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	495140	A. BUILDING _____ B. WING _____	C 10/27/2016

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GOLDEN LIVINGCENTER-ROSE HILL	110 CHALMERS COURT BERRYVILLE, VA 22611

(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 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 10/25/16 through 10/27/16. Complaints were investigated during the survey. Corrections are required for compliance with the following 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 107 at the time of the survey. The survey sample consisted of 20 current resident reviews (Residents #1 through #19 and # 28) and eight closed record reviews (Residents #20 through #27).

F 151 SS=D 483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL

F 151

The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.

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 allow a resident to exercise his rights for one of 28 residents in the survey sample, Resident #25.

Resident #25 was made to sign out of the facility AMA (against medical advice) when he requested to go to the emergency room on 9/30/15 because the physician felt the transfer was unnecessary.

Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of corrections prepared ad executed as a means to continuously improve quality of care and to comply with all applicable State and Federal regulatory requirements.

1. Resident #25 was discharged from the facility
2. All residents who desire to seek outside medical services have the potential to be affected by this practice.
3. All staff, including the Medical Director and Nurse Practitioner, will be in-serviced regarding the AMA policy and residents' rights by the Executive Director.
4. The Executive Director will review all AMAs and ensure no resident rights were violated during the process of the discharge for the next three months. All findings will be reported to QAPI.

November 18, 2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Reid Schuler, LNHA	EXECUTIVE DIRECTOR	11/15/16

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

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Resident #25 was not permitted readmission to the facility because he had signed out AMA.

The findings include:

Resident #25 was admitted to the facility on 9/5/15. Resident #25's diagnoses included but were not limited to: diabetes (1), bipolar disorder (2) and peripheral vascular disease (3). Resident #25's admission MDS (minimum data set) with an ARD (assessment reference date) of 9/12/15 coded the resident as being cognitively intact. Resident #25 was discharged from the facility on 9/30/15.

Review of Resident #25's clinical record revealed a nurse's note dated 9/30/16 that documented, "Situation: Resident and wife requested to call the MD (medical doctor) and go to the hospital. MD didn't want to send Resident out so wife and resident signed AMA (against medical advice) papers.

Background: Resident is S/P (status post) MRSA (4) to Coxxyx (5) (sic) wound. Resident is AXOX3 (alert and oriented times three) AND is a FULL Code. Resident has a colostomy (6) and a catheter (7) that is draining clear yellow urine... Assessment: Residents VS (vital signs) were bp (blood pressure) - 160/70 P (pulse) - 96 T (temperature) - 99.7 R (respirations) - 12. Resident was in bed. Resident rang to inform nursing staff that there was bowel in his wound. Which NP (nurse practitioner) assessed earlier that day. Nurse cleaned wound out with a saline solution and gauze and packed with (topical medication) and gauze. the (sic) wound was pink with no foul odor or necrotic tissue. Residents wife then told nurse and aide that she wanted to

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send resident to hospital for the stool that's coming out rectally but resident refused. Nurse went out to nurses station and wife then came and told nurse that resident wanted to go to hospital. Nurse confirmed with resident and then called (name of nurse practitioner). (Name of nurse practitioner) stated that she had just saw resident earlier that day and that she told him that she wasn't worried about the stool he had coming out rectally. (Name of nurse practitioner) then told me to call (name of physician). I called Doc (doctor) (name of physician) and he stated 'I do not recommend he goes, make him sign an AMA and call 911.' Nurse went into the room with (name) (another nurse) with an AMA form and explained that with them signing the paper it will state that you will be sending him against medical Advice and you will not be able to return to facility. Wife stated that 'yea yea I know and if I have to pay for the ambulance ride I will, I just want him to be checked out.' Nurse received signature from resident and wife and 2 nurses. Nurse then Called 911 at 2015 (8:15 p.m.) and at 2020 (8:20 p.m.) 911 arrived and resident was transported via ambulance to (name of hospital) at 2030 (8:30 p.m.)..."

A note dated 9/30/16 and signed by the former director of nursing documented, "Received phone call from (name of nurse who signed the above note), LPN (licensed practical nurse), stating resident wife had insisted on taking resident to ER (emergency room) to evaluate bowel leakage. States she notified NP who stated she had already discussed this with resident and wife and nurse would need to call (name of physician). States (name of physician) felt there was not a reason to send resident 911 to the hospital and stated it would need to be AMA. States resident

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stated he did not want to go to the ER. States wife to nurses station and stated he now wanted to go. States resident verified. States she and second nurse explained AMA process and wife stated, 'yeah I know all that' and she and resident both signed the form. States 911 was called and resident sent to ER. States hospital now wanting to send resident back and she is trying to explain that he has been discharged AMA. ER physician requesting phone call from DNS (director of nursing services). PC to (name of hospital) and spoke with (name of hospital physician). Explained resident signed out AMA and has been discharged."

The AMA form dated 9/30/15 and signed by Resident #25, the resident's wife, two nurses and the nurse practitioner documented, "Release of responsibility for discharge Against Medical Advice- I, the undersigned, hereby acknowledge that I have been informed of the risk and probable consequences of leaving (name of facility) against medical advice and/or without a physician's discharge order. I hereby assume all responsibility for the care and custody of myself or the following resident and hereby release (name of facility), its employees and/or agents from all responsibility whatsoever for any problematic or unfavorable effects which may result from this action."

The nurse who documented the 9/30/15 nurse's note was no longer employed at the facility.

The former director of nursing who documented the 9/30/15 note was no longer employed at the facility.

On 10/26/16 at 4:05 p.m., an interview was

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conducted with ASM (administrative staff member) #5 (the nurse practitioner). ASM #5 stated she didn't recall specific information regarding Resident #25's discharge on 9/30/15. ASM #5 stated at the time, the policy was unclear regarding patient's rights versus sending a resident to the hospital AMA. ASM #5 stated she thought shortly after Resident #25's discharge, the policy became more clear and sending a resident to the ER (emergency room) when the physician felt it wasn't necessary was considered to be the resident's right and wasn't AMA. ASM #5 stated in the past, prior to Resident #25's discharge, she was told if the resident wanted to go to the ER and she didn't think the transfer was necessary then the discharge was AMA. ASM #5 stated now, the resident is sent to the ER when requested and the discharge is not considered AMA.

On 10/26/16 at 4:30 p.m., a telephone interview was conducted with ASM #3 (Resident #25's physician and the physician referenced in the 9/30/15 nurse's note). ASM #3 stated he didn't remember Resident #25 or the details regarding his discharge. ASM #3 stated usually if a resident wants to go to the ER then the physicians respect their wishes. ASM #3 stated he typically sends residents to the ER when requested and doesn't make residents sign out AMA.

On 10/26/16 at 6:50 p.m., ASM #1 (the current administrator [not employed when Resident #25 was discharged]), ASM #2 (the current director of nursing [nursing supervisor at the time of Resident #25's discharge]) and ASM #4 (the regional nurse) were made aware of the above findings. The administrative staff was asked to provide more information to explain why Resident

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#25 was made to sign out AMA to go to the emergency room.

On 10/27/16 at 9:45 a.m., ASM #1 and ASM #2 was asked to provide any further information regarding Resident #25 being made to sign out of the facility AMA to seek medical attention from the emergency room. ASM #1 stated, "That's not how it's normally done. The resident has a right to seek outside services; go to the hospital and be readmitted." ASM #2 stated there was a discussion amongst administrative staff regarding the matter at the time of Resident #25's discharge and she held the same opinion that she currently does. ASM #2 stated she felt a resident who requests to be sent to the ER when the attending physician does not agree should not be made to sign out AMA and should be readmitted.

The facility policy titled, "AMA Release" documented, "PROCEDURE PURPOSE: To complete the required information whenever a demand is made by a resident (or his/her legal representative) to leave or to be discharged from the nursing facility before the completion of treatment or contrary to the advice of the attending physician. DEFINITION: AMA=Against Medical Advice. PROCEDURE: 1. When a resident or the resident's legal representative expresses the desire to leave the nursing facility before the attending physician has discharged the resident: a. Notify the attending physician. b. Notify the administrator. c. Notify the Director of Nursing Service. d. Notify the resident's legal representative. 2. The attending physician is to give the resident or his/her legal representative information concerning the risks involved in leaving the facility..."

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The facility policy titled, "Resident Rights" documented, "The Resident has a right to a dignified existence, self-determination, and communication with, and access to, persons and services inside and outside the Facility. The Resident has a right to exercise his or her rights as a Resident of the Facility and as a citizen or resident of the United States. The Resident has the right to be free of interference, coercion, discrimination, or reprisal from the Facility in exercising his or her rights...The Resident has the right to participate in planning his or her care and treatment or changes in care an (sic) unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State...The Resident has the right to immediate access to any of the following: c. The Resident's individual physician..."

No further information was presented prior to exit.

(1) "Diabetes is a disease in which your blood glucose or blood sugar levels are too high..." This information was obtained from the website: https://medlineplus.gov/diabetes.html
(2) "Bipolar disorder is a serious mental illness. People who have it go through unusual mood changes..." 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=bipolar&_ga=1.56859114.139120270.1477942321
(3) "Peripheral artery disease (PAD) (also known as peripheral vascular disease) is a condition of the blood vessels that supply the legs and feet. It leads to narrowing and hardening of the arteries. This causes decreased blood flow, which can injure nerves and other tissues..." This

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information was obtained from the website: https://medlineplus.gov/ency/article/000170.htm

(4) "MRSA stands for methicillin-resistant Staphylococcus aureus. It causes a staph infection (pronounced "staff infection") that is resistant to several common antibiotics." 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=mrsa&_ga=1.63468015.139120270.1477942321

(5) "The tailbone (coccyx) is the small bone at the bottom of your backbone, or spine." 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=coccyx

(6) "A colostomy is a stoma created from a part of the colon. For this surgery, the surgeon brings the colon through the abdominal wall and makes a stoma. A colostomy may be temporary or permanent. The colostomy is permanent when the surgeon removes or bypasses the lower end of the colon or rectum. A surgeon may perform a temporary colostomy for a damaged or an inflamed lower part of the colon or rectum that only needs time to rest or heal from injury or surgery. Once the colon or rectum heals, the surgeon repairs the opening in the abdominal wall and reconnects the colon so stool will pass normally. A surgeon performs a colostomy most often to treat rectal cancer, diverticulitis, or fecal incontinence--the accidental loss of stool." This information was obtained from the website: https://www.niddk.nih.gov/health-information/health-topics/digestive-diseases/ostomy-surgery-bowel/Pages/ez.aspx#sec6

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F 151	Continued From page 8 (7) "A urinary catheter is a tube placed in the body to drain and collect urine from the bladder." This information was obtained from the website: https://medlineplus.gov/ency/article/003981.htm	F 151		
F 154 SS=D	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and in the course of a complaint investigation it was determined that the facility staff failed to notify the resident or power of attorney (POA) of an evaluation for one of 28 residents in the survey sample, Resident # 26. Facility staff failed to notify resident and or the POA of a psychological evaluation for Resident # 26. The findings include: Resident # 26 was admitted to the facility on 10/15/15 with diagnoses that included but were not limited to: cancer, hypertension (1), gastroesophageal reflux disease (2) and dysphagia (3).	F 154	1. Resident #26 has been discharged from the facility 2. An audit will be conducted of residents with a psychological evaluation scheduled for the past 7 days to ensure notification of the resident or POA 3. License nurses will be re-educated regarding notifying the resident and/or the POA of a psychological evaluation when scheduled 4. Director of Nursing/designee will validate daily with clinical start up meeting that the Resident or POA notifications are completed for psychological evaluations. The executive director will attend the meeting 2 x weekly for 4 weeks to audit the process.	

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The nursing admission assessment dated 10/15/15 documented Resident # 26's cognitive function as "Intermittent confusion".

The most recent MDS (minimum data set), a five day assessment with an ARD (assessment reference date) of 10/20/15 coded Resident # 26 coded requiring limited to extensive assistance of one staff member for activities of daily living.

The "Admission Record" for Resident # 26 documented, (Name of Spouse) as the power of attorney (POA).

Review of the clinical record for Resident # 26 revealed a "Psychological Evaluation" dated 11/5/2015 and signed by [Name of OSM (other staff member) # 8], consultant clinical psychologist dated 11/5/2015.

Review of the facility's "Progress Notes" dated 10/15/2015 through 12/15/2015 failed to evidence documentation of the POA being notified of the psychological evaluation for resident # 26.

On 10/26/16 at 9:30 a.m., an interview was conducted with RN (registered nurse) # 1, assistant director of nursing. RN $#1 was asked about the process of notifying the POA of a service from an outside consulting psychologist. RN # 1 sated, "We would consult with the family or POA and see if they would mind being referred to the facility's consulting psychologist. If they don't mind, we would make the referral and the physician or the nurse practitioner would review the resident and write an order for the referral." When asked if Resident # 26 or the POA was notified of the psychological evaluation prior to it

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being conducted RN # 1 stated, "No."

On 10/26/16 at 11:30 a.m. an interview was conducted with ASM (administrative staff member # 2, the director of nursing. When asked if Resident # 26 or the POA was notified of the psychological evaluation prior to it being conducted ASM # 2 stated, "Not to my knowledge."

The facility's policy "Notification of Change in Resident Health Status" documented, "The center will consult the resident's physician, nurse practitioner or physician assistant, and if known notify the resident's legal representative or an interested family member when there is: (C) A need to alter treatment significantly (i.e. a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment)."

On 10/27/16 at approximately 2:30 p.m. ASM (administrative staff member) # 1 the administrator, was made aware of the findings.

No further information was provided prior to exit.

Reference:

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

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

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F 154	Continued From page 11 (3) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.	F 154		
F 157 SS=E	Complaint Deficiency 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157	1. Resident #6's physician was notified of refusing insulin for one month. Resident #13's physician was notified for refusing OxyContin 20 mg. Resident #2's physician was notified that the facility did not obtain a lab specimen. Resident #17's physician was notified that the facility did not obtain an orthostatic blood pressure. 2. An audit will be conducted of residents with a documented change in condition, refusal of medication, unavailability of medications, failure to obtain laboratory specimens, and failure to conduct ordered assessments for the past 7 days to ensure notification of physician and responsible party. 3. License nurses will be re-educated regarding physician and responsible party notification of changes in condition, refusal of medication, unavailability of medications, failure to obtain laboratory specimens, , and failure to conduct ordered assessments.	

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legal representative or interested family member.

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 notify the physician for a change in condition for four of 28 residents in the survey sample, Residents #6, #13, #2, and #17.

1. The facility staff failed to notify the physician of Resident #6 refusing her insulin for one month.

2. For Resident #13, facility staff failed to notify the physician when OxyContin 20 mg (1) (milligrams) was not available to be administered on 7/16/16.

3. Facility staff failed to notify the physician that the physician ordered laboratory specimen for clostridium difficile (1) was not obtained for Resident #2.

4. Facility staff failed to notify the physician that the physician ordered orthostatic blood pressures were not obtained for Resident #17.

The findings include:

1. Resident #6 was admitted to the facility on 11/2/15 with diagnoses that included but were not limited to: stroke, adult failure to thrive, diabetes, high blood pressure, Parkinson's disease, and depression. The resident was on hospice care as of 8/8/16.

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

4. Director of Nursing/designee will validate daily with clinical start up meeting that physician and responsible party notifications are completed for changes in conditions, medications not administered or available, physician ordered parameters, failure to obtain laboratory specimens, failure to conduct required assessments, and room change. The executive director will attend the meeting 2 x weekly for 4 weeks to audit the process.

November 18, 2016

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with an assessment reference date of 8/8/16, coded the resident as being severely impaired to make cognitive daily decisions. Resident #6 was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which she required supervision after set up assistance was provided.

The physician order dated, 4/20/16, documented, "Levemir (insulin used to treat diabetes (1)) Flex-Pen Solution 100 Unit/ML (milliliter); inject 15 units subcutaneously at bedtime related to Type 2 Diabetes Mellitus."

The September 2016 MAR (medication administration record) documented, "Levemir Flex-Pen Solution 100 Unit/ML; inject 15 units subcutaneously at bedtime related to Type 2 Diabetes Mellitus." In September the insulin was documented as being refused on 28 out of 30 days. The MAR documented her fasting blood sugars, on the days the resident did not refuse the insulin as, within the: 87- 155 range.

The normal blood sugar levels for people who do not have diabetes are: between 70 and 130 mg/dL (milligrams per deciliter) before meals and less than 180 mg/dL at two hours after meals." (2)

The October 2016 MAR documented, "Levemir Flex-Pen Solution 100 Unit/ML; inject 15 units subcutaneously at bedtime related to Type 2 Diabetes Mellitus." In October the insulin was documented as being refused on 24 of 25 days. The MAR documented her fasting blood sugars, on the days the resident did not refuse the insulin as with in the: 102 - 254 range.

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The comprehensive care plan dated, 11/2/15, and revised on 10/5/16, documented, "Focus: Alteration in blood Glucose (sugar) due to: Insulin Dependent Diabetes Mellitus. Frequent refusals of medication including anti-diabetic medications." The "Interventions" documented in part, "Administer medications as ordered. Notify hospice for medication review and discontinuing d/t (due to) comfort."

The nurse's notes dated 9/29/16 at 2:37 p.m. documented, "Residents family is aware of medication refusal, (administrative staff member #5, the nurse practitioner) aware and stated Hospice would need to d/c (discontinue) meds (medications) if decided. Updated social worker about residents continued refusals." There was no further documentation of speaking to hospice or to the nurse practitioner.

An interview was conducted with LPN (licensed practical nurse) #6 on 10/26/16 at 12:25 p.m. When asked if a resident refuses a medication, what is expected of the nurse, LPN #6 stated, "They should at least try three different times. They should document the refusal. Depends on how often they refuse, I'd want to notify the doctor and RP (responsible party)." When asked what would be done if a resident had continuously refused insulin since the end of September, LPN #6 stated, "We need to notify the nurse practitioner and hospice to get a solution." When asked if you would continue to notify them of each refusal, LPN #6 stated, "Yes, the nurse practitioner or doctor needs to be continuously aware of the situation."

An interview was conducted with administrative staff member (ASM) #5, the nurse practitioner, on

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10/26/16 at 3:00 p.m. When asked if the nurses should notify her in the event a resident refuses their medications, ASM #5 stated, "Yes, but not every day." When asked what would be done if a resident refuses their insulin on a daily basis, ASM #5 stated, "That's a different situation." When asked if she was aware that Resident #6 had refused her insulin almost on a daily basis since the end of September, ASM #5 stated she was not aware that it (insulin) had not been given in the past month.

An interview was conducted with ASM #2, the director of nursing, on 10/26/16 at 3:10 p.m. When asked what actions a nurse takes if a resident refuses their medications, ASM #2 stated, "It's very individualized. It depends on the medication. I expect them to re-approach later. They can offer a different times schedule if okay with the doctor." When asked what would be done if a resident refuses insulin on a daily basis, ASM #2 stated, "That's a more timely matter. If they refuse every day we should be notifying the doctor or nurse practitioner. Depending on the resident it could be life threatening and the resident's safety is at risk."

The facility policy, "Notification of Change in Resident Health Status" documented in part, "Guideline Statement: To ensure that proper notifications are made when a resident has a change in health status. Definitions (As needed): Immediate: As soon as possible no longer than 24 hours. The center will consult the resident's physician, nurse practitioner or physician assistance, and if known notify the resident's legal representative or an interested family member when there is: A. An accident which results in injury and has the potential for requiring

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physician intervention. B. Acute illness or a significant change in resident's physical, mental, or psychosocial status (i.e. deterioration in health, mental, psychosocial status in either life-threatening conditions or clinical complications). C. A need to alter treatment significantly (i.e. a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment)."

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.
The ASM #1, the administrator, ASM #2, the director of nursing, ASM #4, the regional nurse consultant, and RN (registered nurse) #1, the assistant director of nursing, were made aware of the above findings on 10/26/16 at 4:15 p.m.
No further information was provided prior to exit.
(1) This information was obtained from the following website:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d38d65c1-25bf-401d-9c7e-a2c3222da8af
(2) This information was obtained from the following website:
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0024698/
2. For Resident #13, facility staff failed to notify

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the physician when OxyContin 20 mg (1) (milligrams) was not available to be administered on 7/16/16.

Resident #13 was admitted to the facility on 11/12/14 and readmitted on 1/19/16 with diagnoses that included but were not limited to anterior dislocation of the left humerus, atherosclerotic heart disease, dementia without behavioral disturbance, hypertension and osteoarthritis. Resident #13's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 8/15/16. Resident #13 was coded as being cognitively intact in the ability to make daily decisions scoring 13 out of 15 on the BIMS (brief interview for mental status) exam. Resident #13 was coded as requiring extensive assistance from staff with transfers, dressing, and personal hygiene; and total dependence on staff with bathing.

Review of Resident #13's clinical record revealed the following physician order signed by the NP (Nurse Practitioner) dated 7/15/16, "OxyCONTIN Tablet ER 12 Hour Abuse-Deterrent 15 MG (milligrams) ...Give 1 tablet by mouth two times a day for pain management...discontinue dated 7/15/16. "

The following order was put into place on 7/15/16, "OxyCONTIN Tablet ER 12 hour Abuse-Deterrent 20 MG (milligrams) Give 1 tablet by mouth two times a day for pain management."

Review of Resident #13's July 2016 eMAR (electronic medication administration record) revealed that on 7/16/16, Resident #13's 9 a.m. scheduled dose of OxyContin was not

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administered. It was documented that his pain level was a zero at 9 a.m. Further review of the eMAR revealed that resident #13's pain had increased to a level of "7" on a scale from 1-10 (with 10 being the worst pain) the following shift at 9 p.m. Further review of the EMAR documented that OxyContin 20 mg was administered on 7/16/16 at 9 p.m.

Review of the narcotic logs for both the OxyContin 15 mg and the OxyContin 20 mg revealed that Resident #13 did not receive any scheduled OxyContin for 7-3 and 3-11 shifts on 7/16/16.

Review of Resident #13's clinical record revealed the following nurse's note dated 7/16/16 at 12:30 p.m., "OxyContin Tablet ER (extended release) 12 Hour Give 1 tablet by mouth two times a day for pain management...not available unable to get from (Name of pharmacy) EKIT (emergency kit).

Review of (Name of pharmacy's) EKIT documented that the following medication was in the EKIT, "OXYCONTIN TAB 20 MG CR (continuous release)."

There was no evidence that the physician was notified for both occasions on 7/16/16 that Resident #13's OxyContin was not administered.

On 10/26/16 at 1:00 p.m., an interview was conducted with LPN (licensed practical nurse) #2, regarding the process followed if a narcotic for a resident is not available on the medication cart. LPN #2 stated, "We call the pharmacy to see if they can send the medication. If we need a script we will call the MD (medical doctor) or NP (nurse practitioner). Once we have the hard script we

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can pull the medication from the EKIT by using a code pharmacy gives us." When asked the process if the EKIT does not have the medication she stated, "The EKIT always has the medication but you would call the pharmacy and ask them to send STAT (immediately). The pharmacy may even call the backup pharmacy to send to us." LPN #2 stated that if for some reason there is no possible way to get the medication, the medical doctor should be notified to see if the MD wants to write a new order.

On 10/26/16 at 2:15 p.m., an interview was conducted with LPN #1. When asked what process is followed if a narcotic for a resident is not available on the medication cart. LPN #1 stated, "If there is no medication, I would assume there is no script (prescription). You would call MD to sign the script, call pharmacy and pull from the EKIT. If you cannot get the medication from the EKIT, backup pharmacy would send to the facility STAT." LPN #1 stated if the medication cannot be given, the medical doctor should be notified and a progress note should be written explaining the situation. When asked if CR (continuous release) was the same as ER (extended release) she stated, "Yes."

On 10/27/16 at 10:35 a.m., an interview was conducted with OSM (other staff member) #10, the pharmacist. OSM #10 stated that there was no evidence that the OxyContin was requested from the EKIT on 7/16/16. OSM #10 stated that pharmacy did not receive a hard script for the medication until 7/17/16.

The pharmacy sent over a copy of the hard script dated 7/17/16 for this writer on 10/27/16.

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The nurse who worked 7/16/16 during the 7-3 shift no longer works at the facility and could not be reached for an interview.

On 10/27/16 at 1:30 p.m., an interview was conducted with Resident #13. Resident #13 could not recollect a time where his pain medication was not available. He could not recollect a time where he was sitting in pain for extended periods without relief.

On 10/27/16 at 2:20 p.m., a telephone interview was conducted with RN (registered nurse) #7, the nurse who documented OxyContin 20 mg was administered on 7/16/16 3-11 shift when it was not administered. RN #7 stated that it is never ok to document that a medication was given when it was not. RN #7 could not recollect that day.

On 10/27/16 at 11:20 a.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

Facility policy titled, "Notification of Change in Resident Health Status" did not address the above concerns.

No further information was presented prior to exit.

(1) OXYCONTIN is indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setid=BFDFE235-D717-4855-A3C8-A13D26DADEDE.

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3. Facility staff failed to notify the physician that the physician ordered laboratory specimen for clostridium difficile (1) was not obtained for Resident #2.

Resident #2 was admitted to the facility on 5/24/16 and readmitted on 6/18/16 with diagnoses that included but were not limited to: pneumonia, depression, elevated cholesterol, diabetes and irregular heartbeat.

The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 7/21/16 coded the resident as being able to understand others and make his needs known. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the physician's order dated and signed on 6/24/16 documented, "C-Diff (clostridium difficile) Cx (culture) X (times) 3 on 3 separate days."

Review of the care plan did not evidence documentation regarding the need for the clostridium difficile.

Review of the May 2016 treatment administration record did not evidence documentation regarding the clostridium difficile order.

Review of the laboratory specimens documented that the resident had a clostridium difficile specimen obtained on two occasions, 6/24/16 and 6/27/16. There was no documentation that the third specimen had been obtained as ordered and no documentation evidencing the physician was notified.

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Review of the bowel and bladder detail report for June 2016 documented that Resident #2 was incontinent of bowel movements on 6/28/16, 6/29/16 (twice) and 6/30/16.

An interview was conducted on 10/27/16 at 11:55 a.m. with LPN (licensed practical nurse) #9. When asked the process staff follow if they are not able to obtain a laboratory specimen for clostridium difficile as ordered by the physician, LPN #9 stated, "If we can't get a stool or if it's not liquid then we let the doctor know and get a d/c (discontinue) order."

An interview was conducted on 10/27/16 at 2:45 p.m. with RN (registered nurse) #1, the assistant director of nursing. When asked if staff would notify the physician when they could not obtain the clostridium difficile specimen, RN #1 stated, "Well we didn't document it."

On 10/26/16 at 7:00 p.m. ASM (administrative staff member) #1, the administrator and ASM #2 were made aware of the findings.

No further information was obtained prior to exit.

(1) Clostridium difficile, the leading cause of hospital-acquired diarrhea, is known to cause severe colitis. This information was obtained from:
https://www.ncbi.nlm.nih.gov/pubmed/17390162

4. Facility staff failed to notify the physician that the physician ordered orthostatic blood pressures (1) were not obtained for Resident #17.

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Resident #17 was admitted to the facility on 8/21/09 with diagnoses that included but were not limited to: irregular heartbeat, kidney failure, anemia, depression and arthritis.

The most recent MDS, a quarterly assessment, with an ARD of 10/10/16 coded the resident as having 15 out of 15 on the brief interview for mental status indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance for activities of daily living except for eating which the resident could do independently after the meal tray was prepared.

Review of the physician's orders for 8/16/16 documented, "Orthostatic vital signs QD (every day) one time a day. -Order Date- 8/16/16 -D/C- Date 8/27/16."

Review of the August 2016 treatment administration record documented, "Orthostatic vital signs QD (every day) one time a day. -Order Date- 8/16/16 -D/C- Date 8/27/16." On 8/16/16 no blood pressures were documented. On 8/17/16 through 8/28/16 one blood pressure was documented each day not the three blood pressures that are required for obtaining orthostatic blood pressures.

Review of the nurse's notes for 8/16/16 through 8/27/16 did not evidence documentation related to the orthostatic blood pressures.

An interview was conducted on 10/26/16 at 1:40 p.m. with LPN #8. When asked what was included in obtaining orthostatic blood pressures, LPN #8 stated, "You take a lying, sitting and standing blood pressure." When asked if the

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physician would be notified if the blood pressures were not obtained, LPN #8 stated that she would notify the physician and would document that in her nurse's notes.

An interview was conducted on 10/16/16 at 1:45 p.m. with LPN #3. When asked what was included in obtaining orthostatic blood pressure, LPN #3 stated, "You take the blood pressure sitting up, standing and lying down." When asked if the physician would be notified if the blood pressure were not obtained, LPN #3 stated, "Yes. I would write a progress note so you can get a picture of what I did."

On 10/16/16 at 5:00 p.m. ASM #1 and ASM #2 were made aware of the findings.

No further information was provided prior to exit.
1) Orthostatic hypotension is a sudden fall in blood pressure that occurs when a person assumes a standing position. This information was obtained from: http://www.ninds.nih.gov/disorders/orthostatic_hypotension/orthostatic_hypotension.htm
Measuring Orthostatic Blood Pressure. 1. Have the patient lie down for 5 minutes. 2. Measure blood pressure and pulse rate. 3. Have the patient stand. 4. Repeat blood pressure and pulse rate measurements after standing 1 and 3 minutes. This information was obtained from: http://www.cdc.gov/steadi/pdf/measuring_orthostatic_blood_pressure-a.pdf

F 164 SS=D — 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS — F 164

The resident has the right to personal privacy and confidentiality of his or her personal and clinical

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records.

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, resident interview, clinical record review, review of facility documentation and in the course of a complaint investigation it was determined that the facility staff failed to maintain a resident's personal and medical information in a confidential manner for one of 28 residents in the survey sample, (Resident # 26); and failed to maintain personal privacy during medication administration for for one of 28 residents in the survey sample,

1. Resident #26 has been discharged from the facility. Resident #28's medication administration has been noted, responsible party and MD notified

2. All doors will be locked when administrative staff leaves. All visitors must sign in, and a sign out sheet will be created and utilized when other departments or consulting clinicians need to remove a patients' medical chart for review. The nurses on duty will monitor the sign out sheet daily. The ADNS/designee will review a med pass with all current Licensed Nursing staff to ensure visual privacy was accomplished when administering meds.

3. All staff will be educated on the HIPPA policy including during medication pass.

4. Executive Director or designee will validate daily in stand up that the sign out sheet is being followed correctly for 4 weeks, Then monthly for 2 months. The ADNS/designee will conduct med pass observations weekly for all shifts for X 4 weeks. Then monthly for all shifts for 2 X months. All findings will be documented in QAPI.

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Resident # 26

1. Facility staff failed to maintain Resident # 26's personal and medical information in a confidential manner during a psychological evaluation that was not ordered by the physician.

2. Facility staff failed to provide full visual privacy to Resident #28 when administering insulin in his abdomen.

The findings include:

1. Resident # 26 was admitted to the facility on 10/15/15 with diagnoses that included but were not limited to: cancer, hypertension (1), gastroesophageal reflux disease (2) and dysphagia (3).

The nursing admission assessment dated 10/15/15 documented Resident # 26's cognitive function as "Intermittent confusion."

The most recent MDS, a five day assessment with an ARD (assessment reference date) of 10/20/15 coded Resident # 26 coded requiring limited to extensive assistance of one staff member for activities of daily living.

The "Admission Record" for Resident # 26 documented, (Name of Spouse) as the power of attorney (POA).

Review of the clinical record for Resident # 26 revealed a "Psychological Evaluation" dated 11/5/2015 and signed by [Name of OSM (other staff member) # 8], consultant clinical psychologist dated 11/5/2015. Further review of the psychological evaluation revealed Resident #

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26's date of admission to the facility, name of the facility, date of birth, sex, diagnoses, family and social history, general appearance, cognition, and psychomotor activity (4).

Review of the clinical record failed to evidence a physician's order for a psychological evaluation for Resident # 26.

Review of the facility's "Progress Notes" dated 10/15/2015 through 12/15/2015 failed to evidence a note for a physician's order for a psychological evaluation for Resident # 26.

On 10/26/16 at 9:30 a.m., an interview was conducted with RN (registered nurse) # 1, assistant director of nursing. When asked how the facility ensures a resident's personal and medical information is protected, RN # 1 stated, "The resident's clinical records are kept behind the nurse's station." When asked about outside consults having access to a resident's medical and personal information, RN # 1 stated, "If the consultant does not have an order to evaluate and treat they have no need to review a resident's clinical record, it's protected by HIPAA (Health Insurance Portability and Accountability Act)." RN # 1 further stated, "We expect the outside contracted professionals to follow professional standards in respect to HIPAA." When asked if Resident # 26's personal and medical information was kept confidential, RN # 1 stated, "No." When asked if (Name of Clinical Psychologist) who conducted the psychological evaluation on 11/5/2015 for Resident # 26 was still conducting psychological evaluations in the facility, RN # 1 stated, "(Name of Clinical Psychologist) and (Name of Psychological Consulting Group) is no longer contracted with the facility."

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On 10/26/16 at 10:50 a.m. an interview was conducted with LPN (licensed practical nurse) # 3 regarding the confidentiality of a resident's personal and medical information. When asked how the facility ensures a resident's personal and medical information is protected, LPN # 3 stated, "We don't have a whole process that I'm aware of." LPN # 3 further stated, "If there isn't an order, the consultant does not have the right to look at any resident's record." When asked if she recalled Resident # 26 or the psychological evaluation that was done, LPN # 3 stated, "I don't recall him or the evaluation being done."

On 10/26/16 at 11:30 a.m. an interview was conducted with ASM (administrative staff member) # 2, the director of nursing. When asked how the facility ensures a resident's personal and medical information is protected, ASM # 2 stated, "A staff person is at the nurse's station at all times." When asked if Resident # 26's personal and medical information was protected when (Name of Clinical Psychologist) conducted an evaluation without a physician's order, ASM # 2 stated, "No, I don't feel the consultant didn't act in a professional manner in regard to the HIPAA regulations." ASM # 2 further stated that if there wasn't a physician's order they should have not accessed the resident's clinical record. When asked if (Name of Clinical Psychologist) who conducted the psychological evaluation on 11/5/2015 for Resident # 26 was still conducting psychological evaluations in the facility, ASM # 2 stated, "(Name of Clinical Psychologist) and (Name of Psychological Consulting Group) is no longer contracted with the facility."

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The facility's policy "Resident Rights" documented, "The Resident has the right to personal privacy and confidentiality of his or her personal and clinical records ...The Resident may approve or refuse the release of personal and clinical records to any individual outside the facility except when a. The Resident is transferred to another health care institution; b. Record release is required by law or by third party payment contract."

On 10/25/16 at approximately 1:40 p.m. ASM (administrative staff member) # 1, the administrator, provided a document titled "Your Resident rights and Protection Under State and Federal Law." It documented, "RECORDS. Confidentiality of Records. You have the right to confidentiality of your personal and clinical records. You may approve or refuse the release of your personal and clinical records to any individual outside the nursing home unless you are transferred to another health care institution or record release is required by law or third-party payment contract."

On 10/27/16 at approximately 2:30 p.m. ASM (administrative staff member) # 1 the administrator, was made aware of the findings.

No further information was provided prior to exit.

Reference:

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

(2) Stomach contents to leak back, or reflux, into

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the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(3) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

(4) Of or relating to motor action directly proceeding from mental activity. This information was obtained from the website: http://www.merriam-webster.com/dictionary/psychomotor.

(5) The HIPAA Privacy Rule establishes national standards to protect individuals ' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patient's rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections. Complaint Deficiency. This information was obtained from the website: https://www.hhs.gov/hipaa/for-professionals/privacy/

COMPLAINT DEFICIENCY

2. Facility staff failed to provide full visual privacy to Resident #28 when administering insulin in his

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abdomen.

Resident #28 was admitted to the facility on 12/11/15 and readmitted on 3/30/16 with diagnoses that included but were not limited to: diabetes, high blood pressure, traumatic brain injury, depression and psychosis.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 7/14/16 coded the resident as scoring15 out of 15 on the brief interview for mental status indicating the resident was cognitively intact to make daily decisions.

Review of the physician's orders for October 2016 documented, "HumaLOG (1) Solution 100 UNIT/ML (milliliter) inject as per sliding scale...."

Review of the October 2016 medication administration record documented, "HumaLOG Solution (1) 100 Unit/ML..Inject as per sliding scale..."

A medication administration observation was made on 10/25/16 at 4:00 p.m. with RN (registered nurse) #5. RN #5 prepared the humalog insulin for Resident #28. RN #5 entered the resident's room, addressed the resident and explained what she was going to do. RN #5 did not close the door or pull the privacy curtain. RN #5 pulled up the resident's shirt exposing his abdomen to the hallway and gave the resident the insulin in his right lower abdomen. RN #5 then covered the resident's abdomen. RN #5 stated, "I didn't close the door did I?"

On 10/26/16 at 9:00 a.m. an interview was attempted with Resident #28. When asked how

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he felt to have his abdomen exposed to the hallway the resident did not have a response.

An interview was conducted on 10/26/16 at 11:30 a.m. with LPN (licensed practical nurse) #4. When asked what steps staff followed when giving an injection into a resident's abdomen, LPN #4 stated, "I would close the curtain and close the door." When asked why, LPN #4 stated, "Privacy and dignity. I don't think the resident wants someone looking at their belly when getting a shot."

An interview was conducted on 10/26/16 at 3:10 p.m. with LPN (licensed practical nurse) #10. When asked what steps staff followed when giving an injection into a resident's abdomen, LPN #10 stated, "Close the door and if there is another resident in the room pull the curtain to provide privacy."

On 10/26/16 at 7:00 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

An interview was conducted on 10/27/16 at 2:40 p.m. with RN #5, the nurse who gave the injection into the resident's abdomen. When asked what steps staff followed when giving an injection into a resident's abdomen, RN #5 stated, "I should have shut the door and done the injection." When asked why, RN #5 stated, "For his privacy."

Review of the facility's policy titled, "Injectable Medication Administration" documented, Procedure...Provide privacy, explain procedure so resident knows what to expect."

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F 164	Continued From page 33 No further information was provided prior to exit. (1) Humalog-- Humalog® Mix75/25 (Trademark) [75% insulin lispro protamine suspension and 25% insulin lispro injection, (rDNA origin)] is a mixture of insulin lispro solution, a rapid-acting blood glucose-lowering agent and insulin lispro protamine suspension, an intermediate-acting blood glucose-lowering agent. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setid=c73da51a-1899-45ad-b6cf-9c52c36a25dd	F 164		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. 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 provided medically related social services for one of 28 residents in the survey sample, Resident #5. On three separate occasions (6/13/16, 7/29/16, and 9/7/16) Resident #5 had verbalized to a social worker that she wanted to die. On two of the occasions (7/29/16 and 9/7/16) Resident #5 verbalized that she wanted to hurt herself and had a plan. The social worker did not act on these verbalizations to ensure Resident #5's	F 250		

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safety and psychological well-being.

The findings include;

Resident #5 was admitted to the facility on 6/19/15 with diagnoses that included, but were not limited to, dehydration, Alzheimer's, bipolar disorder, dementia, depression and anxiety.

Resident #5's most recent MDS (minimum data set) is a significant change assessment with an ARD (assessment reference date) of 9/7/16. Resident #5 was not coded for her cognition in Section C on this assessment, and the staff assessment was not completed. On Resident #5's admission MDS with an ARD of 7/30/16, Resident #5 was coded in Section C, cognitive patterns, as being unable to answer the questions. The staff assessment in Section C coded Resident #5 as a "3", indicating that this resident was severely impaired for daily decision making.
Further review of Resident #5's MDS with an ARD of 7/30/16 revealed in Section D, Mood, that Resident #5 was coded as scoring a two out of a possible 27 and that she had expressed thoughts that she would be better off dead or of hurting herself several days during the 14 day look back period... Section D was also coded that the responsible staff or provider was informed that there was a potential for resident self-harm.

A review of Resident #5's MDS with an ARD of 9/7/16 revealed a score of 27 out of a possible 27 for mood in Section D. Resident #5 was coded as having thoughts that she would be better off dead, or of hurting herself in some way nearly every day during the 14 day look back period. Section D was also coded that the responsible

1. Resident #5 is currently receiving appropriate psych services

2. An audit of current residents with triggered behaviors or depression in the past 90 days on their most recent MDS assessment will be reviewed for the potential need for medically related social services

3. The Executive Director or designee will In-service the interdisciplinary care plan team regarding communicating the potential need for medically related social services to the Social Services department

4. Mood and Behavior and nurse's notes will be reviewed during the clinical meeting daily to identify residents who require services and notify Social Services for follow up. The ED/designee will attend the meeting 2 X weekly for 4 weeks to validate the process. Results of the audits will be reviewed at QAPI committee meeting monthly for 3 months

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staff or provider was informed that there was a potential for resident self-harm.

A review of Resident #5's progress notes revealed, in part, the following documentation;
"7/29/16 09:59 (9:59 am) Type: General Note. Note Text: Mood assessment completed for ARD 7/30/16. Res (Resident #5) reported having little interest in things. Res (Resident #5) also reported having that (sic) she has thoughts about hurting herself. Responded "yes" when asked if she had a plan. Res (Resident #5) responded "no" when asked if she would like to talk about it. Res (Resident #5) added to psych (psychiatrist) book. ED (executive director) DON (director of nursing) ADON (assistant director of nursing) and nursing notified. Author (name of social worker)."
"9/7/16 02:46 (2:46 a.m.) Type: General Note. Note Text: mood assessment completed for ARD 9/7/16. Res (Resident #5) reported having suicidal ideations. DON, ADON and nursing notified. Res (Resident #5) did seem very robotic when answering questions on the mood assessment. Res (Resident #5) was answering inappropriately with "yes" answers even when the questions were not yes or no questions. Author (name of social worker)."
"9/7/16 16:25 (4:25 p.m.) Type: General Note. Note Text: Behavioral Committee Meeting was held and discussed resident (Resident #5) who is dx (diagnosed) with Bipolar, Vas (vascular) Dementia, Major Depression, anxiety and Manic episodes. Resident is currently taking a cognitive enhancement, antipsychotic and a mood stabilizer per MD (medical doctor) orders. Resident has not had any resident to resident behaviors. Therapy is working with resident at this time. Interventions that have been put in place appear to be working with no further

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changes at this time. Mood assessment completed with resident who stated that she would be better off dead and when asked if she had a plan she kept repeating yes. Unit manager, ADON (assistant director of nursing), DNS (director of nursing services), MD (medical director), ED (executive director) and NP (nurse practitioner) made aware. Resident placed in psych (psychiatrist) book. Author: (name of OSM (other staff member) #3, the director of social services."

A review of Resident #5's care plan created 7/14/16 revealed in part, the following documentation; "Focus. I am dx with Manic Episodes, Depression, Bipolar, Vas Dementia with behaviors and anxiety. I am currently taking a mood stabilizer and antidepressant per MD orders. On 9/7/16 I state (sic) that I thought I would be better off dead. Date Initiated: 9/28/16. On 6/13/16 and 9/7/16 I state (sic) that I thought I would be better off dead. Created on 7/14/16. Date Initiated 9/28/16. Goal. I will talk about positive topics and happy memories during conversations through to the next review. Created 7/14/16. Date Initiated 9/28/16. Interventions/Tasks: Make MD, NP, ED, Nursing, DNS, ADON and SSD (social services department) aware if / when resident make (sic) statements regarding wanting to harm self. Date Initiated: 9/28/16. Please give me my medications that help me with my depression and manage any side effects. Date Initiated 7/14/16. Revision on 9/28/16. Please tell my doctor if my symptoms are not improving to see if I need a change in my medication. Date Initiated 7/14/16. Revision on 9/28/16. Take the time to discuss my feelings when I'm feeling sad. Date Initiated 9/28/16."

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A review of the entries in the psych book used by staff to alert the psychiatric nurse practitioner when a resident should be seen revealed, in part, the following entry for Resident #5; "7/29/16" (Name of Resident #5). Reason for consult: Suicidal Ideation. Date RCVD (received) / initials. 8/4/16 (initials of psychiatric nurse practitioner)."

On 10/26/16 at 3:30 p.m. an interview was conducted with OSM #11, the certified registered nurse practitioner for psychiatry. OSM #11 was asked to describe what she knew about Resident #5. OSM #11 stated, "She (Resident #5) went out and came back on a lot of medications. The primary care physician and I work together. She became extremely lethargic and drowsy and would not eat due to the medications. She (Resident #5) became more bed bound and stopped eating. She (Resident #5) also had an infection." OSM #11 was asked why Resident #5 was on the medications that caused her to stop eating and become more lethargic. OSM #11 stated, "The medications were to help modify her behavior so that the normal daily care could be provided, and so that she wouldn't hurt herself or others." OSM #11 was asked whether or not she was aware of Resident #5 having suicidal ideation. OSM #11 stated, "I had no idea. I have not received any phone calls about her and she has never expressed wanting to hurt herself to me."

A review of the psychiatric notes for Resident #5 dated 8/1/16 documented "Reason for referral" as "Other. Competency evaluation." There was no documentation regarding suicidal ideation. A review of the psychiatric notes for Resident #5 dated 9/8/16 revealed, in part, the following

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documentation, "Chief complaint: The chief complaint is: Asked to evaluate the patient's mental status and adjust medications if needed. Mental Status Exam: No suicidal ideation."

A request was made to speak to the social worker who had conducted the mood assessments on the MDS' dated 7/30/16 and 9/7/16. This surveyor was told that the social worker was no longer employed at the facility.

On 10/27/16 at 9:15 a.m. an interview was conducted with OSM #3, the licensed social worker. OSM #3 was asked which section of the MDS she was responsible for completing. OSM #3 stated, "I do the mood interviews." OSM #3 was asked if the mood interview score was significantly higher from one MDS to the next what she would do. OSM #3 responded, "I would let everyone know, nursing, the ED, NP, DON, ADON and the MD. I would put the resident on the psych list to be seen. I would initiate visual checks and if there was any attempt to hurt themselves I would send them to the hospital." OSM #3 was asked to describe the visual checks. OSM #3 stated, "The staff just checks on them, typically every 15 minutes. I don't know how staff documents it but I will double check." OSM #3 was asked if a resident stated that they wanted to hurt themselves what she would do, as the social worker. OSM #3 stated, "I would go back in a day and see if they were doing better. There should be documentation regarding a follow up visit." OSM #3 was asked whether or not she was aware of Resident #5's verbalization of suicidal ideation. OSM #3 stated, "I was made aware of the last one that occurred (9/7/16)." OSM #3 stated, "We had a behavioral meeting." OSM #3 was asked what was put in place at that

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meeting to address Resident #5's suicidal ideation. OSM #3 stated, "Her (Resident #5's) care plan should have been updated on the dates that she had made the verbalizations. I will have to check and see what I have, I know that (name of past social worker) had been talking about this." OSM #3 was advised that the psychiatric nurse practitioner had stated she was unaware of the suicidal ideation. OSM #3 stated, "We put it in the psych book, so she should have been aware." At this time OSM #3 reviewed the psychiatric book with this surveyor. The only notification of suicidal ideation was on 7/29/16. OSM #3 was asked what was put into place in response to the decline in Resident #5's mood score between 7/30/16 and 9/7/16. OSM #3 stated, "(name of Resident #5) had a period of time where her behaviors had increased. The psychiatric nurse practitioner was looking at the medications and changes had been done to better help her with the behaviors." OSM #3 was asked what was done for Resident #5's decline in mood documented on the 9/7/16 MDS. OSM #3 stated, "I was told it was in the book, I don't know." OSM #3 was asked to state what should have happened. OSM #3 stated, "She (Resident #5) should have been in the psych book, we should have alerted everyone and interventions should have been put in place, we did have a behavior meeting and we do recognize that there was a lapse. We are trying to get better."

On 10/27/16 at 9:40 a.m. an interview was conducted with ASM (administrative staff member) #3, the medical doctor. ASM #3 was asked if he was made aware of Resident #5's suicidal ideation, ASM #3 stated that he was not made aware and this was the first that he had heard of it. ASM #3 further stated, "She

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(Resident #5) has been declining, not eating, she is now on hospice."

On 10/27/16 at 10:40 a.m. an interview was conducted with ASM #2, the director of nursing. ASM #2 was asked if she was made aware of Resident #5's verbalization of suicidal ideation. ASM #2 stated, "We have started a behavioral committee so that we can implement and increase our interdisciplinary team." ASM #2 had no other comments regarding the suicidal ideation.

A review of the facility policy titled "Suicide Prevention and Intervention Guideline" revealed, in part, the following documentation: "Guideline Statement: It is the policy of this center that individuals voicing and/or displaying feelings and / or actions which indicate suicidal ideation, receive services and interventions to help them manage these feelings and maintain their psychosocial well-being. 1. Employees are responsible for monitoring acute mood and behavior changes which may indicate potential suicidal ideation and for reporting these changes to their supervisor and / or nursing supervisor for appropriate assessment and interventions. These changes may include verbal statements, sudden withdrawal, physical displays of intentions to commit suicide, or other similar signs of depression. 3. The assessment process should include the resident's environment for potential safety issues and removal of any items that could be a hazard to the resident. 5. The attending physician and / or the medical director will be informed of the resident's initial assessment including mood, mental status and safety issues and to seek input on the immediate treatment plan. Ongoing updates will be provided to the

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F 250	Continued From page 41 physician, as necessary. 6. If the resident is under the treatment of a psychiatrist or psychologist, they should be contacted for interventions, support and instructions. Inpatient placement may be considered. 7. An immediate written care plan should be developed and implemented specific to the resident's situation and needs. The plan should also include visual checks, which should be completed and documented at an interval that is determined by individualized assessment." An end of day meeting was conducted with ASM #1, the executive director and ASM #2, the director of nursing services on 10/26/16 at 6:40 p.m. ASM #1 and ASM #2 were made aware of the above findings. No further information was provided prior to the end of the survey process.	F 250		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who	F 278		

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willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate MDS (minimum data set) assessment for five of 28 residents in the survey sample, Residents #1, #5, #7, #19 and #15

1. The facility staff failed to complete the BIMS (brief interview for mental status) and pain interviews for Resident #1's 14 day Medicare MDS with an ARD (assessment reference date) of 10/4/16.

2. The facility staff failed to complete Section C, Cognitive Patterns, for Resident #5's significant change MDS (minimum data set) with an ARD (assessment review date) of 9/7/16.

3. Facility staff failed to correctly code Resident #7's activities of daily living on the 7/15/16 quarterly MDS (minimum data set).

4. The facility staff failed to complete the mood

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1. The incomplete BIMS for Resident #1 has been noted and updated, accurate BIMS has been done. The incomplete Section C has been noted for Resident #5. Resident #5 now has an updated, accurate Section C. The current MDS for resident #7 is accurate. The current mood interview for Resident #19 has been completed. Resident #15's missing cognition and pain interviews have been noted and an updated MDS has been completed.

2. An audit will be completed on all current residents to ensure their most recent MDS, BIMS assessment, cognition, and pain interview is current and accurate.

3. The Regional Clinical Assessment Reimbursement Specialists or designee will in-service the Interdisciplinary Care Plan Team on accuracy of the MDS, including completing the BIMS assessment, cognition, and pain interviews accurately.

4. An audit of 10% of the assessments completed will be conducted monthly by the Clinical Assessment Reimbursement Specialists or designee and submitted to QAPI for review monthly X 3 months.

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interview on Resident # 19's annual MDS (Minimum Data Set) assessment with the ARD of 3/2/16.

5. For Resident # 15 the facility staff failed to complete the cognition and pain interviews on the most recent MDS (minimum Data Set) with an ARD (assessment reference date) of 9/22/16.

The findings include:

1. The facility staff failed to complete the BIMS (brief interview for mental status) and pain interviews for Resident #1's 14 day Medicare MDS with an ARD of 10/4/16.

Resident #1 was admitted to the facility on 9/22/16. Resident #1's diagnoses included but were not limited to: urinary tract infection, vision loss and osteoporosis.

Resident #1's most recent MDS, a 14 day Medicare assessment with an ARD of 10/4/16, coded the resident as being understood and as understanding verbal content. Section C "Cognitive Patterns" documented, "C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted? Attempt to conduct interview with all residents." Dashes were coded for sections C0100 through C0500, indicating the BIMS interview was not attempted. Dashes were also coded for the staff assessment for mental status. Section J "Health Conditions" documented, "J0200. Should Pain Assessment Interview be conducted? Attempt to conduct interview with all residents..." Dashes were coded for J0200 through J0600 (the Pain Assessment Interview), indicating the Pain Assessment Interview was not attempted.

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Dashes were also coded for the staff assessment for pain.

On 10/26/16 at 5:00 p.m., an interview was conducted with RN (registered nurse) #2 (the MDS coordinator). RN #2 stated the MDS department was responsible for completing sections C and J on the MDS assessments. RN #2 stated she attempts to interview all residents but then conducts interviews with staff if the residents are unable to complete the interviews. RN #2 stated dashes coded on the interview sections indicated the interviews were not attempted. RN #2 was shown Resident #1's MDS assessment and confirmed the BIMS and pain interviews were not attempted. RN #2 was asked why the interviews were not attempted. RN #2 stated she didn't know but the MDS department was short staffed because one of the MDS coordinators left approximately one month ago. RN #2 stated she references the RAI (resident assessment instrument) manual when completing MDS assessments.

On 10/26/16 at 6:50 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

The CMS (Centers for Medicare & Medicaid Services) RAI manual documented the following:

"SECTION C: COGNITIVE PATTERNS
Intent: The items in this section are intended to determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions.
C0100: Should Brief Interview for Mental Status

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Be Conducted?
Item Rationale
Health-related Quality of Life
·This information identifies if the interview will be attempted.
·Most residents are able to attempt the Brief Interview for Mental Status (BIMS).
·A structured cognitive test is more accurate and reliable than observation alone for observing cognitive performance.
- Without an attempted structured cognitive interview, a resident might be mislabeled based on his or her appearance or assumed diagnosis.
- Structured interviews will efficiently provide insight into the resident's current condition that will enhance good care.
Planning for Care
·Structured cognitive interviews assist in identifying needed supports.
·The structured cognitive interview is helpful for identifying possible delirium behaviors (C1310).
Steps for Assessment
1. Determine if the resident is rarely/never understood verbally or in writing. If rarely/never understood, skip to C0700 - C1000, Staff Assessment of Mental Status.
2. Review Language item (A1100), to determine if the resident needs or wants an interpreter.
·If the resident needs or wants an interpreter, complete the interview with an interpreter. Coding Instructions
Record whether the cognitive interview should be attempted with the resident.
·Code 0, no: if the interview should not be attempted because the resident is rarely/never understood, cannot respond verbally or in writing, or an interpreter is needed but not available. Skip to C0700, Staff Assessment of Mental Status.
·Code 1, yes: if the interview should be attempted

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because the resident is at least sometimes understood verbally or in writing, and if an interpreter is needed, one is available. Proceed to C0200, Repetition of Three Words...

J0200: Should Pain Assessment Interview Be Conducted?
Item Rationale
Health-related Quality of Life
·Most residents who are capable of communicating can answer questions about how they feel.
·Obtaining information about pain directly from the resident, sometimes called "hearing the resident's voice," is more reliable and accurate than observation alone for identifying pain.
·If a resident cannot communicate (e.g., verbal, gesture, written), then staff observations for pain behavior (J0800 and J0850) will be used.
Planning for Care
·Interview allows the resident's voice to be reflected in the care plan.
·Information about pain that comes directly from the resident provides symptom-specific information for individualized care planning.
Steps for Assessment
1. Determine whether the resident is understood at least sometimes. Review Language item (A1100), to determine whether the resident needs or wants an interpreter.
·If an interpreter is needed or requested, every effort should be made to have an interpreter present for the MDS clinical interview.
Coding Instructions
Attempt to complete the interview if the resident is at least sometimes understood and an interpreter is present or not required.
·Code 0, no: if the resident is rarely/never understood or an interpreter is required but not

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available. Skip to Indicators of Pain or Possible Pain item (J0800).
·Code 1, yes: if the resident is at least sometimes understood and an interpreter is present or not required. Continue to Pain Presence item (J0300)..."

No further information was presented prior to exit.

2. The facility staff failed to complete Section C, Cognitive Patterns, for Resident #5's significant change MDS (minimum data set) with an ARD (assessment review date) of 9/7/16.

Resident #5 was admitted to the facility on 6/19/15 with diagnoses that included, but were not limited to, dehydration, Alzheimer's, bipolar disorder, dementia, depression and anxiety.

Resident #5's most recent MDS (minimum data set) is a significant change assessment with an ARD (assessment reference date) of 9/7/16. Resident #5 was not coded for her cognition in Section C on this assessment, and the staff assessment was not completed. On Resident #5's admission MDS with an ARD of 7/30/16, Resident #5 was coded in Section C, cognitive patterns, as being unable to answer the questions. The staff assessment in Section C coded Resident #5 as a "3", indicating that this resident was severely impaired for daily decision making.
A review of Resident #5's significant change MDS with an ARD of 9/7/16 revealed, in part, that Section C, Cognitive Patterns, had not been completed as required. For the question, "Should

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Brief Interview for Mental Status be conducted?" the staff responded with a "1" indicating, "Yes". The questions on the Brief Interview for Mental Status (BIMS) were all answered with a "-" (dash). The summary score was completed with a "-" (dash). All the responses on the staff assessment of the BIMS were completed with a "-" (dash).

On 10/26/16 at 5:15 p.m. an interview was conducted with RN (registered nurse) #2, the MDS coordinator. RN #2 was asked which sections she was responsible for completing. RN #2 stated, "I am responsible for Sections G, C and J on the MDS." RN #2 was asked to provide the process for conducting an interview for Section C, Cognitive Patterns. RN #2 stated, "I attempt to interview every resident, if they are unable to answer the questions I complete the staff assessment." RN #2 was asked under what circumstances an interview would not be conducted, RN #2 stated, "Everybody should be a "1", we should attempt to interview everyone." RN #2 was shown Resident #5's significant change MDS, Section C. RN #2 was asked what a dash indicated in the response boxes. RN #2 stated, "I would assume that if there is a dash then the interview was not completed. Resident #5 should not have had dashes and if she was unable to answer the questions then the staff assessment should have been completed." RN #2 was asked what reference she used to complete the MDS. RN #2 stated that she used the RAI (resident assessment instrument) as a guide to complete the MDS.

On 10/26/16 at 6:40 p.m. an end of day meeting was conducted with ASM (administrative staff member) #1, the executive director, and ASM #2,

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the director of nursing services. ASM #1 and ASM #2 were made aware of the findings. No further information was provided prior to the end of the survey process.
3. Facility staff failed to correctly code Resident #7's activities of daily living on the 7/15/16 quarterly MDS (minimum data set).

Resident #7 was admitted to the facility on 10/25/16 with diagnoses that included but were not limited to: depression, high blood pressure, stroke and dementia.

The most recent MDS, a quarterly assessment, with an ARD (assessment reference date) of 7/15/16 coded the resident as sometimes understanding others and sometimes being able to make self-understood. The resident was coded as a 99 in the brief interview for mental status indicating the resident was not able to answer the questions. In section G titled, "Functional Status" the resident was coded as a "7/2" defined as "7. Activity occurred only once or twice. 2. One person physical assist" for all activities of daily living.

Review of the July 2016 CNA (certified nursing assistant) flow sheet documented, that the resident received assistance for all activities of daily living on a daily basis.

An interview was conducted on 10/26/16 at 5:25 p.m. with RN (registered nurse) #4, the MDS coordinator. When asked who completed section G of the MDS, RN #4 stated, that she did. When asked how the information was obtained to complete section G, RN #4 stated, "That comes automatically from the care tracker." When asked to review section G of Resident #7's

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7/15/16, quarterly MDS, RN #4 stated, "That should have been caught." When asked to review the resident's CNA flow sheet, RN #4 stated, "That doesn't make sense. That's definitely a mistake." When asked why if it was important for the MDS to be accurate, RN #4 stated, "Yes. For one thing it goes straight into Medicare and it's for billing, it could be Medicare fraud. It also goes into quality measures." When asked what policy she used to complete the MDS, RN #4 stated, "The RAI (resident assessment instrument)."

On 10/26/16 at 7:00 p.m. ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the findings.

4. The facility staff failed to complete the mood interview on Resident # 19's annual MDS (Minimum Data Set) assessment with the ARD of 3/2/16.

Resident # 19 was admitted to the facility on 5/31/13 with diagnoses that included but were not limited to: vascular dementia (1), diabetes mellitus (2), anxiety (3), hypertension (4), heart failure, cerebral vascular disease (5).

Resident # 19's most recent comprehensive MDS (minimum dada set) an annual assessment with an ARD (assessment reference date) of 3/2/16 was reviewed. Section B0700 "Makes Self Understood" coded Resident # 19 as "Usually understood" and section B0800 "Able To Understand Others" coded Resident # 19 as "Usually understands."

Section D0100 "Mood" of the quarterly MDS

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assessment with an ARD of 3/2/16 documented, "Should Resident Mood Interview be Conducted? - Attempt to conduct interview with all residents." A "-"(dash) was coded in the box under section D0100 "Yes - Continue to D0200, Resident Mood Interview." Review of Section D0200 "Resident Mood Interview" revealed the interview was not completed and dashes were documented in the boxes. The staff assessment of the resident's mood, Section D0500 and D0600 was documented with dashes.

On 10/27/16 at 10:00 a.m., an interview was conducted with RN (registered nurse) # 2, MDS coordinator, regarding the dashes coded in mood interview sections of Resident # 19's annual MDS with the ARD of 3/2/16. After reviewing the MDS assessment, RN # 2 stated, "Social services completes the mood section but the dashes indicate it wasn't done."

On 10/27/16 at 10:00 a.m., an interview was conducted with OSM (other staff member) # 3, director of social services. After reviewing the mood section of the annual MDS assessment for Resident # 19 with the ARD of 3/2/16, OSM # 3 stated, "The person who completed the mood section is not here." When asked what the dashes indicated in the mood section of the MDS assessment, OSM # 3 stated, "The assessment for mood was not done."

The RAI (resident assessment instrument) documented, "2.5 Assessment Types and Definitions. Assessment Reference Date (ARD) refers to the last day of the observation (or "look back") period that the assessment covers for the resident. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the ARD must also cover this

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time period. The facility is required to set the ARD on the MDS Item Set or in the facility software within the required timeframe of the assessment type being completed. This concept of setting the ARD is used for all assessment types (OBRA and Medicare-required PPS) and varies by assessment type and facility determination. Most of the MDS 3.0 items have a 7 day look back period. If a resident has an ARD of July 1, 2011 then all pertinent information starting at 12:00 a.m. on June 25th and ending on July 1st at 11:59 p.m. should be included for MDS 3.0 coding."
Under " SECTION D: MOOD
Intent: The items in this section address mood distress, a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable.

Steps for Assessment
1. Determine if the resident is rarely/never understood. If rarely/never understood, skip to D0500, Staff Assessment of Resident Mood (PHQ-9-OV©).
2. Review Language item (A1100) to determine if the resident needs or wants an interpreter to communicate with doctors or health care staff (A1100 = 1).
If the resident needs or wants an interpreter, complete the interview with an interpreter."

On 10/27/16 at 2:50 p.m., ASM (administrative staff member) # 1, the administrator, was made aware of the above findings.

No further information was presented prior to exit.

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References:

(1) Dementia is a gradual and permanent loss of brain function. This occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. Vascular dementia (VaD) is caused by a series of small strokes over a long period. This information was obtained from the website: https://medlineplus.gov/ency/article/000746.htm.

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

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

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

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

5. The facility staff failed to complete the cognition and pain interviews on Resident #15's

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30 day MDS (minimum Data Set) assessment with an ARD (assessment reference date) of 9/22/16.

Resident # 15 was admitted to the facility on 8/25/16 with diagnoses that included but were not limited to: acute Cholecystitis (1), tachycardia (2), atrial fibrillation (3), congestive heart failure (4), high blood pressure (5), chronic obstructive lung disease (6), epilepsy (7), anxiety (8), depression (9), gastro esophageal reflux disease (10), diabetes (11), and coronary artery disease (12).

Resident #15's 5 day MDS (minimum data set) assessment with an ARD (assessment reference date) of 9/1/16 coded the resident as having a 12 out of 15 on the BIMS (brief interview for mental status) indicating the resident was moderately cognitively impaired. Section J0200 Should Pain Assessment Interview be Conducted? was coded with a "1" indicating "Yes" the Pain Assessment Interview was completed.

Review of Resident #15's 30 day MDS assessment with an ARD of 9/22/16 documented the following: Section C Cognitive Patterns, C0100. Should the Brief Interview for Mental Status be conducted? was coded with "1" indicating "Yes". When the rest of the section was reviewed the following was documented for sections C0200, C0300, C0400, and C0500 documented: a dash for each question. Section J0200 Should Pain Assessment Interview be Conducted? This section was coded with a "1" indicating that the Pain Assessment Interview should be conducted. When the following sections were reviewed each was found to be documented with a dash. J0300, J0400, J0500, J0600.

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During an interview on 10/26/16 at 5:25 p.m. with RN (registered nurse) # 2, an MDS Coordinator, the concern about the dashes coded on Resident #15's 30 day MDS assessment with an ARD date of 9/22/16, was revealed and a request was made for copies of Resident # 15's MDS assessments. At this time RN # 2 was asked what reference is used when completing the MDS. RN # 2 stated that the RAI (resident assessment instrument) manual is used.

During the end of day interview on 10/26/16 at 6:45 p.m. with ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nurses, ASM # 4, the regional nurse consultant, and RN # 1, the assistant director of nurses, the concern about Resident # 15's 30 day MDS assessment with an ARD of 9/22/16, was revealed.

During an interview on 10/27/16 at 9:40 a.m. with RN # 2 and RN # 4, an MDS coordinator, Resident # 15's 30 day MDS assessment was again discussed. Both RN # 1 and RN # 4 stated that "dashes" mean the interviews were not done. Neither could explain why the interviews were not done.

Prior to exit no further information was provided.

References:

(1) Cholecystitis -- Inflammation of the gallbladder<https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0025033/>

(2) Tachycardia -- Rapid beating of the heart, usually defined as greater than 100 beats per

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minute.
<https://www.ncbi.nlm.nih.gov/pubmedhealth/?term=Tachycardia>+

(3) Atrial fibrillation -- Atrial fibrillation, or AF, is the most common type of arrhythmia. An arrhythmia is a problem with the rate or rhythm of the heartbeat.
<https://www.ncbi.nlm.nih.gov/pubmedhealth/?term=Atrial+fibrillation>+

(4) Congestive heart failure -- A chronic condition in which the heart cannot pump blood properly.
https://www.ncbi.nlm.nih.gov/pubmedhealth/?term=Congestive+heart+failure+

(5) High blood pressure -- A condition present when blood flows through the blood vessels with a force greater than normal. Also called high blood pressure. Hypertension can strain the heart, damage blood vessels, and increase the risk of heart attack, stroke, kidney problems, and death.
https://www.ncbi.nlm.nih.gov/pubmedhealth/?term=High+blood+pressure+

(6) Chronic obstructive lung disease -- A type of lung disease marked by permanent damage to tissues in the lungs, making it hard to breathe. Chronic obstructive pulmonary disease includes chronic bronchitis, in which the bronchi (large air passages) are inflamed and scarred, and emphysema, in which the alveoli (tiny air sacs) are damaged. It develops over many years and is usually caused by cigarette smoking. Also called COPD.
https://www.ncbi.nlm.nih.gov/pubmedhealth/?term=Chronic+obstructive+lung+disease+

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(7) Epilepsy -- A group of disorders marked by problems in the normal functioning of the brain. These problems can produce seizures, unusual body movements, a loss of consciousness or changes in consciousness, as well as mental problems or problems with the senses. https://www.ncbi.nlm.nih.gov/pubmedhealth/?term=Epilepsy++

(8) Anxiety -- Feelings of fear, dread, and uneasiness that may occur as a reaction to stress. A person with anxiety may sweat, feel restless and tense, and have a rapid heartbeat. https://www.ncbi.nlm.nih.gov/pubmedhealth/?term=Anxiety

(9) Depression -- a state of low mood and aversion to activity that can affect a person's thoughts, behavior, feelings and sense of well-being. https://www.ncbi.nlm.nih.gov/pubmedhealth/?term=Depression+

(10) Gastro esophageal reflux disease -- Reflux of stomach contents with symptoms and/or complications from the reflux. https://www.ncbi.nlm.nih.gov/pubmedhealth/?term=Gastro+esophageal+reflux+disease

(11) Diabetes – A disease in which the body does not control the amount of glucose (a type of sugar) in the blood and the kidneys make a large amount of urine. This disease occurs when the body does not make enough insulin or does not use it the way it should. https://www.ncbi.nlm.nih.gov/pubmedhealth/?term=Diabetes+

(12) Coronary artery disease (CAD) is a disease

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F 278	Continued From page 58 in which a waxy substance called plaque builds up inside the coronary arteries. These arteries supply oxygen-rich blood to your heart muscle. https://www.ncbi.nlm.nih.gov/pubmedhealth/?term=Coronary+artery+disease+	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review it was determined that the facility staff failed to develop a comprehensive care plan for four of 28 residents in the survey sample, Residents # 9, # 1, # 12 and # 5.	F 279	1. Residents #9, #12, and #5 all have an up-to-date accurate comprehensive care plan. Resident #1 has discharged from the facility 2. The RNAC will conduct an audit of all comprehensive care plans that have been created within the last 90 days to ensure accuracy and completion 3. The MDS department will be educated on the comprehensive care plan process by the Regional Clinical Assessment Reimbursement Specialists 4. The RNAC will review all comprehensive care plans completed to ensure accuracy for the next three months. All findings will be reported to QAPI. November 18, 2016	

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F 279	Continued From page 59 1. The facility staff failed to develop a comprehensive care plan for the triggered care area of urinary incontinence on Resident # 9's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 1/25/16. 2. The facility staff failed to develop a comprehensive care plan for the triggered care areas of: cognitive loss/dementia, visual function, activities of daily living functional/rehabilitation potential, psychosocial well-being, falls and dehydration/fluid maintenance based on Resident #1's admission MDS (minimum data set) with an ARD (assessment reference date) of 9/29/16. 3. Facility staff failed to develop a nutrition care plan for Resident #12 based on the triggered care area assessment of the admission MDS (minimum data set) assessment dated 1/26/16. 4. The facility staff failed to develop a care plan when Resident #5 verbalized suicidal ideation on 6/13/16. The findings include: 1. The facility staff failed to develop a comprehensive care plan for the triggered care area of urinary incontinence on Resident # 9's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 1/25/16. Resident # 9 was admitted to the facility on 12/4/15 with diagnoses that included but were not limited to: hemiplegia (1), myocardial infarction (2), atherosclerosis (3), hypertension (4) and benign prostatic hyperplasia (5).	F 279		

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The most recent comprehensive MDS, an admission assessment with an ARD (assessment reference date) of 1/25/16 coded the resident as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 being cognitively intact for daily decision making. Resident # 1 was coded as requiring extensive assistance of one staff member for activities of daily living. Review of Section V Care Area Assessment (CAA) Summary revealed "06. Urinary Incontinence and Indwelling Catheter" was coded as "Addressed in Care Plan."

Review of Resident # 9's comprehensive care plan with a revision date of 10/23/16 failed to evidence a care plan to address Resident # 9's urinary incontinence.

On 10/25/16 at 3:50 p.m. an interview was conducted with RN (registered nurse) # 2, MDS coordinator. RN # 2 was asked to review Resident # 9's admission MDS with the ARD of 1/15/16 and the care plan with a revision date of 10/23/16. When ask if there was a care plan for the triggered area of urinary incontinence on Resident # 9's admission MDS assessment, RN # 2 stated, "It's not on the care plan, it should be."

The facility policy "RAI (Resident Assessment Instrument) Process" documented, "(Name of Facility) adhere to all CMS (Centers for Medicare/Medicaid Services) regulations which are considered the definitive source in completion of the RAI process. This includes coding the MDS (Minimum Data Set), completion of Care Area Assessment (CAA) and the development of the comprehensive plan of care."

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On 10/25/16 at approximately 6:45 p.m. ASM (administrative staff member) # 1 the administrator, and ASM # 2, the director of nursing, and RN # 1, the assistant director of nursing, were made aware of the findings.

No further information was provided prior to exit.

References:

(1) Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html.

(2) Heart attack. Most heart attacks are caused by a blood clot that blocks one of the coronary arteries. The coronary arteries bring blood and oxygen to the heart. If the blood flow is blocked, the heart is starved of oxygen and heart cells die. This information was obtained from the website: https://medlineplus.gov/ency/article/000195.htm.

(3) A disease in which plaque builds up inside your arteries. Plaque is a sticky substance made up of fat, cholesterol, calcium, and other substances found in the blood. Over time, plaque hardens and narrows your arteries. That limits the flow of oxygen-rich blood to your body. This information was obtained from the website: https://medlineplus.gov/atherosclerosis.html.

(4) High blood pressure. This information was

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obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(5) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.

2. The facility staff failed to develop a comprehensive care plan for the triggered care areas of: cognitive loss/dementia, visual function, activities of daily living functional/rehabilitation potential, psychosocial well-being, falls and dehydration/fluid maintenance based on Resident #1's admission MDS (minimum data set) with an ARD (assessment reference date) of 9/29/16.

Resident #1 was admitted to the facility on 9/22/16. Resident #1's diagnoses included but were not limited to: urinary tract infection, vision loss and osteoporosis. Resident #1's most recent MDS, a 14 day Medicare assessment with an ARD of 10/4/16, coded the resident as being understood and as understanding verbal content. The section determining the resident's cognitive status was incomplete.

Section V "Care Area Assessment (CAA) Summary" of Resident #1's admission MDS assessment with an ARD of 9/29/16 documented, "1. Check column A if Care Area is triggered. 2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment in the care area. The Care Planning Decision column must be completed within 7 days of completing

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the RAI (resident assessment instrument) (MDS and CAA(s)). Check column B if the triggered care area is addressed in the care plan..." An "X" was documented in the "Care Area Triggered" and "Care Planning Decision" columns beside the care areas including but not limited to "Cognitive Loss/Dementia," "Visual Function," "ADL (activities of daily living) Functional/Rehabilitation Potential," "Psychosocial Well-Being," "Falls" and "Dehydration/Fluid Maintenance," indicating the care areas would be care planned. Review of Resident #1's comprehensive care plan initiated on 9/23/16 failed to reveal documentation regarding the above care areas.

On 10/26/16 at 5:00 p.m., an interview was conducted with RN (registered nurse) #2 (the MDS coordinator). RN #2 stated each care area triggered on the CAA summary must be care planned. Resident #1's admission MDS and comprehensive care plan was reviewed with RN #2. RN #2 confirmed all of the above care areas were not and should have been care planned.

On 10/26/16 at 6:50 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

No further information was presented prior to exit.

3. Facility staff failed to develop a nutrition care plan for Resident #12 based on the triggered care area assessment of the admission MDS (minimum data set) assessment dated 1/26/16.

Resident #12 was admitted to the facility on 1/19/16 with diagnoses that included but were not

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limited to: high blood pressure, depression, seizures and irregular heartbeat.

The most recent MDS, a quarterly assessment, with an ARD (assessment reference date) of 7/27/16 coded the resident as having scored 15 out of 15 on the brief interview for mental status indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring minimal assistance from staff for activities of daily living.

Review of the admission MDS with an ARD of 1/26/16 in the care area assessment triggers summary documented that the resident's body mass index was too high or too low. Review of the care area assessment summary documented, "12. Nutrition. Triggered: + New. CP (care plan) decision: Yes."

Review of the care plan did not evidence documentation related to nutrition.

An interview was conducted on 10/26/16 at 5:25 p.m. with RN (registered nurse) #2, the MDS coordinator. When asked if a care plan would be developed for the care area assessment triggers, RN #2 stated, "Yes." When asked who completed the nutrition section of the MDS, RN #2 stated that the director of dietary services did.

On 10/26/16 at 7:00 p.m. ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the findings.

An interview was conducted on 10/27/16 at 9:30 a.m. with OSM (other staff member) #9, the dietary services manager. When asked if he

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completed the nutrition section of the MDS, OSM #9 stated that he did. When asked if he would he would develop a care plan if nutrition was triggered on the care area assessment, OSM #9 stated, "I just started doing them (care plans). When I first got here I didn't do it. I thought the nurses were doing them." When asked when he started to complete the care plans, OSM #9 stated, "I'm not sure of the specific date, within the last month."

No further information was obtained prior to exit.

4. The facility staff failed to develop a care plan when Resident #5 verbalized suicidal ideation on 6/13/16.

Resident #5 was admitted to the facility on 6/19/15 with diagnoses that included, but were not limited to, dehydration, Alzheimer's, bipolar disorder, dementia, depression and anxiety.

Resident #5's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 9/7/16. Resident #5 was not coded for her cognition in Section C on this assessment, and the staff assessment was not completed. On Resident #5's admission MDS with an ARD of 7/30/16, Resident #5 was coded in Section C, cognitive patterns, as being unable to answer the questions. The staff assessment in Section C coded Resident #5 as a "3", indicating that this resident was severely impaired for daily decision

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making.
Further review of Resident #5's significant change MDS assessment with an ARD of 7/30/16 revealed in Section D, Mood, that Resident #5 was coded as scoring a two out of a possible 27 and that she had expressed thoughts that she would be better off dead or of hurting herself several days during the 14 day look back period... Section D was also coded that the responsible staff or provider was informed that there was a potential for resident self-harm.

A review of Resident #5's MDS with an ARD of 9/7/16 revealed a score of 27 out of a possible 27 for mood in Section D. Resident #5 was coded as having thoughts that she would be better off dead, or of hurting herself in some way nearly every day during the 14 day look back period. Section D was also coded that the responsible staff or provider was informed that there was a potential for resident self-harm.

A review of Resident #5's care plan created 7/14/16 revealed in part, the following documentation; "Focus. I am dx with Manic Episodes, Depression, Bipolar, Vas (vascular) Dementia with behaviors and anxiety. I am currently taking a mood stabilizer and antidepressant per MD orders. On 9/7/16 I state (sic) that I thought I would be better off dead. Date Initiated: 9/28/16. On 6/13/16 and 9/7/16 I state (sic) that I thought I would be better off dead. Created on 7/14/16. Date Initiated 9/28/16. Goal. I will talk about positive topics and happy memories during conversations through to the next review. Created 7/14/16. Date Initiated 9/28/16. Interventions/Tasks: Make MD, NP, ED, Nursing, DNS, ADON and SSD (social services department) aware if / when

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resident make (sic) statements regarding wanting to harm self. Date Initiated: 9/28/16. Please give me my medications that help me with my depression and manage any side effects. Date Initiated 7/14/16. Revision on 9/28/16. Please tell my doctor if my symptoms are not improving to see if I need a change in my medication. Date Initiated 7/14/16. Revision on 9/28/16. Take the time to discuss my feelings when I'm feeling sad. Date Initiated 9/28/16."

On 10/27/16 at 9:15 a.m. an interview was conducted with OSM #3, the licensed social worker. OSM #3 was asked which section of the MDS she was responsible for completing. OSM #3 stated, "I do the mood interviews." OSM #3 was asked if the mood interview score was significantly higher from one MDS to the next what she would do. OSM #3 responded, "I would let everyone know, nursing, the ED (executive director), NP (nurse practitioner), DON (director of nursing), ADON (assistant director of nursing) and the MD (medical doctor). I would put the resident on the psych (psychiatrist) list to be seen. I would initiate visual checks and if there was any attempt to hurt themselves I would send them to the hospital." OSM #3 was asked to describe the visual checks. OSM #3 stated, "The staff just checks on them, typically every 15 minutes. I don't know how staff documents it but I will double check." OSM #3 was asked if a resident stated that they wanted to hurt themselves what she would do, as the social worker. OSM #3 stated, "I would go back in a day and see if they were doing better. There should be documentation regarding a follow up visit." OSM #3 was asked whether or not she was aware of Resident #5's verbalization of suicidal ideation. OSM #3 stated, "I was made

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aware of the last one that occurred (9/7/16)." OSM #3 stated, "We had a behavioral meeting." OSM #3 was asked what was put in place at that meeting to address Resident #5's suicidal ideation. OSM #3 stated, "Her (Resident #5's) care plan should have been updated on the dates that she had made the verbalizations. I will have to check and see what I have, I know that (name of past social worker) had been talking about this." OSM #3 was advised that the psychiatric nurse practitioner had stated she was unaware of the suicidal ideation. OSM #3 stated, "We put it in the psych book, so she should have been aware." At this time OSM #3 reviewed the psychiatric book with this surveyor. The only notification of suicidal ideation was on 7/29/16. OSM #3 was asked what was put into place in response to the decline in Resident #5's mood score between 7/30/16 and 9/7/16. OSM #3 stated, "(name of Resident #5) had a period of time where her behaviors had increased. The psychiatric nurse practitioner was looking at the medications and changes had been done to better help her with the behaviors." OSM #3 was asked what was done for Resident #5's decline in mood documented on the 9/7/16 MDS. OSM #3 stated, "I was told it was in the book, I don't know." OSM #3 was asked to state what should have happened. OSM #3 stated, "She (Resident #5) should have been in the psych book, we should have alerted everyone and interventions should have been put in place, we did have a behavior meeting and we do recognize that there was a lapse. We are trying to get better."

A review of the facility policy titled "Suicide Prevention and Intervention Guideline" revealed, in part, the following documentation: "Guideline Statement: It is the policy of this center that

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F 279	Continued From page 69 individuals voicing and/or displaying feelings and / or actions which indicate suicidal ideation, receive services and interventions to help them manage these feelings and maintain their psychosocial well-being. ... 7. An immediate written care plan should be developed and implemented specific to the resident's situation and needs. The plan should also include visual checks, which should be completed and documented at an interval that is determined by individualized assessment." An end of day meeting was conducted with ASM #1, the executive director and ASM #2, the director of nursing services on 10/26/16 at 6:40 p.m. ASM #1 and ASM #2 were made aware of the above findings. No further information was provided prior to the end of the survey process.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	F 280		

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F 280	Continued From page 70 and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, it was determined that the facility staff failed to review and revise the comprehensive care plan for one of 28 residents in the survey sample, Resident #11. The facility staff failed to revise the care plan for the treatment of shingles for Resident #11. The findings include: Resident #11 was admitted to the facility on 8/26/16 with diagnoses that included but were not limited to: fracture of her hip, restless leg syndrome, chronic obstructive pulmonary disease (COPD), high blood pressure, and history of cancer of the lungs, breasts, kidney and uterus. The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 9/23/16, coded the resident as being cognitively intact to make daily decisions. The resident was coded as requiring limited assistance of one or more staff members for all of her activities of daily living except eating in which she required supervision after set up assistance was provided. Resident #11 was observed in her room on	F 280	1. Care plans for Resident #11 have been reviewed and revised to reflect current medical and nursing needs. 2. An audit of current resident care plans was completed to ensure the care plans reflect current medical and nursing needs. 3. The interdisciplinary team will be re-educated by the Regional Clinical Assessment Reimbursement Specialists or designee regarding resident care plans to reflect resident changes 4. DNS/Designee will review changes in condition daily in clinical start up and care plans will be reviewed and revised as indicated. Results of care plan updates will be reviewed monthly at QAPI for three months November 18, 2016	

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10/25/16 at 3:50 p.m. There was no isolation cart or signage outside or inside the resident's room. A resident interview was conducted with Resident #11. When asked if she had changed rooms, Resident #11 stated that she had changed rooms because she had had shingles and they put her in a private room on isolation. When asked if she still had shingles, Resident #31 stated that no they had healed.

Shingles is a disease caused by the varicella-zoster virus - the same virus that causes chickenpox. After you have chickenpox, the virus stays in your body. It may not cause problems for many years. As you get older, the virus may reappear as shingles. Although it is most common in people over age 50, anyone who has had chickenpox is at risk. (1)

The comprehensive care plan was reviewed. The care plan dated, 9/15/16, documented, "Focus: Infection actual or at risk for related to: 9/12/16 Active Shingles." The "Interventions" documented, "Moniter (sic) resident for skin irritation and drainage and pain. Resident is allowed to go out of her room, while shingles is on her buttocks and covered." The care plan also dated, 9/15/16, documented, "Focus: Infection actual or at risk for related to: 9/12/16 - Active Shingles." The "Interventions" documented, "Administer antibiotics and treatment as ordered. Follow contact precautions. Inform resident and visitors of necessary precautions. Isolation cart, signage on patient door and isolation cart. Provide private room if appropriate."

An interview was conducted with LPN (licensed practical nurse) #3 on 10/26/16 at 11:16 a.m. When asked who updates the care plans, LPN #3

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stated, "MDS, nurses, a lot of people." When asked if Resident #11 was on isolation, LPN #3 stated, "No, she's not." When asked if Resident #11 has shingles at this time, LPN #3 stated, "No." When asked if Resident #11 doesn't have shingles, should active shingles still be on her care plan, LPN #3 stated, "No, it should say history of."

An interview was conducted with LPN #7, the unit manager, on 10/26/16 at 11:25 a.m. When asked who updates the care plans, LPN #7 stated, "All of us. We go through them in the morning meeting, IDT (interdisciplinary team)." When asked if Resident #11 is on isolation, LPN #7 stated, "No, she's not." When asked to review the care plan, LPN #7 stated, "It should say history of. She's not on active isolation."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 10/26/16 at 11:55 a.m. When asked who is responsible for updating the care plan, ASM #2 stated, "Any nurse and the MDS staff." When asked if Isolation should still be on Resident #11's care plan, ASM #2 stated, "No, she doesn't have them now. It should say resolved."

A policy on reviewing and revising the care plan was requested on 10/26/16 at 4:15 p.m. and again on 10/27/16 at 8:00 a.m. None was received.

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

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F 280	Continued From page 73 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..." The ASM #1, the administrator, ASM #2, the director of nursing, ASM #4, the regional nurse consultant, and RN (registered nurse) #1, the assistant director of nursing, were made aware of the above findings on 10/26/16 at 4:15 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/shingles.html	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to follow professional standards of practice for 4 of 28 residents in the survey sample; Residents #27, #13, and #26 and #5. 1. For Resident #27, the facility staff failed to transcribe a physician's order to hold a medication for a new admission. The medication was not yet available to administer.	F 281		

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F 281	Continued From page 74 2. For Resident #13, facility staff administered the wrong dose of Oxycontin (1) on 7/15/16 3-11 shift and 7/17/16 7-3 shift. 3. Facility staff failed to obtain a physician's order prior to a psychological evaluation for Resident # 26. 4. The facility staff failed to transcribe a verbal physician order for laboratory tests completed on Resident #5 on 3/27/16, and 6/3/16. The findings include: 1. For Resident #27, the facility staff failed to transcribe a physician's order to hold a medication for a new admission. The medication was not yet available to administer. Resident #27 was admitted to the facility on 1/5/16 and discharged AMA (against medical advice) on 1/6/16. The resident was in the facility for less than 24 hours. The resident was admitted with the diagnoses of but not limited to pulmonary embolism (PE), deep vein thrombosis (DVT), atrial fibrillation (A-fib), high blood pressure (HTN), pneumonia (PNA), chronic obstructive pulmonary disease (COPD), and lung cancer. Due to the resident's brief stay, an MDS (Minimum Data Set) assessment had not yet been completed. Notes and assessments completed during the brief stay documented the resident was alert and oriented to person, place, and time; continent of bowel and bladder; able to make needs known; hard of hearing; adequate vision, was not in any pain or discomfort; and had	F 281	1. Resident #26 and 27 has been discharged. Resident #13 received incorrect medication dose on 7/15/16 and 7/17/16. The nurse for resident #5 received a verbal order from the physician for labs. The order was not transcribed to the clinical chart, and the order has now been transcribed. Resident #27 did not have a transcribed physician's order to hold a medication. Resident #26 did not have a physician's order prior to a psychological evaluation. 2. Orders will be audited for seven consecutive days by UM/Designee, including notification documentation and accurate transcription of orders. ADNS will do 100% medication pass audit. 3. ADNS or Designee will in-service all licensed nurses on policy and procedure for medication administration, receiving and transcribing physician orders, and notification of physician and responsible party. All licensed nurses will be educated on reviewing MD orders. 4. DNS/Designee will review all new orders and notifications daily in clinical start up. ADNS/Designee will continue to audit medication pass monthly for 3 months. All findings will be reported to QAPI. November 18, 2016	

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no known falls in the 3 months prior to admission.

A review of the clinical record revealed that on admission the resident was ordered Cefdinir (Omnicef) (an antibiotic (1)) 300 mg (milligrams) twice daily for 4 days.

A review of the MAR (Medication Administration Record) revealed the medication was not administered on the day of admission.

A review of the facility's stat (Immediate) box list revealed that this medication was not available in the stat box.

A review of the nurse's notes reveled the following:

1/5/16 at 9:27 p.m., "Awaiting arrival from pharmacy, NP (nurse practitioner) notified and stated okay to hold dose."

1/6/16 at 6:49 a.m., "(name of pharmacy) called in reguards [sic] to resident's ABT (antibiotic) and having PCN (penicillin) allergy with the medication being in the same family of abts. Called NP and NP is aware, NP stated to continue ABT. Called (pharmacy) and they are aware."

1/6/16 at 8:51 a.m., "not available" (this note was associated with the eMAR system).

In an interview with RN (registered nurse, the current assistant director of nurses, the unit manager at the time the resident was in the facility) #1 on 10/26/16 at 1:49 p.m., she stated the pharmacy requires medication orders to be in

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by 6:00 p.m. to receive them the same evening. RN #1 stated the exception would be a stat order, which this medication was not. RN #1 stated the nurse practitioner was notified and did not order the medication stat, but instead chose to hold it. She stated the nurse that took the order was no longer at the facility, but that she should have also written the order, in addition to writing the above referenced nurse's note that the NP had ordered it to be held.

A review of the facility policy, "Ordering and Receiving Non-Controlled Medications from the Dispensing Pharmacy" documented, "Medication orders are written on a medication order form (i.e., telephone order sheet, reorder form, etc.) provided by the pharmacy, written in the chart by the physician, or written on a transfer order form and transmitted to the pharmacy...."

On 10/27/16 at 9:30 a.m., the Administrator and Director of Nursing were made aware of the findings. At 10:41 a.m., the DON stated that the facility uses Lippincott as their nursing reference. No further information was provided by the end of the survey.

Verbal orders should be avoided when possible, because miscommunications can occur and you'll lack a written record of the order ...anytime you accept a verbal order, it's your responsibility to ensure the accuracy of the communication. This holds true even in an emergency ...afterward write and sign the order that was given to you verbally by the prescriber and have the prescriber sign your written copy as soon as possible ...Fundamentals of Nursing Lippincott Williams and Wilkins 2007 page 167-168.

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(1) Information obtained from https://medlineplus.gov/druginfo/meds/a698001.html

2. For Resident #13, facility staff administered the wrong dose of OxyContin (1) on 7/15/16 3-11 shift and 7/17/16 7-3 shift.

Resident #13 was admitted to the facility on 11/12/14 and readmitted on 1/19/16 with diagnoses that included but were not limited to anterior dislocation of the left humerus, atherosclerotic heart disease, dementia without behavioral disturbance, hypertension and osteoarthritis. Resident #13's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 8/15/16. Resident #13 was coded as being cognitively intact in the ability to make daily decisions scoring 13 out of 15 on the BIMS (brief interview for mental status exam). Resident #13 was coded as requiring extensive assistance from staff with transfers, dressing, and personal hygiene; and total dependence on staff with bathing.

Review of Resident #13's clinical record revealed the following physician order signed by the NP (Nurse Practitioner) dated 7/15/16, "OxyCONTIN Tablet ER 12 Hour Abuse-Deterrent 15 MG (milligrams) ...Give 1 tablet by mouth two times a day for pain management...discontinue dated 7/15/16."

The following order was put into place on 7/15/16, "OxyCONTIN Tablet ER 12 hour Abuse-Deterrent

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20 MG (milligrams) Give 1 tablet by mouth two times a day for pain management."

Review Resident #13's July 2016 eMAR (electronic administration record) documented that OxyContin 20 mg was administered on 7/15/16 at 9:00 p.m., and 7/17/16 at 9:00 a.m.

Review of the narcotic logs for both the OxyContin 15 mg and OxyContin 20 mg revealed that OxyContin 15 mg was administered on 7/15/16 at 9:00 p.m. and on 7/17/16 at 9:00 a.m. which was not the correct dose.

On 10/27/16 at 2:16 p.m., an interview was conducted with LPN (licensed practical nurse) #1, the nurse who signed off that OxyContin 20 mg was administered on 7/15/16. When asked the process of administering a medication, LPN #1 stated that you would look at order to the medication and confirm the order prior to administering. LPN #1 stated that it looked like she had given the 15 mg on accident and marked down that 20 mg was given. LPN #1 stated, "I really don't remember."

The nurse who administered OxyContin 15 mg on 7/17/16 but documented she administered OxyContin 20 mg no longer works at the facility and could not be reached for an interview.

On 10/27/16 at 2:30 p.m., an interview was conducted with LPN #8. When asked who destroys narcotics she stated that the RN supervisors can destroy the medications together. She stated that the RN supervisors destroy the medications when they can get to it. LPN #8 looked at the narcotic log for Resident #13's OxyContin 15 and 20 mg. LPN #8 stated that it

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appeared on multiple occasions; nursing was popping out the wrong OxyContin and then wasting it with another nurse once they realized they had popped out the wrong dose. LPN #8 confirmed that on 7/15/16 and 7/17/16 the wrong dose of OxyContin was administered.

On 10/27/16 at 1:13 p.m., ASM (administrative staff member) #2, the DON and RN (registered nurse) #1, the ADON (assistant director of nursing) were made aware of the above concerns. No further information was presented prior to exit.

The following information is provided in Basic Nursing, Essentials for Practice, 6th edition (Potter and Perry, 2007, pages 349-360) was used as a reference for medication administration. A medication order is required for you to administer any medication to a patient. Once you receive and process a medication, place the physician's or health care provider's complete order on the appropriate medication form, the MAR. The MAR includes the patient's name, room, and bed number, as well as the names, dosages, frequencies, and routes of administration for each medication. When transcribing orders, ensure the names of medications, dosages, routes, and times are legible. The nurse checks all orders for accuracy and thoroughness. When orders are transcribed, the same information needs to be checked again by the nurse. It is essential that you verify the accuracy of every medication you give to the patient with the patient's orders. To ensure safe medication administration, be aware of the six rights of medication administration.
1.The right medication

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2. The right dose
3. The right patient
4. The right route
5. The right time
6. The right documentation

(1) OXYCONTIN is indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setid=BFDFE235-D717-4855-A3C8-A13D26DADEDE.

3. Facility staff failed to obtain a physician's order prior to a psychological evaluation for Resident # 26.

Resident # 26 was admitted to the facility on 10/15/15 with diagnoses that included but were not limited to: cancer, hypertension (1), gastroesophageal reflux disease (2) and dysphagia (3).

The nursing admission assessment dated 10/15/15 documented Resident # 26's cognitive function as "Intermittent confusion."

The most recent MDS, a five day assessment with an ARD (assessment reference date) of 10/20/15 coded Resident # 26 coded requiring limited to extensive assistance of one staff member for activities of daily living.

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Review of the clinical record for Resident # 26 revealed a "Psychological Evaluation" dated 11/5/2015 and signed by [Name of OSM (other staff member) # 8], consultant clinical psychologist dated 11/5/2015.

Review of the clinical record failed to evidence a physician's order for a psychological evaluation for Resident # 26.

Review of the facility's "Progress Notes" dated 10/15/2015 through 12/15/2015 failed to evidence a note for a physician's order for a psychological evaluation for Resident # 26.

On 10/26/16 at 9:30 a.m., an interview was conducted with RN (registered nurse) # 1, assistant director of nursing. When asked about the process for obtaining an evaluation from an outside consult, RN # 1 stated, "We would consult with the family or POA and see if they would mind being referred to the facility's consulting psychologist. If they don't mind, we would make the referral and the physician or the nurse practitioner would review the resident and write an order for the referral. When the consultant comes in they check the referral book for the resident's name then the consultant should check the resident's chart for the physician's order. If there isn't an order the consultant should obtain an order." When asked about (Name of Clinical Psychologist) performing the psychological evaluation on Resident # 26 dated 11/5/2016, without the physician's order, RN # 1 stated, "They should have questioned it and obtained the order. The psychologist should have not proceeded without the order, she should have known this." After reviewing Resident # 26's closed record and physician's orders RN # 1

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was asked if there was an order for the psychological evaluation. RN # 1 stated, "No."

On 10/26/16 at 10:50 a.m. an interview was conducted with LPN (licensed practical nurse) # 3 regarding the process of obtaining an evaluation from an outside consultant. LPN # 3 stated, "Notify the nurse practitioner or the physician and obtain the order for the evaluation. Put the name is the referral book. The consultant will look in the referral book for who is to be seen and check for physician's orders to evaluate. If there is no order the consultant would notify nursing that they need an order." When asked about Resident # 26, LPN # 3 stated that she didn't recall him or the evaluation.

On 10/26/16 at 11:00 a.m. an interview was conducted with LPN (licensed practical nurse) # 4 regarding the process of obtaining an evaluation from an outside consultant. LPN # 4 stated, "I would expect any consulting professional to check the medical chart for orders before providing services. If there is no order or could not find the order I would expect them to tell nursing to obtain or find the order." When asked about Resident # 26, LPN # 4 stated that she didn't recall him or the evaluation.

On 10/26/16 at 11:30 a.m. an interview was conducted with ASM (administrative staff member # 2, the director of nursing. When asked about the process of obtaining an evaluation from an outside consultant, ASM # 2 stated, "There should be a physician's order. The professional consultant should sign in, tell the staff how they are and tell the staff who they are in the building to see and what for and ask for the chart. The order should be checked by the consultant."

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When asked if there was an order for Resident # 26's psychological evaluation on 11/5/2015 from (Name of Clinical Psychologist), ASM # 2 stated, "No." ASM # 2 further stated, "(Name of Clinical Psychologist) and (Name of Psychological Consulting Group) is no longer contracted with the facility as a result of this situation." When asked what standard of practice is followed ASM # 2 stated, "We follow Lippincott."

On 10/26/16 at 4:00 p.m. an interview was conducted with ASM # 5, the nurse practitioner. After reviewing the psychological evaluation dated 11/5/2015 for Resident # 26, ASM # 5 was asked about a physician's order for the evaluation. ASM # 5 stated, "To my understanding this provider did evaluations on new admissions without orders."

On 10/26/16 at 4:30 p.m. a telephone interview was conducted with ASM # 3 the physician. When asked if he remembered Resident # 26, ASM # 3 stated, "I don't remember the resident." When asked about the psychological evaluation dated 11/5/2015 for Resident # 26, ASM # 3 stated, "If there was no order, the evaluation should not have been done."

On 10/27/16 at approximately 2:30 p.m. ASM (administrative staff member) # 1 the administrator, was made aware of the findings.

No further information was provided prior to exit.

Reference:

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

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essure.html.

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

(3) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

COMPLAINT DEFICIENCY

4. The facility staff failed to transcribe a verbal physician order for laboratory tests completed on Resident #5 on 3/27/16, and 6/3/16.

Resident #5 was admitted to the facility on 6/19/15 with diagnoses that included, but were not limited to, diabetes, dehydration, Alzheimer's, bipolar disorder, dementia, depression and anxiety.

Resident #5's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 9/7/16. Resident #5 was not coded for her cognition in Section C on this assessment, and the staff assessment was not completed. On Resident #5's admission MDS assessment with an ARD of 7/30/16, Resident #5 was coded in Section C, cognitive patterns, as being unable to answer the questions. The staff assessment in Section C coded Resident #5 as a "3", indicating that this resident was severely impaired for daily decision making.

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A review of Resident #5's clinical record revealed the following progress notes that documented laboratory tests were collected and completed following telephone calls with the physician;
"3/27/2016 12:58:00 (12:58 p.m.) Situation: CNA (certified nursing assistant) reported lient (sic) ingesting 0.25 oz (ounces) Vaseline and 0.5 oz Lancome Renergie Lift Night Cream. Response: MD (medical doctor) notified and he ordered BMP (basic metabolic panel - a blood test (1)) and CBC (complete blood count (2)) for tomorrow AM (morning)."
"6/3/2016 22:32:00 (10:32 p.m.). Situation: Increased confusion with shaking. Response: NP (nurse practitioner) notified and order rec'd (received) for U/A (urinalysis) C&S (culture and screen- a test to determine the microscopic bacterial pathogen present in the urine) via (by) I&O (in and out) cath (catheter). Urine collected and picked up."

An end of day meeting was held on 10/26/16 at 6:40 p.m. with ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing services. ASM #2 was provided a list of laboratory tests that did not have a corresponding physician order. ASM #2 was requested to provide evidence that there was an order transcribed in the clinical record.

On 10/27/16 at 11:30 a.m. LPN (licensed practical nurse) #7 provided this surveyor with copies of the progress notes for the 3/27/16 and 6/3/16 laboratory tests and stated that the orders were not transcribed into the medical record after the nurse had spoken with the doctor. LPN #7 was asked whether or not an order should be transcribed if the physician provides a verbal order. LPN #7 stated, "When an order is

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received over the phone, the order must be placed into the electronic chart and a copy of the electronic request for the laboratory test is to be placed in the paper chart along with the laboratory requisition for collection." LPN #7 was asked whether or not that was done for the above laboratory tests completed for Resident #5. LPN #7 stated it was not.

No further information was presented prior to the end of the survey process.

(1) A basic metabolic panel is a blood test that measures your sugar (glucose) level, electrolyte and fluid balance, and kidney function. This information was obtained from the following website:
https://medlineplus.gov/ency/article/003462.htm
(2) A complete blood count (CBC) measures the different components of the blood cell. This information was obtained from the following website:
https://medlineplus.gov/ency/article/003642.htm

Verbal orders should be avoided when possible, because miscommunications can occur and you'll lack a written record of the order ...anytime you accept a verbal order, it's your responsibility to ensure the accuracy of the communication. This holds true even in an emergency ...afterward write and sign the order that was given to you verbally by the prescriber and have the prescriber sign your written copy as soon as possible ...Fundamentals of Nursing Lippincott Williams and Wilkins 2007 page 167-168.

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

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Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, resident interview, and clinical record review, it was determined that facility staff failed to maintain the highest level of well-being for four of 28 residents in the survey sample, Resident #13, #17, #2 and #9.

1. For Resident #13, facility staff failed to administer scheduled OxyContin 20 mg (milligrams) (1) per physician order on 7/16/16.

2. Facility staff failed to obtain orthostatic blood pressures (1) as ordered by the physician for Resident #17.

3. Facility staff failed to hold Resident #2's insulin when the blood sugar was less than 120 as ordered by the physician.

4. The facility staff placed Resident # 9's right arm in a sling without a physician's order for the use of a sling (6).

The Findings Include:

1. Resident #13 was admitted to the facility on 11/12/14 and readmitted on 1/19/16 with diagnoses that included but was not limited to

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1. Missed narcotic was noted for resident #13. Resident #17 did not have an orthostatic blood pressure recorded per physician order. The physician was not notified when the insulin for insulin for resident #2 was held for a blood sugar less than 120 per physician parameters. Resident #9 did not have a physician order for a sling to be placed on this resident, but the resident was observed to have a sling on his right arm.

2. UM/Designee will do a complete audit of current residents for missed medications/treatments for the past 7 days ensure MD/NP orders are completed. The audit will include missed orthostatic blood pressures, vital signs, and cross referencing blood sugars with insulin orders to ensure insulin is held or administered as ordered. Identified areas of concern will be addressed as indicated. All staff will review orders prior to apply adaptive equipment to residents.

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anterior dislocation of the left humerus, atherosclerotic heart disease, dementia without behavioral disturbance, hypertension and osteoarthritis. Resident #13's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 8/15/16. Resident #13 was coded as being cognitively intact in the ability to make daily decisions scoring 13 out of 15 on the BIMS (brief interview for mental status exam). Resident #13 was coded as requiring extensive assistance from staff with transfers, dressing, and personal hygiene; and total dependence on staff with bathing.

Review of Resident #13's clinical record revealed the following physician order signed by the NP (Nurse Practitioner) dated 7/15/16, "OxyCONTIN Tablet ER 12 Hour Abuse-Deterrent 15 MG (milligrams) ...Give 1 tablet by mouth two times a day for pain management...discontinue dated 7/15/16."

The following order was put into place on 7/15/16, "OxyCONTIN Tablet ER (extended release) 12 hour Abuse-Deterrent 20 MG (milligrams) Give 1 tablet by mouth two times a day for pain management."

Review of Resident #13's July 2016 eMAR (electronic medication administration record) revealed that on 7/16/16, Resident #13's 9:00 a.m. scheduled dose of OxyContin was not administered. It was documented that his pain level was a zero at 9:00 a.m. Further review of the eMAR revealed that resident #13's pain had increased to a level of "7" on a scale from 1-10, 10 being the worst, the following shift at 9:00 p.m. There was no evidence that Resident #13 was

3. ADNS/Designee will educate all licensed nurses on policy and procedure for receiving, transcribing, and following MD/NP orders. ADNS/Designee will educate all nurses to check insulin orders prior to the administration of insulin. Nurses and CNA's will receive education stating they are to have an active order before initiating treatments for residents.

4. DNS/Designee will review all MD/NP orders each day during morning meeting and monthly for 3 months. All findings will be reported and reviewed at QAPI monthly x 3 months.

November 18, 2016

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offered any prn (as needed) pain medication until it was documented that OxyContin 20 mg was administered on 7/16/16 at 9:00 p.m.

Review of the narcotic logs for both the OxyContin 15 mg and the OxyContin 20 mg revealed that Resident #13 did not receive any scheduled OxyContin for 7-3 and 3-11 shifts on 7/16/16.

Review of Resident #13's clinical record revealed the following nurses note dated 7/16/16 at 12:30 p.m., "OxyContin Tablet ER (extended release) 12 Hour Give 1 tablet by mouth two times a day for pain management...not available unable to get from (Name of pharmacy) EKIT (emergency kit).

Review of (Name of pharmacy's) EKIT documented that the following medication was in the EKIT, "OXYCONTIN TAB 20 MG CR (continuous release)."

On 10/26/16 at 1 p.m., an interview was conducted with LPN (licensed practical nurse) #2, regarding the process followed if a narcotic for a resident is not available on the medication cart. LPN #2 stated, "We call the pharmacy to see if they can send the medication. If we need a script we will call the MD (medical doctor) or NP (nurse practitioner). Once we have the hard script we can pull the medication from the EKIT by using a code pharmacy gives us." When asked the process if the EKIT does not have the medication she stated, "The EKIT always has the medication but you would call the pharmacy and ask them to send STAT (Immediate). The pharmacy may even call the backup pharmacy to send to us." LPN #2 stated that if for some reason there is no possible way to get the medication, the medical

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doctor should be notified to see if the MD wants to write a new order.

On 10/26/16 at 2:15 p.m., an interview was conducted with LPN #1. When asked the process if a narcotic for a resident is not available on the medication cart, LPN #1 stated, "If there is no medication, I would assume there is no script. You would call MD (medical doctor) to sign the script, call pharmacy and pull from the EKIT. If you cannot get the medication from the EKIT, backup pharmacy would send to the facility STAT." LPN #1 stated if the medication cannot be given, the medical doctor should be notified and a progress note should be written explaining the situation. When asked if CR (continuous release) was the same as ER (extended release) she stated, "Yes."

On 10/27/16 at 10:35 a.m., an interview was conducted with OSM (other staff member) #10, the pharmacist. OSM #10 stated that there was no evidence that the OxyContin was requested from the EKIT on 7/16/16. OSM #10 stated that pharmacy did not receive a hard script for the medication until 7/17/16.

The pharmacy sent over a copy of the hard script dated 7/17/16 for this writer on 10/27/16.

The nurse who worked 7/16/16 7-3 shift no longer works at the facility and could not be reached for an interview.

On 10/27/16 at 1:30 p.m., an interview was conducted with Resident #13. Resident #13 could not recollect a time where his pain medication was not available. He could not recollect a time where he was sitting in pain for

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extended periods without relief.

On 10/27/16 at 2:20 p.m., a telephone interview was conducted with RN (registered nurse) #7, the nurse who documented OxyContin 20 mg was administered on 7/16/16 3-11 shift when it was not administered. RN #7 stated that it is never ok to document that a medication was given when it was not. RN #7 could not recollect that day.

On 10/27/16 at 11:20 a.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

Facility policy titled, "Controlled Substances," did not address the above concerns.

No further information was presented prior to exit.

(1) OXYCONTIN is indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=BFDFE235-D717-4855-A3C8-A13D26DADEDE.

2. Facility staff failed to obtain physician ordered orthostatic blood pressures (1) as ordered for Resident #17.

Resident #17 was admitted to the facility on 8/21/09 with diagnoses that included but were not limited to: irregular heartbeat, kidney failure, anemia, depression and arthritis.

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The most recent MDS, a quarterly assessment, with an ARD of 10/10/16 coded the resident as having 15 out of 15 on the brief interview for mental status indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance for activities of daily living except for eating which the resident could do independently after the meal tray was prepared.

Review of the physician's orders for 8/16/16 documented, "Orthostatic vital signs QD (every day) one time a day. -Order Date- 8/16/16 -D/C- Date 8/27/16."

Review of the August 2016 treatment administration record documented, "Orthostatic vital signs QD (every day) one time a day. -Order Date- 8/16/16 -D/C- Date 8/27/16." On 8/16/16 no blood pressures were documented. On 8/17/16 through 8/28/16 one blood pressure was documented each day not the three blood pressures that are required for obtaining orthostatic blood pressures.

Review of the nurse's notes for 8/16/16 through 8/27/16 did not evidence documentation related to the orthostatic blood pressures.

An interview was conducted on 10/26/16 at 1:40 p.m. with LPN #8. When asked what was included in obtaining orthostatic blood pressures, LPN #8 stated, "You take a lying, sitting and standing blood pressure." When asked if the physician would be notified if the blood pressures were not obtained, LPN #8 stated that she would notify the physician and would document that in her nurse's notes.

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An interview was conducted on 10/16/16 at 1:45 p.m. with LPN #3. When asked what was included in obtaining orthostatic blood pressure, LPN #3 stated, "You take the blood pressure sitting up, standing and lying down." When asked if the physician would be notified if the blood pressure were not obtained, LPN #3 stated, "Yes. I would write a progress note so you can get a picture of what I did."

On 10/16/16 at 5:00 p.m. ASM (administrative staff member) #1 and ASM #2 were made aware of the findings.

No further information was provided prior to exit.

1) Orthostatic hypotension is a sudden fall in blood pressure that occurs when a person assumes a standing position. This information was obtained from: http://www.ninds.nih.gov/disorders/orthostatic_hypotension/orthostatic_hypotension.htm Measuring Orthostatic Blood Pressure. 1. Have the patient lie down for 5 minutes. 2. Measure blood pressure and pulse rate. 3. Have the patient stand. 4. Repeat blood pressure and pulse rate measurements after standing 1 and 3 minutes. This information was obtained from: http://www.cdc.gov/steadi/pdf/measuring_orthostatic_blood_pressure-a.pdf

3. Facility staff failed to hold Resident #2's insulin when the blood sugar was less than 120 as ordered by the physician.

Resident #2 was admitted to the facility on 5/24/16 and readmitted on 6/18/16 with diagnoses that included but were not limited to: pneumonia, depression, elevated cholesterol,

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diabetes and irregular heart beat.

The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 7/21/16 coded the resident as being able to understand others and make his needs known. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the October 2016 physician's orders documented, "Levemir (1) FlexPen Solution Pen-Injector 100 UNIT/ML (milliliter). Inject 12 unit (sic) subcutaneously in the morning for DM (diabetes mellitus) before meal, DO NOT GIVE if BS (blood sugar) <120...."

Review of the October 2016 medication administration record documented, "Levemir FlexPen Solution Pen-Injector 100 UNIT/ML (milliliter). Inject 12 unit (sic) subcutaneously in the morning for DM (diabetes mellitus) before meal, DO NOT GIVE if BS (blood sugar) <120 (less than 120)...." On 10/10/16 at 7:30 a.m. the blood sugar was documented as being 97 and the Levemir was signed off as being given by the nurse.

Review of the care plan initiated on 5/25/16 and revised on 10/17/16 documented, "Focus. Alteration in Blood Glucose due to: Insulin Dependent Diabetes Mellitus. Interventions. Administer medications as ordered."

Review of the nurse's notes for 10/10/16 did not evidence documentation regarding the insulin.

An interview was conducted on 10/26/16 at 1:45 p.m. with LPN (licensed practical nurse) #3. LPN

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#3 was asked to review the 10/10/16 at 7:30 a.m. medication administration record for the Levemir. When asked what the nurse's initials indicated, LPN #3 stated, "That it (the Levemir) was given and the initials are the user name who gave it." When asked if the medication should have been given, LPN #3 stated, "I would not." When asked what consequences might occur giving the Levemir when the blood sugar was 97, LPN #3 stated, "Their blood sugar is going to drop. Levemir is going to drop it over time because it's long acting. Once notified, the physician would probably have us check the blood sugar more frequently."

Review of the resident's October 2016 medication administration record documented that at 4:30 p.m. the resident's blood sugar was 309.

On 10/26/16 at 7:00 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

An interview was conducted on 10/27/16 at 10:55 a.m. with LPN (licensed practical nurse) #9, the nurse who administered the insulin to Resident #2 on 10/10/16 at 7:30 a.m. When asked to review the medication administration record for the blood sugar and insulin administration on 10/10/16, LPN #9 stated, "If I signed it I probably did give it." When asked if the insulin should have been given, LPN #9 stated, "No, because there's a parameter there."

An interview was conducted on 10/27/16 at 11:30 a.m. with LPN #4. When asked to review the Levemir order and if the insulin should have been given, LPN #4 stated, "If the blood sugar was 97,

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I would definitely not give it (the insulin)."

Review of the facility's policy titled, "Administrative Procedures for All Medications" documented, "Procedures. C. Review 5 Rights (3) times: 1) Prior to removing medication package/container form the cart/drawer...2) Prior to removing the medication from the container...3) After the dose has been prepared and before returning the medication to storage. I. Obtain and record any vital signs or other monitoring parameters ordered or deemed necessary prior to medication administration."

No further information was obtained prior to exit.

(1) Levemir -- clinical judgement should be used for dose adjustments and to account for hypoglycemia. Dosage adjustment and monitoring: Monitor blood glucose in all patient treated with insulin. Hypoglycemia is the most common adverse reaction of insulin therapy and may be life threatening. This information was obtained from: https://www.levemirpro.com/prescribing/dosing.html?utm_source=bing_um&utm_medium=cpc&utm_content=pi%20for%20levemir&utm_campaign=Levemir%20Dosage&utm_term=levemir%20prescribing%20information

4. The facility staff placed Resident # 9's right arm in a sling without a physician's order for the use of a sling (6).

Resident # 9 was admitted to the facility on 12/4/15 with diagnoses that included but were not limited to: hemiplegia (1), myocardial infarction (2), atherosclerosis (3), hypertension (4) and benign prostatic hyperplasia (5).

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The most recent comprehensive MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 1/25/16 coded the resident as scoring 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 being cognitively intact for daily decision making. Resident # 1 was coded as requiring extensive assistance of one staff member for activities of daily living.

On 10/25/16 at 3:00 p.m. and 10/26/16 at 8:15 a.m. observations of Resident # 9 failed to evidence Resident # 9's right arm in a sling.

On 10/27/16 at 8:45 an observation of Resident # 9 was conducted. Resident # 9 was observed to be dressed, sitting up in his wheelchair watching television. Further observation revealed Resident # 9's right arm was in a sling with his forearm extending to the left across his chest. When asked about the sling Resident # 9 stated, "I don't know where it came from. I haven't worn it before. I don't know why they put it on me." When asked who put it on him Resident # 9 stated, "My aide."

Review of the POS (physician's order sheet) for Resident # 9 dated 10/01/2016 - 10/31/2016 failed to evidence the use of a sling.

Review of Resident # 9's comprehensive care plan with a revision date of 10/23/16 failed to evidence the use of a sling.

Review of the MAR (medication administration record) and TAR (treatment administration record) for Resident # 9 dated October 2016 failed to evidence the use of a sling.

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Review of the "Physical Therapy Plan of Care" for Resident # 9 documented, "Last Updated 10/14/2016" failed to evidence the use of a sling.

Review of the "Care Card" for Resident # 9 with a "Start of Care date of 10/02/2016" failed to evidence the use of a sling.

On 10/27/16 at 9:05 a.m. an interview was conducted with LPN (licensed practical nurse) # 7, unit manager. LPN # 7 was asked to observe Resident # 9. LPN # 7 accompanied this surveyor to Resident # 9's room. Resident # 9 was sitting in his wheelchair watching television. LPN # 7 acknowledged that Resident # 9's right arm was in a sling. When asked about the sling on Resident # 9, LPN # 7 stated, "I've never seen it on him." When asked if Resident # 9 was to have his right arm in a sling, LPN # 7 stated, "I'll check." When asked if there should be a physician's order for the use a sling, LPN # 7 stated, "Yes." At 9:15 a.m. LPN # 7 walked into Resident # 9's room and removed the sling from his right arm.

On 10/27/16 at 9:20 a.m. an interview was conducted with CNA (certified nursing assistant) # 8. When asked if he had taken care of Resident # 9 earlier in the morning, CNA # 8 stated, "Yes." CNA #8 was asked if he put the sling on Resident # 9's right arm and if so at what time. CNA # 8 stated, "Yes at about 7:15 (a.m.)." When asked how he knew Resident # 9 was to have his right arm in a sling, CNA # 8 stated, "It's on the care card." CNA # 8 was asked to show this surveyor the care card for Resident # 9 and to point out where on the care card it indicated the use of a sling for Resident # 9. CNA # 8 removed the care

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card from his pocket and showed it to this surveyor. Review of the care card for Resident # 9 failed to evidence the use of a sling for his right arm. When asked to point out the use of the sling for Resident # 9, CNA # 8 reviewed the care card with this surveyor and stated, "I didn't see that the sling wasn't on the care card. I'll ask my supervisor so I do the right thing."

On 10/27/16 at 10:10 a.m. an interview was conducted with LPN # 7 and OSM (other staff member) # 1, director of rehabilitation. OSM # 1 stated that physical therapy did not prescribe the use of a sling for Resident # 9. OSM # 1 further stated, "If it was ordered the CNAs would have been trained on how to apply it." LPN # 7 stated that there was no physician's order for the use of the sling. LPN # 7 further stated, "The CNA should not have applied it and the care card was not followed."

On 10/27/16 at approximately 2:30 p.m. ASM (administrative staff member) # 1 the administrator, was made aware of the findings.

No further information was provided prior to exit.

References:

(1) Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html.

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(2) Heart attack. Most heart attacks are caused by a blood clot that blocks one of the coronary arteries. The coronary arteries bring blood and oxygen to the heart. If the blood flow is blocked, the heart is starved of oxygen and heart cells die. This information was obtained from the website: https://medlineplus.gov/ency/article/000195.htm.

(3) A disease in which plaque builds up inside your arteries. Plaque is a sticky substance made up of fat, cholesterol, calcium, and other substances found in the blood. Over time, plaque hardens and narrows your arteries. That limits the flow of oxygen-rich blood to your body. This information was obtained from the website: https://medlineplus.gov/atherosclerosis.html.

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

(5) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.

(6) An arm and shoulder immobilizer. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000175.htm.

F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329	

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including

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duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure residents were free of unnecessary medications for two of 28 residents in the survey sample, Residents #11 and #2.

1. Resident #11 received an antipsychotic medication that was not intended for her.

2. Facility staff failed to hold Resident #2's insulin when the blood sugar was less than 120 as ordered by the physician.

1. Resident #11 has been discharged from the facility. It was noted that resident #2's insulin was not held when his blood sugar was less than 120 per physician's parameters, and physician was notified.

2. UM/Designee will conduct an audit cross referencing blood sugars with insulin orders to ensure insulin is held or administered as ordered. An audit will be conducted by the UM/Designee of all residents receiving antipsychotic medications with consideration to the residents diagnosis and verification of the physician orders. Identified areas of concern will be addressed as indicated.

3. ADNS/Designee will educate licensed nurses on medication administration guidelines including any dose or order that appears inappropriate considering the resident's age, condition, allergies, or diagnosis is verified by nursing with the attending physician. The prescriber is contacted by nursing to verify or clarify an order (e.g., when the resident has allergies to the medication, there are contraindications to the medication, significant drug interactions are present, the directions are confusing). Medical Director will educate Nurse Practitioner regarding medication orders and resident identification.

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F 329	Continued From page 102 The findings include: 1. Resident #11 was admitted to the facility on 8/26/16 with diagnoses that included but were not limited to: fracture of her hip, restless leg syndrome, chronic obstructive pulmonary disease (COPD), depression, high blood pressure, and history of cancer of the lungs, breasts, kidney and uterus. The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 9/23/16, coded the resident as being cognitively intact to make daily decisions. The resident was coded as requiring limited assistance of one or more staff members for all of her activities of daily living except eating in which she required supervision after set up assistance was provided. The nurse practitioner note dated, 9/20/16, documented in part, "Addendum: Order for Haldol Deconate written in error on 09/16/16 and administered 09/20/16. Informed patient Re: Error and the possible side effects and symptoms that we would be re: (regarding) monitoring for. Pt (patient) verbalizes understanding." Haloperidol deaconate injection 50 mg/mL and haloperidol deaconate injection 100 mg/mL are indicated for the treatment of schizophrenic patients who require prolonged parenteral antipsychotic therapy. (1) The physician order dated, 9/16/16, documented, "Haldol Deconate 50 MG/ML (milligrams/milliliter) IM (intramuscular) Q (every) month." The physician order dated, 9/20/16 documented, ""D/C (discontinue) Haldol order please." The MAR (medication administration record) for	F 329	4. DNS/Designee will review medication orders during morning meeting every day. Results of the monitoring will be reviewed by the QAPI committee monthly x 3 months. November 18, 2016	

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September 2016 documented, "Haldol Deconate Solution 50 MG/ML; Inject 50 mg intramuscularly in the evening starting on the 19th and ending on the 19th every month for give as ordered. Give IM injection once a month every month." The MAR documented the medication was administered on 9/19/16 at 4:00 p.m.
The nurse's note dated, 9/19/16 at 5:45 p.m. documented in part, "Resident received monthly injection of Haldol Deconate 50 mg/1 ML. Given in Lt (left) deltoid as ordered intramuscularly, no adverse reactions."
The comprehensive care plan, dated, 9/1/16, documented in part, "Focus: Res (resident) is currently dx (diagnosed with) depression and anxiety. Res is currently taking an antidepressant and antianxiety per MD (medical doctor) orders. On 9/1/16 and 10/19/16 I stated during mood assessments I have stated yes to feeling that I would be better of (sic) dead. I do not have any plans to hurt myself."
Resident #11 was seen by the psychiatric nurse practitioner on 9/1/16, 10/13/16 and 10/18/16. Resident #11 was seen by the clinical psychologist on 10/24/16. None of the progress notes from these providers documented the use of Haldol Deconate injectable.
An interview was conducted with administrative staff member (ASM) #5, the nurse practitioner, on 10/26/16 at 11:07 a.m. When asked to explain her progress note of 9/20/16, ASM #5 stated, "It was an error on my part. A nurse from the other unit came to me. I wrote the order on (Resident #11's) chart which I had had in front of me. It was meant for a resident on the other unit, not (Resident #11)." When asked how the medication would have affected the resident, ASM #5 stated, "I talked to the psychiatrist nurse practitioner and called our doctor. I take full responsibility. They

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told me it would improve her mood. It could affect her sleep cycle. But luckily she had no effects from it."
An interview was conducted with LPN (licensed practical nurse) #3, the nurse who administered the injection, on 10/26/16 at 5:22 p.m. When asked why she did not question why the resident was getting the injection, LPN #3 stated, "Really, I didn't question it. I figured it was because of all of her anxiety, behaviors and suicidal ideations she had had since admission, so I didn't question it."
The facility policy, "Antipsychotic Medication Review" documented in part, "Procedure: To ensure that the Medical Record of any Resident who receives antipsychotic medication contains documentation supporting the appropriateness and necessity for the use of the drug. Definition: Antipsychotic medications primarily used to manage psychosis (including delusions, hallucinations, or disordered thought), particularly in schizophrenia and bipolar disorders and are also used in the management of rare non-psychotic disorders such as Huntington's disease...Review the physician's order for a complete order that includes: Medication name, dose, frequency, appropriate diagnosis: Schizophrenia, schizoaffective disorder, delusional disorder, mood disorders (e.g. bipolar disorder, severe depression refractory to other therapies and/or with psychotic features), Psychosis in the absence of dementia, medical illnesses with psychotic symptoms (e.g. neoplastic disease or delirium) and/or treatment related psychosis or mania (e.g. high dose steroids), Schizophreniform Disorder, Atypical psychosis, Tourette's Syndrome, Huntington's disease or nausea and vomiting associated with cancer or chemotherapy."
The ASM #1, the administrator, ASM #2, the

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director of nursing, ASM #4, the regional nurse consultant, and RN (registered nurse) #1, the assistant director of nursing, were made aware of the above findings on 10/26/16 at 4:15 p.m. No further information was provided prior to exit.
(1) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=14460

2. Facility staff failed to hold Resident #2's insulin when the blood sugar was less than 120 as ordered by the physician.

Resident #2 was admitted to the facility on 5/24/16 and readmitted on 6/18/16 with diagnoses that included but were not limited to: pneumonia, depression, elevated cholesterol, diabetes and irregular heart beat.

The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 7/21/16 coded the resident as being able to understand others and make his needs known. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the October 2016 physician's orders documented, "Levemir (1) FlexPen Solution Pen-Injector 100 UNIT/ML (milliliter). Inject 12 unit (sic) subcutaneously in the morning for DM (diabetes mellitus) before meal, DO NOT GIVE if BS (blood sugar) <120...."

Review of the October 2016 medication administration record documented, "Levemir FlexPen Solution Pen-Injector 100 UNIT/ML

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(milliliter). Inject 12 unit (sic) subcutaneously in the morning for DM (diabetes mellitus) before meal, DO NOT GIVE if BS (blood sugar) <120 (less than 120)...." On 10/10/16 at 7:30 a.m. the blood sugar was documented as being 97 and the Levemir was signed off as being given by the nurse.

Review of the care plan initiated on 5/25/16 and revised on 10/17/16 documented, "Focus. Alteration in Blood Glucose due to: Insulin Dependent Diabetes Mellitus. Interventions. Administer medications as ordered."

Review of the nurse's notes for 10/10/16 did not evidence documentation regarding the insulin.

An interview was conducted on 10/26/16 at 1:45 p.m. with LPN (licensed practical nurse) #3. LPN #3 was asked to review the 10/10/16 at 7:30 a.m. medication administration record for the Levemir. When asked what the nurse's initials indicated, LPN #3 stated, "That it (the Levemir) was given and the initials are the user name who gave it." When asked if the medication should have been given, LPN #3 stated, "I would not." When asked what consequences might occur giving the Levemir when the blood sugar was 97, LPN #3 stated, "Their blood sugar is going to drop. Levemir is going to drop it over time because it's long acting. Once notified, the physician would probably have us check the blood sugar more frequently."

Review of the resident's October 2016 medication administration record documented that at 4:30 p.m. the resident's blood sugar was 309.

On 10/26/16 at 7:00 p.m. ASM (administrative

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staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

An interview was conducted on 10/27/16 at 10:55 a.m. with LPN (licensed practical nurse) #9, the nurse who administered the insulin to Resident #2 on 10/10/16 at 7:30 a.m. When asked to review the medication administration record for the blood sugar and insulin administration on 10/10/16, LPN #9 stated, "If I signed it I probably did give it." When asked if the insulin should have been given, LPN #9 stated, "No, because there's a parameter there."

An interview was conducted on 10/27/16 at 11:30 a.m. with LPN #4. When asked to review the Levemir order and if the insulin should have been given, LPN #4 stated, "If the blood sugar was 97, I would definitely not give it (the insulin)."

Review of the facility's policy titled, "Administrative Procedures for All Medications" documented, "Procedures. C. Review 5 Rights (3) times: 1) Prior to removing medication package/container form the cart/drawer...2) Prior to removing the medication from the container...3) After the dose has been prepared and before returning the medication to storage. I. Obtain and record any vital signs or other monitoring parameters ordered or deemed necessary prior to medication administration."

No further information was obtained prior to exit.

(1) Levemir -- clinical judgement should be used for dose adjustments and to account for hypoglycemia. Dosage adjustment and monitoring: Monitor blood glucose in all patient

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treated with insulin. Hypoglycemia is the most common adverse reaction of insulin therapy and may be life threatening. This information was obtained from: https://www.levemirpro.com/prescribing/dosing.html?utm_source=bing_um&utm_medium=cpc&utm_content=pi%20for%20levemir&utm_campaign=Levemir%20Dosage&utm_term=levemir%20prescribing%20information

F 332 SS=D — 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE — F 332

The facility must ensure that it is free of medication error rates of five percent or greater.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to ensure a medication error rate of less than five percent.

Facility staff made three medication errors on two residents, Resident #17 and Resident #18 out of 27 opportunities in the medication administration observation resulting in an 11.1% error rate.

The findings include:

1. Resident #17 was admitted to the facility on 8/21/09 with diagnoses that included but were not limited to: irregular heartbeat, kidney failure, anemia, depression and arthritis.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment

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reference date) of 10/10/16 coded the resident as having scored 15 out of 15 on the brief interview for mental status indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance for activities of daily living except for eating which the resident could do independently after the meal tray was prepared.

A medication administration observation was made on 10/26/16 at 8:25 a.m. with LPN (licensed practical nurse) #7. LPN #7 removed a bottle of potassium chloride liquid (1) for Resident #17 from the medication cart. On the label of the bottle it was documented that the potassium chloride was 20 milliequivalents for every 15 ml's (milliliters) LPN #7 then poured 15 ml's into a medicine cup. LPN #7 then removed a container holding a bottle of flonase (2) from the medication cart. On the container was the resident's name and a green sticker with "Shake gently" documented on it. The nurse took the medications into the room and had the resident drink the 15 ml's of potassium chloride. She then sprayed the flonase into the resident's nose without shaking the bottle.

Review of Resident #17's October physician's orders documented, "Flonase Suspension 50 MCG (microgram)/ACT 1 spray in both nostrils one time a day for allergies. Potassium Chloride (20 MEQ [milliequivalents]/15 ML (10%) Liquid Give 40 mEq...30cc to = 40meq."

Review of the resident's medication administration record documented, "Flonase Suspension 50 MCG (microgram)/ACT 1 spray in both nostrils one time a day for allergies. Potassium Chloride (20 MEQ [milliequivalents]/15

1. Resident # 17 and # 18 incorrect medication administration was noted during observation and MD was notified accordingly. Identified licensed nurse received education regarding medication administration guidelines.
2. No other residents were identified.
3. ADNS/Designee will complete medication administration competency and education for medication administration guidelines for licensed nurses.
4. DNS/Designee will review medication pass audit. Medication administration competencies will be completed for 3 licensed nurses per week for 8 weeks. All findings reported to QAPI committee monthly x 3 months.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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ML (10%) Liquid Give 40 mEq...30cc to = 40meq."

An interview was conducted on 10/26/16 at 11:55 a.m. with LPN #7. LPN #7 was asked to read the potassium chloride order and then to look at the label on the bottle. When asked if Resident #17 had received 40 milliequivalents of potassium, LPN #7 stated, "Okay, I see what I did with the potassium, I only gave 20 milliequivalents." When asked how much the resident should have received, LPN #7 stated she should have administered 30 milliliters (for the resident to receive the ordered dose of 20 milliequivalents). LPN #7 was asked to read the container for the flonase for Resident #17. When asked if she had shaken the flonase for the resident as directed on the container, LPN #7 stated, "No." When asked why it was important to shake the flonase, LPN #7 stated, "I can find out." LPN #7 returned to this surveyor at 1:25 p.m. and stated, "The flonase is a suspension so it has to be shaken (to mix it)."

On 10/26/16 at 7:00 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the manufacturer's instructions provided by the facility for flonase documented, "Here's how to get started. 1 Shake. Gently shake spray bottle."

No further information was provided prior to exit.

(1) Potassium Chloride -- Potassium chloride oral solution 20% is an electrolyte replenisher. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDru

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gXsl.cfm?setid=6d2cec16-3127-49b5-9cb1-8407d2b33a3f
(2) Flonase – FLONASE® Nasal Spray is indicated for the management of the nasal symptoms of perennial nonallergic rhinitis in adult and pediatric patients aged 4 years and older. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setid=961a1f15-9dbd-4f83-aae9-a0696d091b83

2. Resident #18 was admitted to the facility on 1/31/15 and readmitted on 6/5/15 with diagnoses that include but were not limited to Multiple sclerosis, cluster headaches, dementia without behavioral disturbance, convulsions and chronic kidney disease.

Resident #18's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 9/5/16. Resident #18 was coded as being moderately cognitively impaired in the ability to make daily decisions scoring 9 out of 15 on the BIMS (Brief Interview for Mental Status exam). Resident #18 was coded as requiring extensive assistance with transfers and dressing, limited assistance with ambulation and total dependence on staff with bathing.

A medication administration observation for Resident #18 was made on 10/26/16 at 8:40 a.m. with LPN #7. LPN #7 took a container from the cart that contained a flonase (2) bottle. On the container was the resident's name and a green sticker with "Shake gently" documented on it. LPN #7 then took the flonase into the resident's room. LPN #7 then sprayed the flonase into the resident's nose without shaking the bottle.

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An interview was conducted on 10/26/16 at 11:55 a.m. with LPN #7. LPN #7 was asked to read the container for the flonase for Resident #18. When asked if she had shaken the flonase for the resident as directed on the container LPN #7 stated, "No." When asked why it was important to shake the flonase, LPN #7 stated, "I can find out." LPN #7 returned to this surveyor at 1:25 p.m. and stated, "The flonase is a suspension so it has to be shaken (to mix it)."

Review of the resident's October 2016 physician's orders documented the resident was to receive flonase 50 mcg to each nostril every day.

Review of the October 2016 medication administration record documented the resident was to receive flonase 50 mcg to each nostril every day.

On 10/26/16 at 7:00 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the manufacturer's instructions provided by the facility for flonase documented, "Here's how to get started. 1 Shake. Gently shake spray bottle."

No further information was provided prior to exit.
(2) Flonase -- FLONASE® Nasal Spray is indicated for the management of the nasal symptoms of perennial nonallergic rhinitis in adult and pediatric patients aged 4 years and older. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=961a1f15-9dbd-4f83-aae9-a0696d091b

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	83			
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F 333		

The facility must ensure that residents are free of any significant medication errors.

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 ensure a resident was free of a significant medication error for one of 28 residents in the survey sample, Resident #11.

The facility staff failed to ensure Resident #11 was not administered medication that was not intended for her. Resident #11 was administered an antipsychotic medication by injection that was not intended to be administered to her.

The findings include:

Resident #11 was admitted to the facility on 8/26/16 with diagnoses that included but were not limited to: fracture of her hip, restless leg syndrome, chronic obstructive pulmonary disease (COPD), depression, high blood pressure, and history of cancer of the lungs, breasts, kidney and uterus.

The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 9/23/16, coded the resident as being cognitively intact to make daily decisions. The resident was coded as

1. Resident #11 discharged.

2. An audit will be conducted by the UM/Designee of all residents receiving antipsychotic medications with consideration to the residents diagnosis and verification of the physician orders.

3. DNS/Designee will review orders daily during morning meeting every day. All finding will be including in QAPI for three months. ADNS/Designee will educate licensed nurses on medication administration guidelines including any dose or order that appears inappropriate considering the resident's age, condition, allergies, or diagnosis is verified by nursing with the attending physician. The prescriber is contacted by nursing to verify or clarify an order (e.g., when the resident has allergies to the medication, there are contraindications to the medication, significant drug interactions are present, the directions are confusing). Medical Director will educate Nurse Practitioner regarding medication orders and resident identification.

4. DNS/Designee will review orders daily during morning meeting. All finding will by including in QAPI for three months.

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requiring limited assistance of one or more staff members for all of her activities of daily living except eating in which she required supervision after set up assistance was provided.

The nurse practitioner note dated, 9/20/16, documented in part, "Addendum: Order for Haldol Deconate written in error on 09/16/16 and administered 09/20/16. Informed patient Re: Error and the possible side effects and symptoms that we would be re: (regarding) monitoring for. Pt (patient) verbalizes understanding."

Haloperidol deaconate injection 50 mg/mL and haloperidol deaconate injection 100 mg/mL are indicated for the treatment of schizophrenic patients who require prolonged parenteral antipsychotic therapy. (1)
The physician order dated, 9/16/16, documented, "Haldol Deconate 50 MG/ML (milligrams/milliliter) IM (intramuscular) Q (every) month."
The physician order dated, 9/20/16 documented, ""D/C (discontinue) Haldol order please."
The MAR (medication administration record) for September 2016 documented, "Haldol Deconate Solution 50 MG/ML; Inject 50 mg intramuscularly in the evening starting on the 19th and ending on the 19th every month for give as ordered. Give IM injection once a month every month." The MAR documented the medication was administered on 9/19/16 at 4:00 p.m.
The nurse's note dated, 9/19/16 at 5:45 p.m. documented in part, "Resident received monthly injection of Haldol Deconate 50 mg/1 ML. Given in Lt (left) deltoid as ordered intramuscularly, no adverse reactions."
The comprehensive care plan, dated, 9/1/16, documented in part, "Focus: Res (resident) is currently dx (diagnosed with) depression and

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anxiety. Res is currently taking an antidepressant and antianxiety per MD (medical doctor) orders. On 9/1/16 and 10/19/16 I stated during mood assessments I have stated yes to feeling that I would be better of (sic) dead. I do not have any plans to hurt myself."
Resident #11 was seen by the psychiatric nurse practitioner on 9/1/16, 10/13/16 and 10/18/16. Resident #11 was seen by the clinical psychologist on 10/24/16. None of the progress notes from these providers documented the use of Haldol Deconate injectable.
An interview was conducted with administrative staff member (ASM) #5, the nurse practitioner, on 10/26/16 at 11:07 a.m. When asked to explain her progress note of 9/20/16, ASM #5 stated, "It was an error on my part. A nurse from the other unit came to me. I wrote the order on (Resident #11's) chart which I had in front of me. It was meant for a resident on the other unit, not (Resident #11)." When asked what effect the medication would have had on her, ASM #5 stated, "I talked to the psychiatrist nurse practitioner and called our doctor. I take full responsibility. They told me it would improve her mood. It could affect her sleep cycle. But luckily she had no effects of it."
An interview was conducted with LPN (licensed practical nurse) #3, the nurse who administered the injection, on 10/26/16 at 5:22 p.m. When asked why she did not question why the resident was getting the injection, LPN #3 stated, "Really, I didn't question it. I figured it was because of all of her anxiety, behaviors and suicidal ideations she had had since admission, so I didn't question it."
The facility policy, "Antipsychotic Medication Review" documented in part, "Procedure: To ensure that the Medical Record of any Resident who receives antipsychotic medication contains

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F 333	Continued From page 116 documentation supporting the appropriateness and necessity for the use of the drug. Definition: Antipsychotic medications primarily used to manage psychosis (including delusions, hallucinations, or disordered thought), particularly in schizophrenia and bipolar disorders and are also used in the management of rare non-psychotic disorders such as Huntington's disease...Review the physician's order for a complete order that includes: Medication name, dose, frequency, appropriate diagnosis: Schizophrenia, schizoaffective disorder, delusional disorder, mood disorders (e.g. bipolar disorder, severe depression refractory to other therapies and/or with psychotic features), Psychosis in the absence of dementia, medical illnesses with psychotic symptoms (e.g. neoplastic disease or delirium) and/or treatment related psychosis or mania (e.g. high dose steroids), Schizophreniform Disorder, Atypical psychosis, Tourette's Syndrome, Huntington's disease or nausea and vomiting associated with cancer or chemotherapy." The ASM #1, the administrator, ASM #2, the director of nursing, ASM #4, the regional nurse consultant, and RN (registered nurse) #1, the assistant director of nursing, were made aware of the above findings on 10/26/16 at 4:15 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=14460	F 333		
F 364 SS=B	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive	F 364		

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F 364	Continued From page 117 value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and facility document review, it was determined that facility staff failed to serve food at a palatable temperature. The findings include: On 10/26/16 at 11:00 a.m., a group interview was conducted with five cognitively intact residents. They all stated that their meals were often served cold. On 10/26/16 at 4:30 p.m., tray line temperatures were recorded on the steam table. The following were recorded: Tomato soup: 200 degrees Chicken soup: 182 degrees Mashed Potatoes: 170 degrees French Fries: 150 degrees Chicken Pot Pie: 179 degrees On 10/26/16 at 6:35 p.m., all trays were delivered to the residents. A test tray was sampled by two surveyors at 6:38 p.m. All food tasted cold. The following temperatures were recorded: Tomato soup: 153 degrees Chicken soup: 133 Mashed potatoes: 106 degrees French Fries: 98 degrees Chicken Pot Pie: 110 degrees Alternate food items that were not tested at 4:30	F 364	1. No residents were identified to be affected by this practice at the time of the review. 2. Dietary manager will conduct an audit on hall tray delivery to identify additional residents who may be served cold food. The facility is utilizing dome lids and started using the electronic temperature device to ensure palatable temperatures. 3. The dietary department has been re-educated on using dome lids and documenting the temperature of all foods prior to serving to ensure the food is at an appropriate serving temperature. 4. The Executive Director/designee will conduct daily temperatures audits for room trays for 3 weeks then monthly. The documented results of the audits will be reviewed by the QAPI committee monthly for 3 months. November 18, 2016	

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p.m.:
Grilled Cheese: 98 degrees
Hamburger: 102 degrees

On 10/26/16 at 6:41 p.m., OSM (Other staff member) #9, the dietary manager was asked if he wanted to try the food, OSM #9 stated, "No, I've had it all before."

On 10/27/16 at 9:15 a.m., an interview was conducted with OSM #9. When asked what he thought was an appropriate serving temperature that was palatable for hot food, OSM #9 stated, "Generally a temperature of 110 and above I would think would be palatable for hot food." When asked what he thought about the test tray the previous night, OSM #9 stated, "I would say it could have been warmer." OSM #9 stated that a variety of issues could have made it so that the food was not warm such as time it took on the tray line, the depths of the pan, if staff are stirring the food, or if the hot plate was warm enough. OSM #9 stated that the kitchen has been trying to work on this issue.

Facility policy titled, "Food Temperatures," did not address temperatures that hot food should be served. The policy documented the following: "The director of dining services is responsible for seeing that all meal service: Is served in an attractive and appetizing manner."

On 10/27/16 at 9:43 a.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

No further information was presented prior to exit.

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

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

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

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

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

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility

1. Nurse failed to secure medication in medication cart during medication observation. No resident identified to be affected.

2. Medication observation will be conducted for each licensed nurse who are responsible for medication administration.

3. ADNS/Designee will provide education to a license nurses responsible for medication administration on medication administration guidelines, including proper procedure for securing medication on the medication cart.

4. DNS/Designee will monitor medication education audits. All findings will be included in QAPI for 3 months.

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document review, it was determined that facility staff failed to secure medication on one of eight medication carts in the facility.

Facility staff failed to secure a bottle containing ferrous sulfate (1) and a medicine cup containing a ferrous sulfate tablet.

The findings include:

An observation of the medication administration was made on 10/25/16 at 4:32 p.m. with LPN (licensed practical nurse) #4. LPN #4 took a bottle of ferrous sulfate 65 mg (milligram) from the medication cart and put one pill into a medicine cup. The bottle was approximately half full. LPN #4 then went into the resident's room leaving the bottle and medicine cup on the top of the medicine cart which was in front of the resident's room. LPN #4 washed her hands at the sink with her back to her medication cart. She then took the resident's blood sugar and returned to the medication cart. LPN #4 did not have continuous line of sight of the medication cart. There were no residents observed around the medication cart at that time. LPN #4 then put the bottle of ferrous sulfate into the cart and took the ferrous sulfate in the medicine cup into the resident's room and administered it.

An interview was conducted on 10/26/16 at 11:30 a.m. with LPN #4. When asked what steps staff follow when leaving their medication cart, LPN #4 stated, "I close the laptop, make sure there's no medicines left out, lock it and bring it close to the door so it's not out of sight." When asked why it was important to make sure there were no medications on the top of the cart when it was not in sight, LPN #4 stated, "A resident could walk

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around and could grab the medication. We don't want them to have any access on top of the cart. The medication administration observation was shared with LPN #4. When asked if the medications had been secured, LPN #4 stated, "No it wasn't."

On 10/26/16 at 7:00 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled, "Medication Storage in the Facility" documented, "Policy. Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Procedures. B. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) permitted to access medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access."

No further information was provided prior to exit.

"Make sure all medications are in locked containers in a room (eg., a medication room) or are under constant surveillance." Potter and Perry, Fundamentals of Nursing, seventh edition, 2009, p. 703.
(1) Ferrous Sulfate -- Ferrous Sulphate is an iron supplement for iron deficiency and iron deficiency anemia when the need for such therapy has been determined by a physician. This information was obtained from:
https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?id=37597

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F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

1. The container of blood sugar test strips have been sanitized

2. Audit will be conducted by the ADNS/Designee on all licensed nurses responsible for administering medication on infection control guidelines during medication pass.

3. ADNS/Designee will educate all licenses nurses responsible for medication administration on proper technique to maintain infection control guidelines.

4. DNS/Designee will monitor audits weekly x 4 then monthly x 2 months. All findings will be included in QAPI.

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This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, it was determined that facility staff failed to maintain infection control practices for two of 13 residents in the medication administration observation, Resident #28 and Resident #18.

1. Facility staff failed to sanitize a container of blood sugar test strips, used in Resident # 28's room, before returning them to the medication cart.

2. Facility staff placed the cap of the eye drop vial on Resident #18's bed.

The findings include:

1. Resident #28 was admitted to the facility on 12/11/15 and readmitted on 3/30/16 with diagnoses that included but were not limited to: diabetes, high blood pressure, traumatic brain injury and depression and psychosis.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 7/14/16 coded the resident as scoring 15 out of 15 on the brief interview for mental status indicating the resident was cognitively intact to make daily decisions.

A medication administration observation was made on 10/25/16 at 4:32 p.m. with LPN (licensed practical nurse) #4. LPN #4 took a container of blood glucose test strips out of the medication cart and took it into the resident's room and set in on the resident's bedside table without a barrier. LPN #4 obtained the resident's

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blood sugar and returned to the cart and put the container of the test strips back into the cart without sanitizing the container.

An interview was conducted on 10/25/16 at 3:10 p.m. with LPN #10. When asked what process staff follows when taking a container from the medication cart into a resident's room and when returning it to the cart, LPN #10 stated, "It should be wiped off." When asked why, LPN #10 stated, "Because it's bringing things from their room into the cart and contaminating the cart."

An interview was conducted on 10/26/16 at 11:30 a.m. with LPN #4. When asked what process staff follows when they take a container into the resident's room and then return it to the cart, LPN #4 stated, "You're supposed to clean it off with an alcohol swab." When asked why staff followed this process, LPN #4 stated, "For infection control." LPN #4 was made aware of the medication administration observation.

On 10/26/16 at 7:00 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled, Administration Procedures For All Medications" documented, "Policy. To administer medications in a safe and effective manner. Procedures. G. Use a barrier (e.g., clean disposable tray or plastic sup) to carry medication containers into the resident's room. This will serve as a barrier between the supplies and the over-the-bed table or other surface on which the supplies are placed while the medication is administration."

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No further information was provided prior to exit.

2. Resident #18 was admitted to the facility on 1/31/15 and readmitted on 6/5/15 with diagnoses that include but were not limited to Multiple sclerosis, cluster headaches, dementia without behavioral disturbance, convulsions and chronic kidney disease.

Resident #18's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 9/5/16. Resident #18 was coded as being moderately cognitively impaired in the ability to make daily decisions scoring 9 out of 15 on the BIMS (Brief Interview for Mental Status exam). Resident #18 was coded as requiring extensive assistance with transfers and dressing, limited assistance with ambulation and total dependence on staff with bathing.

A medication administration observation was made on 10/26/16 at 8:25 a.m. with LPN #7. LPN #7 removed a box containing a vial of eye drops from the medication cart for Resident #18. LPN #7 removed the eye drop vial from the box and entered the resident's room. She put on gloves and removed the top to the eye drop vial and laid the cap on the resident's bed. After administering the eye drops, LPN #7 picked up the cap and placed it on the vial, removed her gloves and put the vial back into the box and into the medication cart.

An interview was conducted on 10/26/16 at 11:55 a.m. with LPN #7. When the observation was reviewed with LPN #7, she stated, "I should have kept it in my hand." When asked why, LPN #7

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F 441	Continued From page 126 stated, "Because it's contaminated." An interview was conducted on 10/26/16 at 3:10 p.m. with LPN #10. When asked what staff did with the top of an eye drop vial during medication administration, LPN #10 stated, "When I take it off I hold it in my hand." When asked if it was acceptable to put the cap on the resident's bed, LPN #10 stated, "No, that will cause infection because it's contaminated." On 10/26/16 at 7:00 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit.	F 441		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to obtain a laboratory specimen as ordered by the physician for one of 28 residents in the survey sample, Resident #2. Facility staff failed to obtain a clostridium difficile (1) laboratory specimen as ordered by the doctor. The findings include:	F 502		

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Resident #2 was admitted to the facility on 5/24/16 and readmitted on 6/18/16 with diagnoses that included but were not limited to: pneumonia, depression, elevated cholesterol, diabetes and irregular heart beat.

The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 7/21/16 coded the resident as being able to understand others and make his needs known. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the physician's order dated and signed on 6/24/16 documented, "C-Diff (clostridium difficile) Cx (culture) X (times) 3 on 3 separate days."

Review of the care plan did not evidence documentation regarding the need for the clostridium difficile.

Review of the May 2016 treatment administration record did not evidence documentation regarding the clostridium difficile order.

Review of the laboratory specimens documented that the resident had a clostridium difficile specimen obtained on two occasions, 6/24/16 and 6/27/16. There was no documentation that the third specimen had been obtained as ordered.

Review of the bowel and bladder detail report for June 2016 documented that Resident #2 was incontinent of bowel movements on 6/28/16, 6/29/16 (twice) and 6/30/16.

An interview was conducted on 10/27/16 at 11:55

1. Resident #2's physician has been notified of the order not being carried out fully
2. UM/Designee will audit 100% of lab orders x 7 days.
3. ADNS/Designee will educate all licenses nurses on lab processing/tracking guidelines.
4. DNS/Designee will review labs daily during morning meeting each day. All findings will be included in QAPI for 3 months.

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a.m. with LPN (licensed practical nurse) #9. When asked the process staff follows if they are not able to obtain a laboratory specimen clostridium difficile ordered by the physician, LPN #9 stated, "If we can't get a stool or if it's not liquid then we let the doctor know and get a d/c (discontinue) order."

An interview was conducted on 10/27/16 at 2:45 p.m. with RN (registered nurse) #1, the assistant director of nursing. When asked if staff would notify the physician when they could not obtain the clostridium difficile, RN #1 stated, "Well we didn't document it."

On 10/26/16 at 7:00 p.m. ASM (administrative staff member) #1, the administrator and ASM #2 were made aware of the findings.

Review of the facility's policy titled, "Lab Processing/Tracking Guideline" documented, "GUIDELINE STATEMENT: To ensure that Diagnostic tests are processed, ordered, obtained, performed, and results receive timely. Facility Diagnostic Testing System Review: 2. The DNS (director of nursing service) or designee will review the Diagnostic Tracking Form or (name of laboratory software) to ensure that the tracking process was initiated. This review is to monitor that any new orders were process, results were obtained, physician/NP (nurse practitioner) notification was conducted and that timely physician/NP response was received."

No further information was obtained prior to exit.

(1) Clostridium difficile, the leading cause of hospital-acquired diarrhea, is known to cause severe colitis. This information was obtained

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F 502	Continued From page 129 from: https://www.ncbi.nlm.nih.gov/pubmed/17390162	F 502		
F 503 SS=D	483.75(j)(1)(i-iv) LAB SVCS - FAC PROVIDED, REFERRED, AGREEMENT	F 503		

If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.

If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories specified in Part 493 of this chapter.

If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements of part 493 of this chapter.

If the facility does not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements of part 493 of this chapter.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and facility policy review, it was determined that facility staff failed to discard expired laboratory supplies for one of two medications rooms.

Facility staff failed to discard fecal occult blood testing supplies that had expired in June 2016 in

1. The expired supplies have been discarded.
2. An audit will be conducted on every item in supply room.
3. ADNS/Designee will conduct education for licensed nurse regarding following manufactures guidelines for discarding expired lab supplies per date noted on product.
4. DNS/Designee will review audits and submit to QAPI monthly for 3 months.

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the South medication room.

The findings include:

An observation was made of the South medication room on 10/26/16 at 1:55 p.m. with LPN (licensed practical nurse) #3. A almost full box of 100 occult blood testing slides with an expiration date of June 2016 was observed. An interview was conducted with LPN #3 at that time. When asked how often the medication rooms were checked, LPN #3 stated, "We check it once a week. Any nurse can do it." When asked what was included in checking the medication rooms, LPN #3 stated, "We're looking for expiration." When asked what consequence would occur if they used the expired supplies, LPN #3 stated, "Well if it's expired I couldn't use that because the liquid (developer) would be no good. The results would be inconclusive." Review of the manufacturer's literature documented, "Precautions Seracult (occult blood testing) slides and tape: Do not use product after the expiration date."

On 10/27/16 at 3:00 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

According to applicable requirements for laboratories specified in Part 493 of this chapter: § 493.1252 Standard: Test systems, equipment, instruments, reagents, materials, and supplies. (4)
d) Reagents, solutions, culture media, control

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materials, calibration materials, and other supplies must not be used when they have exceeded their expiration date, have deteriorated, or are of substandard quality.

F 504 SS=D 483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN

The facility must provide or obtain laboratory services only when ordered by the attending physician.

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 obtain physician orders for a laboratory test for one of 28 residents in the survey sample, Resident #5.

The facility staff failed to obtain a physician order for the collection and testing of urine from Resident #5 on 8/8/2016.

The findings include:

Resident #5 was admitted to the facility on 6/19/15 with diagnoses that included, but were not limited to, diabetes, dehydration, Alzheimer's, bipolar disorder, dementia, depression and anxiety.

Resident #5's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 9/7/16. Resident #5 was not coded for her cognition in Section C on this assessment, and the staff assessment was not completed. On Resident

F 504

1. Staff failed to obtain a physician order for collection and testing of urine for resident #5. It was noted RP/MD/NP aware.

2. UM/Designee will conduct an audit of all labs x 7 days.

3. ADNS/Designee will educate all licensed nurses on obtaining a physician order prior to lab services being requested.

4. DNS/Designee will review lab orders daily during morning meeting. All results will be reviewed by QAPI committee monthly x 3 months.

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#5's admission MDS assessment with an ARD of 7/30/16, Resident #5 was coded in Section C, cognitive patterns, as being unable to answer the questions. The staff assessment in Section C coded Resident #5 as a "3", indicating that this resident was severely impaired for daily decision making.

Review of Resident #5's progress notes revealed, in part, the following documentation: "General Note. 8/8/2016 16:17:00 (4:17 p.m.) Obtained 60 cc (cubic centimeters) of yellow cloudy urine via cath (catheter) @ 1610 (4:10 p.m.) for UA (urinalysis) and C&S (culture and screen - a test to determine the microscopic bacterial pathogen present in the urine). Awaiting lab pickup."

An end of day meeting was held on 10/26/16 at 6:40 p.m. with ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing services. ASM #2 was provided a list of laboratory tests that did not have a corresponding physician order. ASM #2 was requested to provide evidence that there was an order transcribed in the clinical record.

On 10/27/16 at 11:30 a.m. LPN (licensed practical nurse) #7 provided this surveyor with copies of the progress notes for the 8/8/16 laboratory tests and stated that there was not a physician order in the clinical record for the test performed. LPN #7 was asked whether or not nursing should collect laboratory specimens without a physician order. LPN #7 stated, "An order must be received and placed into the electronic chart and a copy of the electronic request for the laboratory test is to be placed in the paper chart along with the laboratory requisition for collection." LPN #7 was asked whether or not that was done for the above

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F 504	Continued From page 133 laboratory test completed for Resident #5. LPN #7 stated it was not. No further information was provided prior to the end of the survey process.	F 504		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. 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 maintain a complete and accurate clinical record for five of 28 residents in the survey sample, Residents #6, #25, #13, #7 and #5. 1. The facility staff failed to document the decision of Resident # 6's family in regards to not having a feeding tube placed. 2. The nurse practitioner failed to document an assessment regarding concern that Resident #25	F 514	1. The facility has documented the decision of Resident #6's family in regards to not having a feeding tube placed. Resident #25 has discharged from the facility. The med error regarding the administration of OxyContin to Resident #13 has been documented. The inaccurate documentation of Resident #7's blood pressure on 9/29/16 and 9/30/16 has been noted. Resident #5's code status was corrected in PCC to match their medical chart. 2. An audit of current resident's medical chart will be completed to validate that resident information is up to date and accurate 3. The DNS or designee will in-service the Health Information Manager and all current Licensed Nursing Staff on documentation, medication administration documentation, refusal of care, and code status order guidelines. 4. The DNS or designee will review documentation and change of code status daily in clinical start up. The results of the audit will be reviewed and submitted to QAPI for 3 months.	November 18, 2016

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(a resident with a colostomy) presented with feces leaking from his anus and failed to document a discussion with the resident's wife concerning this matter.

3. For Resident #13, facility staff documented Oxycontin 20 mg (1) was administered on 7/15/16 and 7/17/16 when 15 mg of Oxycontin was actually administered, and facility staff documented that Oxycontin 20 mg was administered on 7/16/16 3-11 shift, when it was not administered.

4. Facility staff failed to accurately document blood pressures on the medication administration record for Resident #7 on 9/29/16 and 9/30/16 for Resident #7.

5. The facility staff failed to ensure that the correct code status was documented in Resident #5's electronic clinical record and on the Kardex (a communication tool used to provide specific information to the CNA's (certified nursing assistants) working with a resident. The staff was unable to verbalize an accurate code status for Resident #5 when looking in the electronic record.

The findings include:

1. Resident #6 was admitted to the facility on 11/2/15 with diagnoses that included but were not limited to: stroke, adult failure to thrive, diabetes, high blood pressure, Parkinson's disease, and depression. The resident was on hospice care as of 8/8/16.

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The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 8/8/16, coded the resident as being severely impaired to make cognitive daily decisions. Resident #6 was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which she required supervision after set up assistance was provided.

The nurse practitioner's note dated, 12/11/15, documented in part, "Assessment and Plan: 1. Poor Appetite: Remeron (used to treat depression) (1) 15 mg (milligrams) PO (by mouth) q HS (bedtime), dietary consult, house supplements weekly weights."

The nurse practitioner note dated, 12/14/15, documented in part, "Assessment and Plan: 1. Poor PO (by mouth) intake/refusal of meds (medications): Suggested PEG (percutaneous endoscopic gastrostomy) Tube (a feeding tube placed in the stomach through the abdominal wall (2)) /surgical consult."
The nurse practitioner note dated, 12/17/15, documented in part, "Assessment and Plan: 5. Poor PO intake/refusal of meds: Suggested PEG Tube, surgical consults. Started on Remeron 15 mg PO qHS."
The nurse practitioner note dated, 12/22/15, documented in part, "Assessment and Plan: 5. Poor PO intake/refusal of Meds and therapies: Family aware, decision to be made RE (regarding): PEG tube."
The nurse practitioner note dated, 12/28/15, documented in part, "Assessment and Plan: 7. Decreased PO intake? Surgical consult for PEG tube."

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There was no further documentation related to the PEG tube in the nurse practitioner's notes.
The nurse's note dated, 12/16/15 at 10:41 a.m. documented, "Call to family to discuss PEG tube as resident is candidate. Left message with family to return call." Written by RN (registered nurse) #1.
The nurse's note dated, 12/17/15 at 10:15 a.m. documented, "Left message with family X2 (two times) regarding resident refusing medications and PEG consult order. Notified NP (nurse practitioner)." Written by RN (registered nurse) #1.
The nurse's note dated, 12/18/15 at 9:30 a.m. documented, "Spoke with resident's son regarding PEG tube and reason for order. Resident refusing medications and to eat. Expressed that resident is showing signs of depression but is refusing to take any medications that can assist with the depression. Son is meeting with brother (other son) to discuss and was encouraged to make a decision as soon as possible." Written by RN (registered nurse) #1.
There was no further documentation related to the discussion with the family or the decision of the family related to the PEG tube.
On 10/26/16 at 10:35 a.m. the unit manager, LPN (licensed practical nurse) #6 was asked to locate the documentation of the final discussion with the family regarding the placement of the PEG tube.
On 10/26/16 at 1:10 p.m. RN #1 came to this surveyor and stated, "The family decided against the PEG tube. Then the family was here more frequently and her appetite increased and she took her medications more frequently." When asked where the discussion of that was documented, RN #1 stated, "I was on my way out the door and I saw the son here. I went in and he told me of the family decision of not doing the

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PEG tube." When asked where that conversation was documented, RN #1 stated, "I didn't document it." When asked if she should have documented it, RN #1 stated, "Yes, I should have."

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 10/26/16 at 3:10 p.m. When asked if a conversation with a family regarding their decision regarding the placement of a PEG tube should be documented in the clinical record, ASM #2, stated, "The nurse should write a note if it is has an impact on the resident's care."

The facility policy, "Responsibility of Medical Record Documentation" documented, "The provider of care is responsible for ensuring that entries made in the Medical Record are of high quality, including legibility...Documentation should include at a minimum: Provisions of and response to nursing care. Provision of and response to medical treatment and care. Observation and description of significant change/changes in condition. Assessments. Significant changes in Resident's care and Treatment. Outcome of care and treatment provided. Ongoing plan of discharge (or documentation when discharge potential does not exist: Resident's response to activities program. Resident's response to nutrition care services. Provision of and response to rehabilitation services and provision of and response to social service interventions."

Potter-Perry Fundamentals of Nursing, 6th Edition, page 477 reads: "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive

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and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice.

The ASM #1, the administrator, ASM #2, the director of nursing, ASM #4, the regional nurse consultant, and RN (registered nurse) #1, the assistant director of nursing, were made aware of the above findings on 10/26/16 at 4:15 p.m. No further information was provided prior to exit.

2. The nurse practitioner failed to document an assessment regarding concern that Resident #25 (a resident with a colostomy (1)) presented with feces leaking from his anus and failed to document a discussion with the resident's wife concerning this matter.

Resident #25 was admitted to the facility on 9/5/15. Resident #25's diagnoses included but were not limited to: diabetes (2), bipolar disorder (3) and peripheral vascular disease (4). Resident #25's admission MDS (minimum data set) with an ARD (assessment reference date) of 9/12/15 coded the resident as being cognitively intact. Section H coded the resident as having an ostomy. Resident #25 was discharged from the facility on 9/30/15.

Review of Resident #25's clinical record revealed the resident was admitted to the facility with a colostomy.

A nurse's note dated 9/30/16 documented, "Fecal matter leaking into wound from anus. This is a new findings. NP (nurse practitioner) is evaluating new finding of leakage..."

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Another nurse's note dated 9/30/16 documented, "Spoke with NP (name). States saw resident and spoke with wife regarding leakage of stool and plan for care. States wife has decided to go with Hospice and wants to take resident home when able."

A progress note signed by the nurse practitioner on 9/30/16 documented Resident #25 had a colostomy but failed to document any information regarding fecal matter leaking from the resident's anus or information regarding a discussion with Resident #25's wife.

On 10/26/16 at 4:05 p.m., an interview was conducted with ASM (administrative staff member) #5 (the nurse practitioner). ASM #5 was asked to describe her assessment of Resident #25 in regards to the concern about feces leaking from his anus and the discussion held with the resident's wife on 9/30/15. ASM #5 stated she honestly could not recall. ASM #5 reviewed the progress note she wrote on 9/30/15 and stated she documented Resident #25 had a poor prognosis and had a care plan meeting.

On 10/26/16 at 6:50 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings.

The facility policy titled, "Documentation Reviews" documented in part, "PROCEDURE: Perform, on a regular basis, Documentation Reviews for omissions in documentation by physicians, nursing staff, and other health care professionals..."

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No further information was presented prior to exit.

(1) "A colostomy is a stoma created from a part of the colon. For this surgery, the surgeon brings the colon through the abdominal wall and makes a stoma. A colostomy may be temporary or permanent. The colostomy is permanent when the surgeon removes or bypasses the lower end of the colon or rectum. A surgeon may perform a temporary colostomy for a damaged or an inflamed lower part of the colon or rectum that only needs time to rest or heal from injury or surgery. Once the colon or rectum heals, the surgeon repairs the opening in the abdominal wall and reconnects the colon so stool will pass normally. A surgeon performs a colostomy most often to treat rectal cancer, diverticulitis, or fecal incontinence--the accidental loss of stool." This information was obtained from the website: https://www.niddk.nih.gov/health-information/health-topics/digestive-diseases/ostomy-surgery-bowel/Pages/ez.aspx#sec6

(2) "Diabetes is a disease in which your blood glucose, or blood sugar levels are too high..." This information was obtained from the website: https://medlineplus.gov/diabetes.html

(3) "Bipolar disorder is a serious mental illness. People who have it go through unusual mood changes..." 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=bipolar&_ga=1.56859114.139120270.1477942321

(4) "Peripheral artery disease (PAD) (also known as peripheral vascular disease) is a condition of the blood vessels that supply the legs and feet. It leads to narrowing and hardening of the arteries. This causes decreased blood flow, which can

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injure nerves and other tissues..." This information was obtained from the website: https://medlineplus.gov/ency/article/000170.htm

3. For Resident #13, facility staff documented OxyContin 20 mg (1) was administered on 7/15/16 and 7/17/16 when 15 mg of OxyContin was actually administered, and facility staff documented that OxyContin 20 mg was administered on 7/16/16 3-11 shift, when it was not administered.

Resident #13 was admitted to the facility on 11/12/14 and readmitted on 1/19/16 with diagnoses that included but were not limited to anterior dislocation of the left humerus, atherosclerotic heart disease, dementia without behavioral disturbance, hypertension and osteoarthritis. Resident #13's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 8/15/16. Resident #13 was coded as being cognitively intact in the ability to make daily decisions scoring 13 out of 15 on the BIMS (brief interview for mental status exam). Resident #13 was coded as requiring extensive assistance from staff with transfers, dressing, and personal hygiene; and total dependence on staff with bathing.

Review of Resident #13's clinical record revealed the following physician order signed by the NP (Nurse Practitioner) dated 7/15/16, "OxyCONTIN Tablet ER (extended release) 12 Hour Abuse-Deterrent 15 MG (milligrams)...Give 1 tablet by mouth two times a day for pain management...discontinue dated 7/15/16."

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The following order was put into place on 7/15/16, "OxyCONTIN Tablet ER 12 hour Abuse-Deterrent 20 MG (milligrams) Give 1 tablet by mouth two times a day for pain management."

Review Resident #13's July 2016 eMAR (electronic medication administration record) documented that OxyContin 20 mg was administered on 7/15/16 at 9:00 p.m., 7/16/16 at 9:00 p.m., and 7/17/16 at 9:00 a.m.

Review of the narcotic logs for both the OxyContin 15 mg and OxyContin 20 mg revealed that OxyContin 15 mg was administered on 7/15/16 at 9:00 p.m. and on 7/17/16 at 9:00 a.m. which was not the correct dose; and the OxyContin 20 mg was not administered at all on 7/16/16 at 9:00 p.m.

On 10/27/16 at 2:16 p.m., an interview was conducted with LPN (licensed practical nurse) #1, the nurse who signed off that OxyContin 20 mg was administered on 7/15/16. When asked the process of administering a medication, LPN #1 stated that you would look at order to the medication and confirm the order prior to administering. LPN #1 stated that it looked like she had given the 15 mg on accident and marked down that 20 mg was given. LPN #1 stated, "I really don't remember." LPN #1 confirmed that the Resident #13's eMAR was inaccurate documentation.

The nurse who administered OxyContin 15 mg on 7/17/16 but documented, she administered OxyContin 20 mg no longer works at the facility and could not be reached for an interview.

On 10/27/16 at 2:20 p.m., a telephone interview

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was conducted with RN (registered nurse) #7, the nurse who documented OxyContin 20 mg was administered on 7/16/16 3-11 shift when it was not administered. RN #7 stated that it is never ok to document that a medication was given when it was not. RN #7 could not recollect that day.

On 10/27/16 at 2:30 p.m., an interview was conducted with LPN #8. When asked who destroys narcotics she stated that the RN supervisors can destroy the medications together. She stated that the RN supervisors destroy the medications when they can get to it. LPN #8 looked at the narcotic log for Resident #13's OxyContin 15 and 20 mg. LPN #8 stated that it appeared on multiple occasions; nursing was popping out the wrong OxyContin and then wasting it with another nurse once they realized they had popped out the wrong dose. LPN #8 confirmed that on 7/15/16 and 7/17/16 the wrong dose of OxyContin was administered. LPN #8 confirmed that Resident #13's eMAR was inaccurate.

On 10/27/16 at 11:20 a.m., ASM (administrative staff member) #1 and ASM #2 the DON (Director of Nursing) were made aware of the above concerns.

Facility policy titled, "Documentation Reviews" did not address the above concerns.

The following quotation is found in Potter and Perry's Fundamentals of Nursing 6th edition (2005, p. 477): "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be

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accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to the clients."

(1) OXYCONTIN is indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=BFDFE235-D717-4855-A3C8-A13D26DADEDE.

4. Facility staff failed to accurately document blood pressures on the medication administration record for Resident #7 on 9/29/16 and 9/30/16.

Resident #7 was admitted to the facility on 10/25/16 with diagnoses that included but were not limited to: depression, high blood pressure, stroke and dementia.

The most recent MDS, a quarterly assessment, with an ARD (assessment reference date) of 7/15/16 coded the resident sometimes understanding others and sometimes being able to make self understood. The resident was coded as a 99 in the brief interview for mental status indicating the resident was not able to answer the questions. In section G titled, "Functional Status" the resident was coded as a "7/2" defined as "7. Activity occurred only once or twice. 2. One person physical assist" for all activities of daily living.

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Review of the physician's orders for October 2016 documented, "Orthostatic Blood pressure upon waking x3 days in the morning for Orthostatic B/P (blood pressure) -Order Date- 09/28/16."

Review of the September 2016 medication administration record documented, "Orthostatic Blood pressure upon waking x3 days in the morning for Orthostatic B/P (blood pressure) -Order Date- 09/28/16." On 9/29/16 at 6:00 a.m. it was documented, "(Nurse's initials) B/P (blood pressure) 120/8. B/P 2nd 120/6. B/P 3rd X (no blood pressure documented)." On 9/30/16 at 6:00 a.m. it was documented, "(Nurse's initials) B/P 120/7. B/P 2nd 110/6. B/P 3rd X (no blood pressure documented." On 10/1/6 no blood pressures were documented.

Review of the nurse's notes for 9/29/16 and 9/30/16 did not evidence documentation regarding the blood pressures. The nurse's note dated 10/1/16 documented that the resident refused to have the blood pressures taken.

Review of the weights and vitals summary report did not evidence documentation of the vitals for 9/29/16 or 9/30/16 at 6:00 a.m.

An interview was conducted on 10/27/16 at 11:30 a.m. with LPN (licensed practical nurse) #4. When asked to review the September 2016 medication administration record for Resident #7, LPN #4 stated, "You don't know if it's 60 what or 70 what." When asked why it was important to accurately document the blood pressures, LPN #4 stated, "Because they're on a medication to support that." When asked if clinical decisions were based on the documentation, LPN #4

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stated, "Oh yes. I would have put the results in my documentation if I couldn't accurately document them on the MAR (medication administration record)."

The nurse who documented the blood pressures was not available for interview.

On 10/27/16 at 3:00 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled, "Blood Pressure Measurement" documented, "PROCEDURE PURPOSE: To obtain a measurement of the amount of pressure exerts against the walls of an artery. To assess change in condition. To assess effectiveness of medication. PROCEDURE DETAILS: Documentation may include: Time, date, blood pressure reading with systolic/diastolic pressure...Any deviations in pressure...Signature and title."

No further information was obtained prior to exit.

(1) Orthostatic hypotension is a sudden fall in blood pressure that occurs when a person assumes a standing position. This information was obtained from: http://www.ninds.nih.gov/disorders/orthostatic_hypotension/orthostatic_hypotension.htm Measuring Orthostatic Blood Pressure. 1. Have the patient lie down for 5 minutes. 2. Measure blood pressure and pulse rate. 3. Have the patient stand. 4. Repeat blood pressure and pulse rate measurements after standing 1 and 3 minutes. This information was obtained from:

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http://www.cdc.gov/steadi/pdf/measuring_orthostatic_blood_pressure-a.pdf

5. The facility staff failed to ensure that the correct code status was documented in Resident #5's electronic clinical record and on the Kardex (a communication tool used to provide specific information to the CNA's (certified nursing assistants) working with a resident. The staff was unable to verbalize an accurate code status for Resident #5 when looking in the electronic record.

Resident #5 was admitted to the facility on 6/19/15 with diagnoses that included, but were not limited to, diabetes, dehydration, Alzheimer's, bipolar disorder, dementia, depression and anxiety.

Resident #5's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 9/7/16. Resident #5 was not coded for her cognition in Section C on this assessment, and the staff assessment was not completed. On Resident #5's admission MDS assessment with an ARD of 7/30/16, Resident #5 was coded in Section C, cognitive patterns, as being unable to answer the questions. The staff assessment in Section C coded Resident #5 as a "3", indicating that this resident was severely impaired for daily decision making.

A review of Resident #5's physician order summary dated 10/1/16 - 10/31/16 revealed that Resident #5 was a full code, indicating that in the event where she would stop breathing or lose her

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	495140	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER-ROSE HILL	110 CHALMERS COURT BERRYVILLE, VA 22611

(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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pulse cardiopulmonary resuscitation would be initiated by the nursing staff. The order status was documented as active with an order date of 7/23/2016.

A review of Resident #5's paper chart at the nurse's station revealed a DNR (do not resuscitate) form dated and signed by Resident #5's RP (responsible party) on 10/24/16.

On 10/26/16 at 5:30 p.m. an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 was asked if she knew Resident #5's code status. LPN #3 stated, "I think she is a DNR. She was just placed in hospice." LPN #3 was asked how she would verify the code status of a resident. LPN #3 stated, "I can look in the computer." LPN #3 looked at the electronic record and stated, "According to this she (Resident #5) is a full code." LPN #3 asked one of the CNAs at the nurses station what the Kardex showed for Resident #5's code status. The CNA showed LPN #3 and this surveyor that there was not a "stop sign" beside Resident #5's name indicating that she was a full code. LPN #3 was asked who was responsible for updating the code status electronically. LPN #3 stated that the nurses should update the electronic record and that it should have been flagged in the chart for input. LPN #3 was asked if she could state how the different documentation in the computer versus in the paper record could impact the resident. LPN #3 stated, "There would be confusion as to what to do or what not to do."

A review of the facility policy "Cardiopulmonary Resuscitation (CPR) Guideline" revealed, in part, the following documentation: "A staff member other than the one who is providing the

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resuscitative effort must promptly identify/validate current code status."

An end of day meeting was held on 10/26/16 at 6:40 p.m. with ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing services. ASM #1 and ASM #2 were made aware of the discrepancy with code status for Resident #5 at that time.

No further information was provided prior to the end of the survey process.

State of Virginia

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F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 10/25/16 through 10/27/16. Corrections are required for compliance with the following with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 120 certified bed facility was 107 at the time of the survey. The survey sample consisted of 20 current resident reviews (Residents #1 through #19 and # 28) and eight closed record reviews (Residents #20 through #27).	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: 12 VAC 5 - 371 - 150-B.1 Resident Rights cross referenced to F 151 12 VAC 5 - 371 - 140 D.15 A Resident Rights cross referenced to F 154 12 VAC 5 - 371 - 150 A D.15 A Resident Right cross referenced to F 157 12 VAC 5 - 371 - 220 H Resident Rights cross referenced to F 157 12 VAC 5 - 371 - 140 D.15 A Resident Rights cross referenced to F 164 12 VAC 5 - 371 - 360 B, C Resident Rights cross referenced to F 164 12 VAC 5 - 371 - 270 A Quality of Life cross referenced to F 250 12 VAC 5 - 371 - 250 A Resident Assessment cross referenced to F 278 12 VAC 5 - 371 - 250 F, G Resident Assessment	F 001		

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

State of Virginia

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F 001	Continued From Page 1 cross referenced to F 279 12 VAC 5 - 371 - 250 F Resident Assessment cross referenced to F 280 12 VAC 5 - 371 - 200 B.1 Resident Assessment cross referenced to F 281 12 VAC 5 - 371 - 220 A Quality of Care cross referenced to F 309 12 VAC 5 - 371 - 220 B Quality of Care cross referenced to F 329 12 VAC 5 - 371 - 210 A.2 & 220 B Quality of Care cross referenced to F 332 & F 333 12 VAC 5 - 371 - 180 A Infection Control cross referenced to F 441 12 VAC 5 - 371 - 310 A Administration cross referenced to F 502, F 503, & F 504 12 VAC 5 - 371 - 360 E, F Administration cross referenced to F 514	F 001		