STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495257	A. BUILDING _____ B. WING _____	C 03/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(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 3/20/18 through 3/23/18. 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 3/20/18 through 3/23/18. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety code survey/report will follow. The census in this 120 certified bed facility was 115 at the time of the survey. The survey sample consisted of 29 current resident reviews (Residents #28, #413, #80, #39, #75, #13, #5, #418, #15, #94, #104, #320, #36, #21, #43, #89, #50, #108, #421, #6, #87, #103, #316, #319, #102, #23, #52, #45, and #93) and 4 closed record reviews (Residents #74, #114, #214, and #323).	F 000		
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	F 580		5/4/18

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

Electronically Signed | 04/11/2018

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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 (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:

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F 580	Continued From page 2 Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to notify the physician and or resident representative of a change in condition for two of 33 residents in the survey sample, Residents #6, and #39. 1. The facility staff failed to notify Resident #6's representative regarding new treatment and or medication orders on 2/11/18, 2/15/18 and 2/19/18. 2. The facility staff failed to notify the physician of an elevated blood sugar on three occasions in March 2018 for Resident #39. The findings include: 1. The facility staff failed to notify Resident #6's representative regarding new treatment and or medication orders on 2/11/18, 2/15/18 and 2/19/18. Resident #6 was admitted to the facility on 11/21/17 and readmitted on 3/6/18. Resident #6's diagnoses included but were not limited to heart failure, acute kidney failure and high blood sugar. Resident #6's 30 day Medicare MDS (minimum data set) assessment, with an ARD (assessment reference date) of 12/19/17, coded the resident's cognition as severely impaired. A nurse practitioner note dated 2/6/18 documented, "HPI (History of Present Illness): Seeing pt (patient) who has left toes with erythema (redness)...bactroban (1) to toes..." A physician's order with a start date of 2/7/18 documented an order to apply bactroban and a	F 580	The Laurels of Willow Creek wishes to have this submitted plan of correction stand as its written allegation of compliance. Our alleged compliance is May 4th, 2018. Preparation and/or execution of this plan correction does not constitute admission to, nor agreement with, either 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 580 Corrective Action Resident #6's representative has been notified regarding all current treatment and medication orders. Resident #39 no longer resides in the facility. Corrective Action for Those Having the Potential to be Affected All residents have the potential to be affected by this alleged deficient practice. The facility will audit the last 30 days of order changes for RP notification. All insulin orders will be clarified by the MD with parameters of when to notify the	

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F 580	Continued From page 3 dry dressing to the left fourth and fifth toes twice a day for ten days. The order was discontinued on 2/10/18. A physician's order with a start date of 2/7/18 documented an order for Keflex (2) 500 mg (milligrams) three times a day times seven days for a suspected infection. A physician's order with a start date of 2/11/18 documented an order to cleanse the left fourth and fifth toes with normal saline, paint with betadine (3), apply betadine soaked gauze and wrap with kling twice a day. The order was discontinued on 2/15/18. A physician's order with a start date of 2/15/18 documented an order to cleanse the left fourth and fifth toes with normal saline and paint liberally with betadine three times a day. A physician's order with a start date of 2/19/18 documented an order for Ciprofloxacin (4) 500 mg every 12 hours times 30 days for toe infection. Further review of Resident #6's clinical record failed to reveal Resident #6's representative was made aware of the resident's left toe erythema or made aware of any of the above new orders. On 3/21/18 at 2:42 p.m., an interview was conducted with LPN (licensed practical nurse) #4 (the nurse cared for Resident #6 during the day shift on 2/6/18 and 2/7/18). LPN #4 was asked if she notified Resident #6's representative regarding the resident's left toe erythema. LPN #4 stated she notified the resident's representative the same day bactroban was started. When asked if she documented the notification, LPN #4 stated she documented the	F 580	physician of an elevated blood sugar. Systematic Changes All licensed nursing staff with be in-serviced on the facility's MD/RP notification process. DON/designee will conduct quality monitoring in clinical operations meeting to ensure physician and resident representative notification is occurring with each change in condition. Monitoring Monitoring of RP and MD notification will occur five times a week for four weeks will be completed by D.O.N or designee. Monitoring will include tracking and trending of issues found during the clinical operations meeting. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed. Ongoing compliance will be monitored through routine audits completed by the D.O.N or designee in the clinical operations meeting and will be reported to the facility's quality assurance meeting monthly for three months. Completion Date 5/4/18	

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notification at the bottom of a skilled nurse's note and in a progress note.

Review of skilled nurses' notes and progress notes dated 2/7/18 failed to reveal documentation of resident representative notification.

On 3/21/18 at 4:43 p.m., LPN #4 stated she could not find documentation that she notified Resident #6's family regarding the left toe erythema and the new orders but she knew she made the family aware. LPN #4 stated she did document a note that the family was in to visit.

On 3/22/18 at 11:21 a.m., an interview was conducted with RN (registered nurse) #3 and ASM (administrative staff member) #5 (the clinical resource specialist). RN #3 was asked when a resident's representative should be notified. RN #3 stated the representative should be notified if a resident has a fall, change in condition, or medication change. When asked if the representative should be notified regarding a change in a treatment order, RN #3 stated, "I say yes." RN #3 was asked to provide evidence that Resident #6's representative was notified when there was new treatment orders on 2/11/18, 2/15/18 and when Ciprofloxacin was ordered on 2/19/18.

On 3/22/18 at 2:30 p.m., another interview was conducted with RN #3 and ASM #5. RN #3 stated Resident #6's representative was not notified of the new treatment/medication orders on 2/11/18, 2/15/18 and 2/19/18.

On 3/22/18 at 4:40 p.m., ASM #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional manager) and ASM #5

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F 580	Continued From page 5	F 580		

were made aware of the above concern.

On 3/23/18 at 11:24 a.m., the director of medical records stated the facility did not have a policy regarding resident representative notification.

No further information was presented prior to exit.

(1) Bactroban is an antibiotic ointment used to treat skin infections. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a688004.html

(2) Keflex is an antibiotic used to treat infections. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682733.html

(3) Betadine is used to treat skin infections. This information was obtained from the website: https://pubchem.ncbi.nlm.nih.gov/compound/Povidone-iodine#section=Top

(4) Ciprofloxacin is used to treat infections. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a688016.html

2. The facility staff failed to notify the physician of an elevated blood sugar on three occasions in March 2018 for Resident #39.

Resident #39 was admitted to the facility on 1/10/18 with diagnoses that included but were not limited to: diabetes, osteomyelitis (infection in the bone) (1), pneumonia, depression, high blood pressure, peripheral vascular disease (any

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abnormal condition affecting blood vessels outside the heart) (2), pacemaker, and amputation of his toe.

The most recent MDS (minimum data set) assessment, a change in therapy assessment, with an assessment reference date of 3/5/18, coded the resident as scoring a 12 on the BIMS (brief interview for mental status) score, indicating he was moderately impaired to make daily cognitive decisions. The resident was coded as requiring limited assistance of one staff member for most of his activities of daily living.

The physician order dated, 1/10/18 documented, "Insulin Glargine Solution 100 UNIT/ML (milliliters) (a long acting insulin used to treat diabetes) (3); inject 30 units subcutaneously at bedtime for diabetes." The physician order dated, 3/13/18, documented, Blood sugar check two times a day for blood sugar."

The MAR (medication administration record) for March 2018 documented, "Insulin Glargine Solution 100 UNIT/ML inject 30 units subcutaneously at bedtime for diabetes." On 3/4/18 at 9:00 p.m., the nurse documented the blood sugar as"445." On 3/15/18 at 9:00 p.m., the nurse documented the blood sugar as "417." On 3/20/18 at 9:00 p.m., the nurse documented the blood sugar as "413."

The comprehensive care plan dated, 1/29/18, documented in part, "Focus: At risk for fluctuation blood sugars r/t (related to) diabetes." The "Interventions" documented in part, "Obtain labs (laboratory tests)/diagnostics per physician order, report abnormal finding to physician."

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Review of both the skilled nurse's notes and the progress notes for 3/4/18, 3/15/18 and 3/20/18, failed to evidence any documentation of the physician being notified of the elevated blood sugar.

A normal blood sugar in below 99. It is considered diabetes when the blood sugar is above 126. (4)

The facility "Standing Orders" documented in part, "Standing sliding scale for guest who do not have parameters upon admission...CALL MD (medical doctor) for < (less than) 60 or > (greater than) 400."

On 3/22/18 at 11:14 a.m., an interview was conducted with administrative staff member (ASM) #4, the nurse practitioner for Resident #39. ASM #4 was asked if she was notified of blood sugars for residents that had orders for blood sugar testing. ASM #4 stated, "If there are no parameters, I expect to be called if over 250." When asked if she would expect to be called for a blood sugar that is over 400, ASM #4 stated, "Absolutely. Then we aren't controlling his blood sugars."

An interview was conducted with RN (registered nurse) #3, the unit manager, on 3/22/18 at 1:47 p.m. When asked what staff do when a resident blood sugar is over 400, and there are no ordered physician ordered parameters, RN #3 stated, "I would notify the doctor." The above blood sugars were reviewed with RN #3. When asked where the notification of the physician or nurse practitioner is documented, RN #3 stated, "I would think it should be in the nurse's notes."

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An interview was conducted with ASM #2, the director of nursing, on 3/23/18 at 9:08 a.m. When asked what staff should do if a resident has a blood sugar over 400, ASM #2 stated, "They need to notify the physician." When asked what staff would do if there were no physician ordered parameters, ASM #2 stated, "It's a nursing judgment, they should call."

The facility policy, "Physician Notification" documented in part, "Procedures: 1. Notify the physician of a change in the guest's condition. 2. Document the time and date that the physician was notified, the physician's response and any treatment ordered in the Progress Notes."

In Basic Nursing, Essential for Practice, 6th edition (Potter and Perry, 2007, pages 56-59), was a reference source for physician's orders and notification. Failure to monitor the patient's condition appropriately and communicate that information to the physician or health care provider are causes of negligent acts. The best way to avoid being liable for negligence is to follow standards of care, to give competent health care, and to communicate with other health care providers. The physician or health care provider is responsible for directing the medical treatment of a patient.

ASM #1, the administrator, ASM #2, ASM #3 Regional manager, ASM #5, the clinical resource specialist, were made aware of the above findings on 3/22/18 at 5:40 p.m.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the

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F 580	Continued From page 9 Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 423. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 447. (3) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010731/?report=details. (4) This information was obtained from the following website: https://www.niddk.nih.gov/health-information/diabetes/overview/tests-diagnosis	F 580		
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 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	F 622		5/4/18

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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 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)

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F 622	Continued From page 11 (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, clinical record review, and during the course of a complaint investigation, it was determined the facility staff failed to ensure the physician documented in the clinical record when five of 33 residents in the survey sample; Residents #214, #23, #43, #36, and #5, were transferred to the hospital. 1. Resident #214 was transferred and admitted to the hospital on 12/11/17. There were no physician notes in the clinical record regarding why the facility was not able to manage the resident's condition and the reason for Resident #214's transfer to hospital.	F 622	1. The following residents, #23, #43, #36, and #5, received late notes by the physician as to why we were not able to manage the resident's condition. Resident #214 has been discharged. 2. All resident have the potential to be affected by this alleged deficient practice. 3.The D.O.N or designee will review 5 times weekly all residents transferred to the hospital for 3 months. Review will include ensuring MD documented the reason the facility was not able to manage the guest. The D.O.N or Designee will educate	

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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 622	Continued From page 12 2. Resident #23 was transferred and admitted to the hospital on 1/10/18. There were no physician notes in the clinical record regarding why the facility was not able to manage the resident's condition and the reason for Resident #23's transfer to hospital. 3. Resident #43 was transferred and admitted to the hospital on 1/2/18. There were no physician notes in the clinical record regarding why the facility was not able to manage the resident's condition and the reason for Resident #43's transfer to hospital. 4. Resident #36 was transferred and admitted to the hospital on 12/11/17. There were no physician notes in the clinical record regarding why the facility was not able to manage the resident's condition and the reason for Resident #36's transfer to hospital. 5. Resident #5 was transferred to the hospital on 12/9/17. There were no physician notes in the clinical record regarding why the facility was not able to manage the resident's condition and the reason for Resident #5's transfer to hospital. The findings include: 1. Resident #214 was transferred and admitted to the hospital on 12/11/17. There were no physician notes in the clinical record regarding why the facility was not able to manage the resident's condition and the reason for Resident #214's transfer to hospital. Resident #214 was admitted to the facility on	F 622	nursing staff and facility physicians on the proper discharge documentation which will include physician documentation regarding why transfer or discharge is necessary. 4. Monthly for three months the Q.A. Committee will review 20% of discharges to ensure there is MD documentation giving the reason why we were not able to manage the guest at the Laurels. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed.	

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12/4/14 and discharged to the hospital on 12/11/17. The resident had the diagnoses of but not limited to diabetes, congestive heart failure, bipolar disorder, schizophrenia, seizures, high blood pressure, anxiety disorder, dysphagia, and obesity. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 11/27/17. 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 assistance for transfers, dressing, toileting and hygiene; supervision for eating; and as incontinent of bowel and bladder.

The clinical record revealed a nurse's note dated 12/11/17, that documented, "Writer called to guest's room by staff. Writer observe guest sitting in w/c (wheel chair), body shaking, arms halfway in air shaking, eyes fixed. Notified MD (Medical Doctor) in facility, MD eval (evaluation), New order: Ativan [1] 1mg (milligram) SL (sublingual) NOW, send to (hospital) for eval dx (diagnosis): seizure, RP (responsible party) 1st contact phone answering service mailbox full, 2nd contact left message to call facility. Guest sent out on stetcher (sic)."

Further review of the clinical record failed to reveal any documentation by the physician or nurse practitioner regarding why the facility was not able to manage the resident's condition in-house, and the reason for this transfer.

On 3/23/18 at 11:10 a.m., in an interview with ASM (Administrative Staff Member) #4, the nurse practitioner), she stated that she (or the physician) does not typically write a note why could not be managed in house. ASM #4 stated,

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"If we are here we write a note. If we are not here to assess the person, we do not go back and write a note.... If they come back to us, we look at the chart and tell a little story behind why they went out."

A review of the facility policy, "Transfers and Discharges" failed to include any documentation regarding the physician's responsibilities when a resident is transferred to the hospital.

On 03/22/18 at 5:27 p.m., ASM #1 (the administrator), ASM #2 (the Director of Nursing), ASM #3 (the regional manager), and ASM #5 (the clinical resource specialist) were made aware of the findings. No further information was provided by the end of the survey.

[1] Ativan "...is used to relieve anxiety....Lorazepam (Ativan) is also used to treat irritable bowel syndrome, epilepsy, insomnia, and nausea and vomiting from cancer treatment and to control agitation caused by alcohol withdrawal..."
Information obtained from https://medlineplus.gov/druginfo/meds/a682053.html

2. Resident #23 was transferred and admitted to the hospital on 1/10/18. There were no physician notes in the clinical record regarding why the facility was not able to manage the resident's condition and the reason for Resident #23's transfer to hospital.

Resident #23 was admitted to the facility on 10/23/14 and readmitted on 1/15/18 with the

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diagnoses of but not limited to: diabetes, insomnia, glaucoma, spinal stenosis, bipolar disorder, neurogenic bladder, obesity, dementia, depression, anxiety disorder, high blood pressure, and chronic obstructive pulmonary disease. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 1/24/18. The resident was coded as cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating; and as incontinent of bowel.

A review of the clinical record revealed a nurse's note dated 1/10/18, which documented, "Guest sent to hospital for further evaluation. Per (name of doctor). Possible allergic reaction to im [sic] antibiotic.... RP (responsible party) notified and phone call returned and spoken to."

Further review of the clinical record revealed a physician's note dated 1/17/18, two days after the resident was readmitted. However, the note by the physician did not document why the resident's condition could not be managed in-house.

On 3/23/18 at 11:10 a.m., in an interview with ASM (Administrative Staff Member) #4, the nurse practitioner), she stated that she (or the physician) does not typically write a note why could not be managed in house. ASM #4 stated, "If we are here we write a note. If we are not here to assess the person, we do not go back and write a note.... If they come back to us, we look at the chart and tell a little story behind why they went out."

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On 03/22/18 at 5:27 p.m., ASM #1 (the administrator), ASM #2 (the Director of Nursing), ASM #3 (the regional manager), and ASM #5 (the clinical resource specialist) were made aware of the findings. No further information was provided by the end of the survey.

3. Resident #43 was transferred and admitted to the hospital on 1/2/18. There were no physician notes in the clinical record regarding why the facility was not able to manage the resident's condition and the reason for Resident #43's transfer to hospital.

Resident #43 was admitted to the facility on 12/30/14 and readmitted on 1/15/18 with the diagnoses of but not limited to: dementia, diabetes, high blood pressure, and seizures. The most recent MDS (Minimum Data Set) was a 30-day readmission assessment with an ARD (Assessment Reference Date) of 2/11/18. The resident was coded as being mildly impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing, transfers, dressing, toileting and hygiene; limited assistance for eating; and as being incontinent of bowel and bladder.

A nurse's note dated 1/2/18 documented, "guest sent to (hospital) er (emergency room) [sic] for eval (evaluation) r/t (related / to) fall. [sic] seizure [sic] activity and vomiting [sic] rp [sic] notified."

Further review of the clinical record failed to reveal any documentation by the physician or nurse practitioner regarding why the facility was not able to manage the resident's condition

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in-house. Nurse practitioner notes dated 1/16/18, 1/17/18, and 1/18/18 (the resident was readmitted on 1/15/18) documented the resident had pneumonia and sepsis (hospital diagnoses). The notes did not address the seizure, fall, and vomiting as the reasons the resident was sent to the hospital.

On 3/23/18 at 11:10 a.m., in an interview with ASM (Administrative Staff Member) #4, the nurse practitioner), she stated that she (or the physician) does not typically write a note why could not be managed in house. ASM #4 stated, "If we are here we write a note. If we are not here to assess the person, we do not go back and write a note.... If they come back to us, we look at the chart and tell a little story behind why they went out."

On 03/22/18 at 5:27 p.m., ASM #1 (the administrator), ASM #2 (the Director of Nursing), ASM #3 (the regional manager), and ASM #5 (the clinical resource specialist) were made aware of the findings. No further information was provided by the end of the survey.

4. Resident #36 was transferred and admitted to the hospital on 12/11/17. There were no physician notes in the clinical record regarding why the facility was not able to manage the resident's condition and the reason for Resident #36's transfer to hospital.

Resident #36 was admitted to the facility on 1/10/17 and readmitted on 1/8/18 with the diagnoses of but not limited to: diabetes,

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colostomy, pressure ulcer, depression, psychosis, anxiety disorder, spinal stenosis, osteoarthritis, insomnia, and high blood pressure. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/24/18. 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, eating, toileting, and hygiene; and as incontinent of bladder.

A review of the clinical record revealed a nurse's note dated 12/11/17 which documented, "Guest has been yelling out on and off thru the shift. She complained of abdominal pain, and then would repeat words that staff would say to her. She has had one liquid stool this shift, bowel sounds were heard tinkling in the LUQ (left upper quadrant) LLQ (left lower quadrant) and RUQ (right upper quadrant). Writer listened for 5 minutes and no bowel sounds were heard in the RLQ (right lower quadrant). Guests abdomen remains distended, firm and tender to touch...On-call notified of above and order received to send to ER (emergency room) for evaluation. 911 was called, responded and transported guest to (hospital). There was no answer at RP (responsible party) number, message left for RP to call facility back."

The resident was readmitted on 1/8/18. Further review of the clinical record failed to reveal any documentation by the physician or nurse practitioner regarding why the facility was not able to manage the resident's condition in-house, and the reason for this transfer to the hospital.

On 3/23/18 at 11:10 a.m., in an interview with

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ASM (Administrative Staff Member) #4, the nurse practitioner), she stated that she (or the physician) does not typically write a note why could not be managed in house. ASM #4 stated, "If we are here we write a note. If we are not here to assess the person, we do not go back and write a note.... If they come back to us, we look at the chart and tell a little story behind why they went out."

On 03/22/18 at 5:27 p.m., ASM #1 (the administrator), ASM #2 (the Director of Nursing), ASM #3 (the regional manager), and ASM #5 (the clinical resource specialist) were made aware of the findings. No further information was provided by the end of the survey.

5. Resident #5 was transferred to the hospital on 12/9/17. There were no physician notes in the clinical record regarding why the facility was not able to manage the resident's condition and the reason for Resident #5's transfer to hospital.

Resident #5 was admitted to the facility on 1/8/13 with diagnoses that included but were not limited to chronic obstructive pulmonary disease, nose fracture, major depressive disorder, Alzheimer's disease, high blood pressure, and Parkinson's disease. Resident #5's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 12/19/17. Resident #5 was coded as being cognitively impaired in the ability to make daily decisions scoring 07 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #5 was coded as requiring extensive assistance with two staff members with

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locomotion, eating, and personal hygiene; extensive assistance from three staff members with bed mobility, transfers, dressing, and toileting; and total dependence on staff with bathing.

Review of Resident #5's nursing notes revealed that he was transferred to the hospital on 12/9/17. The following was documented at 10:25 p.m., "...At 4:55 p.m., Guest was found on floor by CNA (certified nursing assistant). Guest had lacerations to both arms. Visco paste and dry dressing apply to both arms. Guest was sent to (Name of Hospital) ER (emergency room). vitals: 128/84 (blood pressure), 20 (respirations), 97.6 (temperature), 2 (heart rate). POA (power of attorney) (Name of POA) and (Name of NP [nurse practitioner]) NP was notified. Neuro (neurological) check was in place until ambulance arrived. Bed alarms in place and sounding. Received report from ED (emergency department), guest had a fracture (sic) nose and facial and scalp contusions. Guest arrived back to the facility at 10:15 p.m. via ambulance. Guest is resting comfortably in bed. Neuro checks in place. Bed alarm in place. Fall matt (sic) next to bed. Skin tear orders are in the TAR (treatment administration record)."

There were no physician notes regarding the reason for the facility-initiated transfer for Resident #5 in the clinical record.

On 3/23/18 at 11:04 a.m., an interview was conducted with ASM (administrative staff member) #4, the nurse practitioner. ASM #4 stated that a note would only be written prior to or shortly after a transfer if she or the physician were in the building at the time of the resident's

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F 622	Continued From page 21 change of condition requiring a transfer to the hospital. ASM #4 stated that if they were in the building, they would assess the resident prior to transfer and document their assessment in a progress note. ASM #4 stated that she and the physician do not typically write notes for every transfer to the hospital, especially if they were not in the building during the time of transfer. ASM #4 confirmed that Resident #5 was transferred to the hospital over the weekend and she would not have written a note regarding the hospital transfer. On 3/22/18 at 5:26 p.m., ASM (administrative staff member) #1 the administrator, ASM #2, DON (Director of Nursing) and ASM (administrative staff member) #3 and the regional manager were made aware of the above concerns. No further information was presented 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 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	F 623		5/4/18

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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), 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

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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 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).

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F 623	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, and in the course of a complaint investigation, it was determined that the facility staff failed to provide six of 33 residents in the survey sample, Residents #214, #23, #43, #36, #75, and #5, written notification before a facility initiated transfer to the hospital. 1. The facility staff failed to provide the required written notification to the resident representative and ombudsman regarding the reasons for the transfer, when Resident #214, was transferred to the hospital on 12/11/17. 2. The facility staff failed to provide the required written notification to the resident representative and ombudsman regarding the reasons for the transfer, when Resident #23, was transferred to the hospital on 1/10/18. 3. The facility staff failed to provide the required written notification to the resident representative and ombudsman regarding the reasons for the transfer, when Resident #43, was transferred to the hospital on 1/2/18. 4. The facility staff failed to provide the required written notification to the resident representative and ombudsman regarding the reasons for the transfer, when Resident #36, was transferred to the hospital on 12/11/17. 5. The facility staff failed to provide the required written notification to the resident representative and ombudsman regarding the reasons for the transfer, when Resident #75, was transferred to the hospital on 2/6/18.	F 623	1. Written notification including reason for discharge has been provided to the ombudsman and RP of residents #23, #43,#36,#75,#5 and #214. 2. All residents have the potential to be affected by this alleged deficient practice. 3. The A.D.O.N or designee will educate nursing on providing residents and their RP with the discharge transfer notice and entering corresponding documentation in the medical record. The notice will be given to the resident upon transfer to the hospital, a copy will be put in the resident□'s medical record. In addition, the discharging nurse will document that residents transferred to a hospital have been given discharge transfer notices. During the clinical meeting the D.O.N or designee will review previous day's discharges to ensure the discharged residents received notice as to why they were transferred to the hospital and documentation was completed. The administrator will educate the Social Worker on the facility's discharge policies including Ombudsman notification, using the facility's discharge transfer notice. The Social Worker will provide regular written notification to the ombudsman regarding when the discharges are initiated by the facility. Once a month the Social Worker will identify all residents discharged and will provide a discharged resident list to the Ombudsman including reason for transfers.	

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F 623	Continued From page 25 6. The facility staff failed to provide written notification to Resident #5, the resident representative and ombudsman for a transfer to the hospital on 12/9/17 and 3/4/18. The findings include: 1. The facility staff failed to provide the required written notification to the resident representative and ombudsman regarding the reasons for the transfer, when Resident #214, was transferred to the hospital on 12/11/17. Resident #214 was admitted to the facility on 12/4/14 and discharged to the hospital on 12/11/17. The resident had the diagnoses of but not limited to diabetes, congestive heart failure, bipolar disorder, schizophrenia, seizures, high blood pressure, anxiety disorder, dysphagia, and obesity. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 11/27/17. 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 assistance for transfers, dressing, toileting and hygiene; supervision for eating; and as incontinent of bowel and bladder. The clinical record revealed a nurse's note dated 12/11/17, that documented, "Writer called to guest's room by staff. Writer observe guest sitting in w/c (wheel chair), body shaking, arms halfway in air shaking, eyes fixed. Notified MD (Medical Doctor) in facility, MD eval (evaluation), New order: Ativan [1] 1mg (milligram) SL (sublingual) NOW, send to (hospital) for eval dx	F 623	4. Weekly for four weeks the Nurse Navigator will review all hospital discharges to ensure compliance with Discharge/Transfer Notice and documentation stating form was given to resident and RP and ensure a copy is in the chart. Monthly for three months the Q.A. Committee will review the discharged residents and ensure there confirmation that the Ombudsman was notified and written notification of discharge was provided to the resident and RP.	

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(diagnosis): seizure, RP (responsible party) 1st contact phone answering service mailbox full, 2nd contact left message to call facility. Guest sent out on stetcher (sic)."

A review of the clinical record failed to reveal any evidence that the resident representative and the ombudsman were notified in writing of reason for and transfer of Resident #214's to the hospital.

On 3/22/18 at 4:53 p.m., in an interview with OSM (Other Staff Member, Marketing/Admission), #14 she stated that written notification is not provided regarding hospitalizations, and that she does not notify ombudsman for hospitalization, that she typically does not get involved with discharges. When asked who would notify the ombudsman of a facility initiated transfer or discharge, OSM #14 stated the facility does not typically notify the ombudsman of a discharge to the hospital.

On 3/22/18 at 5:05 p.m.,, in an interview with OSM #6, the social worker, and ASM (Administrative Staff Member) #3, the Regional Manager, ASM #3 stated, "Our ombudsman office told us they do not want this list of any notifications. We were told by our association, Virginia Health Care Association, they don't want it and just do it for involuntary sort of things." He further stated, in regards to the notifications to the resident representative and Ombudsman, "It has not been happening" since regulation went into effect in November (2017), and there is no written notification of transfer to hospital.

A review of the facility policy, "Transfers and Discharges" failed to include any documentation regarding the facility's responsibility to notify the resident representative and ombudsman in

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writing of the resident's transfer to the hospital.

On 03/22/18 at 5:27 p.m., ASM #1 (the administrator), ASM #2 (the Director of Nursing), ASM #3 (the regional manager), and ASM #5 (the clinical resource specialist) were made aware of the findings. No further information was provided by the end of the survey.

[1] Ativan "...is used to relieve anxiety....Lorazepam (Ativan) is also used to treat irritable bowel syndrome, epilepsy, insomnia, and nausea and vomiting from cancer treatment and to control agitation caused by alcohol withdrawal..."
Information obtained from https://medlineplus.gov/druginfo/meds/a682053.html

2. The facility staff failed to provide the required written notification to the resident representative and ombudsman regarding the reasons for the transfer, when Resident #23 was transferred to the hospital on 1/10/18.

Resident #23 was admitted to the facility on 10/23/14 and readmitted on 1/15/18 with the diagnoses of but not limited to: diabetes, insomnia, glaucoma, spinal stenosis, bipolar disorder, neurogenic bladder, obesity, dementia, depression, anxiety disorder, high blood pressure, and chronic obstructive pulmonary disease. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 1/24/18. The resident was coded as cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting

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and hygiene; supervision for eating; and as incontinent of bowel.

A review of the clinical record revealed a nurse's note dated 1/10/18, which documented, "Guest sent to hospital for further evaluation. Per (name of doctor). Possible allergic reaction to im [sic] antibiotic.... RP (responsible party) notified and phone call returned and spoken to."

A review of the clinical record failed to reveal any evidence that the resident representative and the ombudsman were notified in writing of reason for and transfer of Resident #23's to the hospital.

On 3/22/18 at 4:53 p.m., in an interview with OSM (Other Staff Member, Marketing/Admission), #14 she stated that written notification is not provided regarding hospitalizations, and that she does not notify ombudsman for hospitalization, that she typically does not get involved with discharges. When asked who would notify the ombudsman of a facility initiated transfer or discharge, OSM #14 stated the facility does not typically notify the ombudsman of a discharge to the hospital.

On 3/22/18 at 5:05 p.m.,, in an interview with OSM #6, the social worker, and ASM (Administrative Staff Member) #3, the Regional Manager, ASM #3 stated, "Our ombudsman office told us they do not want this list of any notifications. We were told by our association, Virginia Health Care Association, they don't want it and just do it for involuntary sort of things." He further stated, in regards to the notifications to the resident representative and Ombudsman, "It has not been happening" since regulation went into effect in November (2017), and there is no written notification of transfer to hospital.

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On 03/22/18 at 5:27 p.m., ASM #1 (the administrator), ASM #2 (the Director of Nursing), ASM #3 (the regional manager), and ASM #5 (the clinical resource specialist) were made aware of the findings. No further information was provided by the end of the survey.

3. The facility staff failed to provide the required written notification to the resident representative and ombudsman regarding the reasons for the transfer, when Resident #43 was transferred to the hospital on 1/2/18.

Resident #43 was admitted to the facility on 12/30/14 and readmitted on 1/15/18 with the diagnoses of but not limited to: dementia, diabetes, high blood pressure, and seizures. The most recent MDS (Minimum Data Set) was a 30-day readmission assessment with an ARD (Assessment Reference Date) of 2/11/18. The resident was coded as being mildly impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing, transfers, dressing, toileting and hygiene; limited assistance for eating; and as being incontinent of bowel and bladder.

A nurse's note dated 1/2/18 documented, "guest sent to (hospital) er (emergency room) [sic] for eval (evaluation) r/t (related / to) fall. [sic] seizure [sic] activity and vomiting [sic] rp [sic] notified."

A review of the clinical record failed to reveal any evidence that the resident representative and the ombudsman were notified in writing of reason for and transfer of Resident # 43's to the hospital.

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F 623	Continued From page 30 On 3/22/18 at 4:53 p.m., in an interview with OSM (Other Staff Member, Marketing/Admission), #14 she stated that written notification is not provided regarding hospitalizations, and that she does not notify ombudsman for hospitalization, that she typically does not get involved with discharges. When asked who would notify the ombudsman of a facility initiated transfer or discharge, OSM #14 stated the facility does not typically notify the ombudsman of a discharge to the hospital. On 3/22/18 at 5:05 p.m., in an interview with OSM #6, the social worker, and ASM (Administrative Staff Member) #3, the Regional Manager, ASM #3 stated, "Our ombudsman office told us they do not want this list of any notifications. We were told by our association, Virginia Health Care Association, they don't want it and just do it for involuntary sort of things." He further stated, in regards to the notifications to the resident representative and Ombudsman, "It has not been happening" since regulation went into effect in November (2017), and there is no written notification of transfer to hospital. On 03/22/18 at 5:27 p.m., ASM #1 (the administrator), ASM #2 (the Director of Nursing), ASM #3 (the regional manager), and ASM #5 (the clinical resource specialist) were made aware of the findings. No further information was provided by the end of the survey. 4. The facility staff failed to provide the required written notification to the resident representative and ombudsman regarding the reasons for the transfer, when Resident #36 was transferred to the hospital on 12/11/17.	F 623		

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Resident #36 was admitted to the facility on 1/10/17 and readmitted on 1/8/18 with the diagnoses of but not limited to: diabetes, colostomy, pressure ulcer, depression, psychosis, anxiety disorder, spinal stenosis, osteoarthritis, insomnia, and high blood pressure. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/24/18. 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, eating, toileting, and hygiene; and as incontinent of bladder.

A review of the clinical record revealed a nurse's note dated 12/11/17 which documented, "Guest has been yelling out on and off thru the shift. She complained of abdominal pain, and then would repeat words that staff would say to her. She has had one liquid stool this shift, bowel sounds were heard tinkling in the LUQ (left upper quadrant) LLQ (left lower quadrant) and RUQ (right upper quadrant). Writer listened for 5 minutes and no bowel sounds were heard in the RLQ (right lower quadrant). Guests abdomen remains distended, firm and tender to touch...On-call notified of above and order received to send to ER (emergency room) for evaluation. 911 was called, responded and transported guest to (hospital). There was no answer at RP (responsible party) number, message left for RP to call facility back."

A review of the clinical record failed to reveal any evidence that the resident representative and the ombudsman were notified in writing of reason for and transfer of Resident # 36's to the hospital.

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F 623	Continued From page 32 On 3/22/18 at 4:53 p.m., in an interview with OSM (Other Staff Member, Marketing/Admission), #14 she stated that written notification is not provided regarding hospitalizations, and that she does not notify ombudsman for hospitalization, that she typically does not get involved with discharges. When asked who would notify the ombudsman of a facility initiated transfer or discharge, OSM #14 stated the facility does not typically notify the ombudsman of a discharge to the hospital. On 3/22/18 at 5:05 p.m., in an interview with OSM #6, the social worker, and ASM (Administrative Staff Member) #3, the Regional Manager, ASM #3 stated, "Our ombudsman office told us they do not want this list of any notifications. We were told by our association, Virginia Health Care Association, they don't want it and just do it for involuntary sort of things." He further stated, in regards to the notifications to the resident representative and Ombudsman, "It has not been happening" since regulation went into effect in November (2017), and there is no written notification of transfer to hospital. On 03/22/18 at 5:27 p.m., ASM #1 (the administrator), ASM #2 (the Director of Nursing), ASM #3 (the regional manager), and ASM #5 (the clinical resource specialist) were made aware of the findings. No further information was provided by the end of the survey. 5. The facility staff failed to provide the required written notification to the resident representative and ombudsman regarding the reasons for the transfer, when Resident #75 was transferred to the hospital on 2/6/18.	F 623		

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Resident #75 was admitted to the facility on 2/11/11 and readmitted on 2/12/18 with the diagnoses of but not limited to high blood pressure, diabetes, dementia, multiple sclerosis, Parkinson's disease, seizure disorder, anxiety disorder, depression, insomnia, dysphagia, and chronic pain syndrome. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 2/26/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for transfers; extensive care for dressing, bathing, toileting and hygiene; limited assistance for eating; and as incontinent of bowel and bladder.

A review of the clinical record revealed a nurse's note dated 2/6/18, which documented, "Resident yelling out with "head spasms". NP (nurse practitioner) notified and in to see. Resident insists on being sent to the ER (emergency room). Unable to reach sister but got in touch with son, (name), and notified him of residents condition and insisting to go to ER (emergency room). Ambulance called and to pick up and take her to (hospital).

A nurse practitioner note dated 2/6/18 documented, "Seeing patient today who was saying that she was having spasms in her head that were causing her to have pain. She has seen a neurologist and spoke to her son who is trying to secure her an early appt (appointment) with neurologist. She is up and around in her motorized WC (wheelchair) off and on during the day. She has just gone back to bed and felt the spasms were "just not getting better". Since the

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appt (appointment) is over 2 weeks away - spoke with pt (patient) about sending her to the ER. Son on phone with mom and in agreement...."

A review of the clinical record failed to reveal any evidence that the resident representative and the ombudsman were notified in writing of reason for and transfer of Resident # 75's to the hospital.

On 3/22/18 at 4:53 p.m., in an interview with OSM (Other Staff Member, Marketing/Admission), #14 she stated that written notification is not provided regarding hospitalizations, and that she does not notify ombudsman for hospitalization, that she typically does not get involved with discharges. When asked who would notify the ombudsman of a facility initiated transfer or discharge, OSM #14 stated the facility does not typically notify the ombudsman of a discharge to the hospital.

On 3/22/18 at 5:05 p.m., in an interview with OSM #6, the social worker, and ASM (Administrative Staff Member) #3, the Regional Manager, ASM #3 stated, "Our ombudsman office told us they do not want this list of any notifications. We were told by our association, Virginia Health Care Association, they don't want it and just do it for involuntary sort of things." He further stated, in regards to the notifications to the resident representative and Ombudsman, "It has not been happening" since regulation went into effect in November (2017), and there is no written notification of transfer to hospital.

On 03/22/18 at 5:27 p.m., ASM #1 (the administrator), ASM #2 (the Director of Nursing), ASM #3 (the regional manager), and ASM #5 (the clinical resource specialist) were made aware of the findings. No further information was provided

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by the end of the survey.

6. The facility staff failed to provide written notification to Resident #5, the resident representative and ombudsman for a transfer to the hospital on 12/9/17 and 3/4/18.

Resident #5 was admitted to the facility on 1/8/13 with diagnoses that included but were not limited to chronic obstructive pulmonary disease, nose fracture, major depressive disorder, Alzheimer's disease, high blood pressure, and Parkinson's disease. Resident #5's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 12/19/17. Resident #5 was coded as being cognitively impaired in the ability to make daily decisions scoring 07 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #5 was coded as requiring extensive assistance with two staff members with locomotion, eating, and personal hygiene; extensive assistance from three staff members with bed mobility, transfers, dressing, and toileting; and total dependence on staff with bathing.

Review of Resident #5's nursing notes revealed that he was transferred to the hospital on 12/9/17. The following was documented at 10:25 p.m., "...At 4:55 p.m., Guest was found on floor by CNA (certified nursing assistant). Guest had lacerations to both arms. Visco paste and dry dressing apply to both arms. Guest was sent to (Name of Hospital) ER (emergency room). vitals: 128/84 (blood pressure), 20 (respirations), 97.6 (temperature), 2 (heart rate). POA (power of attorney) (Name of POA) and (Name of NP [nurse practitioner]) NP was notified. Neuro

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(neurological) check was in place until ambulance arrived. Bed alarms in place and sounding. Received report from ED (emergency department), guest had a fracture (sic) nose and facial and scalp contusions. Guest arrived back to the facility at 10:15 p.m. via ambulance. Guest is resting comfortably in bed. Neuro checks in place. Bed alarm in place. Fall matt (sic) next to bed. Skin tear orders are in the TAR (treatment administration record)."

Review of Resident #5's clinical record revealed that he was sent to the hospital for a second time due to a fall on 3/4/18. The following was documented in a progress note: "Writer in hallway passing meds (medications), loud crash heard, immediately upon entering room where sound heard, guest noted on floor facedown; blood noted from nose and face and right hand, 911 activated. VS (vital signs) T (temperature)- 97.2, P (pulse)- 58, R (respirations)- 20, BP (Blood Pressure)- 152/60; guest transported to (Name of Hospital). RP (representative) notified of situation. (Name of Hospice Provider), and on call NP (nurse practitioner) for MD (medical doctor) also notified of events."

The next note dated 3/5/18 at 2:53 a.m., documented the following: "Guest returned to facility at approx. (approximately) 1:15 a.m., via stretcher in accompany of 2 EMTS (Emergency medical technicians). Guest noted with bandage over bridge of nose one bandage on his right arm and one on finger on his right hand. Multiple bruising noted to face. Guest diagnosed with fractured nose and head injury- no wake up. Guest alert and talking and answering questions appropriately. Ice pack applied to nose to help with minor discomfort. Neuro (neurological)

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THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(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 623	Continued From page 37 checks started and within normal limits for this guest. Bed is in the lowest position and call bell within reach. Will continue to monitor patient thru (sic) the night." Review of the clinical record did not evidence documentation that the family had been notified in writing about the resident's emergency room transfer on 12/9/17 and 3/4/18. The clinical record did not evidence documentation that the ombudsman had been notified of the transfer on 12/9/17 and 3/4/18. On 3/22/18 at 5:13 p.m., an interview was conducted with ASM (administrative staff member) #3, the regional manager and OSM (other staff member) #6, the director of social services. ASM #3 had stated that their ombudsman office had asked the facility to not send them notifications of every facility-initiated transfer and that they were not doing it. ASM #3 had also stated that facility staff were not providing written notification to the responsible parties when a resident was sent to the hospital. ASM #3 stated that nursing staff were only notifying the representatives verbally when a resident was transferred to the hospital. On 3/22/18 at 5:26 p.m., ASM (administrative staff member) #1 the administrator, ASM #2, DON (Director of Nursing) and ASM (administrative staff member) #3 and the regional manager were made aware of the above concerns. No further information was presented prior to exit.	F 623		
F 624 SS=E	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7)	F 624		5/4/18

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F 624	Continued From page 38 §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, and in the course of a complaint investigation, it was determined that the facility staff failed to orient, prepare, and document the same, a resident for transfer to the hospital for 4 of 33 residents in the survey sample; Residents #214, #23, #43, and #36. 1. The facility staff failed to document that Resident #214 was properly oriented and prepared for a hospital transfer that occurred on 12/11/17. 2. The facility staff failed to document that Resident #23 was properly oriented and prepared for a hospital transfer that occurred on 1/10/18. 3. The facility staff failed to document that Resident #43 was properly oriented and prepared for a hospital transfer that occurred on 1/2/18. 4. The facility staff failed to document that Resident #36 was properly oriented and prepared for a hospital transfer that occurred on 12/11/17. The findings include: 1. The facility staff failed to document that	F 624	1. Resident #214 has been discharged. Residents #23,#43,and #36, have returned to the facility. If they are transferred or discharged in the future they will be oriented for their transfer. 2.All residents have the potential to be affected by this alleged deficient practice. 3. The D.O.N or designee will review in clinical operations meeting, nurse documentation that resident was prepared or oriented for their transfer. Any alleged deficient practice will be corrected. The A.D.O.N or Designee will educate nursing staff on documenting that resident was prepared or oriented for their transfer. 4.The D.O.N or designee will review in clinical operations meeting, that nurse documented that resident was prepared or oriented for their transfer. Any deficient practice will be corrected. Monthly for three months the Q.A. Committee will review 20% of transfers to the hospital to ensure nursing staff documented that resident was prepared or oriented for their transfer.	

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F 624	Continued From page 39	F 624		

Resident #214 was properly oriented and prepared for a hospital transfer that occurred on 12/11/17.

Resident #214 was admitted to the facility on 12/4/14 and discharged to the hospital on 12/11/17. The resident had the diagnoses of but not limited to diabetes, congestive heart failure, bipolar disorder, schizophrenia, seizures, high blood pressure, anxiety disorder, dysphagia, and obesity. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 11/27/17. 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 assistance for transfers, dressing, toileting and hygiene; supervision for eating; and as incontinent of bowel and bladder.

The clinical record revealed a nurse's note dated 12/11/17, that documented, "Writer called to guest's room by staff. Writer observe guest sitting in w/c (wheel chair), body shaking, arms halfway in air shaking, eyes fixed. Notified MD (Medical Doctor) in facility, MD eval (evaluation), New order: Ativan [1] 1mg (milligram) SL (sublingual) NOW, send to (hospital) for eval dx (diagnosis): seizure, RP (responsible party) 1st contact phone answering service mailbox full, 2nd contact left message to call facility. Guest sent out on stetcher (sic)."

Further review of the clinical record failed to reveal any evidence that the resident was prepared and oriented for transfer to the hospital.

On 3/23/18 at 8:48 a.m., in an interview with LPN (Licensed Practical Nurse) #9, she stated that the

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resident should be oriented and prepared for discharge/transfer and that it should be documented.

A review of the facility policy, "Transfers and Discharges" failed to include any documentation regarding the preparation, orientation, and documentation of the same, of a resident who is being transferred to the hospital.

On 03/22/18 at 5:27 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the Director of Nursing), ASM #3 (the regional manager), and ASM #5 (the clinical resource specialist) were made aware of the findings. No further information was provided by the end of the survey.

[1] Ativan "...is used to relieve anxiety....Lorazepam (Ativan) is also used to treat irritable bowel syndrome, epilepsy, insomnia, and nausea and vomiting from cancer treatment and to control agitation caused by alcohol withdrawal..."
Information obtained from https://medlineplus.gov/druginfo/meds/a682053.html

2. The facility staff failed to document that Resident #23 was properly oriented and prepared for a hospital transfer that occurred on 1/10/18.

Resident #23 was admitted to the facility on 10/23/14 and readmitted on 1/15/18 with the diagnoses of but not limited to: diabetes, insomnia, glaucoma, spinal stenosis, bipolar disorder, neurogenic bladder, obesity, dementia, depression, anxiety disorder, high blood

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F 624	Continued From page 41	F 624		

pressure, and chronic obstructive pulmonary disease. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 1/24/18. The resident was coded as cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating; and as incontinent of bowel.

A review of the clinical record revealed a nurse's note dated 1/10/18, which documented, "Guest sent to hospital for further evaluation. Per (name of doctor). Possible allergic reaction to im [sic] antibiotic.... RP (responsible party) notified and phone call returned and spoken to."

Further review of the clinical record failed to reveal any evidence that the resident was prepared and oriented for transfer to the hospital.

On 3/23/18 at 8:48 a.m., in an interview with LPN (Licensed Practical Nurse) #9, she stated that the resident should be oriented and prepared for discharge/transfer and that it should be documented.

On 03/22/18 at 5:27 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the Director of Nursing), ASM #3 (the regional manager), and ASM #5 (the clinical resource specialist) were made aware of the findings. No further information was provided by the end of the survey.

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3. The facility staff failed to document that Resident #43 was properly oriented and prepared for a hospital transfer that occurred on 1/2/18.

Resident #43 was admitted to the facility on 12/30/14 and readmitted on 1/15/18 with the diagnoses of but not limited to: dementia, diabetes, high blood pressure, and seizures. The most recent MDS (Minimum Data Set) was a 30-day readmission assessment with an ARD (Assessment Reference Date) of 2/11/18. The resident was coded as being mildly impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing, transfers, dressing, toileting and hygiene; limited assistance for eating; and as being incontinent of bowel and bladder.

A nurse's note dated 1/2/18 documented, "guest sent to (hospital) er (emergency room) [sic] for eval (evaluation) r/t (related / to) fall. [sic] seizure [sic] activity and vomiting [sic] rp [sic] notified."

Further review of the clinical record failed to reveal any evidence that the resident was prepared and oriented for transfer to the hospital.

On 3/23/18 at 8:48 a.m., in an interview with LPN (Licensed Practical Nurse) #9, she stated that the resident should be oriented and prepared for discharge/transfer and that it should be documented.

On 03/22/18 at 5:27 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the Director of Nursing), ASM #3 (the regional manager), and ASM #5 (the clinical resource specialist) were made aware of the findings. No further information was provided by the end of the

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survey.

4. The facility staff failed to document that Resident #36 was properly oriented and prepared for a hospital transfer that occurred on 12/11/17.

Resident #36 was admitted to the facility on 1/10/17 and readmitted on 1/8/18 with the diagnoses of but not limited to: diabetes, colostomy, pressure ulcer, depression, psychosis, anxiety disorder, spinal stenosis, osteoarthritis, insomnia, and high blood pressure. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/24/18. 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, eating, toileting, and hygiene; and as incontinent of bladder.

A review of the clinical record revealed a nurse's note dated 12/11/17 which documented, "Guest has been yelling out on and off thru the shift. She complained of abdominal pain, and then would repeat words that staff would say to her. She has had one liquid stool this shift, bowel sounds were heard tinkling in the LUQ (left upper quadrant) LLQ (left lower quadrant) and RUQ (right upper quadrant). Writer listened for 5 minutes and no bowel sounds were heard in the RLQ (right lower quadrant). Guests abdomen remains distended, firm and tender to touch...On-call notified of above and order received to send to ER (emergency room) for evaluation. 911 was called, responded and transported guest to (hospital). There was no answer at RP

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F 624	Continued From page 44 (responsible party) number, message left for RP to call facility back." Further review of the clinical record failed to reveal any evidence that the resident was prepared and oriented for transfer to the hospital. On 3/23/18 at 8:48 a.m., in an interview with LPN (Licensed Practical Nurse) #9, she stated that the resident should be oriented and prepared for discharge/transfer and that it should be documented. On 03/22/18 at 5:27 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the Director of Nursing), ASM #3 (the regional manager), and ASM #5 (the clinical resource specialist) were made aware of the findings. No further information was provided by the end of the survey.	F 624		
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	F 625		5/4/18

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F 625	Continued From page 45 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 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 staff interview, resident interview, clinical record review and facility document review, it was determined that the facility staff failed to provide written bed hold policy/notification to the responsible party, within 24 hours of a transfer to the hospital for five of 33 residents in the survey sample; Residents #214, #23, #43, #36, and #75. 1. The facility staff failed to evidence that Resident #214's resident representative was provide a written bed hold policy/notification within 24 hours of a transfer and admission to the hospital on 12/11/17. 2. The facility staff failed to evidence that Resident #23's resident representative was provide a written bed hold policy/notification within 24 hours of a transfer and admission to the hospital on 1/10/18. 3. The facility staff failed to evidence that Resident #43's resident representative was provide a written bed hold policy/notification within	F 625	1. Residents #214 has been discharged, #23,#43, #36 #75, have readmitted to the Laurels. The admission Director has gone over our bed hold policy with them. If they are discharged in the future the nurse will offer a bed hold before transfer. 2. All residents have the potential to be affected by this alleged deficient practice. 3. The A.D.O.N or Designee will educate nursing staff on offering a bed hold notice to the resident and RP upon transfer to hospital or therapeutic leave. The D.O.N or designee will review in clinical operations meeting residents transferred to the hospital to ensure that bed hold was offered to the resident and RP and that the nurse documented in the medical record that bed hold was offered. 4.The D.O.N or designee will review in clinical operations meeting all residents transferred to the hospital to ensure that bed hold was offered to the resident and	

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F 625	Continued From page 46 24 hours of a transfer and admission to the hospital on 1/2/18. 4. The facility staff failed to evidence that Resident #36's resident representative was provide a written bed hold policy/notification within 24 hours of a transfer and admission to the hospital on 12/11/17. 5. The facility staff failed to evidence that Resident #75's resident representative was provide a written bed hold policy/notification within 24 hours of a transfer and admission to the hospital on 2/6/18. The findings include: 1. The facility staff failed to evidence that Resident #214 or the resident representative was provide a written bed hold policy/notification within 24 hours of a transfer and admission to the hospital on 12/11/17. Resident #214 was admitted to the facility on 12/4/14 and discharged to the hospital on 12/11/17. The resident had the diagnoses of but not limited to diabetes, congestive heart failure, bipolar disorder, schizophrenia, seizures, high blood pressure, anxiety disorder, dysphagia, and obesity. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 11/27/17. 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 assistance for transfers, dressing, toileting and hygiene; supervision for eating; and as incontinent of bowel and bladder.	F 625	RP and that the nurse documented in the medical record that bed hold was offered. Monthly for three months the Q.A. Committee will review 20% of transfers to the hospital to ensure proper nursing documentation orienteering residents properly to hospital transfer.	

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The clinical record revealed a nurse's note dated 12/11/17, that documented, "Writer called to guest's room by staff. Writer observe guest sitting in w/c (wheel chair), body shaking, arms halfway in air shaking, eyes fixed. Notified MD (Medical Doctor) in facility, MD eval (evaluation), New order: Ativan [1] 1mg (milligram) SL (sublingual) NOW, send to (hospital) for eval dx (diagnosis): seizure, RP (responsible party) 1st contact phone answering service mailbox full, 2nd contact left message to call facility. Guest sent out on stetcher (sic)."

Further review of the clinical record failed to reveal any evidence that the resident representative was provided a written bed hold notification.

On 3/22/18 at 4:53 p.m., in an interview with OSM (Other Staff Member, Marketing/Admissions) #14, she stated that she calls the family about bed holds and explains the financial obligations. OSM #14 stated she does not document the discussions that she has with the family/resident representative.

On 3/22/18 at 5:05 p.m., in an interview with OSM #6 (the social worker) and ASM #3 (Administrative Staff Member) #3, the Regional Manager, ASM #3 stated that a copy of the bed hold goes in the transfer packet that goes to the hospital with the resident. When asked how does the facility ensure that the resident representative actually received the bed hold form due to the paperwork being managed, first by EMS, and second, by hospital staff. He stated that the facility has no evidence the resident representative ever gets the written bed hold

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notice.

On 3/23/18 at 8:48 a.m., in an interview with LPN (Licensed Practical Nurse) #9, she stated that a Bed Hold is sent in the transfer packet to the hospital and that nurses should document that it was sent.

A review of the facility document, "Bed Hold and Return to Facility" documented, "The facility will provide written information to the guest or guest's representative of this bed hold policy upon leaving for hospitalization or a therapeutic leave."

On 03/22/18 at 5:27 p.m., ASM #1 (the administrator), ASM #2 (the Director of Nursing), ASM #3 (the regional manager), and ASM #5 (the clinical resource specialist) were made aware of the findings. No further information was provided by the end of the survey.

[1] Ativan "...is used to relieve anxiety....Lorazepam (Ativan) is also used to treat irritable bowel syndrome, epilepsy, insomnia, and nausea and vomiting from cancer treatment and to control agitation caused by alcohol withdrawal..."
Information obtained from https://medlineplus.gov/druginfo/meds/a682053.html

2. The facility staff failed to evidence that Resident #23's resident representative was provide a written bed hold policy/notification within 24 hours of a transfer and admission to the hospital on 1/10/18.

Resident #23 was admitted to the facility on

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THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(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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10/23/14 and readmitted on 1/15/18 with the diagnoses of but not limited to: diabetes, insomnia, glaucoma, spinal stenosis, bipolar disorder, neurogenic bladder, obesity, dementia, depression, anxiety disorder, high blood pressure, and chronic obstructive pulmonary disease. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 1/24/18. The resident was coded as cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting and hygiene; supervision for eating; and as incontinent of bowel.

A review of the clinical record revealed a nurse's note dated 1/10/18, which documented, "Guest sent to hospital for further evaluation. Per (name of doctor). Possible allergic reaction to im [sic] antibiotic.... RP (responsible party) notified and phone call returned and spoken to."

Further review of the clinical record failed to reveal any evidence that the resident representative was provided a written bed hold notification.

On 3/22/18 at 4:53 p.m., in an interview with OSM (Other Staff Member, Marketing/Admissions) #14, she stated that she calls the family about bed holds and explains the financial obligations. OSM #14 stated she does not document the discussions that she has with the family/resident representative.

On 3/22/18 at 5:05 p.m., in an interview with OSM #6 (the social worker) and ASM #3 (Administrative Staff Member) #3, the Regional

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Manager, ASM #3 stated that a copy of the bed hold goes in the transfer packet that goes to the hospital with the resident. When asked how does the facility ensure that the resident representative actually received the bed hold form due to the paperwork being managed, first by EMS, and second, by hospital staff. He stated that the facility has no evidence the resident representative ever gets the written bed hold notice.

On 3/23/18 at 8:48 a.m., in an interview with LPN (Licensed Practical Nurse) #9, she stated that a Bed Hold is sent in the transfer packet to the hospital and that nurses should document that it was sent.

On 03/22/18 at 5:27 p.m., ASM #1 (the administrator), ASM #2 (the Director of Nursing), ASM #3 (the regional manager), and ASM #5 (the clinical resource specialist) were made aware of the findings. No further information was provided by the end of the survey.

3. The facility staff failed to evidence that Resident #43's resident representative was provide a written bed hold policy/notification within 24 hours of a transfer and admission to the hospital on 1/2/18.

Resident #43 was admitted to the facility on 12/30/14 and readmitted on 1/15/18 with the diagnoses of but not limited to: dementia, diabetes, high blood pressure, and seizures. The most recent MDS (Minimum Data Set) was a 30-day readmission assessment with an ARD (Assessment Reference Date) of 2/11/18. The

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resident was coded as being mildly impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing, transfers, dressing, toileting and hygiene; limited assistance for eating; and as being incontinent of bowel and bladder.

A nurse's note dated 1/2/18 documented, "guest sent to (hospital) er (emergency room) [sic] for eval (evaluation) r/t (related / to) fall. [sic] seizure [sic] activity and vomiting [sic] rp [sic] notified."

Further review of the clinical record failed to reveal any evidence that the resident representative was provided a written bed hold notification.

On 3/22/18 at 4:53 p.m., in an interview with OSM (Other Staff Member, Marketing/Admissions) #14, she stated that she calls the family about bed holds and explains the financial obligations. OSM #14 stated she does not document the discussions that she has with the family/resident representative.

On 3/22/18 at 5:05 p.m., in an interview with OSM #6 (the social worker) and ASM #3 (Administrative Staff Member) #3, the Regional Manager, ASM #3 stated that a copy of the bed hold goes in the transfer packet that goes to the hospital with the resident. When asked how does the facility ensure that the resident representative actually received the bed hold form due to the paperwork being managed, first by EMS, and second, by hospital staff. He stated that the facility has no evidence the resident representative ever gets the written bed hold notice.

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On 3/23/18 at 8:48 a.m., in an interview with LPN (Licensed Practical Nurse) #9, she stated that a Bed Hold is sent in the transfer packet to the hospital and that nurses should document that it was sent.

A review of the facility document, "Bed Hold and Return to Facility" documented, "The facility will provide written information to the guest or guest's representative of this bed hold policy upon leaving for hospitalization or a therapeutic leave."

On 03/22/18 at 5:27 p.m., ASM #1 (the administrator), ASM #2 (the Director of Nursing), ASM #3 (the regional manager), and ASM #5 (the clinical resource specialist) were made aware of the findings. No further information was provided by the end of the survey.

4. The facility staff failed to evidence that Resident #36's resident representative was provide a written bed hold policy/notification within 24 hours of a transfer and admission to the hospital on 12/11/17.

Resident #36 was admitted to the facility on 1/10/17 and readmitted on 1/8/18 with the diagnoses of but not limited to: diabetes, colostomy, pressure ulcer, depression, psychosis, anxiety disorder, spinal stenosis, osteoarthritis, insomnia, and high blood pressure. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 2/24/18. 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, eating, toileting, and hygiene;

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and as incontinent of bladder.

A review of the clinical record revealed a nurse's note dated 12/11/17 which documented, "Guest has been yelling out on and off thru the shift. She complained of abdominal pain, and then would repeat words that staff would say to her. She has had one liquid stool this shift, bowel sounds were heard tinkling in the LUQ (left upper quadrant) LLQ (left lower quadrant) and RUQ (right upper quadrant). Writer listened for 5 minutes and no bowel sounds were heard in the RLQ (right lower quadrant). Guests abdomen remains distended, firm and tender to touch...On-call notified of above and order received to send to ER (emergency room) for evaluation. 911 was called, responded and transported guest to (hospital). There was no answer at RP (responsible party) number, message left for RP to call facility back."

Further review of the clinical record failed to reveal any evidence that the resident representative was provided a written bed hold notification.

On 3/22/18 at 4:53 p.m., in an interview with OSM (Other Staff Member, Marketing/Admissions) #14, she stated that she calls the family about bed holds and explains the financial obligations. OSM #14 stated she does not document the discussions that she has with the family/resident representative.

On 3/22/18 at 5:05p.m., in an interview with OSM #6 (the social worker) and ASM #3 (Administrative Staff Member) #3, the Regional Manager, ASM #3 stated that a copy of the bed hold goes in the transfer packet that goes to the

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F 625	Continued From page 54	F 625		

hospital with the resident. When asked how does the facility ensure that the resident representative actually received the bed hold form due to the paperwork being managed, first by EMS, and second, by hospital staff. He stated that the facility has no evidence the resident representative ever gets the written bed hold notice.

On 3/23/18 at 8:48 a.m., in an interview with LPN (Licensed Practical Nurse) #9, she stated that a Bed Hold is sent in the transfer packet to the hospital and that nurses should document that it was sent.

On 03/22/18 at 5:27 p.m., ASM #1 (the administrator), ASM #2 (the Director of Nursing), ASM #3 (the regional manager), and ASM #5 (the clinical resource specialist) were made aware of the findings. No further information was provided by the end of the survey.

5. The facility staff failed to evidence that Resident #75's resident representative was provide a written bed hold policy/notification within 24 hours of a transfer and admission to the hospital on 2/6/18.

Resident #75 was admitted to the facility on 2/11/11 and readmitted on 2/12/18 with the diagnoses of but not limited to high blood pressure, diabetes, dementia, multiple sclerosis, Parkinson's disease, seizure disorder, anxiety disorder, depression, insomnia, dysphagia, and chronic pain syndrome. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 2/26/18. The resident was

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F 625	Continued From page 55	F 625		

coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for transfers; extensive care for dressing, bathing, toileting and hygiene; limited assistance for eating; and as incontinent of bowel and bladder.

A review of the clinical record revealed a nurse's note dated 2/6/18, which documented, "Resident yelling out with "head spasms". NP (nurse practitioner) notified and in to see. Resident insists on being sent to the ER (emergency room). Unable to reach sister but got in touch with son, (name), and notified him of residents condition and insisting to go to ER (emergency room). Ambulance called and to pick up and take her to (hospital).

A nurse practitioner note dated 2/6/18 documented, "Seeing patient today who was saying that she was having spasms in her head that were causing her to have pain. She has seen a neurologist and spoke to her son who is trying to secure her an early appt (appointment) with neurologist. She is up and around in her motorized WC (wheelchair) off and on during the day. She has just gone back to bed and felt the spasms were "just not getting better". Since the appt (appointment) is over 2 weeks away - spoke with pt (patient) about sending her to the ER. Son on phone with mom and in agreement...."

Further review of the clinical record failed to reveal any evidence that the resident representative was provided a written bed hold notification.

On 3/22/18 at 4:53 p.m., in an interview with OSM (Other Staff Member, Marketing/Admissions) #14,

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F 625	Continued From page 56 she stated that she calls the family about bed holds and explains the financial obligations. OSM #14 stated she does not document the discussions that she has with the family/resident representative. On 3/22/18 at 5:05 p.m., in an interview with OSM #6 (the social worker) and ASM #3 (Administrative Staff Member) #3, the Regional Manager, ASM #3 stated that a copy of the bed hold goes in the transfer packet that goes to the hospital with the resident. When asked how does the facility ensure that the resident representative actually received the bed hold form due to the paperwork being managed, first by EMS, and second, by hospital staff. He stated that the facility has no evidence the resident representative ever gets the written bed hold notice. On 3/23/18 at 8:48 a.m., in an interview with LPN (Licensed Practical Nurse) #9, she stated that a Bed Hold is sent in the transfer packet to the hospital and that nurses should document that it was sent. On 03/22/18 at 5:27 p.m., ASM #1 (the administrator), ASM #2 (the Director of Nursing), ASM #3 (the regional manager), and ASM #5 (the clinical resource specialist) were made aware of the findings. No further information was provided by the end of the survey.	F 625		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning	F 655		5/4/18

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F 655	Continued From page 57 §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: (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.	F 655		

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F 655	Continued From page 58 (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, facility document review and clinical record review, it was determined that the facility staff failed to develop a complete baseline care plan for two of 33 residents in the survey sample, Residents #104 and #320. 1. The facility staff failed to address dialysis on Resident #104's baseline care plan. 2. The facility staff failed to address psychotropic drug use on Resident #320's baseline care plan. The findings include: 1. The facility staff failed to address dialysis (1) on Resident #104's baseline care plan. Resident #104 was admitted to the facility on 2/28/18. Resident #104's diagnoses included but were not limited to heart failure, end stage renal disease and urinary tract infection. Resident #104's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/7/18, coded the resident as cognitively intact. Section O coded Resident #104 as having received dialysis. Review of Resident #104's clinical record revealed a physician's order dated 3/1/18 for hemodialysis on Tuesdays, Thursdays and Saturdays at (name of facility). Review of Resident #104's baseline care plan dated 2/28/18 with a RN (registered nurse) review	F 655	F 655 Corrective Action Resident #104's baseline care plan has been updated to address dialysis. Resident #320's baseline care plan has been updated to address psychotropic drug use. Corrective Action for Those Having the Potential to be Affected All new admissions receiving dialysis and/or a psychotropic medication have the potential to be affected by this alleged deficient practice. The facility will audit those guests receiving dialysis and/or psychotropic medications to ensure care plans are updated accordingly. Systematic Changes All licensed nursing staff will be in-serviced on the facility's baseline care plan policy. DON/designee will conduct quality monitoring in clinical operations meeting to ensure baseline care plans are being completed per policy. Monitoring Clinical Resource Specialist/designee will audit 100% of baseline care plans for one	

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F 655	Continued From page 59 on 3/1/18 revealed a section that documented, "Services/Treatments- Provided By:" The section documented check boxes beside multiple care areas, including dialysis. Dialysis was not checked off and no information was documented in the "Provided By" column. On 3/22/18 at 11:21 a.m., an interview was conducted with RN #3 and ASM (administrative staff member) #5 (the clinical resource specialist). RN #3 was asked the purpose of an admission baseline care plan. RN #3 stated, "I would say to get a baseline of how we should be taking care of them (the residents)." RN #3 was asked what should be included on a baseline care plan. RN #3 stated, "Medications they are taking, how they transfer, if they have any infections, pain management, if they have any devices, wounds, any isolation precautions, if they are getting therapy." When asked if dialysis should be included on a baseline care plan, RN #3 stated, "Yes." RN #3 stated the baseline care plan should include the days a resident goes to dialysis and the location of the dialysis site. RN #3 stated she likes to know the location of the dialysis facility so she can make sure communication is established between the facility and the dialysis location. At this time, RN #3 and ASM #5 were made aware Resident #104's baseline care plan did not document information regarding dialysis. On 3/22/18 at 2:30 p.m., another interview was conducted with RN #3 and ASM #5. RN #3 stated she updated Resident #104's baseline care plan. ASM #5 stated Resident #104 currently had a comprehensive care plan that took the place of the baseline care plan. When asked if dialysis was included on Resident #104's	F 655	week, 50% for one week, 25% for two weeks, and five per month for two months. Monitoring will include tracking and trending of issues found during the clinical operations meeting. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed. Ongoing compliance will be monitored through routine audits in the clinical operations meeting and will be reported to the facility's quality assurance meeting. Completion Date 5/4/18	

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baseline care plan, ASM #5 stated information regarding dialysis was added to Resident #104's baseline care plan after this surveyor's review.

On 3/22/18 at 4:40 p.m., ASM #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional manager) and ASM #5 were made aware of the above concern.

The facility policy titled, "ADMISSION BASELINE CARE PLAN" documented, "To ensure that all guests admitted to the facility have instructions needed to provide effective and person-centered guest care that meets professional standards of quality of care. The admission baseline care plan will include minimum health care information necessary to properly care for the guest."

No further information was presented prior to exit.

(1) "When your kidneys are healthy, they clean your blood. They also make hormones that keep your bones strong and your blood healthy. When your kidneys fail, you need treatment to replace the work your kidneys used to do. Unless you have a kidney transplant, you will need a treatment called dialysis.
There are two main types of dialysis. Both types filter your blood to rid your body of harmful wastes, extra salt, and water.
Hemodialysis uses a machine. It is sometimes called an artificial kidney. You usually go to a special clinic for treatments several times a week." This information was obtained from the website: https://medlineplus.gov/dialysis.html

2. The facility staff failed to address psychotropic drug use on Resident #320's baseline care plan.

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F 655	Continued From page 61	F 655		

Resident #320 was admitted to the facility on 3/8/18. Resident #320's diagnoses included but were not limited to heart failure, unspecified dementia (1) with behavioral disturbance and generalized anxiety disorder. Resident #320's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/15/18, coded the resident's cognition as moderately impaired. Section N documented Resident #320 received antipsychotic medication six out of the last seven days.

Review of Resident #320's clinical record revealed a physician's order dated 3/8/18 for Seroquel (2) 12.5 mg (milligrams) one time a day for Depression, to be administered at dinner. The order was revised on 3/9/18 and documented an order for Seroquel 25mg- 0.5 tablet in the evening for dementia.

Resident #320's baseline care plan dated 3/8/18 with a RN (registered nurse) review on the same date documented a general section regarding psychotropic drug use. The section documented check boxes beside multiple listed interventions including: "Refer to behavior management program. Complete Aims test (3). Identify target behaviors. Observe guest for side effects, report as indicated." The psychotropic drug use section was not completed. There were no checks beside any of the listed interventions.

On 3/22/18 at 11:21 a.m., an interview was conducted with RN #3 and ASM (administrative staff member) #5 (the clinical resource specialist). RN #3 was asked the purpose of admission baseline care plans. RN #3 stated, "I would say

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to get a baseline of how we should be taking care of them (the residents)." RN #3 was asked what should be included on a baseline care plan. RN #3 stated, "Medications they are taking, how they transfer, if they have any infections, pain management, if they have any devices, wounds, any isolation precautions, if they are getting therapy." When asked if antipsychotic medication use should be documented on the baseline care plan, RN #3 stated, "We need to do an AIMS and a risk vs benefit." When asked if that should be documented on the baseline care plan, RN #3 stated, "Yes." When asked what other information regarding antipsychotic medication use should be documented on the care plan, RN #3 stated, "What they are taking, how often they are taking it. I think it's important if they have any documented side effects, any abnormal movements of the tongue, trunk and extremities." At this time, RN #3 and ASM #5 were made aware Resident #320's baseline care plan did not document information regarding psychotropic drug use.

On 3/22/18 at 2:30 p.m., another interview was conducted with RN #3 and ASM #5. RN #3 stated Resident #320's baseline care plan was updated. When asked if the baseline care plan addressed antipsychotic medication use, ASM #5 stated, "It was probably circled but not detailed." RN #3 and ASM #5 was made aware psychotropic drug use was not circled on the resident's baseline care plan during this surveyor's review. ASM #5 stated, "It may not have been." ASM #5 stated a comprehensive care plan was now in place so Resident #320's baseline care plan was not effective.

On 3/22/18 at 4:40 p.m., ASM #1 (the

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administrator), ASM #2 (the director of nursing), ASM #3 (the regional manager) and ASM #5 were made aware of the above concern.

No further information was presented prior to exit.

(1) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions. Their personalities may change. They may become agitated or see things that are not there." 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=dementia&_ga=2.139034935.566140716.1522143307-139120270.1477942321

(2) "Quetiapine (Seroquel) tablets and extended-release (long-acting) tablets are used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). Quetiapine tablets and extended-release tablets are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). In addition, quetiapine tablets and extended-release tablets are used with other medications to prevent episodes of mania or depression in patients with bipolar disorder. Quetiapine extended-release

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F 655	Continued From page 64 tablets are also used along with other medications to treat depression. Quetiapine tablets may be used as part of a treatment program to treat bipolar disorder and schizophrenia in children and teenagers. Quetiapine is in a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698019.html (3) AIMS (Abnormal Involuntary Movement Scale) is a standardized test used to evaluate abnormal movement disorders caused by antipsychotic medications. This information was obtained from the website: https://www.nami.org/Learn-More/Mental-Health-Conditions/Related-Conditions/Tardive-Dyskinesia	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		5/4/18

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F 656	Continued From page 65 (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 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, resident interview, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to implement / follow the comprehensive plan of care for three of 33 residents in the survey sample, Resident #94, 15, and 52. 1. The facility staff failed to apply Resident #15's left hand splint per the comprehensive plan of care. 2. The facility staff failed to ensure Resident #94's	F 656	F 656 Corrective Action Resident #15's left hand splint is applied as ordered. Resident #94's bed is in low position per physician order. Resident #52 no longer resides in the facility.	

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F 656	Continued From page 66 bed was in a low position per the comprehensive plan of care. 3. The facility staff failed to Resident #52's comprehensive care plan regarding fall interventions. The findings include: 1. The facility staff failed to apply Resident #15's left hand splint per the comprehensive plan of care. Resident #15 was admitted to the facility on 5/9/17 was diagnoses that included but were not limited to anemia, heart failure, high blood pressure, diabetes, post stroke with left sided weakness, and Non-Alzheimer's Dementia. Resident #15's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 1/10/18. Resident #15 was coded as being intact in cognitive function scoring 12 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #15 was coded as requiring extensive assistance from two plus persons with bed mobility, personal hygiene, and dressing; and dependent on staff with toileting and bathing. On 3/20/18 at 2:10 p.m., an observation was made of Resident #15. She was sleeping in bed. Her left hand was contracted. No splints or devices were in place. On 3/20/18 at 3:13 p.m., an observation was made of Resident #15. She was sleeping in bed. Her left hand was contracted. No splints or devices were in place.	F 656	Corrective Action for Those Having the Potential to be affected All residents have the potential to be affected by this alleged deficient practice. Facility will audit those guest's with splint, low bed, and/or nonskid sock interventions to ensure comprehensive care plan is being followed. Systematic Changes All licensed nursing staff will be in-serviced on following comprehensive care plans. DON/designee will conduct room rounds to ensure comprehensive care plan for devices and fall interventions are being followed. Monitoring Monitoring of splints, low beds, and nonskid socks will occur four times a week for four weeks . Monitoring will include tracking and trending of issues found during room rounds. Monitoring will be completed by the D.O.N or designee. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed. Ongoing compliance will be monitored through routine room rounds and will be reported to the facility's quality assurance meeting monthly for three months. Completion Date	

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F 656	Continued From page 67 On 3/21/18 at 9:04 a.m., an interview was conducted with Resident #15. During the interview, Resident #15 mentioned she is always losing her call bell and hand splint in her bed. Resident #15 stated her hand splint is always falling off. At that time, Resident #15 had her hand splint in place. Resident #15 stated that she wore a splint to her left hand because of her stroke. On 3/22/18 at 8:28 a.m., an observation was made of Resident #15. She was sleeping in bed. Her left hand was contracted. No splints or devices were in place. Her left hand splint was lying on the bedside table. On 3/22/18 at 1:20 p.m., an observation was made of Resident #15. Her splint was in place. Review of Resident #15's OT (occupational discharge summary) dated 9/27/17 documented the following discharge recommendations: "Discharge Recommendations: L (left) resting hadn (sic) splint to be worn at all times. Nursing to remove splint for skin checks and hygeine (sic)...Restorative Program Established/Trained = Not indicated at this time." Further review of Resident #15's OT notes dated 9/26/17 and 9/27/17, revealed that the Resident and Staff were educated on how to use the left hand splint. Review of Resident #15's most recent POS (physician order sheet) revealed the following order: "Pt (patient) to wear left resting hand splint at all times for contracture management. May be removed as needed for hygiene and skin	F 656	5/4/18	

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checks."

Review of Resident #15's ADL (activities of daily living) care plan dated 5/19/17 and updated 9/21/17, documented the following: "ADL: Requires assistance with ADL's related to s/p (status post) CVA (cerebral vascular accident)...Will be able to do ADL's with limited assistance by next review...9/21/17 Left resting splint hand splint as ordered."

On 3/22/18 at 8:37 a.m., an interview was conducted with RN (registered nurse) #2, the MDS nurse. When asked the purpose of the care plan, RN #2 stated that the purpose of the care plan was to serve as a guide with patient care. RN #2 stated that it was used to communicate with other staff members. When asked the reasons why a care plan would not be followed, RN #2 stated there should be no reason that the care plan would not be followed because the care plans should be accurate. RN #2 stated that staff who have access to PCC (point click care) (computer system) can access the care plan. When asked how CNAs had access to the care plan, RN #2 stated they use a care card that is also updated with changes.

On 3/22/18 at 1:30 p.m., an interview was conducted with CNA (certified nursing assistant) #6, Resident #15's CNA. When asked how CNAs know the needs for each resident, including what splints need to be into place, CNA #6 stated that she would ask the nurse. When asked if there was reference to refer to, to serve as a guide for resident care, CNA #6 stated she could look at the resident's care card. When asked who was responsible for ensuring splints were in place, CNA #6 stated the CNAs could put the splints on

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but that nurses have to ensure that they are in place. When asked if Resident #15 had hers off at any point that day. CNA #6 stated it was off during AM (morning) care, and when the aromatherapy specialist came in. When asked when the aromatherapy specialist came in, CNA #6 stated at around 9:00 a.m. CNA #6 stated the aromatherapy specialist will take off the brace to put on oils. CNA #6 stated that AM care was around 7:00 a.m. When asked if she could recall putting the brace back on after AM care, CNA #6 stated that she thought she did.

Review of Resident #15's care card documented the following: "left hand splint braces as tolerated."

On 3/22/18 at 1:49 p.m., an interview was conducted with LPN (licensed practical nurse) #9, Resident #15's nurse. When asked if Resident #15 was supposed to have anything in place to prevent further contracture, LPN #9 stated Resident #15 was supposed to have a splint in place to her left hand. When asked how often Resident #15 was supposed to have her splint in place, LPN #9 stated that she was supposed to have her splint in place at all times. When asked who was responsible for ensuring splints were in place, LPN #9 stated the nurses were responsible. LPN #9 stated the splint sometimes slides off the resident.

On 3/23/18 at 8:04 a.m., an interview was conducted with LPN #11, the unit manager. When asked why Resident #15 needed a left hand splint, LPN #11 stated that she came to their unit (west) with the hand splint. LPN #11 stated she needed to wear the splint because she had left sided weakness and a contracture to her

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left hand post stroke. LPN #11 stated the resident could be non-compliant with the brace, and pick at the brace with her right hand until it falls off. LPN #11 stated they had just changed the order on 3/22/18, to wear the splint as tolerated. When asked if it was documented anywhere that Resident #15 was non-compliant with her brace, LPN #11 stated she didn't think so, LPN #11 turned to LPN #9 and asked if she had ever documented that Resident #15 picks at her brace. LPN #9 stated she thought the brace would slide off.

On 3/22/18 at 5:26 p.m., ASM (administrative staff member) #1 the administrator, ASM #2, DON (Director of Nursing) and ASM (administrative staff member) #3 and the regional manager were made aware of the above concerns.

The facility policy titled, "Care Plan," did not address the above concerns. No further information was presented prior to exit.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...

2. The facility staff failed to ensure Resident #94's bed was in a low position per the comprehensive

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plan of care.

Resident #94 was admitted to the facility on 9/20/16 and readmitted on 2/19/18 with diagnoses that included but were not limited to stroke, unspecified dementia without behavioral disturbance, high blood pressure, major depressive disorder, atrial fibrillation, muscle weakness, dysphagia (difficulty swallowing), and osteoporosis. Resident #94's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 3/3/18. Resident #94 was coded as being severely cognitively impaired in the ability to make daily decisions scoring 05 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #94 was coded as requiring extensive assistance from one staff member with bed mobility, dressing, toileting, and personal hygiene; total dependence from staff with eating, and bathing; and limited assistance with one staff member for transfers.

Review of Resident #94's most recent POS (physician order sheet) revealed the following order dated 1/19/18: "Low bed for safety."

Review of Resident #94's fall prevention care plan dated 1/18/18, documented the following: "FALLS: At risk for fall related to injury related to unsteady gait, impaired mobility, bladder and bowel incontinence, psychotropic drug use and DX (diagnoses): HTN (hypertension), depression, osteoporosis, and Dementia....Goal: Will be free from fall related injuries through next review...Interventions: Low bed as ordered."

On 3/21/18 at 4:48 p.m., Resident #94 was sleeping in bed. His bed was not in the lowest

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position.

On 3/22/18 at 8:23 a.m., Resident #94 was sleeping in bed. His bed was not in the lowest position.

On 3/22/18 at 1:20 p.m., Resident #94 was sleeping in bed. His bed was not in the lowest position.

On 3/22/18 at 1:45 p.m., Resident #94 was sleeping in bed. His bed was not in the lowest position.

Review of Resident #94's most recent fall risk assessment dated 2/18/18 documented Resident #94 as being at "moderate risk" for falls.

Further, review if Resident #94's clinical record revealed that he only had one fall this year on 3/4/18. It was documented that Resident #94 had slid from his wheelchair. Fall interventions were put into place after this fall.

Review of Resident #94's nursing care card documented the following: "put (sic) to bed after lunch/low bed."

On 3/22/18 at 1:45 p.m., an interview was conducted with CNA (certified nursing assistant) #6. When asked how CNAs know the needs for each resident, including fall preventive measures, CNA #6 stated she would ask the nurse. When asked if there was a reference to refer to, to serve as a guide for resident care, CNA #6 stated she could look at the resident's care card. When asked what a "low bed" meant, CNA #6 stated that a low bed meant the bed should be all the way to the floor. CNA #6 stated she was not

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Resident #94's CNA that shift. CNA #6 followed this writer to Resident #94's room. When asked if his bed was in the lowest position, CNA #6 stated, "No." At this time, LPN (licensed practical nurse) was observed walking into Resident #94's room, and lowering his bed to the floor.

On 3/22/18 at 1:51 p.m., an interview was conducted with LPN (licensed practical nurse) #8. When asked why she lowered Resident #94's bed, LPN #8 stated that his bed was higher than it should have been. LPN #8 stated when she lowered his bed that was the first time she entered Resident #94's room. LPN #8 stated she had just arrived to the facility an hour prior. LPN #8 stated, "Whoever transferred him back into bed, did not lower the bed, but I corrected it once I saw it." LPN #8 was informed of the several observations made of Resident #94's bed not in the low position when the resident was in bed. LPN #8 again stated she had just arrived to the unit. When asked if Resident #94 was a fall risk, LPN #8 stated that Resident #94 had an order for the low bed and that his chart had documented him as a fall risk. LPN #8 stated Resident #94 was not really a fall risk because he doesn't attempt to get out of bed. LPN #8 agreed that his bed should have in the lowest position, (all the way to the floor). LPN #8 confirmed the care plan was not being implemented / followed.

On 3/22/18 at 5:26 p.m., ASM (administrative staff member) #1 the administrator, ASM #2, DON (Director of Nursing) and ASM (administrative staff member) #3 and the regional manager were made aware of the above concerns. No further information was presented prior to exit.

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3. The facility staff failed to Resident #52's comprehensive care plan regarding fall interventions.

Resident #52 was admitted to the facility on 8/30/17 with the diagnoses of but not limited to anxiety, depression, high blood pressure, heart failure, enterocolitis, and gastro-esophageal reflux. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 2/13/18. The resident was coded as moderately cognitively impaired in ability to make daily life decisions. The resident required extensive assistance for transfers, dressing, toileting and hygiene; limited assistance for eating; and was incontinent of bowel and bladder.

On 3/23/18 at 12:31 p.m., incident reports regarding falls that Resident #52 had sustained, were reviewed in the presence of ASM (Administrative Staff Member) #2, the Director of Nursing). One dated 3/21/18 documented that the resident was not wearing non-skid socks.

A review of the clinical record revealed Resident #52's comprehensive care plan contained one for "Falls: At risk for fall related injury...." This care plan was initiated on 9/10/17. The interventions included one for "Non skid socks on at all times...." This intervention was dated 3/1/18.

On 3/23/18 at 12:31 p.m., while reviewing the incident report with ASM #2, she was asked if the care plan was implemented / followed. ASM #2 stated that the care plan was not followed.

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F 656	Continued From page 75 A review of the facility policy, "Care Plan" did not address the requirement for staff to follow the care plan. No further information was provided by the end of the survey.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		5/4/18

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F 657	Continued From page 76 Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to review and revise the care plan for five of 33 residents in the survey sample, Resident #5, 50, 28, 13 and 52. 1. The facility staff failed to review or revise Resident #5's comprehensive care plan after a fall on 3/4/18. 2. The facility staff failed to review or revise Resident #50's comprehensive care plan after a fall on 1/25/18 and 3/19/18. 3. The facility staff failed to revise Resident #28's comprehensive care plan in a timely manner after a fall on 1/29/18 (care plan revised on 2/6/18) and a fall on 2/13/18 (care plan revised on 3/21/18). 4. The facility staff failed to revise Resident #13's comprehensive care plan in a timely manner after a fall on 12/15/17. The care plan was not revised until 1/12/18. 5. The facility staff failed to revise Resident #52's comprehensive care plan in a timely manner after falls on 1/29/18 (care plan revised on 2/26/18), 2/1/18 (care plan revised on 3/1/18), and on 2/7/18 the care plan was not revised at all. The findings include: 1. The facility staff failed to review or revise Resident #5's comprehensive care plan after a fall on 3/4/18. Resident #5 was admitted to the facility on 1/8/13 with diagnoses that included but were not limited	F 657	1. Resident #5, #50, #28, and #13's care plans have been updated with fall interventions. Resident #52 no longer resides in the facility. 2.All residents with falls have the potential to be affected by this alleged deficient practice. All residents with a fall from the time of survey exit will have their care plans reviewed and revised as necessary. 3.Regional Clinical Resource Specialist will educate the MDS staff, DON, ADON, and Unit Managers on revisions of care plans related to falls. DON/designee will conduct quality monitoring in clinical operations meeting to ensure fall care plans are updated with each new fall intervention. 4. Monitoring for fall interventions being reviewed and revised in a timely manner will occur during the clinical operations meeting 4 times a week for four weeks. Monitoring will include tracking and trending of issues found during the clinical operations meeting. Monitoring will be completed by D.O.N or designee. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed. Monthly for three months the Q.A. Committee will review variances and ensure compliance.	

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to chronic obstructive pulmonary disease, nose fracture, major depressive disorder, Alzheimer's disease, high blood pressure, and Parkinson's disease. Resident #5's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 12/19/17. Resident #5 was coded as being cognitively impaired in the ability to make daily decisions scoring 07 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #5 was coded as requiring extensive assistance with two staff members with locomotion, eating, and personal hygiene; extensive assistance from three staff members with bed mobility, transfers, dressing, and toileting; and total dependence on staff with bathing.

Review of Resident #5's clinical record revealed that he had a fall on 3/4/18. The following was documented in a progress note: "Writer in hallway passing meds (medications), loud crash heard, immediately upon entering room where sound heard, guest noted on floor facedown; blood noted from nose and face and right hand, 911 activated. VS (vital signs) T(temperature)- 97.2, P (pulse)- 58, R(respirations)- 20, BP (Blood Pressure)- 152/60; guest transported to (Name of Hospital). RP (representative) notified of situation. (Name of Hospice Provider), and on call NP (nurse practitioner) for MD (medical doctor) also notified of events."

The next note dated 3/5/18 at 2:53 a.m., documented the following: "Guest returned to facility at approx. (approximately) 1:15 a.m., via stretcher in accompany of 2 EMTS (emergency medical technicians). Guest noted with bandage over bridge of nose one bandage on his right arm

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and one on finger on his right hand. Multiple bruising noted to face. Guest diagnosed with fractured nose and head injury- no wake up. Guest alert and talking and answering questions appropriately. Ice pack applied to nose to help with minor discomfort. Neuro (neurological) checks started and within normal limits for this guest. Bed is in the lowest position and call bell within reach. Will continue to monitor patient thru (sic) the night."

A nurses' note dated 3/9/18 documented the following: "I have spoken to RP (responsible party) about us putting a helmet of (sic) guest because of the multiple falls and fractures of nose. She declined at this time states that she thinks it would make (Name of resident) fell (sic) uncomfortable having one on. he (sic) only likes his baseball caps."

Review of the fall incident report dated 3/4/18, revealed that the immediate intervention was to send the resident out to the hospital.

Review Resident #5's care plan dated 10/17/17 and revised 3/21/17 failed to reflect the fall on 3/4/18. Resident #5's care plan failed to reflect his fractured nose.

Further review of Resident #5's clinical record revealed that he had not had any other falls since 3/4/18.

On 3/22/18 at 8:37 a.m., an interview was conducted with RN (registered nurse) #2, the MDS nurse. When asked the purpose of the care plan, RN #2 stated that the purpose of the care plan was to serve as a guide with patient care. RN #2 stated that it was used to communicate

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with other staff members. When asked when the care plan was updated, RN #2 stated that the care plan was updated with any change in the resident's care. When asked who was responsible for updating the care plan, RN #2 stated any member of the care team could update the care plan. RN #2 stated floor nurses could update the care plan especially after a fall has occurred. RN #2 stated that it was important for the care plan to be accurate because it needs to be a current reflection the resident.

On 3/22/18 at 11:46 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). When asked about the process staff follows when a resident has a fall, ASM #2 stated if a resident has a fall, the nurses should investigate why the fall had occurred and attempt to come up with an intervention to prevent future falls. ASM #2 stated the nurses would then notify the family and the physician, and then write a nursing note regarding the incident. ASM #2 stated that floor nurses did not update the care plan. ASM #2 stated the unit manager or the MDS nurse was responsible for updating the care plan. ASM #2 stated if the IDT (interdisciplinary team) could not think of any more interventions to put into place for a frequent faller, than she would expect to see a note in the resident's chart stating the care plan was reviewed. When asked what was done for Resident #5 after he had fallen on 3/4/18, ASM #2 stated Resident #5 was a frequent faller and the IDT had reviewed his care plan and could not come up with any further fall preventative interventions. ASM #2 stated that the nursing team tried to talk to the family about the resident wearing a helmet, but the family had declined that intervention. ASM #2 confirmed she could not

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find a note documenting the care plan was reviewed. ASM #2 stated she would expect to see the fractured nose on Resident #5's care plan. ASM #2 confirmed that she did not see the fractured nose on Resident #5's care plan.

On 3/22/18 at 5:26 p.m., ASM (administrative staff member) #1 the administrator, ASM #2, DON (Director of Nursing) and ASM (administrative staff member) #3 and the regional manager were made aware of the above concerns. No further information was presented prior to exit.

The facility policy titled, "Care Plans," did not address the above concerns. No further information was presented prior to exit.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..."

2. The facility staff failed to review or revise Resident #50's care plan after a fall on 1/25/18 and 3/19/18.

Resident #50 was admitted to the facility on 3/7/08 and readmitted on 2/21/18 with diagnoses

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that included but were not limited to anemia, high blood pressure, diabetes, Non-Alzheimer's dementia, Parkinson's disease, and Seizure disorder. Resident #50's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/13/18. Resident #50 was coded as being moderately impaired in cognitive function scoring 11 out of possible 15 on the BIMS (Brief Interview for Mental status) exam. Resident #50 was coded as requiring extensive assistance from one staff member with most ADLS (activities of daily living).

Review of Resident #50's clinical record revealed she had fallen on 1/25/18. The following was documented in a nursing note, "Nurse head loud noise, went into room, found guest sitting on buttocks on fall mat beside bed with forehead against overbed (sic) table that was against wall; rom (range of motion) preformed, wnl (within normal limits); pink area noted to right forehead, no swelling or open area noted; neuro checks (neurological checks) started and wnl (within normal limits); ask guest what happened, stated was trying to get into wheelchair and it moved, noted only one brake locked on wheelchair; will monitor that when guest is out of wheelchair, staff checks that both brakes are locked; vs (vital signs) 138/78, (blood pressure), 82 (pulse), 18 (respirations), 97 % (percent oxygen saturation) on ra (room air), 96.7 (temperature).

Review of the fall incident report dated 1/25/18 documented the following intervention: "Staff to make sure when guest not in w/c that both breaks are locked."

Review of Resident #50's fall care plan dated

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9/15/17 failed to evidence this intervention.

Further review of Resident #50's clinical record revealed another fall dated 3/19/18 at 4:15 a.m. The following note was documented: "At approximately 4:15 a.m., writer at nurses (sic) station and heard noise outside room 300 upon (sic) further investigation the following was noted. Guest was sitting on the floor in her doorway wearing a loose fitting hospital gown, bare feet and adult brief which was dry. Guest noted to be scratching herself fiercely stating, "I'm scootin (sic) my heiney (sic)! I am soooooooo (sic) itchy!!!!! (sic)" Guest was assessed for injury and after none being found she was assisted off the floor by 2 staff members into her bed. Writer applied PRN (as needed) Triamcinolone Cream [1] to her rash from head to toe and given PRN Benadryl [2], provided fresh linens. Guest stated, "Oh my goodness that feels so good!!!! (sic)" Guest drifted back to sleep shortly thereafter. MD/RP (medical doctor/responsible party) both aware of incident. VS (vital signs) 97.8 (temperature, 98 (pulse), 18 (respirations) 138/74 (blood pressure)."

Review of the fall incident report dated 3/19/18 documented that the immediate intervention was the application of the Triamcinolone cream and prn (as needed) Benadryl. The following was also documented: "Guest complains of itchiness due to undergoing treatment. MD/NP to assess, request scheduled Benadryl."

Review of Resident #50's March 2018 MAR (medication administration record) revealed that the Benadryl was ordered to be scheduled on 3/19/18 and the first dose was given at 10:00 p.m. on 3/19/18.

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Review of the Resident's care plan dated 9/15/17, failed to evidence this fall and the above intervention. Review of her clinical record failed to evidence that the care plan was reviewed.

On 3/22/18 at 8:37 a.m., an interview was conducted with RN (registered nurse) #2, the MDS nurse. When asked the purpose of the care plan, RN #2 stated that the purpose of the care plan was to serve as a guide with patient care. RN #2 stated that it was used to communicate with other staff members. When asked when the care plan was updated, RN #2 stated that the care plan was updated with any change in the resident's care. When asked who was responsible for updating the care plan, RN #2 stated any member of the care team could update the care plan. RN #2 stated floor nurses could update the care plan especially after a fall has occurred. RN #2 stated that it was important for the care plan to be accurate because it needs to be a current reflection the resident.

On 3/22/18 at 11:46 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). When asked about the process staff follows when a resident has a fall, ASM #2 stated if a resident has a fall, the nurses should investigate why the fall had occurred and attempt to come up with an intervention to prevent future falls. ASM #2 stated the nurses would then notify the family and the physician, and then write a nursing note regarding the incident. ASM #2 stated that floor nurses did not update the care plan. ASM #2 stated the unit manager or the MDS nurse was responsible for updating the care plan. ASM #2 stated if the IDT (interdisciplinary team) could not think of any

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more interventions to put into place for a frequent faller, than she would expect to see a note in the resident's chart stating the care plan was reviewed. When asked if Resident #50's care plan was reviewed or revised after her fall on 1/25/18, ASM #2 stated, "Nope. Shoot." When asked if her care plan was reviewed or revised after her fall on 3/19/18, ASM #2 stated, "I do not see a note if the care plan was reviewed. I do not see where it was revised."

On 3/22/18 at 5:26 p.m., ASM (administrative staff member) #1 the administrator, ASM #2, DON (Director of Nursing) and ASM (administrative staff member) #3 and the regional manager were made aware of the above concerns. No further information was presented prior to exit.

[1] Triamcinolone Cream is used to relieve redness, itching, swelling, or other discomfort caused by skin conditions. This medication is a corticosteroid.
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012519/?report=details.
[2] Benadryl- Benadryl is an antihistamine that is used for symptoms of allergic rhinitis, common cold and urticaria, pruritus (itchiness) and anaphylaxis (allergic reaction). This information was obtained from The National Institutes of Health.
https://livertox.nih.gov/Diphenhydramine.htm.

3. For Resident #28, the facility staff failed to revise the care plan in a timely manner after a fall on 1/29/18 (care plan revised on 2/6/18) and a fall on 2/13/18 (care plan revised on 3/21/18).

Resident #28 was admitted to the facility on

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11/24/17 with the diagnoses of but not limited to breast cancer, depression, insomnia, dementia, and high blood pressure. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 1/29/18. The resident was severely cognitively impaired in ability to make daily life decisions. The resident required extensive care for toileting, hygiene, transfers, dressing, and eating; and was incontinent of bowel and bladder.

A review of the incident reports for falls that Resident #28 had was conducted on 3/23/18 from 12:00 p.m., to 12:45p.m., with ASM #2 (Administrative Staff Member, the Director of Nursing). The incident reports were reviewed in conjunction with the resident's care plan. The following were noted:

Resident #28 had a fall on 1/29/18. The incident report dated 1/29/18 documented that a fall mat was added to the resident's fall interventions. The care plan 12/7/17 was not updated until 2/6/18 for this intervention. Approximately a week later.
Resident #28 had a fall on 2/13/18. The incident report dated 2/13/18 documented the doctor was to assess the resident's medications. The care plan dated 12/7/17 was not updated until 3/21/18 for this intervention, approximately 5 weeks later.

On 3/23/18 at 12:45p.m., when reviewing each above incident, ASM #2 stated the time period that lapsed between the incident and the care plan revision was excessive.

A review of the facility document "Care Plan" failed to evidence any direction for staff to review

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and revise the care plan.

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

On 3/23/18 at 12:25p.m., when reviewing each above incident, ASM #2 stated the time period that lapsed between the incident and the care plan revision was excessive.

A review of the facility document "Care Plan" failed to evidence any direction for staff to review and revise the care plan.

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

4. For Resident #13, the facility staff failed to revise the care plan in a timely manner after a fall on 12/15/17. The care plan was not revised until 1/12/18.

Resident #13 was admitted to the facility on 10/12/17 with the diagnoses of but not limited to heart failure, diabetes, depression, high blood pressure. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 1/6/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident required extensive care for bathing, hygiene, toileting, dressing and transfers; limited assistance for ambulation; supervision for eating; and was incontinent of bowel and bladder.

A review of the incident reports for falls that Resident #13 had was conducted on 3/23/18 from 12:00p.m., to 12:45p.m., with ASM #2

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(Administrative Staff Member, the Director of Nursing). The incident reports were reviewed in conjunction with the resident's care plan. The following was noted:

Resident #13 had a fall on 12/15/17. The incident report 12/15/17 documented a dycem cushion was added to the wheel chair as a fall intervention. The care plan dated 10/20/17 was not revised to included this intervention until 1/12/18, approximately a month later.

On 3/23/18 at 12:07p.m., when reviewing the above incident, ASM #2 stated the time period that lapsed between the incident and the care plan revision was excessive.

A review of the facility document "Care Plan" failed to evidence any direction for staff to review and revise the care plan.

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

5. For Resident #52, the facility staff failed to revise the care plan in a timely manner after falls on 1/29/18 (care plan revised on 2/26/18), 2/1/18 (care plan revised on 3/1/18), and on 2/7/18 the care plan was not revised at all.

Resident #52 was admitted to the facility on 8/30/17 with the diagnoses of but not limited to anxiety, depression, high blood pressure, heart failure, enterocolitis, and gastro-esophageal reflux. The most recent MDS (Minimum Data Set) was a significant change assessment with an

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ARD (Assessment Reference Date) of 2/13/18. The resident was coded as moderately cognitively impaired in ability to make daily life decisions. The resident required extensive assistance for transfers, dressing, toileting and hygiene; limited assistance for eating; and was incontinent of bowel and bladder.

A review of the incident reports for falls that Resident #52 had was conducted on 3/23/18 from 12:00p.m., to 12:45p.m., with ASM #2 (Administrative Staff Member, the Director of Nursing). The incident reports were reviewed in conjunction with the resident's care plan. The following were noted:

Resident #52 had a fall on 1/29/18. The incident report 1/29/18 documented that a fall mat was added to the resident's fall interventions. A review of the care plan 9/10/17 revealed this intervention was not added to the care plan until 2/26/18, nearly a month later.

Resident #52 had a fall on 2/1/18. The incident report 2/1/18 documented that the bedside commode was removed from the bedside as a fall intervention. A review of the care plan 9/10/17 revealed this intervention was not added to the care plan until 3/1/18, a month later.

Resident #52 had a fall on 2/7/18. The incident report 2/7/18 documented the resident was educated on using the call bell when needing assistance as an intervention. This intervention was not added to the care plan at all as of the review on 3/23/18.

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F 657	Continued From page 89 On 3/23/18 at 12:25p.m., when reviewing each above incident, ASM #2 stated the time period that lapsed between the incident and the care plan revision was excessive. A review of the facility document "Care Plan" failed to evidence any direction for staff to review and revise the care plan. No further information was provided by the end of the survey.	F 657		
F 658 SS=E	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 observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to follow professional standard of practice for four of 33 residents in the survey sample, Residents #102, #413 #418 and Resident #108. 1. The facility staff failed to transcribe and clarify a physician order for Resident #103, to hold carvedilol a medication used to treat high blood pressure. Resident #103 was not prescribed and or taking this medication. 2. a. The facility staff transcribed a physician order onto Resident #413's treatment administration record to cleanse the resident's nephrostomy site every day shift. Resident #413	F 658	1. Resident #103's carvedilol order has been clarified. Resident #413's nephrostomy order has been discontinued. Resident #418's diet order has been clarified. Resident #108's triamcinolone cream order has been clarified by the Nurse Practitioner. 2. All residents have the potential to be affected by this alleged deficient practice. The facility will audit the last 30 days of beta blocker orders, ostomy orders, diet slips requiring orders, and topical cream orders. Corrections will be made as necessary.	5/4/18

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F 658	Continued From page 90 did not have a nephrostomy site. b. The facility staff documented a treatment for Resident #413, which was not completed. 3. The facility staff failed to transcribe a physician order for a diet for Resident #418. 4. The facility staff failed to follow professional standards of practice for implementing a treatment order. The nurse practitioner failed to write an order for a topical steroid cream that she intended to use as treatment for Resident #108's rash. The findings include: 1. The facility staff failed to transcribe and clarify a physician order for Resident #103, to hold carvedilol a medication used to treat high blood pressure. Resident #103 was not prescribed and or taking this medication. Resident #103 was admitted to the facility on 2/23/18 with diagnoses that included but were not limited to: fracture of femur, high blood pressure, heart attack, chronic obstructive pulmonary disease (COPD) (a general term for chronic non-reversible lung disease that is usually a combination or emphysema and chronic bronchitis) (1), and depression. The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 3/7/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. The resident was coded as requiring	F 658	3. DON or designee will educate physicians on following through with orders written in progress notes. DON or designee will educate nursing staff regarding writing orders for completed diet slips, and confirming placement of ostomies prior to writing ostomy orders. 4. Physician progress notes will be monitored four times a week for four weeks, twice weekly for four weeks, and once weekly for one week to ensure any orders included in the progress note is carried out as an electronic order. Diet slips will be reviewed for the last 30 days to ensure an electronic order has been entered. Diet slips will be monitored four times a week for four weeks, twice weekly for two weeks, and once weekly for one week. Ostomy orders will be monitored four times a week for four weeks, twice weekly for two weeks, and once weekly for one week to ensure orders are being entered accurately. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed. All monitoring will be completed by D.O.N or designee. Ongoing compliance will be monitored through routine audits in the clinical operations meeting and will be reported to the facility's quality assurance meeting monthly for three months.	

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extensive assistance of one staff member for all of her activities of daily living.

Review of the clinical record evidenced a physician telephone order dated, 3/12/18 at 6:00 p.m. written by the doctor. The order documented, ""Hold carvedilol (used to treat high blood pressure and heart disease) (2) 12.5 mg (milligrams) tonight 3/12/18. Call before giving AM (morning) dose on 3/13/18." A nurse never transcribed the order.

Review of the POS (physician order summary) failed to evidence the resident was prescribed this medication.

Review of the MAR (medication administration record) for March 2018, failed to evidence the resident receiving Carvedilol. Further review of the MAR failed to evidence that any medications were held on 3/12/18.

An interview was conducted with RN (registered nurse) #3 on 3/22/18 at 4:23 p.m. p.m. When asked who transcribes physician orders, RN #3 stated, "The nurse's do." RN #3 was shown the physician order dated 3/12/18. When asked if a nurse had transcribed the order, RN #3 stated, "Doctors are supposed to flag or tell us there are orders on the chart. So there is a failure to transcribe an order and a failed to clarify the order as (Resident #103) isn't on the drug the physician ordered."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 3/23/18 at 9:08 a.m. When asked the process for the transcription of physician orders, ASM #2 stated, "When an order is written they (the doctor

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or nurse practitioner) will flag the chart. The nurse is to read the order and then transcribe those orders into the computer. And before they save it there is a pop up with the five rights of medication administration and they have to acknowledge that they meet the five rights." When asked if a nurse should follow the physician orders, ASM #2 stated, "Yes, unless the nurse feels the order will inflict harm and then they should clarify the order." The order of 3/12/18 was shared with ASM #2.

An interview was conducted with ASM #8, the doctor; on 3/23/18 at 9:11 a.m., ASM #8 was asked to review his written order of 3/12/18. ASM #8 was then asked to review, the physician orders for Resident #103 in the computer. ASM #8 stated, "That is my mistake. She wasn't on that medication."

According to "Fundamentals of Nursing-Lippincott, Williams and Wilkins 2007 page 169, "After you receive a written medication order, transcribe it onto a working document approved by your health care facility...read the order carefully, concentrate on copying it correctly, check it when you're finished.

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3 Regional manager, ASM #5, the clinical resource specialist, were made aware of the above findings on 3/22/18 at 5:40 p.m. A copy of the facility policy on transcribing physician orders was requested.

On 3/23/18 at 11:25 a.m., other staff member (OSM) #11, the medical records staff member, informed this surveyor the facility did not have a

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policy on transcribing or clarifying physician orders.

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 124.
(2) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009479/

2. a. The facility staff transcribed a physician order onto Resident #413's treatment administration record to cleanse the resident's nephrostomy site every day shift. Resident #413 did not have a nephrostomy site.

Resident #413 was admitted to the facility on 3/15/18 with diagnoses that included but were not limited to: fracture of his femur, gout, high blood pressure, history of renal cancer and diabetes.

There was no MDS (minimum data set) assessment completed at the time of survey. The Nursing Admission Assessment, documented the resident was alert and oriented to time, place and person. The resident was documented as needing assistance of the staff with most of his activities of daily living.

The physician orders dated, 3/19/18, documented, "Nephrostomy - cleanse site every day shift."

Nephrostomy is a surgical intervention to make

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an opening from the outside of the body to the renal pelvis (part of the kidney that collects urine). This may be done to drain urine from a blocked kidney or blocked ureter into a bag outside the body. (1)

The TAR (treatment administration record) for March documented, "Nephrostomy - cleanse site every day shift."

Review of the clinical record on 3/21/18 at 4:53 p.m. failed to evidence any documentation the resident has a nephrostomy tube.

Review of the "Baseline Care Plan" failed to evidence any documentation of a nephrostomy.

Review of the hospital history and physical dated 3/4/18, failed to evidence any documentation of a nephrostomy.

Review of the nurse's notes failed to evidence any documentation of a nephrostomy.

An interview was conducted with Resident #413 and his wife on 3/21/18 at 4:41 p.m. The resident and his wife stated that he does not have a tube into his kidney. He has had one kidney removed and uses the urinal.

An interview was conducted with LPN (licensed practical nurse) #4 on 3/22/18 at 9:09 a.m. When asked if Resident #413 had a nephrostomy, LPN #4 stated, "I was told in report that he does have a nephrostomy." When asked if she had seen the nephrostomy, LPN #4 stated, "This is my first time working with him."

An interview was conducted with CNA (certified

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nursing assistant) #9 on 3/22/18 at 9:11 a.m. When asked if resident #413 had a nephrostomy, CNA #9 stated, "I took care of him on Monday and I didn't see a nephrostomy."

On 3/22/18 at 9:16 a.m., LPN #4, accompanied by this surveyor went to look at Resident #413. LPN #4 interviewed the resident, then took her hands, and swept over both sides of the resident's mid back. (Resident #413 was not allowed to turn because there was new swelling at the site of his fractured leg) LPN #4 was asked if any other residents on the unit that had a nephrostomy tube. LPN #4 stated she was no ware of any.

An interview was conducted with RN (registered nurse) #3 on 3/22/18 at 1:47 p.m. When asked if Resident #413 had a nephrostomy, RN #3 stated, "I just heard about this this morning. No, he does not."

According to Potter and Perry's, Fundamentals of Nursing, 7th edition, page 268 documents the following statements: "Clarifying an order is competent nursing practice, and it protects the client and members of the health care team. When you carry out an incorrect or inappropriate intervention, it is as much your error as the person who wrote or transcribed the original order."

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3 Regional manager, ASM #5, the clinical resource specialist, were made aware of the above findings on 3/22/18 at 5:40 p.m.

No further information was provided prior to exit.

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

b. The facility staff documented a treatment for Resident #413, which was not completed.

The TAR (treatment administration record) for March documented, "Nephrostomy - cleanse site every day shift." The TAR documented the treatment was completed as ordered on 3/20/18 and 3/21/18, day shift.

An interview was conducted with LPN #4 on 3/22/18 at 9:16 a.m. The above TAR was reviewed with her. When asked if a nurse should sign a treatment that they did not do, LPN #4 stated, "No, that is false documentation."

An interview was conducted with RN (registered nurse) #3, the unit manager; on 3/22/18 at 1:47 p.m., RN #3 was asked to review the above TAR. RN #3 stated, "I was made aware of this earlier today." When asked what it means that two nurses documented they did a treatment when the resident does not have a nephrostomy, RN #3 stated, "It tells me they didn't look at the resident."

According to Potter and Perry's, Fundamentals of Nursing, 7th edition, page 268 documents the following statements: "Clarifying an order is competent nursing practice, and it protects the client and members of the health care team. When you carry out an incorrect or inappropriate intervention, it is as much your error as the

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person who wrote or transcribed the original order."

The following quotation is found in Lippincott's Fundamentals of Nursing 5th edition (2007, page 237): "The client record serves as a legal document of the client's health status and care received..... Because nurses and other healthcare team members cannot remember specific assessments or interventions involving a client years after the fact, accurate and complete documentation at the time of care is essential. The care may have been excellent, but the documentation must prove it."

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3 Regional manager, ASM #5, the clinical resource specialist, were made aware of the above findings on 3/22/18 at 5:40 p.m.

No further information was provided prior to exit.

3. The facility staff failed to transcribe a physician order for a diet for Resident #418.

Resident #418 was admitted to the facility 3/10/18 with diagnoses including but were not limited to: Esophageal cancer, diabetes, dementia, high blood pressure and history of falling.

There was no completed MDS (minimum data set) assessment completed at the time of survey. The Nursing Admission Assessment dated, 3/10/18 documented the resident was alert to person, time and place. It was documented the resident required extensive assistance of one or

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more staff members for all of his activities of daily living.

Resident #418 was observed on 3/21/18 at 8:17 a.m. sitting up in a wheelchair. His tube feeding was observed infusing. Several cups were noted on the bedside table. When asked if he drinks fluids, Resident #418 stated, "Yes, I drink eight glasses of ice water every day and I would like some now."

On 3/22/18 at approximately 8:15 a.m., Resident #418 was observed in his bed. The tube feeding was running. There was a tray of puree food and thin liquids in front of the resident.

The physician orders dated 3/10/18, documented in part, "Nothing by mouth. Enteral Feed Order every shift Glucerna* 1.5 @ (at) 90 cc/hr (cubic centimeters per hour) up at 4:00 p.m. and down at 10:00 a.m.

*Glucerna is a liquid food supplement for diabetic. (1)

An interview was conducted CNA (certified nursing assistant) #10 on 3/22/18 at 2:10 p.m. When asked if Resident #418 eats food, CNA #10 stated, "Yes, for about the last two or three weeks." When asked what type of tray he receives, CNA #10 stated, "He gets puree food with thin liquids."

An interview was conducted with LPN (licensed practical nurse) #2 on 3/22/18 at 2:15 p.m. When asked what kind of diet Resident #418 is on, LPN #2 stated, "He has recently been upgraded to puree." When asked if he drinks liquids, LPN #2 stated, "I don't give him any, I only give him things

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through his tube." The orders were reviewed with LPN #2. The orders documented the resident was on nothing by mouth and feedings through his feeding tube. There was no documented evidence of an oral diet order.

An interview was conducted with RN (registered nurse) #3, the unit manager, on 3/22/18 at approximately 2:25 pm. When asked what Resident #418's diet is, RN #3 stated, "We got an order from his gastro (gastroenterologist) he could have anything he wanted so we are starting him with puree. We wrote the diet slip but did not write the order. Wife did not give us the paper with this information until yesterday. So we have a transcription problem."

LPN #4 overheard the above conversation and stated, "It's in the discharge not from the doctor that did his radiation. (Name of nurse practitioner) signed off on it." When asked the order should be in the computer, LPN #4 stated, "Yes, that is my mistake."

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3 Regional manager, ASM #5, the clinical resource specialist, were made aware of the above findings on 3/22/18 at 5:40 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/pubmed/16634993 4. The facility staff failed to follow professional standards of practice for implementing a treatment order. The nurse practitioner failed to write an order for a topical steroid cream that she

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intended to use as treatment for Resident #108's rash.

Resident #108 was admitted 11/14/14 and readmitted on 6/29/17 with diagnoses that included but were not limited to; high blood pressure, peripheral vascular disease, diabetes, high cholesterol, seizure disorder, anxiety disorder, depression, manic disorder, and Schizophrenia. Resident #108's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/26/18. Resident #108 was coded as being cognitively intact in the ability to make daily decisions scoring 12 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #108 was coded as requiring extensive assistance from one staff member with most ADLS (activities of daily living).

Review of Resident #108's progress notes revealed the following note dated 12/15/17 by the nurse practitioner that documented in part, the following: "Seeing patient today who has a rash on chest area which seems to be itchy...7. rash-new. will apply triamcinolone (sic) cream [1] to area."

Review of the physician order sheets from December 2017 through March 2018 failed to evidence an order for the Triamcinolone cream.

Review of the December 2017 through March 2018 MARs (medication administration record) and TARS (treatment administration record) failed to evidence that facility staff were applying the Triamcinolone cream.

Further review of the December 2017 TAR

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revealed that Resident #108 was already receiving Aveeno Anti-itch lotion to the arms and legs two times a day for dry skin.

Progress notes from the NP dated 1/2/18, 1/15/18, 1/16/18, 2/18/18 documented the following: "...7. rash improved."

Further review of the clinical record revealed that Resident #108 was ordered "Benadryl [2] 0.5 mg (milligrams), 1 capsule by mouth as needed for itching BID (two times a day)" on 1/30/18 and a "Dermatology Consult" on 1/31/18 for her rash. Progress notes could not be found in the clinical record regarding the these two orders.

A progress note dated 3/13/18 from the nurse practitioner documented the following: "Seeing patient today due to an ongoing rash on chest and arma (sic). She has been treated with steroid creams which did not help. Pt (patient) exposed to scabies. No fever or chills...7. rash- ongoing due to exposure to scabies- will treat with ivermectin [3] and repeat in 1 week."

On 3/22/18 at 10:31 a.m., an interview was conducted with ASM (administrative staff member) #4, the nurse practitioner. ASM #4 confirmed that she forgot to write the order for the Triamcinolone cream. ASM #4 stated she would usually write her plan for treatment in a note and then write orders based on her note. ASM #4 stated she does not expect nursing staff to read her progress notes. ASM #4 stated she usually writes the orders after an assessment. ASM #4 read her progress notes with this writer and stated it appeared she intended for Resident #108 to receive the Triamcinolone cream. ASM #4 stated she must have thought the resident was

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F 658	Continued From page 102 receiving the cream when the rash came back. According to Potter and Perry's, Fundamentals of Nursing, 6th edition, page 419 documents the following statements: "The physician should write all orders and the nurse must make sure they are transcribed correctly." On 3/22/18 at 5:26 p.m., ASM (administrative staff member) #1 the administrator, ASM #2, DON (Director of Nursing) and ASM (administrative staff member) #3 and the regional manager were made aware of the above concerns. [1] Triamcinolone Cream is used to relieve redness, itching, swelling, or other discomfort caused by skin conditions. This medication is a corticosteroid. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012519/?report=details. [2] Benadryl- Benadryl is an antihistamine that is used for symptoms of allergic rhinitis, common cold and urticaria, pruritus (itchiness) and anaphylaxis (allergic reaction). This information was obtained from The National Institutes of Health. https://livertox.nih.gov/Diphenhydramine.htm. [3] Ivermectin is an antiinfective agent with activity against several parasitic nematodes and scabies and is the treatment of choice for onchocerciasis (river blindness). It is typically given as one or two oral doses. This information was obtained from The National Institutes of Health. https://livertox.nih.gov/Ivermectin.htm.	F 658		
F 684	Quality of Care	F 684		5/4/18

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F 684 SS=E	Continued From page 103 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure residents received treatment and services in accordance with professional standards of practice and the comprehensive person-centered care plan for one of 33 residents in the survey sample, Residents #45,. The facility staff failed to follow the recommendations of a consultant for Resident #45 to receive daily showers. The findings include: The facility staff failed to follow the recommendations of a consultant for Resident #45 to receive daily showers. Resident #45 was admitted to the facility on 1/17/18 with a recent readmission on 2/17/18, with diagnoses that included but were not limited to: amputation below the knee on right leg, diabetes, high blood pressure, and a stroke.	F 684	1. Resident #45 is now receiving daily showers. 2. All residents with a consulting wound physician have the potential to be affected by this alleged deficient practice. The facility will audit the last 30 days of wound consult orders for recommendations. 3. Nursing managers will be in-serviced on ensuring consult recommendations are reviewed by the physician and followed as ordered. 4. D.O.N or designee will monitor wound consults five times a week for four weeks. Variances will be corrected at the time of observations, education and corrective actions will be provided as needed. Ongoing compliance will be monitored through routine audits in the clinical operations meeting and will be reported the facility's quality assurance meeting monthly for three months.	

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The most recent MDS (minimum data set) Assessment, a Medicare 30 day assessment, with an assessment reference date of 2/12/18, coded the resident as being cognitively intact, scoring a 13 on the BIMS (brief interview for mental status) score. Resident #45 was coded requiring limited assistance of one staff member for most of his activities of daily living.

The clinical record review evidenced a "Report of Consultation" dated, 1/31/18. The report documented in part, "Recommendations: Shower daily." The nurse practitioner, administrative staff member (ASM) #10, signed on 2/1/18 that she agreed with the above consultation recommendations."

The clinical record review evidenced a "Report of Consultation" dated, 2/28/18 that documented, "Recommendations: daily shower with soap and water." The nurse practitioner or physician did not sign this consultation form.

Review of the clinical record failed to evidence a physician order for daily showers.

Review of the CNA (certified nursing assistant) documentation for February 2018 documented the resident received a shower on 2/1/18 and 2/15/18. The resident refused a shower on 2/5/18.

The CNA documentation for March 2018 documented the resident received a shower on 3/1/18, 3/12/18 and 3/15/18.

An interview was conducted with Resident #45 on 3/22/18 at 8:16 a.m. When asked if he gets a shower every day, Resident #45 stated he

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doesn't. He usually gets one a week.

An interview was conducted with ASM #10 on 3/22/18 at 11:11 a.m. When asked about the process staff follows when a resident goes out to a consultant and returns with orders, ASM #10 stated, "I sign the bottom of the consult that we agree with the consults." When asked if she wrote the orders/recommendations, ASM #10 stated, "No, the nurse is supposed to take off the orders written after we (ASM #10 or ASM #8, the physician) have reviewed it." When asked if she was aware that resident #45 is supposed to have a shower daily per the consultant's recommendations, ASM #10 stated, "No, I was not aware of that."

An interview was conducted with RN (registered nurse) #3, the unit manager, on 3/22/18 at 1:47 p.m. When asked about the process staff follows when a resident goes out for a consult and returns with recommendations, RN #3 stated, "They have a sheet that goes with the resident and we attach a medication list. We also attack any recent laboratory tests. When they come back, they give the papers to (Unit clerk). When asked what staff does if the resident has orders on the sheet, RN #3 stated, "We get them approved by our doctor." RN #3 was shown the Report of Consultation for Resident #45 on 1/31/18 and 2/28/18. RN #3 stated, "He's supposed to be getting daily showers."

An interview was conducted with ASM #2, the director of nursing, on 3/23/18 at 9:08 a.m. When asked about the process staff follows when a resident goes out to a consultant and returns with orders, ASM #2 stated, "Those consultant sheets are considered orders. Those orders should be

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F 684	Continued From page 106 approved by the primary care doctor and then taken off as orders." ASM #2 was shown the consultation documentation and CNA documentation for Resident #45. ASM #2 stated, "He should be getting showers daily." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3 Regional manager, ASM #5, the clinical resource specialist, were made aware of the above findings on 3/22/18 at 5:40 p.m. A copy of the facility policy on following physician orders was requested. On 3/23/18 at 11:25 a.m. OSM (other staff member) #11, the medical records staff member, informed the survey team the facility did not have a policy on following physician orders. No further information was obtained prior to exit.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and	F 688		5/4/18

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F 688	Continued From page 107 assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and facility document review, it was determined that the facility staff failed to provide services to prevent contractures for one of 33 residents in the survey sample, Resident #15. The facility staff failed to ensure Resident #15's left arm splint was in place per physician's order to prevent further contractures. The findings include: Resident #15 was admitted to the facility on 5/9/17 was diagnoses that included but were not limited to anemia, heart failure, high blood pressure, diabetes, post stroke with left sided weakness, and Non-Alzheimer's Dementia. Resident #15's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 1/10/18. Resident #15 was coded as being intact in cognitive function scoring 12 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #15 was coded as requiring extensive assistance from two plus persons with bed mobility, personal hygiene, and dressing; and dependent on staff with toileting and bathing. On 3/20/18 at 2:10 p.m., an observation was made of Resident #15. She was sleeping in bed. Her left hand was contracted. No splints or devices were in place.	F 688	Corrective Action Resident # 15's splint is applied as ordered. Corrective Action for Those Having the Potential to be Affected All residents with splint orders have to potential to be affected by this alleged deficient practice. The facility will audit all splint orders to ensure comprehensive care plan is being followed. Systematic Changes All licensed nursing staff will be in-serviced on following physician orders for splints. DON/designee will conduct room rounds to ensure comprehensive care plan for splints is being followed. Monitoring D.O.N or designee will monitor splint placement four times a week for four weeks. Monitoring will include tracking and trending of issues found during room rounds. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed. Ongoing compliance will be monitored	

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F 688	Continued From page 108 On 3/20/18 at 3:13 p.m., an observation was made of Resident #15. She was sleeping in bed. Her left hand was contracted. No splints or devices were in place. On 3/21/18 at 9:04 a.m., an interview was conducted with Resident #15. During the interview, Resident #15 mentioned she is always losing her call bell and hand splint in her bed. Resident #15 stated her hand splint is always falling off. At that time, Resident #15 had her hand splint in place. Resident #15 stated that she wore a splint to her left hand because of her stroke. On 3/22/18 at 8:28 a.m., an observation was made of Resident #15. She was sleeping in bed. Her left hand was contracted. No splints or devices were in place. Her left hand splint was lying on the bedside table. On 3/22/18 at 1:20 p.m., an observation was made of Resident #15. Her splint was in place. Review of Resident #15's OT (occupational discharge summary) dated 9/27/17 documented the following discharge recommendations: "Discharge Recommendations: L (left) resting hadn (sic) splint to be worn at all times. Nursing to remove splint for skin checks and hygiene (sic)...Restorative Program Established/Trained = Not indicated at this time." Further review of Resident #15's OT notes dated 9/26/17 and 9/27/17, revealed that the Resident and Staff were educated on how to use the left hand splint. Review of Resident #15's most recent POS	F 688	through routine room rounds and will be reported to the facility's quality assurance meeting monthly for 3 months.	

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(physician order sheet) revealed the following order: "Pt (patient) to wear left resting hand splint at all times for contracture management. May be removed as needed for hygiene and skin checks."

Review of Resident #15's ADL (activities of daily living) care plan dated 5/19/17 and updated 9/21/17, documented the following: "ADL: Requires assistance with ADL's related to s/p (status post) CVA (cerebral vascular accident)...Will be able to do ADL's with limited assistance by next review...9/21/17 Left resting splint hand splint as ordered."

On 3/22/18 at 8:37 a.m., an interview was conducted with RN (registered nurse) #2, the MDS nurse. When asked the purpose of the care plan, RN #2 stated that the purpose of the care plan was to serve as a guide with patient care. RN #2 stated that it was used to communicate with other staff members. When asked the reasons why a care plan would not be followed, RN #2 stated there should be no reason that the care plan would not be followed because the care plans should be accurate. RN #2 stated that staff who have access to PCC (point click care) (computer system) can access the care plan. When asked how CNAs had access to the care plan, RN #2 stated they use a care card that is also updated with changes.

On 3/22/18 at 1:30 p.m., an interview was conducted with CNA (certified nursing assistant) #6, Resident #15's CNA. When asked how CNAs know the needs for each resident, including what splints need to be into place, CNA #6 stated that she would ask the nurse. When asked if there was reference to refer to, to serve as a guide for

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resident care, CNA #6 stated she could look at the resident's care card. When asked who was responsible for ensuring splints were in place, CNA #6 stated the CNAs could put the splints on but that nurses have to ensure that they are in place. When asked if Resident #15 had hers off at any point that day. CNA #6 stated it was off during AM (morning) care, and when the aromatherapy specialist came in. When asked when the aromatherapy specialist came in, CNA #6 stated at around 9:00 a.m. CNA #6 stated the aromatherapy specialist will take off the brace to put on oils. CNA #6 stated that AM care was around 7:00 a.m. When asked if she could recall putting the brace back on after AM care, CNA #6 stated that she thought she did.

On 3/22/18 at 1:49 p.m., an interview was conducted with LPN (licensed practical nurse) #9, Resident #15's nurse. When asked if Resident #15 was supposed to have anything in place to prevent further contracture, LPN #9 stated Resident #15 was supposed to have a splint in place to her left hand. When asked how often Resident #15 was supposed to have her splint in place, LPN #9 stated that she was supposed to have her splint in place at all times. When asked who was responsible for ensuring splints were in place, LPN #9 stated the nurses were responsible. LPN #9 stated the splint sometimes slides off the resident. When asked if her order was followed if the splint was not in place, LPN #9 stated that if the splint was off then the order was not followed.

On 3/23/18 at 8:04 a.m., an interview was conducted with LPN #11, the unit manager. When asked why Resident #15 needed a left

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hand splint, LPN #11 stated she came to their unit (west) with the hand splint. LPN #11 stated she needed to wear the splint because she had left sided weakness and a contracture to her left hand post stroke. LPN #11 stated the resident could be non-compliant with the brace, and pick at the brace with her right hand until it falls off. LPN #11 stated they had just changed the order on 3/22/18, to wear the splint as tolerated. When asked if it was documented anywhere that Resident #15 was non-compliant with her brace, LPN #11 stated that she didn't think so, LPN #11 turned to LPN #9 and asked if she had ever documented that Resident #15 picks at her brace. LPN #9 stated she thought the brace would slide off.

On 3/22/18 at 5:26 p.m., ASM (administrative staff member) #1 the administrator, ASM #2, DON (Director of Nursing) and ASM (administrative staff member) #3 and the regional manager were made aware of the above concerns.

On 3/23/18 at 11:24 a.m., OSM (other staff member) #11, stated that she did not have polices regarding following physician's orders.

No further information was presented prior to exit.

In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients. Therefore all orders must be assessed if one is found to be erroneous or harmful further clarification from the physician is necessary."

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	495257	A. BUILDING _____ B. WING _____	C 03/23/2018

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THE LAURELS OF WILLOW CREEK	11611 ROBIOUS ROAD MIDLOTHIAN, VA 23113

(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 689 SS=D	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, facility document review, and clinical record review, it was determined that facility staff failed to implement measures to prevent falls for one of 33 residents in the survey sample, Resident #94. The facility staff failed to ensure Resident #94's bed was in the lowest position while he was in bed per the physician orders. The findings include: Resident #94 was admitted to the facility on 9/20/16 and readmitted on 2/19/18 with diagnoses that included but were not limited to stroke, unspecified dementia without behavioral disturbance, high blood pressure, major depressive disorder, atrial fibrillation, muscle weakness, dysphagia (difficulty swallowing), and osteoporosis. Resident #94's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 3/3/18. Resident #94 was coded as being severely cognitively impaired in the ability to make daily decisions scoring 05 out of 15 on the BIMS (Brief Interview for Mental	F 689	F 689 Corrective Action Resident #94's bed is in lowest position per physician's order Corrective Action for Those Having the Potential to be affected All residents with a physician's order for low bed have the potential to be affected by this alleged deficient practice. The facility will audit all low bed orders to ensure comprehensive care plan is being followed. Systematic Changes All licensed nursing staff will be in-serviced on following physician orders for low beds. DON/designee will conduct room rounds to ensure comprehensive care plan for low bed is being followed. Monitoring	5/4/18

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F 689	Continued From page 113 Status) exam. Resident #94 was coded as requiring extensive assistance from one staff member with bed mobility, dressing, toileting, and personal hygiene; total dependence from staff with eating, and bathing; and limited assistance with one staff member for transfers. Review of Resident #94's most recent POS (physician order sheet) revealed the following order dated 1/19/18: "Low bed for safety." Review of Resident #94's fall prevention care plan dated 1/18/18, documented the following: "FALLS: At risk for fall related to injury related to unsteady gait, impaired mobility, bladder and bowel incontinence, psychotropic drug use and DX (diagnoses): HTN (hypertension), depression, osteoporosis, and Dementia....Goal: Will be free from fall related injuries through next review...Interventions: Low bed as ordered." On 3/21/18 at 4:48 p.m., Resident #94 was sleeping in bed. His bed was not in the lowest position. On 3/22/18 at 8:23 a.m., Resident #94 was sleeping in bed. His bed was not in the lowest position. On 3/22/18 at 1:20 p.m., Resident #94 was sleeping in bed. His bed was not in the lowest position. On 3/22/18 at 1:45 p.m., Resident #94 was sleeping in bed. His bed was not in the lowest position. Review of Resident #94's most recent fall risk assessment dated 2/18/18 documented Resident	F 689	D.O.N or Designee will monitor low beds four times a week for four weeks. Monitoring will include tracking and trending of issues found during room rounds. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed. Ongoing compliance will be monitored through routine audits in the clinical operations meeting and will be reported to the facility's quality assurance meeting monthly for three months. Completion 5/4/18	

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F 689	Continued From page 114	F 689		

#94 as being at "moderate risk" for falls.

Further, review if Resident #94's clinical record revealed that he only had one fall this year on 3/4/18. It was documented that Resident #94 had slid from his wheelchair. Fall interventions were put into place after this fall.

Review of Resident #94's nursing care card documented the following: "put (sic) to bed after lunch/low bed."

On 3/22/18 at 1:45 p.m., an interview was conducted with CNA (certified nursing assistant) #6. When asked how CNAs know the needs for each resident, including fall preventive measures, CNA #6 stated she would ask the nurse. When asked if there was a reference to refer to, to serve as a guide for resident care, CNA #6 stated she could look at the resident's care card. When asked what a "low bed" meant, CNA #6 stated that a low bed meant the bed should be all the way to the floor. CNA #6 stated she was not Resident #94's CNA that shift. CNA #6 followed this writer to Resident #94's room. When asked if his bed was in the lowest position, CNA #6 stated, "No." At this time, LPN (licensed practical nurse) was observed walking into Resident #94's room, and lowering his bed to the floor.

On 3/22/18 at 1:51 p.m., an interview was conducted with LPN (licensed practical nurse) #8. When asked why she lowered Resident #94's bed, LPN #8 stated that his bed was higher than it should have been. LPN #8 stated when she lowered his bed that was the first time she entered Resident #94's room. LPN #8 stated she had just arrived to the facility an hour prior. LPN #8 stated, "Whoever transferred him back into

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F 689	Continued From page 115 bed, did not lower the bed, but I corrected it once I saw it." LPN #8 was informed of the several observations made of Resident #94's bed not in the low position when the resident was in bed. LPN #8 again stated she had just arrived to the unit. When asked if Resident #94 was a fall risk, LPN #8 stated that Resident #94 had an order for the low bed and that his chart had documented him as a fall risk. LPN #8 stated Resident #94 was not really a fall risk because he doesn't attempt to get out of bed. LPN #8 agreed that his bed should have in the lowest position, (all the way to the floor). LPN #8 confirmed that the physician orders and the care plan was not being followed. On 3/22/18 at 5:26 p.m., ASM (administrative staff member) #1 the administrator, ASM #2, DON (Director of Nursing) and ASM (administrative staff member) #3 and the regional manager were made aware of the above concerns. The facility policy titled, "Falls Awareness Program," did not address the above concerns. No further information was presented prior to exit.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary	F 690		5/4/18

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F 690	Continued From page 116 incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide appropriate indwelling catheter services for one of 33 residents in the survey sample, Resident #6. The facility staff failed to obtain a physician's order for the size of Resident #6's indwelling catheter.	F 690	Resident #6's order has been clarified to include catheter size. Corrective Action for Those Having the Potential to be affected All residents with catheters have the potential to be affected by this alleged deficient practice. The facility will audit all residents with catheter orders. Systematic Changes	

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F 690	Continued From page 117 The findings include: Resident #6 was admitted to the facility on 11/21/17 and readmitted on 3/6/18. Resident #6's diagnoses included but were not limited to heart failure, acute kidney failure and high blood sugar. Resident #6's 30 day Medicare MDS (minimum data set) assessment, with an ARD (assessment reference date) of 12/19/17, coded the resident's cognition as severely impaired. Multiple observations of Resident #6 during the survey revealed the resident was utilizing an indwelling catheter (1). Review of Resident #6's clinical record revealed the following orders: 3/16/18- 24 hour total foley (indwelling catheter) output every evening shift 3/16/18- Foley catheter care every shift 3/16/18- Foley output every shift Further review of Resident #6's physician's orders, failed to reveal an order for the size of the catheter. On 3/22/18 at 11:21 a.m., an interview was conducted with RN (registered nurse) #3 and ASM (administrative staff member) #5 (the clinical resource specialist). RN #3 was asked if residents who have catheters should have a physician's order for the size of the catheter. RN #3 stated, "Yes. We normally put in an order for size and balloon (the amount of liquid injected into part of the catheter to keep the device in place), output for every shift and 24 hour total and diagnosis." RN #3 was informed Resident #6 did not have a physician's order for catheter size. RN #3 was then asked if there should be an order.	F 690	All licensed nursing staff will be in-serviced on obtaining a physician's order for indwelling catheter size. DON/designee will conduct quality monitoring in clinical operations meeting to ensure orders for indwelling catheters include size. Monitoring Monitoring catheter orders will occur five times a week for four weeks. Monitoring will include tracking and trending of issues found during the clinical operations meeting. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed. Ongoing compliance will be monitored through routine audits in the clinical operations meeting and will be reported to the facility's quality assurance meeting monthly for three months.	

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F 690	Continued From page 118 RN #3 stated, "I have always been told there should be but have to check on policy wise." RN #3 was asked the purpose of having a physician's order for catheter size. RN #3 stated, "In case we need to change it, we know what size and to make sure it doesn't get overinflated or underinflated if we do have to change it." On 3/22/18 at 2:30 p.m., another interview was conducted with RN #3 and ASM #5. RN #3 stated, "We now have an order for Foley size and cc's (cubic centimeters) balloon." RN #3 confirmed Resident #6 did not previously have an order. On 3/22/18 at 4:40 p.m., ASM #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional manager) and ASM #5 were made aware of the above concern. The facility policy titled, "CATHERIZATION-MALE" documented, "An indwelling catheter will be inserted by a licensed nurse, under a physician's order..." No further information was presented prior to exit. (1) An indwelling catheter is a tube that drains urine from the bladder to a bag outside of the body. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000140.htm	F 690		
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.	F 695		5/4/18

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F 695	Continued From page 119 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, resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to administer oxygen per the physician order for two of 33 residents in the survey sample, Residents #103 and #316. 1. The facility staff failed to administer Resident #103's oxygen per the physician prescribed rate. 2. The facility staff failed to administer oxygen to Resident #316 at the physician prescribed rate. The findings include: 1. The facility staff failed to administer Resident #103's oxygen per the physician prescribed rate. Resident #103 was admitted to the facility on 2/23/18 with diagnoses that included but were not limited to: fracture of femur, high blood pressure, heart attack, chronic obstructive pulmonary disease (COPD) (a general term for chronic non-reversible lung disease that is usually a combination or emphysema and chronic bronchitis) (1), and depression. The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment,	F 695	F695 Corrective Action Resident #103's oxygen is being administered per the physician's prescribed rate. Resident #103 suffered no adverse effects and did not require transfer to a higher level of care. Resident #316's oxygen is being administered per the physician's prescribed rate. Resident #316 suffered no adverse effects and did not require transfer to a higher level of care. Corrective Action for Those Having the Potential to be affected All residents with orders for oxygen have the potential to be affected by this alleged deficient practice. The facility will audit all residents with oxygen orders to ensure liters are set per physician's prescribed rate. Systematic Changes All licensed nursing staff will be in-serviced on following physician orders	

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F 695	Continued From page 120 with an assessment reference date of 3/7/18, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one staff member for all of her activities of daily living. In Section O - Special Treatments, Procedures and Programs, the resident was coded as using oxygen while a resident in the facility. Observation was made of Resident #103 on 3/21/18 at 11:40 a.m., 3/22/18 at 11:21 a.m., and 3/22/18 at 1:42 p.m., Resident # 103 had oxygen on via a nasal cannula (a tube with prongs that insert into the nose) connected to an oxygen concentrator. During each observation, the oxygen flow rate on the oxygen concentrator was set at 3L/min (liters per minute). Each time the oxygen flow rate was observed Resident #103 stated to this surveyor, "It's supposed to be on 2 liters." The physician order dated, 2/24/18, documented, "Oxygen 2L/min via nasal cannula as needed for COPD." The TAR (treatment administration record) for March 2018 documented, "Oxygen 2L/min via nasal cannula as needed for COPD." The oxygen was signed off on the TAR for 3/20/18, 3/21/18 and 3/22/18 for all three shifts as administered per the physician order. An interview was conducted with Resident #103 on 3/22/18 at 1:44 p.m. Resident # 103 was asked if she adjusts the oxygen rate on the oxygen concentrator, Resident #103 stated, she does not, only the staff adjust it.	F 695	for oxygen. DON/designee will conduct room rounds to ensure liters are set per physician's prescribed rate. Monitoring Monitoring that oxygen is being administered at the physician prescribed rate will occur four times a week for four weeks by D.O.N or designee. Monitoring will include tracking and trending of issues found during room rounds. Variances will be corrected at the time of observation, education and corrective actions will be provided as needed. Ongoing compliance will be monitored through routine audits in the clinical operations meeting and will be reported to the facility's quality assurance meeting monthly for three months. Completion 5/4/18	

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F 695	Continued From page 121	F 695		

An interview was conducted with RN (registered nurse) #3, the unit manager, on 3/22/18 at 1:47 p.m., regarding how oxygen should be administered, RN #3 stated, "Per the physician order."

On 3/22/18 at 2:10 p.m., LPN (licensed practical nurse) #2 was asked to accompany this surveyor to Resident #103's room to verify the oxygen setting. LPN #2 stated the oxygen flow rate was on 3L/min. When asked what flow rate of oxygen Resident #103 was prescribed, LPN #2 stated, "I need to check the computer." LPN #2 proceeded to check the physician orders for oxygen and stated, Resident
#103 is supposed to be on 2L/min. When asked why it would be a concern for a resident with COPD to be on more oxygen than is prescribed, LPN #2 stated, "It can be detrimental for her. It has to do with her oxygen exchange."

The copy of the care plan was requested on 3/22/18 at 5:00 p.m. No copy of the care plan was presented prior to exit.

ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3 Regional manager, ASM #5, the clinical resource specialist, were made aware of the above findings on 3/22/18 at 5:40 p.m.

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 3/23/18 at 9:08 a.m., regarding how oxygen should be administered. ASM #2 stated, "Per the physician order. The nurse is to check what the settings should be per the order." When asked how to read the oxygen concentrator, ASM #2

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F 695	Continued From page 122	F 695		

stated, "The prescribed line should go through the center of the floating ball." When asked why is would be a concern for a resident with COPD to be getting more oxygen than the prescribed rate, ASM #2 stated, "Their lung capacity can't handle the higher rate and they will decompensate. They cannot exchange the air."

The facility policy, "Service Delivery" documented in part, "Procedure: 1. Check the chart for a physician's order." The facility policy, "Oxygen Concentrators" documented in part, "2. Turn concentrator on and adjust liter flow (to that ordered by physician). Listened for start up alarm. The black liter flow ball on the gauge should be positioned in the middle of the number line prescribed by the physician."

"Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration. "(2).

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 124.
(2) Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122.

2. The facility staff failed to administer oxygen to Resident #316 at the physician prescribed rate.

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F 695	Continued From page 123	F 695		

Resident #316 was admitted to the facility on 3/6/18. Resident #316's diagnoses included but were not limited to difficulty swallowing, manic depression and high cholesterol. Resident #316's admission MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/13/18, coded the resident as cognitively intact.

Review of Resident #316's clinical record revealed a physician's order dated 3/7/18 for continuous oxygen at a rate of two liter per minute.

Resident #316's comprehensive care plan dated 3/19/18 documented, "Respiratory difficulty r/t (related to) COPD (chronic obstructive pulmonary disease) (1), resp (respiratory) failure, AFIB (atrial fibrillation) (2), use of BiPap (3)/oxygen- often removes/refuses to use...Administer medication & treatments per physician orders..." The care plan did not document Resident #316 adjusted the flowmeter on the oxygen concentrator.

On 3/20/18 at 1:31 p.m., Resident #316 was observed sitting in a wheelchair in the bedroom. A nasal cannula (device used to administer oxygen) was in the resident's nose and was attached to an oxygen concentrator. The oxygen was delivered at a rate of two and a half liters as evidenced by the middle of the ball in the flowmeter placed at the two and a half liter line (observed at eye level).

On 3/20/18 at 4:45 p.m., Resident #316 was in bed with her eyes closed. A nasal cannula was in the resident's nose and attached to an oxygen concentrator that was out of the resident's reach.

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The oxygen was delivered at a rate of two and a half liters as evidenced by the middle of the ball in the flowmeter placed at the two and a half liter line (observed at eye level).

On 3/22/18 at 3:25 p.m., an interview was conducted with RN (registered nurse) #3. RN #3 was asked where the ball in an oxygen concentrator flowmeter should be placed if a resident has a physician's order for two liters. RN #3 stated, "It should be positioned where it says two and there is a line." When asked what part of the ball should be placed on that line, RN #3 stated, "I always put the middle of it." RN #3 confirmed Resident #316 had a physician's order for two liters of oxygen. RN #3 was asked if Resident #316 has ever moved the flowmeter in the oxygen concentrator. RN #3 stated, "I haven't seen her but she has that ability." RN #3 stated no one has ever reported to her that Resident #316 moved the flowmeter. At this time, RN #3 was asked to observed Resident #316's oxygen concentrator. Resident #316 was sitting up in bed. The concentrator was out of the resident's reach. The ball in the flowmeter was between two liters and two and a half liters. RN #3 confirmed the oxygen rate was not set at two liters.

On 3/22/18 at 4:40 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional manager) and ASM #5 (the clinical resource specialist) were made aware of the above concern.

The facility document titled, "Oxygen Concentrators" documented, "2. Turn concentrator on and adjust liter flow (to that

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ordered by physician). Listen for start up alarm. The black liter flow ball on the gauge should be positioned in the middle of the number line (2.0, 2.5, 3.0, and 3.5) prescribed by the physician. 3. Liter Flow should be checked by being eye level with flow meter..."

No further information was presented prior to exit.

(1) "COPD (chronic obstructive pulmonary disease) makes it hard for you to breathe. The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it." 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=copd&_ga=2.160000441.566140716.1522143307-139120270.1477942321

(2) "An arrhythmia is a problem with the speed or rhythm of the heartbeat. Atrial fibrillation (AF) is the most common type of arrhythmia. The cause is a disorder in the heart's electrical system." 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=afib

(3) "Positive airway pressure (PAP) treatment uses a machine to pump air under pressure into the airway of the lungs. This helps keep the windpipe open during sleep. The forced air delivered by CPAP (continuous positive airway pressure) prevents episodes of airway collapse

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F 695	Continued From page 126 that block the breathing in people with obstructive sleep apnea and other breathing problems...Bilevel positive airway pressure (BiPAP or BIPAP) has a higher pressure when you breathe in and lower pressure when you breathe out." This information was obtained from the website: https://medlineplus.gov/ency/article/001916.htm	F 695		
F 758 SS=D	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	F 758		5/4/18

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F 758	Continued From page 127 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 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 observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to ensure residents were free from unnecessary psychotropic medications for two of 33 residents in the survey sample, Residents #320 and #263. 1.a. The facility staff failed to evidence justification for an increase in Resident #320's anxiety medication. 1.b. The facility staff administered Seroquel to Resident #320 without adequate indications for use. 2. The facility staff failed to provide a clinical indication for the administration of Ativan [1] (an	F 758	1.Resident #320 was discharged 04/09/18. Resident #263 no longer resides in the facility. 2. All residents receiving antianxiety and antipsychotic medications have the potential to be affected by this alleged deficient practice. The facility will audit the last 30 days of facility initiated or changed antianxiety and antipsychotic medications for MD and/or NP supporting documentation. 3.D.O.N or designee will in-service facility physicians on providing supporting documentation when changing the frequency or initiating antianxiety or antipsychotic medications. Don or designee will conduct quality monitoring in	

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F 758	Continued From page 128 anxiety medication) to Resident # 263. The findings include: 1.a. The facility staff failed to evidence justification for an increase in Resident #320's anxiety medication. Resident #320 was admitted to the facility on 3/8/18. Resident #320's diagnoses included but were not limited to heart failure, unspecified dementia (1) with behavioral disturbance and generalized anxiety disorder. Resident #320's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/15/18, coded the resident's cognition as moderately impaired. Section N documented resident #320 received antipsychotic medication six out of the last seven days and antianxiety medication one out of the last seven days. Review of Resident #320's clinical record revealed a physician's order dated 3/8/18 for clonazepam (2) 0.5 mg (milligrams) twice daily as needed for anxiety. Review of Resident #320's March 2018 eMAR (electronic medication administration record) revealed the resident was administered clonazepam once on 3/11/18. The order was discontinued on 3/13/18. An order dated 3/13/18 documented to give clonazepam 0.5 mg twice daily as needed for anxiety for nine day. Review of Resident #320's March 2018 eMAR revealed the resident was not administered clonazepam from 3/13/18 through 3/16/18. This order was discontinued on 3/16/18.	F 758	clinical operations meeting to ensure facility initiated or changed orders for antianxiety and antipsychotics include supporting documentation. 4. D.O.N or designee Monitoring for antianxiety and antipsychotic medication documentation will occur four times a week for four weeks. Variances will be corrected at the time of observations, education and corrective actions will be provided as needed. Ongoing compliance will be monitored through routine audits in the clinical operations meeting and will be reported to the facility's quality assurance meeting monthly for three months.	

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A telephone order dated 3/15/18 documented, "(A triangle to indicate the word 'change') clonazepam to 0.5 mg 1 tab (tablet) po (by mouth) BID (twice daily) scheduled."
A document titled, "PRESCRIPTIONS FOR CONTROLLED MEDICATION IN LONG TERM CARE FACILITY" dated 3/16/18 documented, "DRUG: clonazepam 0.5 mg. DIRECTIONS: one tab two times a day. QUANTITY: 30. PRESCRIBER'S SIGNATURE: (Signed by ASM [administrative staff member) #4 [the nurse practitioner])..."

A computer order dated 3/16/18 documented to give clonazepam 0.5 mg twice daily for anxiety. Review of Resident #320's March 2018 eMAR revealed the resident was administered scheduled clonazepam twice a day from 3/17/18 through 3/21/18.

Resident #320's comprehensive care plan dated 3/21/18 documented, "(Name of Resident #320) displays impaired cognition as evidenced by a BIMS (Brief Interview for Mental Status) score below 13 r/t (related to) dx (diagnosis) of dementia, history of sundowning and anxiety. At risk for adverse consequences r/t use of psychotropic drug use..."

Review of the nurses' notes for Resident #320 from 3/8/18 until 3/16/18 failed to reveal documentation that Resident #320 presented with increased anxiety. As noted above, Resident #320 was only administered as needed clonazepam once on 3/11/18.

A nurse practitioner note dated 3/12/18 documented, "Psych: not anxious, not agitated, cooperative and pleasantly confused..."

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A nurse practitioner note dated 3/15/18 documented, "Psych: not anxious, not agitated, cooperative and pleasantly confused...A/P (Assessment/Plan)...6. Anxiety- Stable, continue home meds (medications) for now." The note failed to document why Resident #320's clonazepam was changed from as needed to scheduled.

On 3/22/18 at 9:45 a.m., an interview was conducted with ASM #4 (the nurse practitioner). ASM #4 was asked why Resident #320's clonazepam was changed from as needed to scheduled. ASM #4 reviewed her notes and stated, "I can't really tell from my notes but I clearly wrote a hard script and the order in the chart. I don't recall. My note doesn't really tell you. Clearly, I changed it for a reason. I would have to wonder if she was on it at home but can't see. I can't find it." ASM #4 continued to review Resident #320's clinical record. ASM #4 stated the hospital documentation of Resident #320's home medications only documented clonazepam for anxiety and did not document whether the medication was as needed or scheduled. ASM #4 was asked if she was aware if Resident #320 had presented with increased anxiety. ASM #4 stated, "She's been pretty calm overall." ASM #4 asked this surveyor if the doctors' book had been reviewed. ASM #4 stated staff writes concerns that she addresses in the doctors book. ASM #4 stated there must have been a reason she changed the resident's clonazepam from as needed to scheduled because she wrote the order in two places (on a telephone order and on the prescription for controlled medication).

Review of Resident #320's unit doctors book

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failed to reveal documentation that Resident #320 had presented with increased anxiety.

On 3/22/18 at 11:21 a.m., an interview was conducted with RN (registered nurse) #3 (Resident #320's unit manager) and ASM #5 (the clinical resource specialist). RN #3 was asked if Resident #320 had presented with increased anxiety since her admission. RN #3 stated she had not observed any increased anxiety. RN #3 stated Resident #320 did have some anxiety but she did not think this had heightened.

On 3/22/18 at 4:40 p.m., ASM #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional manager) and ASM #5 were made aware of the above concern.

The facility policy titled, "PSYCHOTROPIC MEDICATIONS" documented, "The facility will only use psychotropic therapy when appropriate to enhance the guest's quality of life, while maximizing the functional potential and wellbeing of the guest. All guests receiving psychotropic medications will be reviewed (for appropriate diagnosis, mood, mental status, and/or behavior) upon admission, quarterly, or more frequently as determined by the Behavior Management Committee..."

No further information was presented prior to exit.

(1) "Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions. Their

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personalities may change. They may become agitated or see things that are not there." 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=dementia&_ga=2.139034935.566140716.1522143307-139120270.1477942321

(2) Clonazepam is used to relieve panic attacks. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682279.html

1.b. The facility staff administered Seroquel (1) to Resident #320 without adequate indications for use.

Review of Resident #320's clinical record revealed a physician's order dated 3/8/18 for Seroquel 12.5 mg (milligrams) one time a day for Depression, to be administered at dinner. On 3/9/18 the order was revised, and documented an order for Seroquel 25mg- 0.5 tablet in the evening for dementia.

Review of Resident #320's March 2018 eMAR (electronic medication administration record) revealed the resident was administered Seroquel each day from 3/10/18 through 3/21/18.

Resident #320's comprehensive care plan dated 3/21/18 documented, "(Name of Resident #320) displays impaired cognition as evidenced by a BIMS (Brief Interview for Mental Status) score below 13 r/t (related to) dx (diagnosis) of dementia, history of sundowning and anxiety. At

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risk for adverse consequences r/t use of psychotropic drug use..."

Review of March 2018 nurses' notes failed to reveal Resident #320 presented with any psychotic behaviors that would potentially harm herself or others. The notes failed to reveal documentation of yelling, combativeness, delusions or hallucinations.

A nurse practitioner note dated 3/9/18 documented, "Psych: no agitation...A/P (Assessment/Plan)...Dementia/Anxiety-Klonopin (2), seroquel..."

A nurse practitioner note dated 3/12/18 documented, "Psych: not anxious, not agitated, cooperative and pleasantly confused..."

A nurse practitioner note dated 3/15/18 documented, "Psych: not anxious, not agitated, cooperative and pleasantly confused..."

Multiple observations of Resident #320 were conducted during the survey. The resident was pleasant during each observed interaction with staff and this surveyor.

On 3/22/18 at 9:45 a.m., an interview was conducted with ASM (administrative staff member) #4 (the nurse practitioner). ASM #4 was asked the indication for use regarding Resident #320's Seroquel. ASM #4 stated Resident #320 was on the medication while she was at the hospital. ASM #4 was asked why the medication was prescribed to Resident #320. ASM #4 stated she was not sure. ASM #4 stated sometimes if residents are admitted to the facility on those types of medications, she does not

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automatically take them off the medications because she likes to get to know the resident first. ASM #4 stated she probably would not have automatically changed Resident #320's Seroquel. When asked to describe Resident #320's behaviors, ASM #4 stated she did not know what they were. ASM #4 stated the resident was very stable at this time. ASM #4 stated Resident #320 was pleasantly confused and currently had no behavior issues. ASM #4 stated she tries "to get people off Seroquel." ASM #4 stated she slowly cuts down on residents' antipsychotic medications and she usually begins this process after a week of admission. When asked why she had not attempted this for Resident #320, ASM #4 stated, "I don't have the answer to that but that would be appropriate. She's doing well. She would be a person to be appropriate to do that." When asked what she would do in regards to Resident #320's Seroquel, ASM #4 stated she would stop the medication because the resident was on a low dose.

On 3/22/18 at 11:21 a.m., an interview was conducted with RN (registered nurse) #3 and ASM #5 (the clinical resource specialist). RN #3 was asked why Resident #320 was receiving Seroquel. RN #3 stated she would have to find out because she did not know off the top of her head. RN #3 was asked to describe Resident #320's behaviors. RN #3 stated she had personally noticed Resident #320 wanders without attempting to leave the facility, and presents with normal dementia related behaviors such as asking for the same thing and trying to transfer herself.

On 3/22/18 at 4:40 p.m., ASM #1 (the administrator), ASM #2 (the director of nursing),

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ASM #3 (the regional manager) and ASM #5 were made aware of the above concern.

No further information was presented prior to exit.

(1) "Quetiapine Seroquel) tablets and extended-release (long-acting) tablets are used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). Quetiapine tablets and extended-release tablets are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). In addition, quetiapine tablets and extended-release tablets are used with other medications to prevent episodes of mania or depression in patients with bipolar disorder. Quetiapine extended-release tablets are also used along with other medications to treat depression. Quetiapine tablets may be used as part of a treatment program to treat bipolar disorder and schizophrenia in children and teenagers. Quetiapine is in a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain...
Important warning for older adults with dementia: Studies have shown that older adults with dementia (a brain disorder that affects the ability to remember, think clearly, communicate, and perform daily activities and that may cause changes in mood and personality) who take antipsychotics (medications for mental illness) such as quetiapine have an increased risk of

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death during treatment.
Quetiapine is not approved by the Food and Drug Administration (FDA) for the treatment of behavioral problems in older adults with dementia..."

(2) Klonopin is used to treat panic attacks. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682279.html

2. The facility staff failed to provide a clinical indication for the administration of Ativan [1] (an anxiety medication) to Resident # 263.

Resident # 263 was admitted on 11/07/17 with diagnoses that included but were not limited to fractured femur (2), osteoporosis (3), dementia (4), chronic obstructive pulmonary disease (5), hypertension (6) mixed anxiety (7), gastroesophageal reflux disease (8) and depressive disorder (9).

Resident # 263's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/15/18 coded Resident # 7 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 (zero) - 15, 14 being cognitively intact for making daily decisions. Resident # 7 was coded as requiring extensive assistance of one staff member for ADLs (activities of daily living) and supervision with eating.

The "Nurse Practitioner's Note" dated 11/10/2017 for Resident # 263 and electronically signed by ASM # 4, nurse practitioner, documented in part,

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"Seeing pt (patient) today who is new to the facility and would like to have her lorazepam scheduled like at home. Further review of the note documented, "Psych: not anxious, not agitated, cooperative."

Review of the clinical record for Resident # 263 revealed a physician's order dated 11/10/17. The physician's order documented, "Drug: Ativan (1) 0.5 MG (milligram) tab (tablet). Directions: 1 (one) tab po (by mouth) @ (at) 9a (9:00 a.m.) & (and) 9p (9:00 p.m.) scheduled for anxiety. Prescriber's Signature: (ASM [administrative staff member] # 4), nurse practitioner."

The electronic medication administration record (eMAR) dated 11/01/2017 through 11/31/2017 for Resident # 263 documented, "Ativan Tablet 0.5 MG (Lorazepam) Give 1 (one) tablet by mouth two times a day for anxiety. Start Date: 11/10/2017. D/C (discontinue) Date: 11/15/2017. Further review of the eMAR revealed Resident # 263 received Ativan on 11/10/17 at 9:00 p.m. through 11/15/17 at 9:00 a.m."

The facility's POS (physician's order sheet) dated 11/15/2017 for Resident # 263 documented, "Ativan Tablet 0.5 MG (Lorazepam). Give 1 (one) tablet by mouth two times a day for anxiety. Order Status: Discontinued. Discontinued date: 11/15/2017. Ordered by: (ASM # 4)."

On 03/21/18 at 10:30 a.m., an interview was conducted with LPN (licensed practical nurse) # 1. When asked if he knew (Resident # 263) LPN #1 stated he recalled the resident. When asked if he administered Ativan 0.5 MG at 9:00 p.m. on 11/12/17, LPN # 1 stated, "Yes." LPN # 1 further stated, "After a while she (resident # 263) started

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to become lethargic and they stopped the Ativan."

On 03/22/18 at 9:35 a.m., an interview was conducted with ASM (administrative staff member) # 4, nurse practitioner. After reviewing the electronic medication administration record (eMAR) dated 11/01/2017 through 11/31/2017 for Resident # 263, her physician's order dated 11/10/17 and the "Nurse Practitioner Note" dated 11/10/17, ASM # 4 was asked what Ativan is prescribed for and why it was prescribed for Resident # 263. ASM # stated, "It's prescribed for anxiety. I usually don't prescribe Ativan but the family requested it and I prescribed it for a short period and I try to get the resident off of it." When asked how the dosage is determined for a resident, ASM # 4 stated, "I start with the lowest amount first." When asked if she would have prescribed the Ativan if the family didn't request it, ASM # 4 stated, "There must have been something, I can't recall. The family doesn't dictate what I prescribe."

On 03/23/17 at 10:35 a.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked if she was the director of nursing in November and December 2017 ASM # 2 stated, "No. I was the ADON (assistant director of nursing)." When asked what the indicated use is for Ativan, ASM # 2 stated, "Anxiety." When asked to describe the procedure for documentation regarding a resident receiving Ativan demonstrating anxious behaviors, ASM # 2 stated, "It would be documented on the nurse's daily notes, nurse's progress notes or on the POC (point of care). ASM # 2 stated the POC was the CNAs documentation on the electronic health record. Resident # 263's eMAR dated 11/01/17 through

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11/31/17, nurse's progress notes, the nurse Practitioner's notes and order for Ativan dated 11/10/17, the POCs and nurse's daily notes dated 11/07/17 through 11/30/17, were reviewed with ASM #2. ASM # 2 was then asked of there was documentation of anxiety for Resident # 263. ASM # 2 stated, "There is no documentation of anxiety." When asked if there was adequate indication, for Ativan to be prescribed and administered to Resident #263 documented in the clinical record, ASM # 2 stated, "I wouldn't think so."

The facility's policy "Psychotropic Medications" documented, "The facility will only use psychotropic therapy when appropriate to enhance the guest's quality of life, while maximizing the functional potential and wellbeing of the guest. All guest receiving psychotropic medications will be reviewed (for appropriate diagnosis, mood, mental status, and/or behavior) upon admission, quarterly or more frequently as determined by the Behavior Management Committee. The Behavior Management Committee will make recommendations for the reduction of psychotropic medications based on improvements in mood, mental status, and/or behavior." Under "Procedure" it documented, "1. All guests receiving psychotropic drugs will have an appropriate diagnosis documented in the Physician's Progress Notes and/or noted by the physician in the admission orders."

On 03/22/18 at approximately 5:30 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, ASM # 3, regional manager, were made aware of the above findings.

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No further information was provided prior to exit.

Complaint deficiency

References:
(1) Lorazepam is used to relieve anxiety. Lorazepam is in a class of medications called benzodiazepines. It works by slowing activity in the brain to allow for relaxation. Lorazepam may increase the risk of serious or life-threatening breathing problems, sedation, or coma if used along with certain medications.
This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682053.html.

(2) You had a fracture (break) in the femur in your leg. It is also called the thighbone. 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) Makes your bones weak and more likely to break.
This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/osteoporosis.html.

(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) Disease that makes it difficult to breath that

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F 758	Continued From page 141 can lead to shortness of breath) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (6) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (7) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary. (8) 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. (9) 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 758		
F 812 SS=E	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	F 812		5/4/18

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F 812	Continued From page 142 from local producers, subject to applicable State 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, and facility document review, it was determined that the facility staff failed to serve food in a sanitary manner for one of two dining rooms, the main dining room. The facility staff failed to serve food and drink to residents in a sanitary manner during a dinning observation. The findings include: On 3/20/18 at 12:12 p.m., the dining observation was conducted. At 12:35 p.m., CNA (Certified nursing assistant) #12 was observed taking a tray off the cart and removing the plate from the tray. CNA #12 grabbed the plate with her bare fingers touching the edge of the plate. CNA #12 then served this plate to a resident. CNA #12 then sanitized her hands and grabbed another plate with her bare fingers touching the edge of the plate. On 3/20/18 at 12:37 p.m., an observation of CNA #5 was conducted in the dining room. CNA #5	F 812	1. Meals in dining rooms are being served in a sanitary manner. 2. All resident have the potential to be affected by this alleged deficient practice. 3.The A.D.O.N or designee will educate the nursing staff on proper food handling techniques and hand washing hygiene. The dietary manager or designee will observe 3 meals a week for four weeks to ensure deficient practice does not occur. 4.Twice monthly for three months the A.D.O.N or Designee will observe meals to ensure proper food handling techniques and hand hygiene. Findings will be reported to the Q.A. Committee monthly for three months, any further deficient practice will result in education and or disciplinary action.	

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was observed taking a tray off the cart and removing the plate from the tray. CNA #5 then grabbed the plate with her bare fingers touching the edge of the plate. CNA #5 brought this plate to a resident. CNA #5 did not sanitize her hands before grabbing another plate with her bare fingers touching the edge of the plate and serving it to a resident. CNA #5 had long fake nails with dark green polish.

On 3/20/18 at 12:44 p.m., an observation was made of LPN (licensed practical nurse) #8 feeding a resident. LPN #8 was observed grabbing the resident's cup by the rim of the cup with her bare hands.

On 3/22/18 at 1:58 p.m., an interview was conducted with LPN #8. When asked how to maintain infection control when assisting a resident with feeding, LPN #8 stated she usually wears gloves when feeding a resident. When asked how she would hold a cup for a resident, LPN #8 demonstrated by picking up a paper cup around the bottom. When asked if it was ever ok to pick up the cup by the top rim, LPN #8 stated it was not ok because hands "may or may not be dirty." LPN #8 was made aware of the above observations.

On 3/22/18 at 4:10 p.m. and interview was conducted with CNA #5. When asked how to maintain infection control while serving residents' food in the dining room. CNA #5 stated that staff should sanitize their hands between serving residents their plates. When asked how staff should hold a plate, CNA #5 demonstrated using a plastic plate. CNA #5 held the plastic plate with her hands underneath the plate. When asked if it was ok for bare fingers to touch the edge of the

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F 812	Continued From page 144 plate, CNA #5 stated that their bare hands/fingers should never be touching the edge of the plate. When asked why bare hands should never touch the plate, CNA #5 stated, "I guess it shouldn't touch it because your hands could be dirty." CNA #5 was not aware of the above observation. On 3/22/18 at 5:26 p.m., ASM (administrative staff member) #1 the administrator, ASM #2, DON (Director of Nursing) and ASM (administrative staff member) #3 and the regional manager were made aware of the above concerns. On 3/23/18 at 11:24 a.m., OSM (other staff member) #11, medical records, stated that she did not have polices regarding serving food in a sanitary manner.	F 812		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 842		5/4/18

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F 842	Continued From page 145 (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. §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	F 842		

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F 842	Continued From page 146 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 resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to maintain a complete and accurate clinical record for four of 33 residents in the survey sample, Residents #413, #39, #45, and #263. 1. The facility staff failed to ensure other resident's information was not in Resident #413's clinical record. 2. The facility staff failed to ensure other resident's information was not in Resident #39's clinical record. 3. The facility staff failed to document the administration of treatments for Resident #45. 4. The nurse practitioner notes failed to document the discontinued psychotropic medication, Ativan (1) for Resident # 263. The findings include: 1. The facility staff failed to ensure other resident's information was not in Resident #413's clinical record.	F 842	1.Resident #39,and #413's medical records were audited and no other resident information was found. Resident #263 no longer resides in facility. Resident#45's treatments are being documented appropriately. 2.All residents have the potential to be affected by this alleged deficient practice. All residents receiving antianxiety and antipsychotic medications have the potential to be affected by this alleged deficient practice. The facility will audit the last 30 days of facility initiated or changed antianxiety and antipsychotic medications for MD and/or NP supporting documentation. 3.The A.D.O.N or Designee will educate the Medical Records employee on the facility's Medical Record Chart analysis policy. Medical Records will then educate nursing staff on filing of telephone orders and physician order sheets using the facility's chart order policy. The A.D.O.N will educate the nursing staff on properly documenting the	

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F 842	Continued From page 147 Resident #413 was admitted to the facility on 3/15/18 with diagnoses that included but were not limited to: fracture of his femur, gout, high blood pressure, history of renal cancer and diabetes. There was no MDS (minimum data set) assessment completed at the time of survey. The Nursing Admission Assessment, documented the resident was alert and oriented to time, place and person. The resident was documented as needing assistance of the staff with most of his activities of daily living. The clinical record was reviewed on 3/21/18. A copy of another resident's POS (physician order summary) was located in Resident #413's clinical record. Copies of flagged information from Resident #413's clinical record was requested on 3/21/18 at approximately 4:00 p.m. On 3/22/18 at 7:30 a.m., the copies requested were provided to this surveyor. The other resident's POS was not in the packet of papers. An interview was conducted with ASM (administrative staff member) #1, the administrator on 3/22/18 at 8:00 a.m. When informed that papers that were flagged by this surveyor in Resident #413's clinical record were not provided ASM #1 stated, "He'd go check on it." Other staff member (OSM) #11, medical records, came to this surveyor on 3/22/18 at 8:10 a.m. and stated while she was photocopying the record of Resident #413, she noticed another resident's POS in the chart. OSM #11 stated she removed	F 842	administration of treatments in the Tars. The Unit Mangers or designee 3 times a week x 4 weeks will be at one shift change to ensure nurses are looking at Tars for completion. Five times weekly in clinical operations meeting, the D.O.N or designee will review the Tars to ensure completion, any deficient practice will result in education or disciplinary action. Don or designee will in-service facility physicians on providing supporting documentation when discontinuing antianxiety medications. Don or designee will conduct quality monitoring in clinical operations meeting to ensure facility discontinued orders for antianxiety include supporting documentation. 4. The Q.A. Committee will review 10% of facility records a month for three months to ensure records are complete and have the right resident information in them. Monthly for three months the Q.A. Committee will review the 10% residents receiving treatments to ensure there are no holes on the Tars. Any deficient practice will result in additional education or disciplinary action. The DON or designee will monitor for antianxiety medication documentation four times a week for four weeks. Variances will be corrected at the time of observations, education and corrective actions will be provided as needed. Ongoing compliance will be monitored through routine audits in the clinical operations meeting and will be reported to	

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F 842	Continued From page 148 the POS and had it in her box because that paper didn't belong in Resident #413's clinical record. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3 Regional manager, ASM #5, the clinical resource specialist, were made aware of the above findings on 3/22/18 at 5:40 p.m. No further information was provided prior to exit. 2. The facility staff failed to ensure other resident's information was not in Resident #39's clinical record. Resident #39 was admitted to the facility on 1/10/18 with diagnoses that included but were not limited to: diabetes, osteomyelitis (infection in the bone) (1), pneumonia, depression, high blood pressure, peripheral vascular disease (any abnormal condition affecting blood vessels outside the heart) (2), pacemaker, and amputation of his toe. The most recent MDS (minimum data set) assessment, a change in therapy assessment, with an assessment reference date of 3/5/18, coded the resident as scoring a 12 on the BIMS (brief interview for mental status) score, indicating he was moderately impaired to make daily cognitive decisions. The resident was coded as requiring limited assistance of one staff member for most of his activities of daily living. Review of the clinical record evidenced a physician telephone order for another resident in Resident #39's clinical record. The telephone	F 842	the facility's quality assurance meeting.	

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order was for a medication, Zoloft (used to treat depression (3)) to be discontinued. This medication was not one prescribed for Resident #39.

An interview was conducted with LPN (licensed practical nurse) #4 on 3/22/18 at 9:25 a.m. The telephone order for the other resident, in Resident #39's chart, was shown to LPN #4. LPN #4 stated, "That shouldn't be there."

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 3/22/18 at 9:57 a.m. When asked who files things in the resident's charts, ASM #2 stated, "It could be the nurse practitioner or the unit clerk if a pile was given to her by the nurse practitioner." The item not belonging to Resident #39 was shown to ASM #2. When asked if the nurse took off the order shouldn't she have noticed the order was on the wrong record, ASM #2 stated, "When the nurse took off that order she should have noticed that." When asked what should have been done with the order, ASM #2 stated, "it should have been filed in the accurate chart. The nurse taking of the order should have confirmed the correct person that is in the correct chart. The nurse should not sign the order off it they have not carried off the order in (name of computer program)."

ASM #1, the administrator, ASM #2, ASM #3, the regional manager, ASM #5, the clinical resource specialist, were made aware of the above findings on 3/22/18 at 5:40 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the

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Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 423.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 447.
(3) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012108/?report=details

3. The facility staff failed to document the administration of treatments for Resident #45.

Resident #45 was admitted to the facility on 1/17/18 with a recent readmission on 2/17/18, with diagnoses that included but were not limited to: amputation below the knee on right leg, diabetes, high blood pressure, and a stroke.

The most recent MDS (minimum data set) Assessment, a Medicare 30 day assessment, with an assessment reference date of 2/12/18, coded the resident as being cognitively intact, scoring a 13 on the BIMS (brief interview for mental status) score. Resident #45 was coded requiring limited assistance of one staff member for most of his activities of daily living.

The physician orders dated, 2/28/18, documented in part:
"1. Cleanse left thigh with normal saline pat dry apply hydroform (sic) blue (Hydrofera Blue moist wound healing dressing inhibits growth of microorganisms (1)) and over with dry dressing every evening shift for wound healing.
2. Cleanse right bka (below knee amputation) with normal saline, pat dry apply meplite (sic.)

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and cover with dry dressing every evening shift for wound healing.
3. Clean right tma (third metatarsal amputation) with normal saline pat dry apply meplite (sic) and cover with dry dressing every evening."

The TAR (treatment administration record) for March 2018 documented in part,
"1. Cleanse left thigh with normal saline pat dry apply hydroform blue and over with dry dressing every evening shift for wound healing.
2. Cleanse right bka with normal saline, pat dry apply meplite (sic) (Mepitel® is a gentle, effective wound contact layer using Safetac®. The open mesh design enables good transfer of exudate to a secondary dressing and easy delivery of topical treatments (2)) and cover with dry dressing every evening shift for wound healing.
3. Clean right tma with normal saline pat dry apply meplite (sic) and cover with dry dressing every evening."

Of the 21 opportunities for documentation of treatment for all three orders above, there were nine blank spaces on each of the places for each prescribed treatment on the TAR.

The comprehensive care plan dated, 1/31/18, documented in part, "Focus: Amputation." The "Interventions" documented in part, "Wound treatments per order."

An interview was conducted with Resident #45 on 3/22/18 at 8:27 a.m. When asked if all of his dressing changes are completed every day, Resident #45 stated, "Yes, they are done daily."

An interview was conducted with RN (registered nurse) #3, the unit manager, on 3/22/18 at 1:47

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p.m. When asked what blank signature spots for a treatment (holes) on the TAR mean, RN #3 stated, "No documented, not done." The TAR for Resident #45 was reviewed with RN #3. RN #3 was informed the resident stated he was getting his dressing changes completed. RN #3 stated, "There shouldn't be any holes in the TAR."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 3/23/18 at 9:08 a.m. When asked holes on the TAR meant, ASM #2 stated, "Not documented, not done." ASM #2 then reviewed Resident #45's TAR for March.

ASM #1, the administrator, ASM #2, ASM #3, the regional manager, ASM #5, the clinical resource specialist, were made aware of the above findings on 3/22/18 at 5:40 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://www.bing.com/search?q=hydrofoam+blue+dressing&src=IE-SearchBox&FORM=IESR3N.
(2) This information was obtained from the following website: http://www.molnlycke.com.au/advanced-wound-care-products/wound-contact-layers/mepitel/#confirm

4. The nurse practitioner notes failed to document the discontinued psychotropic medication, Ativan (1) for Resident # 263.

Resident # 263 was admitted on 11/07/17 with diagnoses that included but were not limited to fractured femur (2), osteoporosis (3), dementia

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(4), chronic obstructive pulmonary disease (5), hypertension (6) mixed anxiety (7), gastroesophageal reflux disease (8) and depressive disorder (9).

Resident # 263's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/15/18 coded Resident # 7 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 (zero) - 15, 14 being cognitively intact for making daily decisions. Resident # 7 was coded as requiring extensive assistance of one staff member for activities for ADLs (activities of daily living) and supervision with eating.

The electronic medication administration record (eMAR) dated 11/01/2017 through 11/31/2017 for Resident # 263 documented, "Ativan Tablet 0.5 MG (Lorazepam) Give 1 (one) tablet by mouth two times a day for anxiety. Start Date: 11/10/2017. D/C (discontinue) Date: 11/15/2017. Further review of the eMAR revealed Resident # 263 received Ativan on 11/10/17 at 9:00 p.m. through 11/15/17 at 9:00 a.m."

The facility's POS (physician's order sheet) dated 11/15/2017 for Resident # 263 documented, "Ativan Tablet 0.5 MG (Lorazepam). Give 1 (one) tablet by mouth two times a day for anxiety. Order Status: Discontinued. Discontinued date: 11/15/2017. Ordered by: (ASM # 4)."

The "Nurse Practitioner Notes" dated 11/16/17, 11/20/17, 11/24/17 and 11/27/17 documented, "Continue all meds (medications). 4. Anxiety - ongoing: restart lorazepam (Ativan) scheduled." Further review of the nurse practitioner notes dated 11/16/2017 at 16:38 (4:38 p.m.),

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11/20/2017 at 13:13 (1:13 p.m.), 11/24/2017 at 12:35 p.m., and 11/27/2017 at 10:19 a.m. documented, Author: (ASM # 4) [e-signed] (electronically signed)."

On 03/22/18 at 9:35 a.m., an interview was conducted with ASM (administrative staff member) # 4, nurse practitioner. ASM # 4 was asked to review her notes dated 11/16/2017 at 16:38 (4:38 p.m.), 11/20/2017 at 13:13 (1:13 p.m.), 11/24/2017 at 12:35 p.m., and 11/27/2017 at 10:19 a.m. When asked about the documentation "Continue all meds (medications) 4. Anxiety - ongoing: restart lorazepam (Ativan) scheduled" ASM # 4 stated, "It's an error in documentation."

On 03/22/18 at approximately 5:30 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, ASM # 3, regional manager, were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) Lorazepam is used to relieve anxiety. Lorazepam is in a class of medications called benzodiazepines. It works by slowing activity in the brain to allow for relaxation. Lorazepam may increase the risk of serious or life-threatening breathing problems, sedation, or coma if used along with certain medications.
This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682053.html.

(2) You had a fracture (break) in the femur in your

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leg. It is also called the thighbone. 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) Makes your bones weak and more likely to break.
This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/osteoporosis.html.

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

(7) Fear.
This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.

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

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F 842	Continued From page 156 https://www.nlm.nih.gov/medlineplus/gerd.html. (9) 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 842		