The facility staff failed to administer Resident # 336's oxygen according to the physician's orders. 7. The facility staff failed to store Resident # 98's C-PAP (continuous positive airway pressure) [1] mask covered when not in use. The findings include: 1. The facility staff failed to administer Resident # 43's oxygen according to the physician's orders. Resident #43 was admitted to the facility on 10/23/17 with a most recent readmission on 4/9/18, with diagnoses that included but were not limited to: heart failure, pneumonia, diabetes, chronic obstructive pulmonary disease (a chronic lung disease that makes it hard to breath) (1), high blood pressure, anxiety, and severe obesity. The most recent MDS (minimum data set) assessment, a significant change assessment,	F 695	Resident #99: No longer resides at the facility Resident #117: Oxygen was corrected to the ordered setting. No negative outcome resulted from this practice Resident #83: Oxygen was corrected to the ordered setting. No negative outcome resulted from this practice Resident # 338: Oxygen was corrected to the ordered setting. No negative outcome resulted from this practice Resident #336: Oxygen was corrected to the ordered setting. No negative outcome resulted from this practice Resident #98: CPAP mask was bagged. No negative outcome resulted from this practice. Residents receiving respiratory treatments have the potential to be affected. The DON or designee will educate licensed nursing staff on verifying that oxygen settings match orders and storage of respiratory equipment. The DON or designee will audit current residents with oxygen orders and CPAP orders. Room rounds will be completed to ensure oxygen is at the correct settings and respiratory equipment is stored properly. Nursing administration will conduct rounds	

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F 695	Continued From page 196 with an assessment reference date of 4/16/18, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating she has severe cognitive impairment for daily decision making. The resident was coded as requiring extensive assistance of at least two or more staff members for bed mobility and transfers, and at least one person physical assist for dressing, toileting, eating and personal hygiene. A review of the comprehensive care plan dated 10/23/17, with a most recent revision on 4/9/18, documented in part, "Need: difficulty breathing". In the Interventions section of this focus it is documented in part, "Administer treatments per physician order ...O2 (oxygen) as ordered". A review of Resident #43's clinical record documented the physician order stating "oxygen 3 liters/min (minute) via nasal cannula continuously every shift for SOB (shortness of breath)". Observation on 6/12/18 at 8:35 a.m., 10:30 a.m., and 2:00 p.m. noted Resident # 43 reclining in her bed with oxygen on via nasal cannula (a plastic tube with two prong that are inserted just inside the nose) connected to an oxygen concentrator that was set at between 4.5-5 L/min. On 6/14/18 at 8:12 a.m., RN (registered nurse) #1 was asked to review MD's oxygen orders for Resident #43. RN #1 confirmed the order documented a rate of 3 L/min. RN #1 was asked to assess Resident #43's current flow rate. She confirmed it was at 4.5-5 L/min. She then set the oxygen flowmeter to the ordered rate of 3 L/min.	F 695	weekly for four weeks for oxygen settings and the storage of respiratory equipment. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee. Continued compliance will be monitored though the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: July 27, 2018	

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The oxygen concentrator's manufacturer's instructions documented, "To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the knob until the ball rises to the line. Now, center the ball on the L/min prescribed".

ASM (administrative staff member) #1, the administrator and ASM #2, director of nursing, where made aware of the above concerns on 6/14/18 at 3:00 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://medlineplus.gov/ency/article/000091.htm

2. The facility staff failed to administer Resident # 99's oxygen according to the physician's orders.

Resident #99 was admitted to the facility on 5/8/17 with a most recent readmission of 5/29/17 with diagnoses that included but were not limited to: ALS (amyotrophic lateral sclerosis) (a disease of the nerve cells in the brain, brain stem and spinal cord that control voluntary muscle movement) (1), difficulty swallowing, diabetes, high blood pressure, and generalized muscle weakness.

The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 5/15/18, coded the resident as scoring a "9" on the BIMS (brief interview for mental status) score, indicating she has moderate cognitive impairment for daily

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decision making. The resident was coded as requiring extensive assistance of at one staff member physical assist for bed mobility, transfers, dressing, toileting, eating and personal hygiene. In Section O - Special Treatments, the resident was coded as using oxygen during the look back period.

A review of the comprehensive care plan dated 11/28/17, with a most recent revision on 2/27/18, documented in part, "Need: Potential difficulty breathing". In the Interventions section of this focus it is documented in part, "Administer treatments per physician order".

A review of Resident #99's clinical record documented the physicians order stating "O2 (oxygen) via NC (nasal cannula) (a plastic tube with two prong that are inserted just inside the nose) continuous at 2 LPM (liters/minute) every shift for low O2 saturation".

Observation on 6/12/18 at 8:32 a.m., 10:45 a.m., and 2:14 p.m., noted Resident #99 was reclining in her bed with oxygen on via nasal cannula connected to an oxygen concentrator set at between 2.5-3 L/min.

On 6/14/18 at 8:12 a.m., RN (registered nurse) #1 was asked to review MD's oxygen orders for Resident #99. RN #1 confirmed the order documented a rate of 2 L/min. Asked RN #1 to assess Resident #99's current flow rate. She confirmed it was at 2.5-3 L/min. She then set the oxygen flowmeter to the ordered rate of 2 L/min.

The oxygen concentrator's manufacturer's instructions documented, "To properly read the flowmeter, locate the prescribed flowrate line on

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the flowmeter. Next, turn the knob until the ball rises to the line. Now, center the ball on the L/min prescribed".

ASM (administrative staff member) #1, the administrator and ASM #2, director of nursing, where made aware of the above concerns on 6/14/18 at 3:00 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://medlineplus.gov/ency/article/000688.htm

3. The facility staff failed to administer Resident # 117's oxygen according to the physician's orders.

Resident #117 was admitted to the facility on 6/22/16 with recent readmission on 5/9/18, with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (a chronic lung disease that makes it hard to breath) (1), a stroke with right sided paralysis, dementia, high blood pressure, and a gastrostomy tube (a tube that is inserted through the wall of the abdomen directly into the stomach in order to give drugs, liquids and liquid food to a patient) (2).

The most recent MDS (minimum data set) assessment, a 14 day Medicare assessment, with an assessment reference date of 5/23/18, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating he has severe cognitive impairment of daily decision making. The resident was coded as requiring extensive assistance of at least one staff member for bed mobility, transferring,

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dressing, eating, toilet use and personal hygiene. In Section O - Special Treatments, the resident was coded as using oxygen during the look back period.

A review of the comprehensive care plan dated 11/28/17, with a most recent revision on 2/27/18, documented in part, "Need: Potential difficulty breathing". In the Interventions section of this focus it is documented in part, "Administer treatments per physician order".

A review of Resident #117's clinical record documented the MD (medical doctor) order stating "Oxygen 2 L/min (liters/minute) via NC (nasal cannula) every shift for sob (shortness of breath)".

Observation on 6/12/18 at 8:49 a.m., 11:10 a.m., and 4:16 p.m., noted Resident #117 reclining in his bed with oxygen on via nasal cannula (a plastic tube with two prong that are inserted just inside the nose) connected to an oxygen concentrator set at 1.5 L/min.

On 6/14/18 at 8:12 a.m., RN (registered nurse) #1 was asked to review MD's oxygen orders for Resident #117. RN #1 confirmed the order documented a rate of 2 L/min. Asked RN #1 to assess Resident #117's current flow rate. She confirmed it was at 1.5 L/min. She then set the oxygen flowmeter to the ordered rate of 2 L/min.

The oxygen concentrator's manufacturer's instructions documented, "To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the knob until the ball rises to the line. Now, center the ball on the L/min prescribed".

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ASM (administrative staff member) #1, the administrator and ASM #2, director of nursing, where made aware of the above concerns on 6/14/18 at 3:00 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://medlineplus.gov/ency/article/000091.htm

(2) This information was obtained from the following website: https://www.cancer.gov/publications/dictionaries/cancer-terms/def/gastrostomy-tube

4. The facility staff failed to administer oxygen to Resident #83 at the physician ordered rate.

Resident #83 was admitted on 5/12/11 and readmitted on 10/19/17 with the diagnoses of but not limited to heart failure, high blood pressure, respiratory failure, Hepatitis C, thyrotoxicosis, pressure ulcer, stroke, anxiety disorder, osteomyelitis, and pneumonia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 5/11/18. The resident was cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for hygiene, toileting, dressing, and transfers; supervision for eating; and as incontinent of bowel and bladder.

A review of the clinical record revealed a physician's order dated 5/8/18 for "O2 (oxygen {1}) 2 liters continuous per nasal cannula every

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shift for CHF (congestive heart failure) Call Dr (doctor) if pulse ox (oxygen saturation) 89% or below."

Observations were made of Resident #83 on 6/12/18 at 12:53 p.m., 6/12/18 at 4:32 p.m., 6/13/18 at 8:30 a.m., and 6/13/18 at 12:42 p.m.. At each observation, the resident's oxygen concentrator rate was set at 1.5 liters and not the physician ordered 2 liters.

On 6/13/18 at 12:43 p.m., LPN #5 (Licensed Practical Nurse) was asked to look at Resident #83's oxygen concentrator. When asked to verify the level the concentrator was set at, LPN #5 stated "about 1.5 maybe a little more but certainly not at 2" (liters as ordered.).

On 6/14/18 at 12:40 p.m., in an interview with LPN #4, when asked how staff know if the oxygen is set at the correct rate, LPN #4 stated that the measurement lines on the flowmeter should be through the center of the ball for setting the rate.

A review of the care plan for Resident #83 revealed one for "Cardiac: At risk for decreased Cardiac output R/T (related to): HTN (hypertension - high blood pressure), CHF (congestive heart failure) w/ (with) O2 (oxygen) usage, Hx (history) of CVA (cerebral vascular accident - stroke)." This care plan was dated 10/20/17. The interventions included one dated 10/20/17 for "O2 via as ordered."

A review of the facility policy, "Medication Administration" documented, "All medications and treatments shall be initiated, administered, and/or discontinued in accordance with written physician

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orders...Procedure: 2. Compare the medication package/container to the guest's Medication Administration Record (MAR) to validate the correct medication, dosage, route, and time of administration...."

A review of the manufacturer's instructions on the oxygen concentrator documented, "To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the knob until the ball rises to the line. Now, center the ball on the L/min (liters per minute) line prescribed."

On 6/14/18 at approximately 5:00 PM, the Administrator was made aware of the concerns. No further information was provided.

{1} According to Fundamentals of Nursing, Fifth Edition, Lippincott Williams & Wilkins, 2007, page 851, "Because oxygen is a drug, its use requires a prescription. Policies and standing orders often permit the nurse to administer oxygen in emergency situations if the physician is not immediately available to write an order. Although oxygen is generally safe when used properly, certain precautions must be observed. As with all drugs, the potential exists for causing harm with misuse." On page 852, Procedure 36-5, "3. Identify client and proceed with 5 rights of medication administration...Rationale: Oxygen is a drug and administering using the 5 rights avoids potential errors....10. Monitor continuous therapy by assessing for pressure areas on the skin and nares every 2 hours and rechecking flow rate every 4 to 8 hours. Rationale: Permit early detection of skin breakdown or inadequate flow rate."

5. The facility staff failed to administer Resident #

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338's oxygen according to the physician's orders.

Resident # 338 was admitted to the facility on 06/10/18 with diagnoses that included but were not limited to: sepsis (1), hypothyroidism (2), depressive disorder (3), and respiratory failure (4).

Resident # 338's admission MDS (minimum data set) assessment was not due at the time of the survey. The "Admission Assessment" for Resident # 338 dated 06/10/18 documented she was oriented to person, place and time. Under the heading "Respiratory" it documented, "15. Oxygen therapy."

On 6/11/18 at 3:35 p.m., an observation of Resident # 338's oxygen was conducted. Resident # 338 was lying in bed receiving oxygen by nasal cannula connected to an oxygen concentrator. Observation of the flow meter on the oxygen concentrator revealed the oxygen flow rate of four and a half liters per minute.

On 6/12/18 at 9:40 a.m., an observation of Resident # 338's oxygen was conducted. Resident # 338 was lying in bed receiving oxygen by nasal cannula connected to an oxygen concentrator. Observation of the flow meter on the oxygen concentrator revealed the oxygen flow rate between four and four and a half liters per minute.

On 6/12/18 at approximately 4:40 p.m., an observation of Resident # 338's oxygen was conducted. Resident # 338 was lying in bed receiving oxygen by nasal cannula connected to an oxygen concentrator. Observation of the flow meter on the oxygen concentrator revealed the

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oxygen flow rate between four and four and a half liters per minute.

The POS (physician's order sheet) dated June 2018 documented, " O2 (oxygen) 6L (six liters) via (by) nasal cannula continuous every shift for shortness of breath. Start Date: 06/10/18."

The eTAR (electronic treatment administration record) dated June 2018 documented, "O2 (oxygen) 6L (six liters) via (by) nasal cannula continuous every shift for shortness of breath. Start Date: 06/10/18." Further review of the eTAR revealed Resident # 338 was receiving oxygen at six liters during the day, evening and night shifts on June 11th and 12th 2018.

On 06/14/18 at 8:06 a.m., an interview was conducted with LPN (licensed practical nurse) # 11. When asked to describe the procedure for checking a resident's oxygen flow rate, LPN # 11 stated, "It's checked throughout the shift." When asked how to read the read the oxygen flow rate, LPN # 11 stated, "The line should pass through the middle of the ball." When asked what Resident # 338's oxygen flow rate was ordered at, LPN looked up the physician's order sheet and stated, "O2 at six liters." After reading the flow meter on Resident # 338's oxygen concentrator in Resident # 338's room, LPN # 11 stated, "It's at six liters." When informed of the observations on 06/11/18 and 06/12/18, LPN stated, "It should have been checked."

On 06/15/18 at 8:40 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked to describe the procedure for ensuring the oxygen flow rate is maintained at the correct setting ASM

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2 stated, "The oxygen should be checked every time the nurse goes into the resident's room."

On 06/14/18 at approximately 6:15 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, and ASM # 5, clinical resource specialist, were made aware of the above findings.

No further information was provided prior to exit.

References:

(1) Sepsis is an illness in which the body has a severe, inflammatory response to bacteria or other germs. The symptoms of sepsis are not caused by the germs themselves. Instead, chemicals the body releases cause the response. This information was obtained from the website: https://medlineplus.gov/ency/article/000666.htm.

(2) Not enough thyroid hormone to meet your body's needs. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/hypothyroidism.html.

(3) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(4) When not enough oxygen passes from your lungs into your blood. This information was

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obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.

6. The facility staff failed to administer Resident # 336's oxygen according to the physician's orders.

Resident # 336 was admitted to the facility on 06/06/18 with diagnoses that included but were not limited to: end stage renal disease (1), diabetes mellitus (2), depressive disorder (3), gastroesophageal reflux disease (4), and hypertension (5).

Resident # 336's admission MDS (minimum data set) was assessment was not due at the time of the survey. The "Admission Assessment" for Resident # 336 dated 06/07/18 documented she was oriented to person, place and time.

On 06/13/18 at 3:55 p.m., an observation of Resident # 336's oxygen concentrator was conducted. The flow meter on the Oxygen concentrator documented the oxygen flow rate between four and four and a half liter per minute. Resident # 336 was dressed, sitting up in her wheelchair reading and receiving oxygen by nasal cannula connected to the oxygen concentrator.

On 06/13/18 at 5: p.m., an observation of Resident # 336's oxygen concentrator was conducted. The flow meter on the Oxygen concentrator documented the oxygen flow rate between four and four and a half liter per minute. Resident # 336 was dressed, sitting up in her wheelchair receiving oxygen by nasal cannula connected to the oxygen concentrator.

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The POS (physician's order sheet) dated June 2018 documented, " Oxygen 3L (three liters) via (by) nasal cannula continuous every shift. Start Date: 06/06/18."

The eTAR (electronic treatment administration record) dated June 2018 documented, "O2 (oxygen) 3L (six liters) via (by) nasal cannula continuous every shift. Start Date: 06/06/18." Further review of the eTAR revealed Resident # 336 was receiving oxygen at three liters during the evening and night shifts on 06/13/18.

On 06/14/18 at 8:06 a.m., an interview was conducted with LPN (licensed practical nurse) # 11. When asked to describe the procedure for checking a resident's oxygen flow rate, LPN # 11 stated, "It's checked throughout the shift." When asked how to read the oxygen read flow rate, LPN # 11 stated, "The line should pass through the middle of the ball." When asked about Resident # 336's physician ordered oxygen flow rate, LPN looked up the physician's order sheet and stated, "O2 at three liters." After reading the flow meter on Resident #338's oxygen concentrator in Resident # 338's room, LPN # 11 stated, "It's at four liters." When informed of the observations on 06/13/18, LPN stated, "It should have been checked I'll get an order for four liters."

On 06/15/18 at 8:40 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked to describe the procedure for ensuring the oxygen flow rate is maintained at the correct setting, ASM # 2 stated, "The oxygen should be checked every time the nurse goes into the resident's room."
On 06/14/18 at approximately 6:15 p.m., ASM (administrative staff member) # 1, administrator,

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ASM # 2, director of nursing, and ASM # 5, clinical resource specialist, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/000500.htm.

(2) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(3) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(4) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(5) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

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7. The facility staff failed to store Resident # 98's C-PAP (continuous positive airway pressure) [1] mask covered when not in use.

Resident # 98 was admitted to the facility on 05/10/18 with diagnoses that included but were not limited to: hypertension (1), anxiety (2), dysphagia (3), and hyperlipidemia (4).

Resident # 98's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 05/17/18, coded Resident # 98 as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 - being cognitively intact for making daily decisions. Resident # 98 was coded as requiring extensive assistance of one staff member for activities of daily living. Section O "Special Treatments, procedures and Programs" coded Resident # 98 as having a CPAP.

On 06/11/18 at 3:55 p.m., an observation of Resident # 98's room revealed a C-PAP (continuous positive air pressure) mask lying on top of the bedside table uncovered. Resident # 98 was lying on her bed watching television. The POS (physician's order sheet) dated June 2018 documented, "Please apply C-pap machine with distilled water every night at setting 16 every night for sleep apnea. Start Date: 05/23/18."

On 06/15/18 at 8:40 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked to describe the process for ensuring a C-PAP mask is stored in a sanitary manner, ASM # 2 stated, "If the C-PAP was not in use it should have been put in a bag."

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F 695	Continued From page 211 On 06/14/18 at approximately 6:15 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, and ASM # 5, clinical resource specialist, were made aware of the above findings. No further information was provided prior to exit. References: (1) CPAP is an airway treatment that applies a constant pressure of forced air to keep the airway open. This information was obtained from the website: https://medlineplus.gov/ency/imagepages/9685.htm. (2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (3) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary. (4) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. (5) Cholesterol is a fat (also called a lipid) that your body needs to work properly. Too much bad cholesterol can increase your chance of getting heart disease, stroke, and other problems. The medical term for high blood cholesterol is lipid disorder, hyperlipidemia, or hypercholesterolemia. This information was obtained from the website:	F 695		

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F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to follow and provide a comprehensive pain management plan for three of 50 residents in the survey sample, Residents # 24, 336, and 121. 1. The facility staff failed to document the location of the pain and the attempts at non-pharmacological interventions prior to the administration of Morphine to Resident #24. 2. The facility staff failed to attempt non-pharmacological interventions prior to the use of prn (as needed) pain medication for Resident # 336. 3. The facility staff failed to attempt non-pharmacological interventions prior to the use of prn (as needed) pain medication for Resident # 121. The findings include: 1. The facility staff failed to document the location of the pain and the attempts at	F 697	F697 Resident #24: No negative outcome has occurred from this practice. Pain assessment has been completed. Resident #336: No negative outcome occurred from this practice. Pain assessment has been completed. Resident #121: No negative outcome occurred from this practice. Pain assessment has been completed. All residents in the facility have the potential to be affected. The DON or designee will educate licensed nursing staff on offering non pharmacological pain interventions prior to the use of pain medications. The DON or designee will educate licensed nursing staff on proper documentation of pain location. The DON or designee will audit residents	7/27/18

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F 697	Continued From page 213 non-pharmacological interventions prior to the administration of Morphine for Resident #24. Resident #24 was admitted to the facility on 3/30/18 with diagnoses that included but were not limited to: cancer of the brain, anxiety disorder, history of breast cancer, high blood pressure, paralysis on one side, and encephalopathy (any brain disorder or disease) (1). The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 4/27/18 coded the resident as rarely understood and rarely understanding others. The resident was coded as having both short and long-term memory difficulties and as severely impaired to make daily cognitive decisions. The physician order dated, 5/29/18, documented, "Morphine Sulfate (concentrate) (used for the management of acute and chronic pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate) (2) Solution 20 MG/ML (milligrams per milliliter), Give 0.25 ml by mouth every 4 hours as needed for pain/sob (shortness of breath)." The May 2018 MAR (medication administration record) documented the above medication order. The medication was documented as having been administered on the following dates and times: 5/29/18 at 5:34 p.m. for a pain level of 4. The review of the eMAR (electronic medication administration record) failed to evidence documentation of the location of the pain and any non-pharmacological interventions attempted prior to the administration of the medication.	F 697	with PRN pain medications for non pharmacological pain interventions and documentation of pain location. Nursing administration will review residents with PRN pain medication for the documentation of non pharmacological approaches and pain location 5 times a week for 4 weeks. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee Continued compliance will be monitored though the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: July 27, 2018	

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The June 2018 MAR documented the above medication order. The medication was documented as having been administered on the following dates and times:
6/2/18 at 7:06 p.m. for a pain level of 5. The eMAR documented the indication for the administration was for "Yelling out." The eMAR failed to evidence documentation of any non-pharmacological interventions prior to the administration of the medication.
6/4/18 at 5:28 a.m. for a pain level of 5. The eMAR documented the indication for the administration was for "Given for S/S (signs and symptoms) of pain." The eMAR failed to evidence documentation of any non-pharmacological interventions prior to the administration of the medication.
6/4/18 at 10:11 a.m. for a pain level of 2. The review of the eMAR failed to evidence documentation of the location of the pain and any non-pharmacological interventions attempted prior to the administration of the medication.
6/9/18 at 11:42 p.m. for a pain level of 4. The review of the eMAR failed to evidence documentation of the location of the pain and any non-pharmacological interventions attempted prior to the administration of the medication.
6/11/18 at 12:02 a.m. for a pain level of 9. The review of the eMAR failed to evidence documentation of the location of the pain and any non-pharmacological interventions attempted prior to the administration of the medication.
6/11/18 at 9:43 p.m. for a pain level of 7. The review of the eMAR failed to evidence documentation of the location of the pain and any non-pharmacological interventions attempted prior to the administration of the medication.

The comprehensive care plan, dated, 3/30/18 and

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revised on 4/11/18, documented, "Need: Pain risk r/t (related to) craniotomy r/t glioblastoma brain tumor, arthritis, sleep apnea and GERD (gastroesophageal reflux disease)." The "Interventions" documented in part: "Administer medication for pain and observe for effectiveness/side effect and report ineffectiveness to physician. Assist to position of comfort with physical support as necessary. Attempt to evaluate characteristics of pain; on a scale of 0-10 or verbal description scale; mild, moderate, severe, very severe, horrible. Observe for complaints and/or nonverbal signs of pain such as; grimacing, yelling, crying, moaning, guarding. Report to nurse and or physician as needed."

An interview was conducted with LPN (licensed practical nurse) #5 on 6/13/18 at 3:26 p.m. regarding resident complaints of pain. LPN #5 stated she would assess for pain, location, pain scale if capable, try altering the resident's position, offer a back rub, use pillows to reposition and if ineffective, would give medication. When asked where the pain location, intensity and things attempted is documented, LPN #5 stated it should all be documented in the nurse's notes. A box pops up when you give the medication and you can just write a note there.

The facility policy, "Pain Management" documented in part, "The Pain Management Program will be sued by nursing staff to evaluate, provide appropriate interventions, and monitor the effectiveness of the pain regimen for guests experiencing acute and/or chronic pain, in order to promote comfort and the ability to reach their highest functional level. Situations when guest may be evaluated for pain include, but are not

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limited to: Guest exhibits restless ness or combative behavior, guest verbalizes pain and/or requests pain medication, guest exhibits non-verbal cures, i.e., grimacing, wringing of hands. If the guest is unable to verify pain due to cognitive or physical impairments, the nurse will utilize the Wong-Baker Faces Pain rating scale of 0-10. The nurse should also observe for non-verbal cues such as facial expression, grimacing, wringing of hands, etc...The location and movement of the pain will be documented...The nurse will develop a written care plan for pain relief, considering medicinal and non-medicinal interventions. (Non-medicinal interventions should be attempted before medicinal interventions are explored). Examples: Non-Medicinal: 1. education/instruction, music relaxation, refocusing, adjustment of environment; i.e., noise level, lighting, temperature, back rub, exercise, positioning devices/repositioning, aromatherapy and therapy administered interventions (moist heat, tens unit, ultrasound). Medicinal: 1. Evaluate guest's pain intensity (i.e., interview and observation). 2. Administer medication as prescribed."

According to Fundamentals of Nursing, Fifth Edition, 2007, Lippincott Williams & Wilkins, page 1176 to 1207. "Pain, one of the most complex human experiences, is an invisible phenomenon influenced by the interaction of affective (emotional), behavioral, cognitive, and physiologic-sensory factors. Because pain is a highly individual experience, the basis for pain management is simply the client's description of pain. Pain exists whenever the person says it does....Typically people describe pain by its location, intensity, quality, and temporal pattern. Sensory components of the pain experience are

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subjective but can be measured using standardized tools....Assessment: An accurate assessment focusing on pain's cause is essential for determining proper therapy. Ongoing assessment also is important for implementing an effective pain management plan....Document pain assessment information in an accessible location. Even the best pain assessment conducted by the one nurse is of limited value unless he or she shares the information with other healthcare professionals responsible for the client's care. Subjective Data: In an attempt to assess the client's pain, obtain answers to the following questions: Where is the pain located? What is the magnitude or intensity (level) of the pain? What level of pain would the client like to have? What level of pain would the client be willing to tolerate? How does the pain feel to the client; how is it described (its quality)? How does the pain change with rest, activity, or time (its temporal pattern)?...Inadequate or poor pain assessment is a leading factor in poor pain control...Objective data....Physiologic responses to pain are the result of the activation of the autonomic nervous system. With acute pain, the general responses observed include tachycardia, elevated blood pressure, increased respiratory rate, diaphoresis, and gastric distress. With persistent chronic pain, these responses may be modified or absent....Related symptoms may give additional clues about pain. Nausea and vomiting, fatigue, anorexia, and withdrawal are common with pain....Observe the client's facial expressions and body movements. Wincing, frowning, and grimacing can indicate pain...Body movements may represent protective actions to decrease the pain. Body movements such as rubbing, splinting, guarding, immobilizing, elevating the painful extremity, or changing

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positions frequently may increase with pain..."

The administrator, ASM (administrative staff member) #1 and the director of nursing, ASM #2, were made aware of the above findings on 6/13/18 at 6:15 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 192.
(2) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3f3a870e-f325-475b-8453-fe3d1bb8f54a.
2. The facility staff failed to attempt non-pharmacological interventions prior to the use of prn (as needed) pain medication for Resident # 336.

Resident # 336 was admitted to the facility on 06/06/18 with diagnoses that included but were not limited to: end stage renal disease (1), diabetes mellitus (2), depressive disorder (3), gastroesophageal reflux disease (4), and hypertension (5).

Resident # 336's admission MDS (minimum data set) assessment was not due at the time of the survey. The "Admission Assessment" for Resident # 336 dated 06/07/18 documented she was oriented to person, place and time. Under the heading, "H. Pain" Resident # 336 was coded as not having any pain in the last five days.

The physician's orders dated March 2018 for Resident # 336 documented, "Acetaminophen (6)

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Tablet 325 MG (milligram). Give 2 (two) tablets by mouth every 4 (four) hours as needed for pain for pain scale 1-3. Start Date: 06/06/18." "Norco (7) tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 (one) tablet by mouth every 4 (four) hours as needed for pain scale 7-10. Start Date: 06/06/18."

The eMAR (electronic medication administration record) dated June 2018 for Resident # 336 documented the above physician's orders. Review of the eMAR revealed Acetaminophen was administered to Resident # 336 on 06/11/18 at 1500 (3:00 p.m.) with a pain level of 2 (two). Norco was administered to Resident # 336 on 06/09/18 at 8:12 a.m. with a pain level of 7 (seven), at 16:40 (4:16 p.m.) with a pain level of 9 (nine) and on 06/10/18 at 11:17 a.m. with a pain level of 7 (seven) and at 2128 (9:28 p.m.) with a pain level of 8 (eight).

Review of the "Nurse's "Progress Notes" dated 06/06/18 through 06/12/18 failed to evidence documentation of non- pharmacological interventions prior to the administration of the as needed acetaminophen and Norco.

On 06/14/18 at 10:52 a.m., an interview was conducted with LPN (licensed practical nurse) # 4. When asked to describe the procedure and documentation for administering prn (as needed) pain medication, LPN # 4 stated, "Ask where the pain is, and what level the pain is using 0-10 scale with 10 being the worse pain, document it in the computer on the MAR (medication administration record) and in nurse's notes. Administer pain medication and then follow up with the resident to see how effective it was, using the pain scale. We try non-pharmacological

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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
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interventions before giving the pain meds (medication). You should document that the intervention was attempted, what the intervention was and if the resident refused." After reviewing the June 2018 eMARS and nurse's notes dated 06/01/18 through 06/13/18 for Resident 336, LPN # 4 was asked if non-pharmacological interventions were attempted prior to the administration of Resident # 336's prn (as needed) pain medication. LPN # 4 stated, "I can't say the non-pharmacological interventions were attempted. If it wasn't documented it wasn't done."

On 06/15/18 at 8:40 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked to describe the procedure and documentation for administering prn (as needed) pain medication, ASM # 2 stated, "Ask what level of pain they have and the location, regardless of the pain level attempt non-pharmacological intervention, reassess the resident's pain, if not effective, administer pain medication. Document the non-pharmacological intervention attempted and if successful in the progress notes." After reviewing the June 2018 eMARS and nurse's notes dated 06/01/18 through 06/13/18, ASM # 2 was asked if non-pharmacological interventions were attempted prior to the administration of as needed pain medication to Resident # 336's. ASM # 2 stated, "If it wasn't documented it wasn't done."

On 06/14/18 at approximately 6:15 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, and ASM # 5, clinical resource specialist, were made aware of the above findings.

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No further information was provided prior to exit.

References:
(1) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(2) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(3) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(4) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

(5) Symptoms of a brain problem. They happen because of sudden, abnormal electrical activity in the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.html.

(6) Acetaminophen is used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the

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pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a681004.html.

(7) Hydrocodone is an opioid pain medication. An opioid is sometimes called a narcotic. Acetaminophen is a less potent pain reliever that increases the effects of hydrocodone. The combination of acetaminophen and hydrocodone is used to relieve moderate to severe pain. This information was obtained from the website: https://www.rxlist.com/norco-5-325-drug/patient-images-side-effects.htm.

3. The facility staff failed to attempt non-pharmacological interventions prior to the use of prn (as needed) pain medication for Resident # 121.

Resident # 121 was admitted to the facility on 04/04/17 with a readmission of 05/16/18 with diagnoses that included but were not limited to hypertension (1), gastroesophageal reflux disease (2), diabetes mellitus (3), depression (4) and chronic obstructive pulmonary disease (5).

Resident # 121's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/23/18, coded Resident # 121 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily

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decisions. Resident # 121 was coded as requiring extensive assistance of one staff member for activities of daily living. Section "J0300 Pain Presence" coded Resident # 121 as having pain frequently with a pain level of 10.

The physician's orders dated June 2018 for Resident # 121 documented, "MAPAP (Acetaminophen) [6] 500 MG (milligram). Give 1 (one) tablet by mouth every 8 (eight) hours a needed for Pain. Start Date: 05/16/18." "Tramadol (7) 50 MG. Give 1 (one) tablet by mouth every 8 (eight) hours a needed for Pain. Start Date: 05/16/18." "Tramadol 50 MG. Give 2 (two) tablets by mouth every 8 (eight) hours a needed for Pain. Start Date: 05/16/18."

The eMAR (electronic medication administration record) dated May 2018 documented the above physicians orders. Review of the May 2018 eMAR revealed tramadol 50 mg one tablet was administered to Resident # 121:
On 05/17/18 at 2047 (8:47 p.m.) with a pain level of 4 (four).
On 05/26/18 at 2002 (8:02 p.m.) with a pain level of 4 (four).
On 05/29/18 at 1529 (3:29 p.m.) with a pain level of 4 (four).
On 05/30/18 at 2230 (10:30 p.m.) with a pain level of 5 (five).
On 05/31/18 at 2312 (11:12 p.m.) with a pain level of 4 (four).
Review of the May 2018 eMAR revealed tramadol 50 mg two tablets were administered to Resident # 121: On 05/07/18 at 2245 (10:45 p.m.) with a pain level of 5 (five).
On 05/11/18 at 1134 (11:34 a.m.) with a pain level of 4 (four).

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Review of the May 2018 eMAR revealed MAPAP 500 mg was administered to Resident # 121 on 05/31/18 at 0957 (9:57 a.m.) with a pain level of 6 (six).

The eMAR (electronic medication administration record) dated June 2018 documented, "MAPAP (Acetaminophen) 500 MG (milligram). Give 1 (one) tablet by mouth every 8 (eight) hours a needed for Pain. Start Date: 05/16/18." "Tramadol 50 MG. Give 1 (one) tablet by mouth every 8 (eight) hours a needed for Pain. Start Date: 05/16/18."

Review of the June 2018 eMAR revealed tramadol 50 mg one tablet was administered to Resident # 121: On 06/05/18 at 1339 (1:39 p.m.) with a pain level of 7 (seven). On 06/06/18 at 1525 (3:25 p.m.) with a pain level of 5 (five). On 06/11/18 at 1324 (1:24 p.m.) with a pain level of 5 (five). On 06/12/18 at 1330 (1:30 p.m.) with a pain level of 5 (five).

Review of the June 2018 eMAR revealed MAPAP 500 mg one tablet was administered to Resident # 121: On 06/01/18 at 1700 (5:00 p.m.) with a pain level of 2 (two). On 06/02/18 at 1646 (4:46 p.m.) with a pain level of 5 (five).

Review of the Nurse's "Progress Notes" dated 05/16/18 through 06/13/18 failed to evidence documentation of non- pharmacological interventions prior to the administration of tramadol and MAPAP.

On 06/14/18 at 10:52 a.m., an interview was conducted with LPN (licensed practical nurse) # 4. When asked to describe the procedure and documentation for administering prn (as needed)

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pain medication, LPN # 4 stated, "Ask where the pain is, and what level the pain is using 0-10 scale with 10 being the worse pain, document it in the computer on the MAR (medication administration record) and in nurse's notes. Administer pain medication and then follow up with the resident to see how effective it was, using the pain scale. We try non-pharmacological interventions before giving the pain meds (medication). You should document that the intervention was attempted, what the intervention was and if the resident refused." After reviewing the May and June 2018 eMARS, and nurse's notes dated 05/16/18 through 06/13/18, for Resident # 121, LPN # 4 was asked if non-pharmacological interventions were attempted prior to the administration of as needed pain medication to Resident # 121's. LPN # 4 stated, "I can't say the non-pharmacological interventions were attempted. If it wasn't documented it wasn't done."

On 06/15/18 at 8:40 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked to describe the procedure and documentation for administering prn (as needed) pain medication, ASM # 2 stated, "Ask what level of pain they have and the location, regardless of the pain level attempt non-pharmacological intervention, reassess the resident's pain, if not effective, administer pain medication. Document the non-pharmacological intervention attempted and if successful in the progress notes." After review the May and June 2018 eMARS and nurse's notes dated 05/16/18 through 06/13/18, ASM # 2 was asked if non-pharmacological interventions were attempted prior to the administration of as needed pain medication to Resident # 121. ASM

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2 stated, "If it wasn't documented it wasn't done."

On 06/14/18 at approximately 6:15 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, and ASM # 5, clinical resource specialist, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(2) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(3) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(4) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm.

(5) Disease that makes it difficult to breath that

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F 697	Continued From page 227 can lead to shortness of breath). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (6) Acetaminophen is used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a681004.html. (7) Tramadol is used to relieve moderate to moderately severe pain. Tramadol extended-release tablets and capsules are only used by people who are expected to need medication to relieve pain around-the-clock. Tramadol is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695011.html.	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent	F 698		7/27/18

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F 698	Continued From page 228 with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to provide dialysis care and services for one of 50 residents in the survey sample, Resident # 336. The facility staff failed to check the bruit and thrill (1) and monitor the dialysis catheter for infection for Resident # 336. The findings include: Resident # 336 was admitted to the facility on 06/06/18 with diagnoses that included but were not limited to: end stage renal disease (2), diabetes mellitus (3), depressive disorder (4), gastroesophageal reflux disease (5), and hypertension (6). Resident # 336's admission MDS (minimum data set) was assessment was not due at the time of the survey. The "Admission Assessment" for Resident # 336 dated 06/07/18 documented she was oriented to person, place and time. Under the heading "Genitourinary" it documented, "5. Dialysis: Hemodialysis. 6. Type of dialysis Access: AV Shunt." The physician's order for Resident # 336 dated 06/13/2018 documented, "Check bruit and thrill every shift. Start Date: 06/06/18." "Monitor dialysis catheter for s/s (signs/symptoms) infection every shift. Start	F 698	Ftag 698 Resident #336: Bruit and thrill has been checked. No negative outcome has occurred from this practice. Residents receiving dialysis have the potential to be affected. The DON or designee will educate licensed nursing staff on procedure for checking bruit and thrill for dialysis residents and providing appropriate documentation. The DON or designee will complete an audit of current dialysis residents and treatment documentation of bruit and thrill. The DON or designee will monitor documentation of bruit and thrill on the TAR 5 days a week for 4 weeks. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee. Continued compliance will be monitored though the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date:	

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date: 06/06/18."

The eMAR (electronic medication administration record) dated "June 2018" for Resident # 336 documented, "Check bruit and thrill every shift. Start Date: 06/06/18." Further review of the eMAR revealed blanks for the dates of 06/08/18, 06/09/18, 06/10/18, and 06/13/18 indicating the bruit and thrill was not checked. "Monitor dialysis catheter for s/s (signs/symptoms) infection every shift. Start date: 06/06/18." Further review of the eMAR revealed blanks for the dates of 06/08/18, 06/09/18, 06/10/18, and 06/13/18 indicating the dialysis catheter was not checked.

Review of the facility's nursing "Progress Notes" dated 06/06/18 through 06/13/18 failed to evidence documentation of the bruit and thrill and monitoring of the dialysis catheter was being as ordered.

On 06/15/18 at 8:40 a.m. an interview was conducted with ASM (administrative staff member) # 2, director of nursing regarding Resident # 336's bruit and thrill and monitoring of the dialysis catheter for infection. ASM #2 completed review of the eMAR, physician's orders, and progress dated 06/06/18 through 06/13/18, and agreed the physician's orders were not followed for the monitoring of infection and the bruit and thrill. ASM # 2 stated, "The physician's order should have been followed. Since there is no documentation the bruit and thrill and catheter were monitor and checked I can't say it was done."

Medical Surgical Nursing made Incredibly Easy, Lippincott Williams & Wilkins copyright 2004 page 565 "Dialysis Monitoring and Aftercare: After

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completion of hemodialysis, monitor the vascular access site for bleeding. If bleeding is excessive, maintain pressure on the sited and notify the doctor. To prevent clotting or other problems with blood flow, make sure that the arm used for vascular access isn't used for any other procedure, including I.V. line insertion, blood pressure monitoring, and venipuncture. At least four times per day, assess circulation at the access site by auscultating for the presence of bruits and palpating for thrills. Unlike most other circulatory assessments, bruits and thrills should be present here. Lack of a bruit at a venous access site for dialysis may indicate a blood clot requiring immediate surgical attention."
On 06/14/18 at approximately 6:15 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, and ASM # 5, clinical resource specialist, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) A bruit is an audible vascular sound associated with turbulent blood flow. Although usually heard with the stethoscope, such sounds may occasionally also be palpated as a thrill. In the head and neck, these auscultatory sounds may originate in the heart (cardiac valvular murmurs radiating to the neck), the cervical arteries (carotid artery bruits), the cervical veins (cervical venous hum), or arteriovenous (AV) connections (intracranial AV malformations). These sounds may be normal, innocent findings (i.e., a venous hum in a child) or may point to underlying pathology (i.e., a carotid artery bruit caused by atherosclerotic stenosis in an adult). Head and neck bruits loom especially important

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today because physicians encounter arterial occlusive disease more frequently as a greater proportion of our population lives longer. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/books/NBK289/

(2) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .

(3) You had a fracture (break) in the femur in your leg. It is also called the thigh bone. You may have needed surgery to repair the bone. You may have had surgery called an open reduction internal fixation. In this surgery, your surgeon will make a cut to open your fracture. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000166.htm.

(4) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(5) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(6) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the

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F 698	Continued From page 232 website: https://medlineplus.gov/ency/article/003213.htm.	F 698		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by:	F 755		7/27/18

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F 755	Continued From page 233 Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure medications were available for one of 50 residents in the survey sample, Resident #90. The facility staff failed to ensure four of Resident #90's medications were available for administration. The findings include: Resident #90 was admitted to the facility on 5/9/18 with a recent readmission on 5/29/18 with diagnoses that included but were not limited to: cerebral infarct (area of dead tissue resulting from diminished or stopped blood flow to the tissue area in the brain) (1), high blood pressure, seizures, feeding tube, paralysis on one side, and human immunodeficiency virus (HIV) disease (a virus that causes acquired immunodeficiency syndrome) (2). The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 5/21/18, coded the resident as having both short and long term memory difficulties. The resident was coded as being severely impaired to make daily cognitive decisions. Resident #90 was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living. The physician orders dated, 5/9/18, documented the following medication orders: -"Lexiva Suspension 50 mg/ml (milligrams/milliliter), Give 700 mg via Peg-Tube (feeding tube) two times a day for HIV." (LEXIVA	F 755	Ftag 755 Resident #90: Medication is available in the facility for the resident. No negative outcome occurred from this practice. All residents have the potential to be affected. The DON or designee will educate licensed nursing staff on what to do when medication is not available. The DON or designee will audit all medication carts to identify any medications that are not available. The DON or designee will monitor medication carts weekly for four weeks to identify medications that are not available. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee. Continued compliance will be monitored though the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: July 27, 2018	

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is indicated in combination with other antiretroviral agents for the treatment of human immunodeficiency virus infection).(3)
- Norvir Solution 80 mg/ml, Give 1.25 ml by mouth two times a day for HIV, give with meals. (Norvir is used in combination with other drugs to treat the infection caused by HIV) (4)
- Prezista Suspension, give 600 mg via Peg-tube two times a day for HIV. (Prezista is under in combination of other drugs to treat HIV).(5)
- Tivicay Tablet 50 mg, give 1 tablet by mouth two times a day for HIV."(Tivicay is used in combination with other drugs to treat the infection caused by HIV) (6).

The May 2018 MAR (medication administration record) documented the above medications. The MAR documented the Lexiva Suspension was not administered on 5/10/18 at 9:00 a.m. and 5:00 p.m., on 5/11/18 at 9:00 a.m. and 5:00 p.m. and on 5/12/18 at 9:00 a.m.

The eMAR(electronic medication administration record) notes documented the following:
5/10/18 at 2:47 p.m. - Lexiva suspension - order to be clarified.
5/10/18 at 8:05 p.m. - Lexiva suspension - awaiting approval from administration.
5/11/18 at 12:05 p.m. - Lexiva suspension - Not available from pharmacy - MD (medical doctor) aware.
5/11/18 at 9:25 p.m. - Lexiva suspension - awaiting pharm (pharmacy)
5/12/18 at 9:35 a.m. - Lexiva suspension - not available.

The May 2018 MAR documented the Norvir suspension was not administered on 5/10/18 at 9:00 a.m. and 5:00 p.m.

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The eMAR notes documented the following:
5/10/18 at 2:49 p.m. - Norvir suspension - clarification needed.
5/10/18 at 8:00 p.m. - Norvir suspension - awaiting approval from administration.

The May 2018 MAR documented the Prezista suspension was not administered on 5/10/18 at 9:00 a.m. and 5:00 p.m., 5/11/18 at 9:00 a.m. and 5:00 p.m. and on 5/12/18 at 9:00 a.m. and 5:00 p.m.

The eMAR notes documented the following:
5/10/18 at 2:50 p.m. - Prezista suspension - clarification needed.
5/10/18 at 8:07 p.m. - Prezista suspension - awaiting approval from administration.
5/11/18 at 12:05 p.m. - Prezista suspension - Will give upon arrival
5/11/18 at 9:26 p.m. - Prezista suspension - no explanation as to why it was not given.
5/12/18 at 9:36 a.m. - Prezista suspension - will give upon arrival.
5/12/18 at 9:44 p.m. - Prezista suspension - awaiting approval from management.

The May 2018 MAR documented the Tivicay was not administered on 5/9/18 at 5:00 p.m.

The eMAR notes documented the following:
5/9/18 at 10:53 p.m. - Tivicay - awaiting pharmacy.

The comprehensive care plan dated, 5/22/18, failed to evidence a care plan to address the administration of the HIV medications. The diagnosis of HIV was throughout the care plan but no specific care plan to address the

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medications.

An interview was conducted with LPN (licensed practical nurse) #9 on 6/14/18 at 10:07 a.m. When asked the process for obtaining medications when a resident is admitted, LPN #9 stated, "We put the medication orders into the computer. We print out the orders and face sheet and fax it to the pharmacy. We follow that up with a phone call." When asked what is the nurse to do when the medications are not in the cart at the scheduled time of administration, LPN #9 stated, "We check the (name of back up drug system in the facility)." When asked if the medications were unusual medications, LPN #9 stated, "I call the doctor and tell them the meds (medications) aren't here and then call the pharmacy and have it sent stat (right away). Usually the medications are here in four hours."

An interview was conducted with RN (registered nurse) #2, on 6/14/18 at 10:19 a.m. When asked the process for obtaining medications upon admission, RN #2 stated, "(Name of nurse who does admission paperwork) puts them in the computer, copies the orders, sends them to the pharmacy and follow up with a phone call." When asked what happens when a medication is not available at the scheduled time of administration, RN #2 stated, "We check the (name of back up drug system in facility) and or call the pharmacy and notify the doctor that it's not available." When shown the eMAR notes above, RN #2 stated, "I was not involved in any of this."

An interview was conducted with ASM (administrative staff member) #1, the administrator, on 6/14/18 at 2:00 p.m. When asked her involvement with the above

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medications, AM #1 stated, "I was aware the resident was coming on the medications. I had given the former director of nursing, the authority to get the medications needed." When asked if she was aware of the multiple doses the resident missed, ASM #1 stated, "I didn't know that." ASM #1 was made aware of the above concern.

The facility policy documented in part, "This policy 7.0 sets forth procedures relating to medication shortages and unavailable medications. 1. Upon discovery that facility has an inadequate supply of a medication to administer to a resident, facility staff should immediately initiate action to obtain the medication from pharmacy. IF the medication shortage is discovered at the time of medication administration, facility staff should immediately take the action specified in Sections 2 or 3 as applicable. 2. If a medication shortage is discovered during normal pharmacy hours: Facility nurse should call pharmacy to determine the status of the order. IF the medication has not been ordered, the licensed facility nurse should place the order or reorder for the next scheduled delivery. If the next available delivery causes delay or a missed dose in the resident's medications schedule, facility nurse should obtain the medication from the emergency medication supply to administer the dose. If the medication is not available in the Emergency Medication Supply, facility staff should notify pharmacy and arrange for an emergency delivery. 3. If the medication shortage is discovered after normal pharmacy hours: A licensed facility nurse should obtain the ordered medication from the Emergency Medication Supply. If the ordered medication is not available in the Emergency Medication Supply, the licensed facility nurse should all pharmacy's emergency answering

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service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include: Emergency delivery or use of an emergency (back-up) third party pharmacy. If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain orders or directions. If the medication is unavailable from pharmacy or a third party pharmacy, and cannot be supplied from the manufacturer, facility should obtain alternate physician/prescriber orders, as necessary."

No further information was obtained prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 296.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 276.
(3) This information was obtained from the following website:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=24feb9be-32a6-45fd-a896-f3e202edd8a9
(4) This information was obtained from the following website:
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012017/?report=details.
(5) This information was obtained from the following website:
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009822/?report=details.
(6) This information was obtained from the following website:
https://aidsinfo.nih.gov/drugs/560/descovy/0/patient

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F 758	Continued From page 239	F 758		
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 §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	F 758		7/27/18

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F 758	Continued From page 240 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, facility document review and clinical record review, it was determined the facility staff failed to ensure three of 50 residents in the survey sample, Residents #24, 238, and 43, were free from unnecessary psychotropic medications. 1. a. The facility staff failed to ensure the PRN (as needed) Ativan had a stop date for Resident #24. 1.b. The facility staff failed to document the reason for the administration of Ativan and failed to attempt non-pharmacological interventions prior to the administration of the medication. 2. The facility staff failed to ensure the physician prescribed PRN (as needed) Ativan for Resident #238, had a stop date. 3. The facility staff failed to ensure Resident #43 was free from the unnecessary use of Ativan. The findings include: 1.a. Resident #24 was admitted to the facility on	F 758	Ftag 758 Resident #34: Ativan orders were reviewed by the physician and a stop date was entered. No negative outcome occurred as a result of this practice. Resident#238: Ativan orders were reviewed by the physician and a stop date was entered. No negative outcome has occurred as a result of this practice. Resident#43: Ativan orders were reviewed by the physician and corrections made. No negative outcome occurred as a result of this practice. All residents with orders for PRN Ativan have the potential to be affected. The DON or designee will educate licensed nursing staff and physicians on documenting reasons why medication is being given, attempting and documenting non pharmacological approaches, and entering stop dates for PRN Ativan orders.	

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F 758	Continued From page 241 3/30/18 with diagnoses that included but were not limited to: cancer of the brain, anxiety disorder, history of breast cancer, high blood pressure, paralysis on one side, and encephalopathy (any brain disorder or disease) (1). The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 4/27/18 coded the resident as rarely understood and rarely understanding others. The resident was coded as having both short and long-term memory difficulties and being severely impaired to make daily cognitive decisions. Resident # 24 was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living. The physician order dated, 5/25/18, documented, "Lorazepam (Ativan) (used to treat anxiety)(2) Concentrate 2 mg/ml (milligrams/milliliters) give 0.25 ml sublingually (under the tongue) every 6 hours as needed for anxiety. Lorazepam solution 2 mg/ml, give 0.25 ml sublingually every 3 hours as needed for anxiety." Neither order had a stop date. The May 2018 MAR (medication administration record) documented the above physician orders. The Ativan was documented as having been administered on 5/28/18 at 9:17 a.m. and 5/29/18 at 5:34 p.m. The June 2018 MAR documented the above physician order. The Ativan was documented as having been administered on 6/2/18 at 7:05 p.m., 6/4/18 at 5:27 a.m. a.m. and 11:10 a.m., on 6/11/18 at 12:04 a.m., 4:18 a.m. and 9:42 p.m., on 6/12/18 at 8:45 a.m. and on 6/13/18 at 12:17	F 758	The DON or designee will audit all PRN Ativan orders and establish stop dates with the physician. Documentation will be audited as well. The DON or designee will monitor orders for PRN Ativan to ensure stop dates are in place, need for medication use is documented, and that non pharmacological interventions were attempted before use. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee. Continued compliance will be monitored though the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: July 27, 2018	

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a.m.

The comprehensive care plan dated, 6/5/18, documented in part, "Focus: At risk for increased anxiety related to dx (diagnosis) and history of anxiety disorder." The "Interventions" documented in part, "Administer anti-anxiety medications per physician order. Observe or ineffectiveness/side effects, report abnormal findings to the physician."

An interview was conducted with RN (registered nurse) #2 on 6/13/18 at 5:05 p.m. When asked how long a physician order for as needed anti-anxiety medication is good for, RN #2 stated, "Two weeks. Then the doctor has to reassess." When informed the above order for Ativan was written on 5/28/18, RN #2 stated, "The doctor needs to reevaluate the usage of this medication."

The facility policy, "Psychotropic Medication Use" documented in part, "5. PRN orders for psychotropic drugs should be limited to 14 days. IF the attending physician or prescribing practitioner believe that it is appropriate for the PRN order to be extended beyond the 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order."

The administrator and director of nursing were made aware of the above finding on 6/13/18 t 6:15 p.m.

No further information was provided prior to exit.
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 192.

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(2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010988/?report=details

1.b. The facility staff failed to document the reason for the administration of Ativan and failed to attempt non-pharmacological interventions prior to the administration of the medication.

The physician order dated, 5/25/18, documented, "Lorazepam (Ativan) (used to treat anxiety)(2) Concentrate 2 mg/ml (milligrams/milliliters) give 0.25 ml sublingually (under the tongue) every 6 hours as needed for anxiety. Lorazepam solution 2 mg/ml, give 0.25 ml sublingually every 3 hours as needed for anxiety." Neither order had a stop date.

The May 2018 MAR (medication administration record) documented the above physician orders. The Ativan was documented as having been administered on the following dates and times: 5/28/18 at 9:17 a.m. - The eMAR (electronic medication administration record) failed to evidence documentation of the reason for the administration of the medication and any non-pharmacological interventions attempted prior to the administration of the medication. 5/29/18 at 5:34 p.m. - The eMAR failed to evidence documentation of any non-pharmacological interventions attempted prior to the administration of the medication.

The June 2018 MAR documented the above physician order. The Ativan was documented as having been administered on the following dates

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and times:
6/2/18 at 7:05 p.m. - The eMAR failed to evidence documentation of any non-pharmacological interventions attempted prior to the administration of the medication.
6/4/18 at 5:27 a.m. - The eMAR failed to evidence documentation of any non-pharmacological interventions attempted prior to the administration of the medication.
6/4/18 at 11:10 a.m. - The eMAR failed to evidence documentation of the reason for the administration of the medication and any non-pharmacological interventions attempted prior to the administration of the medication.
6/11/18 at 12:04 a.m. - The eMAR failed to evidence documentation of the reason for the administration of the medication and any non-pharmacological interventions attempted prior to the administration of the medication.
6/11/18 at 4:18 a.m. - The eMAR failed to evidence documentation of the reason for the administration of the medication and any non-pharmacological interventions attempted prior to the administration of the medication.
6/11/18 at 9:42 p.m. - The eMAR failed to evidence documentation of the reason for the administration of the medication and any non-pharmacological interventions attempted prior to the administration of the medication.
6/12/18 at 8:45 a.m. - The eMAR failed to evidence documentation of the reason for the administration of the medication and any non-pharmacological interventions attempted prior to the administration of the medication.
6/13/18 at 12:17 a.m. - The eMAR failed to evidence documentation of any non-pharmacological interventions attempted prior to the administration of the medication.

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An interview was conducted with LPN (licensed practical nurse) #5 and #12 on 6/13/18 at 3:26 p.m. When asked staff does if a resident is anxious or having increased anxiety, LPN #12 stated, "You check to see if they have any medication to help alleviate the anxiety." LPN #5 stated, "We have to try other thing, like repositioning, sitting with them, see if they are hungry prior to giving the medication." When asked where this information is documented, LPN #12 stated, "A box comes up when you click on the medication with a nurse's note to fill in. You just type it there."

An interview was conducted with RN (registered nurse) #2, on 6/13/18 at 5:05 p.m., RN #2 was asked about the process staff follows for administering as needed antianxiety medications. RN #2 stated, "You have to assess the resident. Then try some non-pharmacological interventions and follow up if it worked. If it didn't work then you can administer the medication." When asked where the assessment and the things attempted prior to the administration of the medications is documented, RN #2 stated, "In the eMAR notes or in a nurse' note."

The facility policy, "Psychotropic Medication Use" documented in part, "3. Psychotropic medications may7 be used to address behaviors only if non-drug approaches and interventions were attempted prior to their use."

The administrator, ASM (administrative staff member) #1, and the director of nursing, ASM #2, were made aware of the above finding on 6/13/18 at 6:15 p.m.

2. The facility staff failed to ensure the physician

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prescribed PRN (as needed) Ativan for Resident #238, had a stop date.

Resident #238 was admitted to the facility on 5/25/18 with diagnoses that included but were not limited to: Squamous cell cancer of the skin of the scalp, dementia, repeated falls, and a fracture of the humerus (bone in the upper arm).

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 6/1/18 coded the resident as scoring a "4" on the BIMS (brief interview for mental status) score, indicating he was severely impaired to make daily cognitive decisions..

The physician order dated, 5/28/18, documented, "Ativan (used to treat anxiety) (1) Tablet 0.5 mg (milligrams), give 1 tablet by mouth every 8 hours as needed for anxiety." There was no stop date for this medication order documented.

The May 2018 MAR (medication administration record) documented the above medication. Review of the May 2018 MAR revealed the medication was documented as administered on 5/29/18 at 5:59 p.m.

The June 2018 MAR documented the above medication. Further review of the MAR revealed It the medication was documented as administered on 6/5/18 at 4:20 p.m., 6/8/18 at 3:51 p.m. and 6/9/18 at 10:31 a.m.

The comprehensive care plan dated, 6/6/18, documented in part, "Focus: Actual Behavior Problem: pulling wound vac (vacuum) tubing." The "Interventions" documented in part,

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"Administer anti-psychotropic, anti-anxiety, antidepressant meds (medications) per physician order."

An interview was conducted with RN (registered nurse) #2 on 6/13/18 at 5:05 p.m. When asked how long a as needed physician order for anti-anxiety medication is good for, RN #2 stated, "Two weeks. Then the doctor has to reassess." When informed the above order for Ativan was written on 5/28/18, RN #2 stated, "The doctor needs to reevaluate the usage of this medication."

The facility policy, "Psychotropic Medication Use" documented in part, "5. PRN orders for psychotropic drugs should be limited to 14 days. IF the attending physician or prescribing practitioner believe that it is appropriate for the PRN order to be extended beyond the 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order."

The administrator and director of nursing were made aware of the above finding on 6/13/18 at 6:15 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010988/?report=details

3. The facility staff failed to ensure Resident #43 was free from the unnecessary use of Ativan.

Resident #43 was admitted to the facility on

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10/23/17 with a most recent readmission on 4/9/18, with diagnoses that included but were not limited to: heart failure, pneumonia, diabetes, chronic obstructive pulmonary disease (a chronic lung disease that makes it hard to breath) (1), high blood pressure, anxiety, and severe obesity.

The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 4/16/18, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating she has severe cognitive impairment for daily decision making. The resident was coded as requiring extensive assistance of at least two or more staff members for bed mobility and transfers, and at least one person physical assist for dressing, toileting, eating and personal hygiene. In Section N - Medications, the resident was coded as using anti-anxiety medications during the look back period.

The physician order dated, 4/9/18, documented, "Lorazepam (Ativan) (used to treat anxiety)(2) Concentrate 2 mg/ml (milligrams/milliliters) give 0.25 ml by mouth every 4 hours as needed for anxiety. The order did not have a stop date.

The May 2018 MAR (medication administration record) documented the above physician orders. The Ativan was documented as having been administered on 5/1/18 at 5:43 a.m. and 11:29 p.m.; 5/8/18 at 3:33 a.m.; and 5/24/18 at 5:51 p.m.

The June 2018 MAR documented the above physician order. The Ativan was documented as having been administered on 6/11/18 at 1:56 a.m.

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The comprehensive care plan dated, 4/16/18, documented in part, "Need: At risk for increased anxiety related to dx (diagnosis) and history of anxiety disorder." The "Interventions" documented in part, "Administer anti-anxiety medications per physician order. Observe for ineffectiveness/side effects, report abnormal findings to the physician."

An interview was conducted with RN (registered nurse) #2 on 6/13/18 at 5:05 p.m. When asked how long an as needed anti-anxiety medication is good for, RN #2 stated, "Two weeks. Then the doctor has to reassess." When informed the above order for Ativan was written on 5/28/18, RN #2 stated, "The doctor needs to reevaluate the usage of this medication."

The facility policy, "Psychotropic Medication Use" documented in part, "5. PRN orders for psychotropic drugs should be limited to 14 days. IF the attending physician or prescribing practitioner believe that it is appropriate for the PRN order to be extended beyond the 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order."

ASM (administrative staff member) #1, the administrator and ASM #2, director of nursing, where made aware of the above concerns on 6/14/18 at 3:00 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://medlineplus.gov/ency/article/000091.htm

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F 758	Continued From page 250 (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682053.html	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure residents were free from significant medication error for one of 50 residents in the survey sample, Resident #34. The facility staff crushed Resident #34 extended release potassium chloride and administered the medication in applesauce. The findings include: Resident #34 was admitted to the facility on 9/3/14 with diagnoses that included but were not limited to CVA (cerebral vascular disease), aphasia (difficulty speaking), high blood pressure, and paralysis to right side of body. Resident #34's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 4/8/18. Resident #34 was coded as being severely impaired in cognitive function scoring 00 out of 15 on the BIMS (brief interview for mental status) exam.	F 760	Ftag 760 Resident #34: Liquid potassium was ordered and is in the facility. No negative outcome occurred because of this practice. Residents who receive crushed medications have the potential to be affected. The DON or designee will educate licensed nursing staff on appropriate medications that can be crushed. The DON or designee will audit medication orders for residents who receive crushed medications. Corrections will be made as needed. Nursing administration will monitor new medication orders for crushed medications five times daily for four weeks Additional education and/or counseling will be provided as indicated. Concerns	7/27/18

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F 760	Continued From page 251 On 6/13/18 at 8:09 a.m., medication administration observation was conducted with LPN (licensed practical nurse) #3. LPN #3 was observed preparing the following medication for Resident #34: 1) Neurotoin 300 mg (milligram) capsule 2) Norvasc 10 mg tablet 3) Lasix 20 mg tablet 4) Levetiracetam 500 mg tablet 5) Lopressor 25 mg tablet. 6) Potassium chloride 20 MEQ (milliequivlant) Tab ER (extended release) - 2 tablets 7) Cranberry Capsule 400 mg tablet On 6/13/18 at 8:31 p.m., LPN #3 crushed all medications with exception of the cranberry and neurotin capsule. LPN #3 had crushed the two potassium chloride tablets. At 8:32 a.m., LPN #3 put on a pair of gloves and opened the cranberry and neurotin capsule. LPN #3 dumped the contents into the medication cup. LPN #3 added applesauce and administered the medication to Resident #34. On 6/13/18 at 1:37 p.m., an interview was conducted with LPN #3. When asked if potassium extended release tablets can be crushed, LPN #3 stated, "That is the way I have been doing it." LPN #3 also stated that crushing the potassium was the way she was trained. LPN #3 stated she crushed the medication because the resident could not swallow. When asked if other forms of the potassium could be obtained, LPN #3 stated she could get the potassium in liquid form with a physician's order. When asked what extended release meant, LPN #3 stated that the medication was longer acting. When asked if	F 760	will be reported by the DON/Designee to the quality assurance committee. Continued compliance will be monitored though the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: July 27, 2018	

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crushing the potassium could interfere with the absorption of the potassium, LPN #3 stated, "Not that I am aware of." When asked if nurses had a DO NOT CRUSH List at the medication cart, LPN #3 stated that they should.

On 6/13/18 at 2:09 p.m., an interview was conducted with OSM (other staff member) #9, the consulting pharmacist. OSM #9 stated that potassium chloride tablets should not be crushed but should be dissolved in water. OSM #9 stated that crushing potassium chloride tablets could lead to all of the medication going into the stomach at one time which may lead to GI (gastrointestinal) irritation. OSM #9 stated that there was very little risk crushing potassium; OSM #9 stated that crushing potassium tablets would not cause hyperkalemia (high potassium) but that he would not recommend crushing extended release tablets.

On 6/14/18 at 10:13 a.m., an interview was conducted with LPN #1, the unit manager. When asked if nursing could crush potassium extended release tablets, LPN #1 stated that it was never okay to crush potassium. LPN #1 stated that crushing extended release tablets cause the medication dose to be received, all at the same time. LPN #1 stated that crushing potassium could lead to some issues. When asked what those issues were, LPN #1 stated that she did not know off hand.

Review of Resident #34's most recent BMP (basic metabolic panel) dated 1/19/18, documented Resident #34's potassium as being within normal range.

On 6/14/18 at approximately 5 p.m., ASM

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(administrative staff member) #1, the administrator was made aware of the above concerns.

Review of the facility's "DO NOT CRUSH LIST," documents in part, the following: Potassium Chloride: Reason: Extended release; may dissolve in 4 ounces of water and drink contents followed by adding another 1 ounce of water, swirling and drinking, followed by adding another 1 ounce of water, swirling and drinking.

The following information was taken from The National Institutes of Health at https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=8d140d5e-a5d7-5302-3572-e606dd247410: "Take potassium chloride extended-release tablets with meals and with a glass of water or other liquid. Do not take on an empty stomach because of its potential for gastric irritation. Swallow tablets whole without crushing, chewing or sucking. Solid oral dosage forms of potassium chloride can produce ulcerative and/or stenotic lesions of the gastrointestinal tract, particularly when the drug remains in contact with the gastrointestinal mucosa for a prolonged period of time. Consider the use of liquid potassium in patients with dysphagia, swallowing disorders, or severe gastrointestinal motility disorders."

1) Neurotoin 300 mg capsule works in the brain to prevent seizures and relieve pain for certain conditions in the nervous system. It is not used for routine pain caused by minor injuries or arthritis. Gabapentin is an anticonvulsant. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH

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T0010419/?report=details.

2) Norvasc 10 mg tablet is indicated for the treatment of hypertension, to lower blood pressure. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=ABD6A2CA-40C2-485C-BC53-DB1C652505ED.

3) Lasix 20 mg tablet used to decrease edema (excess fluid) in patients with heart failure, liver impairment or kidney disease. This information was obtained from Davis's Drug Guide for Nurses, 11th edition, p. 587.

4) Levetiracetam 500 mg tablet used to help control certain types of seizures in the treatment of epilepsy. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010898/?report=details.

5) Lopressor 25 mg tablet used to treat high blood pressure, angina (chest pain), and heart failure. May lower the risk of death after a heart attack. This medicine is a beta-blocker. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011186/?report=details.

6) Potassium chloride 20 MEQ Tab ER (extended release) - 2 tablets- Potassium Chloride is a metal halide composed of potassium and chloride. Potassium maintains intracellular tonicity, is required for nerve conduction, cardiac, skeletal and smooth muscle contraction, production of energy, the synthesis of nucleic

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F 760	Continued From page 255 acids, maintenance of blood pressure and normal renal function. This agent has potential antihypertensive effects and when taken as a nutritional supplement may prevent hypokalemia. This information was obtained from The National Institutes of Health. https://pubchem.ncbi.nlm.nih.gov/compound/potassium_chloride#section=Top. 7) Cranberry Capsule 400 mg tablet have been tested as a nutritional supplementation in the prevention of recurrent lower-urinary tract infections. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmed/25635978.	F 760		
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 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	F 761		7/27/18

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F 761	Continued From page 256 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview it was determined the facility staff failed to store medications in accordance with professional standards of practice for one of three medication storage rooms, the medication room on the Jefferson Unit. The facility staff failed to label the open date of a bottle of Ativan (1) that was received by the facility on 11/22/2017. The findings include: On 6/12/18 at 9:00 a.m., observation of the medication storage rooms was conducted. On 6/12/18 at 9:08 a.m., a 30 ml (milliliter) bottle of Ativan was found opened and available for use. The Ativan bottle had the following instructions on the bottle: "Discard 90 days after opening." There was no open date found on the bottle. The date the facility received the Ativan was dated 11/22/17. On 6/12/18 at 9:09 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated that the night shift usually checks the refrigerator for expired items. RN #1 stated all medications should be labeled with an open date once they are opened. RN #1 stated that the date 11/22/17, was the date the facility received the medication. RN #1 could not tell this writer when the Ativan was opened. RN #1 stated that	F 761	F761 No negative outcome occurred from this practice Residents receiving liquid Ativan have the potential to be affected. The DON or designee will educate licensed nursing staff on the dating and labeling of medication. The DON or designee will audit all medication rooms and medication carts for proper labeling, dating and storage of medication. The DON or designee will audit medication storage rooms and medication carts weekly for four weeks. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee. Continued compliance will be monitored though the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion date: July 27, 2018	

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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 761	Continued From page 257 the Ativan should have been sent back to the pharmacy or discarded. On 6/14/18 at approximately 5 p.m., ASM (administrative staff member) #1, the administrator, was made aware of the above concerns. A policy could not be provided regarding the above concerns. Review of the manufacture's information for Ativan documented the following: "Discard opened bottle after 90 days." No further information was presented prior to exit. (1) Ativan (Lorazepam) is used to treat anxiety disorders. It is also used for short-term relief of the symptoms of anxiety or anxiety caused by depression. Lorazepam is a benzodiazepine that works in the brain to relieve symptoms of anxiety. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010988/?report=details.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812		7/27/18

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F 812	Continued From page 258 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review it was determined that the facility staff failed to store, prepare, and serve food in a sanitary manner for 1 of 50 residents in the survey sample, (Resident #2) and in the kitchen. 1. The facility staff failed to wear gloves when making a sandwich for Resident #2. 2. The facility staff failed to store food and dishware in a sanitary manner in the facility kitchen. The findings include: 1. Resident #2 was admitted to the facility on 3/3/16, with diagnoses that included but were not limited to: dementia chronic pain, weakness, difficulty swallowing, and cervicalgia (neck pain) (1). . The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/5/18, coded the	F 812	F812 1.Resident #2: No negative outcome occurred from this practice 2.No negative outcome occurred from this practice. All residents have the potential to be affected. The DON or designee will educate licensed nursing staff on the proper handling of resident food. The dietary manager will educate dietary staff on proper storage for food and dishware. The dietary manager will observe dishes drying after all meals for 5 days. The dietary manager will audit food storage areas. The DON and designees will observe all meals for 2 days to ensure food is being handled in a sanitary fashion. NHA and dietary manager will round on	

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F 812	Continued From page 259 resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating she has severe cognitive impairment of daily decision making. On 6/11/18 at 5:01 p.m. an observation of the activity room dining area was performed. On 6/11/18 at 5:20 p.m., Resident #2's tray was set in front of her and CNA, (certified nursing assistant) #5 proceeded to use her bare hands to open the roll on the resident's tray and then placed a piece of fried fish into the roll. CNA #5 then handed the roll to Resident #2. An interview was conducted with CNA #5 on 6/14/18 at 4:15 p.m., regarding the above observation. CNA #5 stated she should have been wearing gloves before she picked up the roll and began making the sandwich. When asked why she should have been wearing gloves, she stated, "to be sanitary". When asked how she would feel if a dining staff made her a sandwich without gloves, CNA #5 stated she would not like that at all. ASM (administrative staff member) #1, the administrator, and ASM #2 (the director of nursing) were made aware of the above findings on 6/14/18 at 3:00 p.m. No further information was obtained prior to exit. (1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2943658/	F 812	the kitchen weekly for four weeks to observe the storage of food and dishware. The DON or designee will observe dining 2 times a week for four weeks to ensure sanitary food handling practices are occurring. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee. Continued compliance will be monitored though the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: July 27, 2018	

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F 812	Continued From page 260	F 812		

2. The facility staff failed to store food and dishware in a sanitary manner in the facility kitchen.

On 6/11/18 at 2:45 p.m., a tour was conducted of the facility kitchen, with OSM #4 (Other Staff Member, the dietary manager). The following items were identified:
- In a box of sugar-free chocolate chip cookie frozen dough, the bag opened and exposed to the environment in the freezer.
- A box of frozen cheese pizzas was noted to be opened, unwrapped, with a piece of cardboard laying on top of top pizza. The bag was not sealed for protection.

- Two 6-inch deep full size steam table pans were wet nesting. Two 6-inch deep 1/4 size steam table pans wet nesting.

- The handles to convection oven greasy.

- A 5-pound tub of cottage cheese was opened and half empty with no opened date documented or labeled.

On 6/11/18 at approximately 3:00 p.m., in an interview with OSM #4, he stated that the above items should not have been left the way they were.

A review of the facility policy, "Frozen Storage" documented, "Frozen foods shall be stored in a manner that optimizes food safety and quality." The policy did not specify that packages must be sealed to protect the food from the environment of the freezer.

A review of the facility policy, "Manual Ware

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Washing" documented, "10. Pans shall be allowed to air-dry on sanitized drain board/rack/cart. Wet pans shall not be stacked."

A review of the facility policy, "Date Marking" documented, "3. The ready-to-eat PHF (potentially hazardous food) if held for more than 24 hours shall be date marked. The day the original container is opened shall be counted as day 1. The date marked by the facility shall not exceed the "use by" date from the manufacturer."

On 6/14/18 at approximately 5:00 p.m., the Administrator was made aware of the concerns.

No further information was provided.

According to the Food and Drug Administration, 2017 Federal Food Code,

3-202.15 Package Integrity.
FOOD packages shall be in good condition and protect the integrity of the contents so that the FOOD is not exposed to ADULTERATION or potential contaminants.

Preventing Contamination from the Premises
3-305.11 Food Storage.
(A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD:
(1) In a clean, dry location;
(2) Where it is not exposed to splash, dust, or other contamination; and
(3) At least 15 cm (6 inches) above the floor.

commercially processed food
. Open and hold cold
(B) Except as specified in (E) -(G) of this

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F 812	Continued From page 262 section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: Pf (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; Pf and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. Drying 4-901.11 Equipment and Utensils, Air-Drying Required. After cleaning and SANITIZING, EQUIPMENT and UTENSILS: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface SANITIZING solutions), before contact with FOOD; and (B) May not be cloth dried except that UTENSILS that have been air-dried may be polished with cloths that are maintained clean and dry.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F 842		7/27/18

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(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

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

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F 842	Continued From page 264 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, resident interview, and facility document review, it was determined that the facility staff failed to ensure a complete and accurate clinical record for two of 50 residents in the survey sample; Residents #83 and #114. 1. The facility staff documented oxygen was administered to Resident #83 at the correct rate when it was not. 2. The facility staff failed to document that they were checking Resident #114's blood sugar on	F 842	F842 Resident #83: Oxygen settings corrected. No negative outcome occurred from this practice. Resident # 114: No negative outcome occurred as a result of this practice. Residents who receive oxygen or require blood sugar monitoring have the potential to be affected.	

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F 842	Continued From page 265 several occasions in June and May of 2018. The findings include: 1. Resident #83 was admitted on 5/12/11 and readmitted on 10/19/17 with the diagnoses of but not limited to heart failure, high blood pressure, respiratory failure, Hepatitis C, thyrotoxicosis, pressure ulcer, stroke, anxiety disorder, osteomyelitis, and pneumonia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 5/11/18. The resident was coded as cognitively intact in ability to make daily life decisions. A review of the clinical record revealed a physician's order dated 5/8/18 for "O2 (oxygen {1}) 2 liters continuous per nasal cannula every shift for CHF (congestive heart failure) Call Dr (doctor) if pulse ox (oxygen saturation) 89% or below." Observations were made of Resident #83 on 6/12/18 at 12:53 p.m., 6/12/18 at 4:32 p.m., 6/13/18 at 8:30 a.m., and 6/13/18 at 12:42 p.m.. At each observation, the resident's oxygen concentrator rate was set at 1.5 liters and not the physician ordered 2 liters. On 6/13/18 at 12:43 p.m., LPN #5 (Licensed Practical Nurse) was asked to look at Resident #83's oxygen concentrator. When asked to verify the level the concentrator was set at, LPN #5 stated "about 1.5 maybe a little more but certainly not at 2" (liters as ordered.). A review of the clinical record revealed the TAR	F 842	The DON or designee will educate licensed nursing staff on ensuring that oxygen settings match oxygen orders. Education will be provided to licensed nursing staff on documenting blood sugar readings. The DON or designee will monitor oxygen settings weekly for 4 weeks. MARs for residents who receive blood sugar monitoring will be reviewed 5 times a week for 4 weeks. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee. Continued compliance will be monitored though the facility□s quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion date: July 27, 2018	

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(Treatment Administration Record) for June 2018. This record revealed the following line item: "O2 (oxygen) 2 liters continuous per nasal cannula every shift for CHF Call Dr if pulse ox 89% or below." The TAR was signed off as being administered at the ordered 2 liters by nurses for the above observations dates and shifts.

On 6/14/18 at 4:41 in an interview with LPN #1. LPN #1 stated the nurses should check the oxygen to ensure it is at the right rate before they sign it off on the TAR. LPN #1 stated it is not documented accurately if the oxygen is not at the right rate when the nurses signed off.

A review of the care plan for Resident #83 revealed one for "Cardiac: At risk for decreased Cardiac output R/T (related to): HTN (hypertension - high blood pressure), CHF (congestive heart failure) w/ (with) O2 (oxygen) usage, Hx (history) of CVA (cerebral vascular accident - stroke)." This care plan was dated 10/20/17. The interventions included one dated 10/20/17 for "O2 via as ordered."

A review of the facility policy, "Medication Administration" documented, "All medications and treatments shall be initiated, administered, and/or discontinued in accordance with written physician orders...Procedure: 2. Compare the medication package/container to the guest's Medication Administration Record (MAR) to validate the correct medication, dosage, route, and time of administration...." There was nothing included regarding ensuring the accuracy of the documentation.

On 6/14/18 at approximately 5:00 PM, the

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Administrator was made aware of the concerns. No further information was provided.

According to Fundamentals of Nursing, Lippincott Williams and Wilkins Philadelphia 2007 page 53. "Accurate documentation shows the care that you (nurses) provide meets the patient's needs and expressed wishes. It proves you are following the accepted standards of nursing care mandated by the law, your profession, and your health care facility..." and on page 93, "The medical record is the main source of information and communication among nurses, doctors, physical therapists, social workers, and caregivers. Everyone's notes and documentation is important because together they represent a complete picture of the patient's care."

{1} According to Fundamentals of Nursing, Fifth Edition, Lippincott Williams & Wilkins, 2007, page 851, "Because oxygen is a drug, its use requires a prescription. Policies and standing orders often permit the nurse to administer oxygen in emergency situations if the physician is not immediately available to write an order. Although oxygen is generally safe when used properly, certain precautions must be observed. As with all drugs, the potential exists for causing harm with misuse." On page 852, Procedure 36-5, "3. Identify client and proceed with 5 rights of medication administration...Rationale: Oxygen is a drug and administering using the 5 rights avoids potential errors....10. Monitor continuous therapy by assessing for pressure areas on the skin and nares every 2 hours and rechecking flow rate every 4 to 8 hours. Rationale: Permit early detection of skin breakdown or inadequate flow rate."

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2. The facility staff failed to document that they were checking Resident #114's blood sugar on several occasions in June and May of 2018.

Resident #114 was admitted to the facility on 12/18/17 and readmitted on 3/6/18 with diagnoses that included but were not limited to peripheral vascular disease, muscle weakness, schizophrenia, and end stage renal disease. Resident #114's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 5/22/18. Resident #114 was coded as being intact in cognitive function scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status exam.

Review of Resident #114's most recent POS (physician order sheet) dated 6/13/18, documented the following order: "Accu-check A (sic) AM. in the morning notify MD (medical doctor) if BS (blood sugar) < (less than) 60 or > (greater) than 250." This order was initiated on 4/6/18.

Review of Resident #114's May and June 2018 TARs (Treatment Administration Record) revealed holes or blank spaces on the following dates at 6:30 a.m.: 5/7/18., 5/14/18, 5/15/18, 5/16/18, 5/18/18, 5/28/18, 5/29/18, 6/3/18, 6/6/18, and 6/11/18.

Review of Resident #114's June and May 2018 nursing notes failed to evidence documentation of her blood sugars on the above dates.

Review of Resident #114's care plan dated 12/29/17 documented the following: "Blood SU (sugars): At risk for fluctuation blood sugars R/T

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(related to) Diabetes. Goal: Guest will be free from signs of complications from fluctuation blood sugars such as mental status changes, tremors/shakiness, dizziness, weakness, appetite loss thru next review...Interventions: Administer medications per orders. Observe for ineffectiveness and side effects. Report findings to physician. Observe and document s/sx (symptoms) of complications from fluctuating blood sugar. Report abnormal findings to physician..."

Further review of Resident #114's POS dated 6/13/18 revealed that Resident #114 was not on any forms of insulin.

On 6/14/18 at 9:06 a.m., an interview was conducted with RN (registered nurse) #1. When asked what check marks meant on the MARS/TARS (medication administration record / treatment administration record), RN #1 stated check marks meant that the medication/treatment was administered. When asked what blanks/holes meant on the MARs/TARs, RN #1 stated that blanks did not necessarily mean the medication or treatment was not administered. RN #1 stated that the nurse might have forgot to sign the MAR/TAR. When asked if blood sugars checked should be documented, RN #1 stated that blood sugars should be documented. RN #1 stated that the nurse might have written the blood sugars in a nursing note.

On 6/14/18 at 10:32 a.m., an interview was conducted with RN (registered nurse) #2. When asked what checks meant on the MARS and TARs, RN #2 stated that checks meant the medication was administered. When asked what blanks or holes meant on the MAR, RN #2 stated

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that blanks/holes meant the medication or treatment was missed or that the nurse forgot to sign the MAR/TAR. RN #2 stated that she wouldn't know if Resident #114's blood sugar was checked unless there was a nursing note.

On 6/14/18 at 12:08 p.m., an interview was attempted with the 11-7 shift nurse who did not blood sugar readings for the above dates. She could not be reached for an interview.

On 6/14/18 at approximately 3 p.m., an interview was conducted with Resident #114. Resident #114 stated that the nurse checks her blood sugar every morning.

On 6/14/18 at approximately 5 p.m., ASM (administrative staff member) #1, the administrator, was made aware of the above concerns. No further information was presented prior to exit.

The following quotation is found in Potter and Perry's Fundamentals of Nursing 6th edition (2005, p. 477): "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to the clients." Potter and Perry (2005) also includes the following information: "As members of the health care team, nurses need to communicate

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F 842	Continued From page 271 information about clients accurately and in a timely, effective manner."	F 842		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or 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;	F 880		7/27/18

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F 880	Continued From page 272 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete infection control program as evidenced by, failure to implement policies and procedures for water management and the detection and prevention of Legionella; and failed	F 880	Ftag 880 1. No negative outcome has occurred as a result from this practice. The water testing has been scheduled 2. Resident #98- CPAP mask was bagged. No negative results occurred as	

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F 880	Continued From page 273 to follow infection control practices for one of 50 sampled residents, (Resident #98); and for five of seven residents in the medication administration observation (Residents #128, #43, #16, #102 and #34). 1. The facility staff failed to implement policies and procedures for water management and the detection and prevention of Legionella. 2. The facility staff failed to store Resident # 98's C-PAP (continuous positive airway pressure) [1] mask in a sanitary manner. 3. The facility staff failed to maintain infection control practices during medication administration observation for Resident #128. 4. The facility staff failed to maintain infection control practices during medication administration observation for Resident #43 and Resident #16. 5. The facility staff failed to maintain infection control practices during medication administration observation for Resident #102 and Resident #34. The findings include: 1. The facility staff failed to implement policies and procedures for water management and the detection and prevention of Legionella. Review of the facility document titled, "(Name of facility) Legionella Water Management Program" revealed documentation of how water enters the facility, is distributed through the facility, is heated in the facility and is discarded from the facility. Review of another document titled, "Identifying	F 880	a result of this practice. 3. Resident #128- No negative outcome has occurred as a result of this practice. 4. Resident #43: No negative outcome has occurred from this practice Resident # 16: No negative outcome has occurred from this practice. 5. Resident #102- No negative outcome occurred from this practice Resident #43- No negative outcome occurred from this practice. All residents currently in the facility have the potential to be affected. The NHA or designee will educate the maintenance director on the Legionella program and required testing. The DON or designee will educate licensed nursing staff on the proper storage of respiratory equipment and infection control practices with medication pass. The Maintenance director will have the water tested for Legionella. The DON or designee will audit current residents on a CPAP for proper storage of the mask. A medication pass observation with all licensed nursing staff will be conducted. The maintenance director will monitor the water source weekly for four weeks for any changes or new risk. The DON or designee will conduct medication pass observations 3 times a	

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F 880	Continued From page 274 Buildings at Increased Risk" revealed a facility risk assessment for Legionella growth and spread. Neither form documented any evidence of testing protocols that were conducted. On 6/13/18 at 8:54 a.m., an interview was conducted with ASM (administrative staff member) #1 (the administrator). ASM #1 stated she had no evidence that any testing protocols had been completed. The facility policy titled, "LEGIONELLOSIS/LEGIONNAIRES' DISEASE/LEGIONELLA AND OTHER WATER-BORNE PATHGENS PREVENTION" documented, "The facility will utilize sound engineering and housekeeping practices to minimize the risk of exposing guests, associates, and visitors to the legionella bacteria and other water-borne pathogens. To minimize the potential for exposure to the legionella bacteria or other water-borne pathogen, the facility will adhere to the following standards: -Utilize an approved contractor to perform water chemistry sampling for whirlpools, tubs, and cooling towers according to manufacturer's recommendations. -Perform testing for the Legionella bacteria only when specifically directed by a State or Local Health Department and under the guidance of the (name of company) environmental services and infection control consultant..."No further information was provided prior to exit. 2. The facility staff failed to store Resident # 98's C-PAP (continuous positive airway pressure) [1] mask in a sanitary manner. Resident # 98 was admitted to the facility on 05/10/18 with diagnoses that included but were	F 880	week for 4 weeks. Additional education and/or counseling will be provided as indicated. Concerns will be reported by the DON/Designee to the quality assurance committee. Continued compliance will be monitored though the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: July 27, 2018	

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not limited to: hypertension (1), anxiety (2), dysphagia (3), and hyperlipidemia (4).

Resident # 98's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 05/17/18, coded Resident # 98 as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 - being cognitively intact for making daily decisions. Resident # 98 was coded as requiring extensive assistance of one staff member for activities of daily living. Section O "Special Treatments, procedures and Programs" coded Resident # 98 as having a CPAP.

On 06/11/18 at 3:55 p.m., an observation of Resident # 98's room revealed a C-PAP(continuous positive air pressure) mask lying on top of the bedside table uncovered. Resident # 98 was lying on her bed watching television.
The POS (physician's order sheet) dated June 2018 documented, "Please apply C-pap machine with distilled water every night at setting 16 every night for sleep apnea. Start Date: 05/23/18."

On 06/15/18 at 8:40 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked to describe the process for ensuring a C-PAP mask is stored in a sanitary manner ASM # 2 stated, "If the C-PAP was not in use it should have been put in a bag."

In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 648. "Box 34-2 Sites for and Causes of Health Care-Associated Infections under Respiratory Tract -- Contaminated respiratory

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therapy equipment."

On 06/14/18 at approximately 6:15 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, and ASM # 5, clinical resource specialist, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) CPAP is an airway treatment that applies a constant pressure of forced air to keep the airway open. This information was obtained from the website: https://medlineplus.gov/ency/imagepages/9685.htm.

(2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(3) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.

(4) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

(5) Cholesterol is a fat (also called a lipid) that your body needs to work properly. Too much bad cholesterol can increase your chance of getting heart disease, stroke, and other problems. The medical term for high blood cholesterol is lipid disorder, hyperlipidemia, or hypercholesterolemia.

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This information was obtained from the website: https://medlineplus.gov/ency/article/000403.htm.

3. The facility staff failed to maintain infection control practices during medication administration observation for Resident #128.

Resident #128 was admitted to the facility on 7/13/17 with diagnoses that included but were not limited to syncope and collapse, hypothyroidism, high blood pressure, unspecified dementia without behavioral disturbance. Resident #128's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 5/24/18. Resident #128 was coded as being severely impaired in cognitive function scoring three out of 15 on the BIMS (Brief Interview for Mental Status) exam.

On 6/12/18 at 9:25 a.m., medication administration was conducted with LPN (licensed practical nurse) #7. At 10:30 a.m., LPN #7 was observed preparing the following medications for Resident #128:

(1) Allpurinol 100 mg tablet
(2) Norvasc 5 mg; 1 tablet
(3) Colace 100 mg; 1 capsule
(4) Lisinopril 40 mg; 1 tablet
(5) Zoloft 25 mg; 1 tablet

At 10:31 a.m., LPN #7 dropped the Zoloft tablet and the tablet landed on top of the medication cart. LPN #7 then grabbed the Zoloft tablet with her bare fingers and dropped it into the medication cup with the other medications. On 6/12/18 at 10:38 a.m., LPN #7 administered the

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medications to Resident #128. Resident #128 took all her medication including the Zoloft tablet.

On 6/13/18 at 1:37 p.m., an interview was conducted with LPN #3. When asked if it was ever okay to pick medications up with her bare hands that dropped on the medication cart, and to administer medications that have fallen on the medication cart, LPN #3 stated, "No."

On 6/13/18 at 4:12 p.m., and 4:45 p.m., an interview was attempted with LPN #7. She could not be reached for an interview.

On 6/14/18 at approximately 5:00 p.m., ASM (administrative staff member) #1, the administrator, was made aware of the above concerns.

The facility policy titled, "Medication Administration" did not address the above concerns.

(1) Allpurinol 100 mg tablet used for the treatment of gout. This information was obtained from The National Institutes of Health. https://livertox.nih.gov/Allopurinol.htm.
(2) Norvasc 5 mg; 1 tablet is used alone or together with other medicines to treat angina (chest pain) and high blood pressure (hypertension). This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008948/?report=details.
(3) Colace 100 mg used to soften the passage of stool. This information was obtained from Davis's Drug Guide for Nurses, 11th edition, p. 442.
(4) Lisinopril 40 mg; 1 tablet treats high blood

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pressure and heart failure. Also given to reduce the risk of death after a heart attack. This medicine is an ACE inhibitor. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010968/?report=details.
(5) Zoloft 25 mg; 1 tablet- antidepressant that is also used to treat generalized anxiety disorder. This information was obtained from Davis's Drug Guide for Nurses, 11th edition, p. 1103.

4. The facility staff failed to maintain infection control practices during medication administration observation for Resident #43 and Resident #16.

Resident #43 was admitted to the facility on 10/23/17 and readmitted on 4/9/18 with diagnoses that included but were not limited to heart failure, type two diabetes mellitus, and COPD (chronic obstructive pulmonary disease). Resident #43's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 4/16/18. Resident #43 was coded as being severely impaired in cognitive function scoring 03 out of possible 15 on the BIMS (brief interview of mental status) exam.

Resident #16 was admitted to the facility on 6/16/17 with diagnoses that included but were not limited to multiple sclerosis, muscle weakness, type two diabetes, and muscle weakness. Resident #16's most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 3/18/18. Resident #16 was coded as severely impaired in

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cognitive function, on the staff interview for mental status exam.

On 6/12/18 at 4:06 p.m., medication administration observation was conducted with LPN (licensed practical nurse) #10. At 4:08 p.m., LPN #10 was at the medication cart. LPN #10 removed the glucometer from the cart and an alcohol swab and gauze pad. LPN #10 opened the gauze pad and alcohol swab and held them with her bare fingers. Her bare fingers were directly touching the opened gauze pad and swab. LPN #10 was not observed washing or sanitizing her hands prior to this. LPN #10 then placed the gauze pad on the medication cart and put on gloves. LPN #10 then walked into Resident #43's room, swabbed Resident #43's finger with the contaminated alcohol wipe, and pricked her finger. LPN #10 obtained the Resident's blood sugar reading and then held the contaminated gauze pad over Resident #43's finger. LPN #10 discarded the gauze pad and proceeded out the door to the computer. Using the same gloves that was used to obtain the blood sugar, LPN #10 entered the resident's blood sugar into the computer. LPN #10's gloved fingers were touching the computer keyboard and mouse. LPN #10 then opened the medication cart, took out Resident #43's Humalog (1) insulin and drew up 8 units of insulin per the physician's order. LPN #10 touched Resident #43's insulin pen using the same contaminated gloves. LPN #10 then took out another gauze pad and alcohol wipe and opened the items touching them with the same contaminated gloves. LPN #10 then entered the resident's room, administered Resident #43's insulin to her right deltoid and then discarded the needle. LPN #10 opened the medication cart using the same contaminated

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gloves, put the insulin pen away and then removed the gloves. LPN #10 did not wash her hands before proceeding to the next Resident (Resident #16).

At 4:30 p.m., LPN #10 took out a gauze pad and alcohol swab from the medication cart. LPN #10 opened the gauze pad and alcohol swab and touched the items with her bare hands. LPN #10 put the gauze pad directly on top of the medication cart and put on a new pair of gloves. LPN #10 then carried the glucometer, gauze pad and alcohol swab into Resident #16's room. LPN #10 swabbed Resident #16's finger with the contaminated alcohol wipe and pricked his finger. LPN #10 obtained the Resident's blood sugar reading and then held the contaminated gauze pad over Resident #16's finger. LPN #10 did not sanitize the glucometer in between Resident #43 and Resident #16. LPN #10 was then observed removing her gloves and entering Resident #16's blood sugar result into the computer. LPN #10 did not wash or sanitize her hands after obtaining Resident #16's blood sugar. Resident #16 did not need insulin coverage.

On 6/13/18 at 9:35 a.m., an interview was conducted with OSM (other staff member) #10, the consultant for AgaMatrix Presto Pro System glucometer. OSM #10 stated that the glucometers were able to be used on multiple residents. OSM #10 stated that the glucometers should be cleaned between each resident. When asked how the glucometers should be cleaned, OSM #10 directed this writer to the manufacter's booklet pg. 46.

Review of the manufacture's information (p. 46) for cleaning the glucometer documents in part,

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the following: "[1] Cleaning the system. In order to avoid damage to the AgaMatrix Presto Pro System (glucometer) use only cleaners or disinfectants with the following active ingredients:-Water, Soap, 70% (percent or less) isopropyl alcohol, 1:10 dilution of sodium hypochlorite (Household bleach) in water. Wipe front to back of the meter with a soft cloth dampened (not wet) with any of the above substances. Make sure that no streaks remain after wiping, and always ensure that the AgaMatrix Presto Pro System is thoroughly dried after cleaning."

On 6/13/18 at 3:43 p.m., an interview was conducted with LPN #10. When asked how to maintain infection control practices while checking blood sugars and administering insulin, LPN #10 stated that she uses gloves check blood glucose and then changes them out right before she draws up the insulin. When asked when she would sanitize or wash her hands during medication pass, LPN #10 stated that she does not sanitize or wash her hands in between residents in the same room; she will just change her gloves. LPN #10 stated that the hand sanitizer was too drying on her hands. When asked if she could wash her hands as opposed to using the sanitizer, LPN #10 stated that she could wash her hands if she brought her own special soap. LPN #10 stated that she washes her hands every third room. When asked the purpose of hand washing, LPN #10 stated for infection control. When asked if the glucometers are supposed to be wiped down in between each use, LPN #10 stated that she wipes the glucometer at the begining of the shift. LPN #10 stated that she does not wipe the glucometers down in between each use. LPN #10 stated that

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she is supposed to wipe down the glucometers between each resident to prevent blood Bourne pathogens. When asked if she is supposed to remove her gloves after resident care prior to touching the computer keyboard and mouse pad, LPN #10 stated that she should have. When asked if she left her gloves on after checking Resident #43's blood sugar and administering her Humalog, LPN #10 stated, "I sure did."

On 6/14/18 at approximately 5:00 p.m., ASM (administrative staff member) #1, the administrator, was made aware of the above concerns.

The facility policy titled, "Hand Hygiene," documents in part, the following: "When to wash your hands...3. Before and after performing an invasive procedure (e.g. fingerstick blood sampling)...after removing gloves."

(1) Humalog-Insulin lispro protamine and insulin lispro is a combination of a fast-acting insulin and an intermediate-acting type of human insulin. Insulin is used by people with diabetes to help keep blood sugar levels under control. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010739/?report=details.

5. The facility staff failed to maintain infection control practices during medication administration observation for Resident #102 and Resident #34.

Resident #102 was admitted to the facility on

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11/1/17 with diagnoses that included but were not limited to Alzheimer's disease, hypothyroidism, and high blood pressure. Resident #102's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 5/19/18. Resident #102 was coded as being severely impaired in cognitive function scoring 05 out of 15 on the BIMS (Brief Interview for Mental Status) exam.

Resident #34 was admitted to the facility on 9/3/14 with diagnoses that included but were not limited to CVA (cerebral vascular disease), aphasia (difficulty speaking), high blood pressure, and paralysis to right side of body. Resident #34's most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 4/8/18. Resident #34 was coded as being severely impaired in cognitive function scoring 00 out of 15 on the BIMS (brief interview for mental status) exam.

On 6/13/18 at 8:19 p.m., medication administration observation was conducted with LPN #3. LPN #3 was observed preparing the following medications for Resident #102:

1) Nexium 40 mg (milligrams) tablet
2) Losartan potassium 50 mg tablet
3) Mirlax 17 Grams- 17 Grams

LPN #3 did not wash or sanitize her hands prior to preparing the above medications. LPN #3 did not wash/sanitize her hands after the medication was administered to Resident #102. At 8:30 a.m., LPN #3 began preparing the following medication for Resident #34:

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4) Neurotoin 300 mg capsule
5) Norvasc 10 mg tablet
6) Lasix 20 mg tablet
7) Levetiracetam 500 mg tablet
8) Lopressor 25 mg tablet.
9) Potassium chloride 20 MEQ (milliequivalent) Tab ER (extended release) - 2 tablets
10) Cranberry Capsule 400 mg tablet

While LPN #3 was preparing the above medications, two pills had fallen out of the package onto the medication cart. LPN #3 picked up the medication with her bare hands and placed the pills into the medication cup. LPN #3 crushed the medication and mixed the crushed medication with applesauce. LPN #3 then administered the applesauce with medication to Resident #102. LPN #3 then washed her hands for nine seconds before leaving the room.

On 6/13/18 at 1:37 p.m., an interview was conducted with LPN #3. When asked how to maintain infection control practices during medication pass, LPN #3 stated that nurses should wash hands and not pick up medications with bare hands due to contamination. When asked when she would wash her hands during medication pass, LPN #3 stated, "Anytime hands are soiled, anytime you feel the need to wash them." When asked if she should wash her hands in between residents during medication pass, LPN #3 stated, "It depends on if something were to happen if I gave medications." LPN #3 stated that she does not wash her hands in-between each resident. When asked if it was ever okay to pick medications up with her bare hands that dropped on the medication cart, and to

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administer medications that have fallen on the medication cart, LPN #3 stated, "No." LPN #3 also stated that it should have been okay because her medication cart was clean and wiped down with an alcohol cloth right before medication pass started.

On 6/14/18 at approximately 5:00 p.m., ASM (administrative staff member) #1, the administrator, was made aware of the above concerns.

The facility policy titled, "Hand Hygiene," documents in part, the following: "When to wash your hands...3. Before and after performing an invasive procedure (e.g. fingerstick blood sampling)...after removing gloves."

1) Nexium tablet is used to treat conditions where there is too much acid in the stomach. It is used to treat duodenal and gastric ulcers, erosive esophagitis, and gastroesophageal reflux disease (GERD). This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010169/.

2) Losartan potassium tablet used to decrease blood pressure. This information was obtained from The National Institutes of Health. https://www.nlm.nih.gov/medlineplus/druginfo/meds/a695008.html.

3) Mirlax relieves occasional constipation (irregularity); generally produces a bowel movement in 1 to 3 days. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=1771d3bf-954d-49ea-b260-3d356e5dcfa

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F 880	Continued From page 287 5. 4) Neurotoin capsule works in the brain to prevent seizures and relieve pain for certain conditions in the nervous system. It is not used for routine pain caused by minor injuries or arthritis. Gabapentin is an anticonvulsant. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010419/?report=details. 5) Norvasc 10 mg tablet is indicated for the treatment of hypertension, to lower blood pressure. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=ABD6A2CA-40C2-485C-BC53-DB1C652505ED. 6) Lasix 20 mg tablet used to decrease edema (excess fluid) in patients with heart failure, liver impairment or kidney disease. This information was obtained from Davis's Drug Guide for Nurses, 11th edition, p. 587. 7) Levetiracetam 500 mg tablet used to help control certain types of seizures in the treatment of epilepsy. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010898/?report=details. 8) Lopressor 25 mg tablet used to treat high blood pressure, angina (chest pain), and heart failure. May lower the risk of death after a heart attack. This medicine is a beta-blocker. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH	F 880		

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F 880	Continued From page 288 T0011186/?report=details. 9) Potassium chloride 20 MEQ Tab ER (extended release) - 2 tablets- Potassium Chloride is a metal halide composed of potassium and chloride. Potassium maintains intracellular tonicity, is required for nerve conduction, cardiac, skeletal and smooth muscle contraction, production of energy, the synthesis of nucleic acids, maintenance of blood pressure and normal renal function. This agent has potential antihypertensive effects and when taken as a nutritional supplement may prevent hypokalemia. This information was obtained from The National Institutes of Health. https://pubchem.ncbi.nlm.nih.gov/compound/potassium_chloride#section=Top. 10) Cranberry Capsule 400 mg tablet have been tested as a nutritional supplementation in the prevention of recurrent lower-urinary tract infections. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmed/25635978.	F 880		