STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495416	A. BUILDING _____ B. WING _____	06/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHBY PONDS INC	21160 MAPLE BRANCH TERRACE ASHBURN, VA 20147

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted from 6/6/18 through 6/8/18. Significant corrections are required for compliance with the following 42 CFR Part 483 of the Federal Long Term Care requirements. The life safety code survey/report will follow. The census at this 44 certified bed facility was 40 at the time of the survey. The survey sample consisted of 13 current residents, Residents #35, 19, 29, 32, 5, 24, 148, 30, 39, 41, 13, 44, and 25 and two closed records, Residents #46a and 46b.	F 000		
F 577 SS=B	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and	F 577		7/20/18

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

Electronically Signed | 06/27/2018

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F 577	Continued From page 1 accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interview, it was determined that the facility staff failed to ensure survey results were accessible to all residents in the facility. The facility staff failed to ensure that survey results were in a location that was accessible to all residents and that signage was posted on where to find the survey results. The findings include: On 6/6/18 at 2:00 p.m., a group interview was conducted with four cognitively intact residents All four residents stated that they did not know where the survey results binder was located. All four residents propelled themselves in their wheelchair. On 6/6/18 at 2:45 p.m., observation of the survey results was conducted. The survey results binder was located on top of a tall table in the lobby. The survey results binder would not be visible to those bound to their wheelchair. There was no posted notice of the availability of the survey results binder. On 6/7/18 at approximately 6:30 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. They confirmed this writer's observations.	F 577	1. Survey binder results were moved to a location accessible for all residents immediately. Binder was also labeled on spine to ensure it is clearly identifiable. 2. Facility will educate residents of new survey binder location 3. Survey binder was moved permanently and education will completed to ensure residents are aware of location. 4. NHA or designee will complete a monthly audit X 3 months of survey binder location starting July 2018. All findings will be brought to our monthly QA/QI meetings for review.	

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F 577	Continued From page 2 No further information was presented prior to exit.	F 577		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically	F 580		7/20/18

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F 580	Continued From page 3 update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that facility staff failed to notify the physician for a change in condition for one of 15 residents in the survey sample, Resident #19. The facility staff failed to notify the physician when Resident #19 missed four doses of her Carbidopa-Levadopa on 6/2/18, 6/3/18, 6/6/18 and 6/7/18. The findings include: Resident #19 was admitted to the facility on 11/19/15 with diagnoses that included but were not limited to Parkinson's disease, high blood pressure and muscle weakness. Resident #19's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/1/18. Resident #19 was coded as being intact in cognitive function scoring 14 out of possible 15 on the BIMS (Brief Interview for Mental Status)	F 580	1.Physician was notified of medication hold for resident #19 on 6/2/18, 6/3/18, 6/4/18, 6/6/18 and 6/7/18. 2.DON or designee will complete 100% audit of residents receiving carbidopa-levadopa to ensure missed dosages of medications are documented. 3.SDC or designee will educate licensed nurses on physician notification guidelines. 4.ADON or designee will monitor administration of Carbipoda-Levadopa for any missed dosage monthly X 3 months starting July 2018. All findings will be brought to our monthly QA/QI meetings for review.	

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exam. Resident #19 was coded as requiring total dependence on staff with most ADLS (activities of daily living).

On 6/7/18 at approximately 3:30 p.m., an interview was conducted with Resident #19. Resident #19 stated that she was concerned that she does not receive her Sinemet (1) every three hours, like she is supposed to. Resident #19 stated that she has told the nurses when she is supposed to receive her sinemet.

Review of Resident #19's most recent POS (physician order sheet) revealed the following order: "Carbidopa 25 mg (milligrams)-levadopa 100 mg tablet (Sinemet) Tablet Oral Six times daily. Schedule: 6:00 a.m., 9:00 a.m., 12:00 p.m., 3:00 p.m., 6:00 p.m., 9:00 p.m." This order was initiated on 5/23/18.

Review of Resident #19's June 2018 MAR (medication administration record) revealed that she did not receive her Carbidopa-Levadopa on the following dates and times:
- 6/2/18 at 12:00 p.m.
- 6/3/18 at 6:00 p.m.
- 6/6/18 at 12:00 p.m.
- 6/7/18 at 12:00 p.m.

The following notes were documented on the MAR: "Not administered (see note)."

Review of Resident #19's June 2018 nursing notes failed to evidence why the Carbidopa-Levadopa was not administered on 6/2/18, 6/6/18 and 6/7/18. A note was written on 6/3/18 documenting that the resident was sleeping. There was no evidence that the physician was notified of the missed doses of the

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Carbidopa-Levadopa.

On 6/8/18 at 10:32 a.m., an interview was conducted with RN (registered nurse) #1, the nurse who did not administer the Carbidopa-Levadopa on all the above dates. When asked if she was familiar with Resident #19's Sinemet, RN #1 stated, "Yes, she takes it six times." When asked what would be some reasons why Resident #19 did not receive her Sinemet, RN #1 stated that most of the time Resident #19 was sleeping. RN #1 stated that she was told when she first started working at the facility, not to wake the residents up to take their medications. RN #1 stated that when Resident #19 is awake, she would give the Sinemet. RN #1 stated that she usually gives the next scheduled dose because she receives the medication so frequently, it is usually time for the next dose by the time Resident #19 is awake. RN #1 stated she has not notified the doctor of the missed medication because the medication was her regular scheduled medication. RN #1 stated that missed medication should be documented in a nursing note. RN #1 was not sure if she documented for all above dates.

On 6/8/18 at 10:39 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). When asked what the nurses should do if a resident was consistently missing their scheduled medication because they were sleeping, ASM #2 stated that she would expect her nurses to notify the physician to see if he wants nursing staff to wake the resident, or for a schedule change. ASM #2 stated she would expect to see documentation on a nursing note or on the MAR, every time a resident misses their scheduled

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F 580	Continued From page 6 dose. On 6/8/18 at approximately 12:00 p.m., ASM #2 was made aware of the above concerns. The facility policy titled, "Physician Notification Guidelines," documents in part, the following: "The charge nurse will notify the provider of changes in a resident's condition/status...If a charge nurse has any doubt about whether a physician should be called, the situation will be discussed with the nursing supervisor and/or nursing administrator on-call. The basic rule of thumb to follow will be, when in doubt call the physician/provider to secure guidance assistance and direction to handle the situation." No further information was presented prior to exit. (1) Sinemet (Carbidopa/Levadopa) used to treat symptoms of Parkinson's disease. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009448/?report=details.	F 580		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved	F 622		7/20/18

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sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

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

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F 622	Continued From page 8 communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide the required	F 622	1.Facility cannot send comprehensive care plan goals for residents that have already discharged.	

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F 622	Continued From page 9 documentation for a facility initiated transfer to the hospital for three of 15 residents in the survey sample, Residents #24, #44 and #35. 1. The facility staff failed to evidence that Resident #24's comprehensive care plan goals were provided to the receiving provider for a facility initiated transfer on 3/22/18. 2. The facility staff failed to evidence that Resident #44's comprehensive care plan goals were provided to the receiving provider for a facility initiated transfer on 4/26/18. 3. The facility staff failed to evidence that all required information was provided to the receiving provider for a facility-initiated transfer of Resident #35 on 1/28/18. The findings include: 1. Resident #24 was admitted to the facility on 2/14/18 and readmitted on 3/26/18 withe diagnoses that included but were not limited to: poor circulation to the feet, amputation of toes on right foot, dementia, anxiety and weakness. The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 4/27/18 coded the resident as having scored a three out of 15 on the BIMS (brief interview for mental status) indicating the resident was acutely impaired cognitively. The resident was coded a requiring assistance for all activities of daily living. Review of the nurse's notes dated 3/22/18 at 7:02 a.m., documented, "Called to guest's room during care. Guest's brief was wet and soaked with dark	F 622	2.DON or designee will review all facility initiated transfers from 6/8/18 to ensure comprehensive care plan goals were sent to receiving provider. 3.SDC or designee will educated licensed nurses on sending comprehensive goals to receiving provider for facility initiated transfers. 4.Clinical Manager or designee will monitor facility initiated transfers to ensure comprehensive care plan goals were provided to the receiving provider monthly x 3months starting July 2018. All findings will be brought to our monthly QA/QI meetings for review.	

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brown blood with a foul smell. No bowel movement. Vital signs within normal range....Denies any pain nor discomfort. NP (nurse practitioner notified) and ordered for guest to be send (sic) to the ER (emergency room)." Further review of the notes did not evidence that the resident's comprehensive care plan goals had been sent with the resident.

An interview was conducted on 6/8/18 at 9:55 a.m. with RN (registered nurse) #2, the unit manager, regarding what is sent to the hospital with the resident on a facility-initiated transfer. RN #2 stated, "A copy of the medication list, their face sheet a copy of the MAR (medication administration record." When asked if the comprehensive care plan was sent with the resident, RN #2 stated, "No."

An interview was conducted on 6/8/18 at 10:44 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked what documentation was sent to the hospital with the resident on a facility-initiated transfer, ASM #2 stated, "When the resident goes to the hospital we send a med (medication) list and a face sheet and give report." When asked if the resident's comprehensive care plan was sent to the hospital, ASM #2 stated, "No."

On 6/8/18 at approximately 12:00 p.m. ASM #1, the administrator and ASM #2, the director of nursing, were made aware of the findings.

Review of the facility's policy title, "Facility Initiated Transfer/Discharge" documented, "Policy: A guest or resident may not be discharged from the facility unless specific criteria is met. The discharge must be documented in the

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medical record and appropriate information is communicated to receiving health care provider." There was no documentation evidencing that the comprehensive care plan was to be sent with the resident.

No further information was provided prior to exit.

2. The facility staff failed to evidence that Resident #44's comprehensive care plan goals were provided to the receiving provider for a facility initiated transfer on 4/26/18.

Resident #44 was admitted to the facility on 4/9/18 and readmitted on 4/29/18 with diagnoses that included but were not limited to: urinary retention, pneumonia, seizures, difficulty swallowing, feeding tube, communication deficit and difficulty walking.

The most recent MDS, a 30 day assessment, with an ARD of 5/25/18 coded the resident as having a six out of 15 on the BIMS indicating the resident was severely cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the nurse's notes dated 4/26/18 at 3:02 p.m. documented, "At about 12:14PM (p.m.), writer was notified about Resident not responding. Assessment made. Resident noted unresponsive with an initial vital signs of 96.3 ax (temperature taken under in the armpit), 94 (pulse), 88/64 (blood pressure), 91% (oxygen saturation) at 2lit (liters) NC (nasal cannula - soft plastic prongs that fit in the nose to deliver oxygen) MD (medical doctor) was notified and was present at site....MD ordered to transfer

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Resident to the ER (emergency room) for further evaluation."

An interview was conducted on 6/8/18 at 9:55 a.m. with RN (registered nurse) #2, the unit manager, regarding what is sent to the hospital with the resident on a facility-initiated transfer. RN #2 stated, "A copy of the medication list, their face sheet a copy of the MAR (medication administration record." When asked if the comprehensive care plan was sent with the resident, RN #2 stated, "No."

An interview was conducted on 6/8/18 at 10:44 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked what documentation was sent to the hospital with the resident on a facility-initiated transfer, ASM #2 stated, "When the resident goes to the hospital we send a med (medication) list and a face sheet and give report." When asked if the resident's comprehensive care plan was sent to the hospital, ASM #2 stated, "No."

On 6/8/18 at approximately 12:00 p.m. ASM #1, the administrator and ASM #2, the director of nursing, were made aware of the findings.
3. The facility staff failed to evidence that all required information was provided to the receiving provider for a facility-initiated transfer of Resident #35 on 1/28/18.

Resident #35 was admitted to the facility on 11/19/15 and readmitted on 5/12/18 with diagnoses that included but were not limited to pneumonia, end stage renal disease, heart failure, atrial fibrillation, and Chron's disease. Resident #35's most recent MDS (minimum data set) assessment was a 14 day scheduled

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assessment with an ARD (assessment reference date) of 5/24/18. Resident #35 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #35's clinical record revealed that he had been transferred to the hospital on 1/28/18. The following note was documented: "Resident is alert and oriented x3 (person, place, time), V/S (vital signs) were 143/60, (blood pressure), 92 (pulse), 93 % (oxygen saturation percent), 100.5 (temperature) (fever). Resident complains about Chills, Cough, body ache. Administer PRN (as needed) Tylenol (1) & (and) Mucinex (2) as ordered, For follow up recheck his temp. (temperature) again it was 100 F (Fahrenheit) and complains about SOB (shortness of breath), administer 2 L (liters). Called daughter and inform resident about resident's condition. Notified MD (medical doctor). As further orders, send to ER (emergency room) for observation."

There was no evidence that the required documentation; physician contact information, responsible party contact information, advanced directives, any special instructions for ongoing care, and the comprehensive care plan goals were sent with the resident at the time of transfer on 1/28/18.

On 6/18/18 at 10:00 a.m., an interview was conducted with RN (registered nurse) #2, the unit manager. When asked what documents are sent with residents when they are transferred to the hospital, RN #2 stated that the nursing staff with send the resident's medication list, face sheet, and a copy of the MAR (Medication

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Administration Record) to show when the last medication was given. RN #2 stated that the care plan does not go with the resident to the hospital at the time of transfer. When asked if nurses document what documents were sent with the resident at the time of the transfer, RN #2 stated, "No."

On 6/8/18 at 10:47 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (director of nursing). When asked what documents were sent with the resident during a transfer to the hospital, ASM #2 stated that nursing would send the medication list, face sheet and also give report to EMS (emergency medical services) for anything pertinent. ASM #2 stated that they also send any pertinent or abnormal laboratory results. When asked if the comprehensive care plan was sent with the resident, ASM #2 stated that the care plan was not sent with the resident.

On 6/8/18 at 10:50 a.m., ASM #2, the DON was made aware of the above concerns.

No further information was presented prior to exit.

(1) Tylenol- Treats minor aches and pains and also reduces fever. This information was obtained from The National Insitutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008785/?report=details.

(2) Mucinex- Used to clear mucous or phlegm from the chest when you have congestion from the cold or flu. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010512/?report=details.

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F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623		7/20/18

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F 623	Continued From page 16 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623		

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F 623	Continued From page 17 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide required written notification of a facility initiated transfer to the resident's representative and/or ombudsman for three of 15 residents in the survey sample, Residents #24, #44 and 35. 1. The facility staff failed to provide written notification to the resident representative and ombudsman for a transfer to the hospital on 3/22/18 for Resident #24. 2. The facility staff failed to provide written notification to the resident representative and ombudsman for a transfer to the hospital on 4/26/18 for Resident #44. 3. The facility staff failed to provide written notification to Resident #35's resident representative and the ombudsman for a	F 623	1. Facility will send written notification to resident representative and Ombudsman of facility initiated transfers for residents #24, #44, and #35. 2. DON or designee will review all facility initiated transfers from 6/8/18 to ensure written notification was sent to resident/resident representative and ombudsman. 3. SDC or designee will educate nurses to provide written notice to resident representative for facility initiated transfers. NHA or designee will educate Admin staff to provide written notification to Ombudsman for facility initiated transfers. 4. DON or designee will monitor facility initiated transfers to ensure compliance of written notification for facility initiated transfers monthly x 3 months starting July 2018. All findings will be brought to our	

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F 623	Continued From page 18 facility-initiated transfer on 1/28/18. The findings include: 1. Resident #24 was admitted to the facility on 2/14/18 and readmitted on 3/26/18 withe diagnoses that included but were not limited to: poor circulation to the feet, amputation of toes on right foot, dementia, anxiety and weakness. The most recent MDS (minimum data set), a significant change assessment, with an ARD (assessment reference date) of 4/27/18 coded the resident as having scored a three out of 15 on the BIMS (brief interview for mental status) indicating the resident was acutely impaired cognitively. The resident was coded a requiring assistance for all activities of daily living. Review of the nurse's notes dated 3/22/18 at 7:02 a.m., documented, "Called to guest's room during care. Guest's brief was wet and soaked with dark brown blood with a foul smell. No bowel movement. Vital signs within normal range....Denies any pain nor discomfort. NP (nurse practitioner notified) and ordered for guest to be send (sic) to the ER (emergency room)." Further review of the notes did not evidence that the resident's comprehensive care plan goals had been sent with the resident. An interview was conducted on 6/8/18 at 10:44 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked about notification when a resident is transferred to the hospital, ASM #2 stated, "We notify them (family) by phone 99% of the time unless they are here at the time." When asked if the resident or resident representative received anything in writing, ASM	F 623	monthly QA/QI meetings for review.	

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#2 stated, "No." When asked if the ombudsman was notified in writing of a facility initiated transfer, ASM #2 stated, "No but our volunteer ombudsman comes in three times a week and she asks who is out and we discuss it."

An interview was conducted on 6/8/18 at 11:02 a.m. with RN (registered nurse) #5, the admissions director. When asked if the ombudsman was notified when there was a facility initiated transfer, RN #5 stated, "No, not directly, no. She does come in routinely and she gets a copy of the census."

On 6/8/18 at approximately 12:00 p.m. ASM #1, the administrator, and ASM #2 were made aware of the findings.

Review of the facility's policy title, "Facility Initiated Transfer/Discharge" documented, "Policy: A guest or resident may not be discharged from the facility unless specific criteria is met. The discharge must be documented in the medical record and appropriate information is communicated to receiving health care provider. 8. A list of residents is temporarily transferred on an emergency basis to an acute care facility may be maintained and submitted to Ombudsman a minimum of monthly."

No further information was provided prior to exit.

2. The facility staff failed to provide written notification to the resident representative and ombudsman for a transfer to the hospital on 4/26/18 for Resident #44.

Resident #44 was admitted to the facility on

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4/9/18 and readmitted on 4/29/18 with diagnoses that included but were not limited to: urinary retention, pneumonia, seizures, difficulty swallowing, feeding tube, communication deficit and difficulty walking.

The most recent MDS (Minimum data set), a 30 day assessment, with an ARD (assessment reference date) of 5/25/18 coded the resident as having a six out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.

Review of the nurse's notes dated 4/26/18 at 3:02 p.m. documented, "At about 12:14PM (p.m.), writer was notified about Resident not responding. Assessment made. Resident noted unresponsive with an initial vital signs of 96.3 ax (temperature taken under in the armpit), 94 (pulse), 88/64 (blood pressure), 91% (oxygen saturation) at 2lit (liters) NC (nasal cannula - soft plastic prongs that fit in the nose to deliver oxygen) MD (medical doctor) was notified and was present at site....MD ordered to transfer Resident to the ER (emergency room) for further evaluation."

An interview was conducted on 6/8/18 at 10:44 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked about notification when a resident is transferred to the hospital, ASM #2 stated, "We notify them (family) by phone 99% of the time unless they are here at the time." When asked if the resident or resident representative received anything in writing, ASM

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#2 stated, "No." When asked if the ombudsman was notified in writing of a facility initiated transfer, ASM #2 stated, "No but our volunteer ombudsman comes in three times a week and she asks who is out and we discuss it."

An interview was conducted on 6/8/18 at 11:02 a.m. with RN (registered nurse) #5, the admissions director. When asked if the ombudsman was notified when there was a facility initiated transfer, RN #5 stated, "No, not directly, no. She does come in routinely and she gets a copy of the census."

On 6/8/18 at approximately 12:00 p.m. ASM #1, the administrator, and ASM #2 were made aware of the findings.

No further information was provided prior to exit.
3. The facility staff failed to provide written notification to Resident #35's resident representative and the ombudsman for a facility-initiated transfer on 1/28/18.

Resident #35 was admitted to the facility on 11/19/15 and readmitted on 5/12/18 with diagnoses that included but were not limited to pneumonia, end stage renal disease, heart failure, atrial fibrillation, and Chron's disease. Resident #35's most recent MDS (minimum data set) assessment was a 14 day scheduled assessment with an ARD (assessment reference date) of 5/24/18. Resident #35 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #35's clinical record revealed that he had been transferred to the hospital on

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1/28/18. The following note was documented: "Resident is alert and oriented x3 (person, place, time), V/S (vital signs) were 143/60, (blood pressure), 92 (pulse), 93 % (oxygen saturation percent), 100.5 (temperature) (fever). Resident complains about Chills, Cough, body ache. Administer PRN (as needed) Tylenol (1) & (and) Mucinex (2) as ordered, For follow up recheck his temp. (temperature) again it was 100 F (Fahrenheit) and complains about SOB (shortness of breath), administer 2 L (liters). Called daughter and inform resident about resident's condition. Notified MD (medical doctor). As further orders, send to ER (emergency room) for observation."

There was no documented evidence that the resident representative was provided written notification for the reason for transfer and that the ombudsman was made aware of the transfer on 1/28/18.

On 6/6/18 at 3:29 p.m., an interview was conducted with Resident #35 and his responsible party, his daughter. Both the resident and daughter stated that they are never given anything in writing discussing the reason for transfer. The daughter stated that she is always made aware verbally of a hospital transfer.

On 6/8/18 at 10:00 a.m., an interview was conducted with RN (registered nurse) #2, the unit manager. When asked if the resident or representative is ever provided written documentation documenting the reason for a transfer, RN #2 stated that notification was all verbal, and not written. When asked if the ombudsman was made aware of a facility-initiated transfer, RN #2 stated that

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F 623	Continued From page 23 nursing did not notify the ombudsman. On 6/8/18 at 11:04 a.m., an interview was conducted with RN #5, the Director of Healthcare Sales and Admissions. RN #5 stated that the ombudsman was not notified directly for facility-initiated transfers. RN #5 stated the ombudsman visited frequently, and was provided a copy of the census when she is in the building. On 6/8/18 at approximately 12:00 p.m., ASM (administrative staff member) #2, the DON (Director of Nursing) was made aware of the above concerns. No further information was presented prior to exit. (1) Tylenol- Treats minor aches and pains and also reduces fever. This information was obtained from The National Insitutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008785/?report=details. (2) Mucinex- Used to clear mucous or phlegm from the chest when you have congestion from the cold or flu. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010512/?report=details.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was	F 641	1. MDS for resident #35 with ARD of 5/24/18 has been corrected. MDS for	7/20/18

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F 641	Continued From page 24 determined that facility staff failed to ensure an accurate MDS (minimum data set) assessment for two of 15 residents in the survey sample, Resident #35, and #41. 1a. The facility staff failed to accurately code restraints on Resident #35's 14 day scheduled MDS assessment with an ARD (assessment reference date) of 5/24/18. 1b. The facility staff failed to reflect a fall that Resident #35 had on 4/1/18 on his quarterly assessment with an ARD of 4/24/18. 2. The facility staff failed to accurately code restraints on Resident #41's MDS (minimum data set), a 30 day assessment, with an ARD (assessment reference date) of 5/23/18. The findings include: 1a. Resident #35 was admitted to the facility on 11/19/15 and readmitted on 5/12/18 with diagnoses that included but were not limited to pneumonia, end stage renal disease, heart failure, atrial fibrillation, and Chron's disease. Resident #35's most recent MDS (minimum data set) assessment was a 14 day scheduled assessment with an ARD (assessment reference date) of 5/24/18. Resident #35 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #15 was coded as requiring supervision to limited assistance with one staff member for ADLS (activities of daily living). Section P (Restraints) coded Resident #35 as having bed rails as a restraint.	F 641	resident #35 with ARD of 4/24/18 has been corrected. MDS for resident #41 with ARD of 5/23/18 has been corrected 2. DON or designee will review MDS assessments from 6/8/18 to current date for accuracy. 3. SDC or designee will educate MDS coordinator on Erickson Living MDS completion and management policy. 4. ADON or designee will monitor 5 MDS assessments for accuracy monthly x 3 months starting July 2018.	

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On 6/6/18 at 3:29 p.m., an observation of Resident #35's room was conducted. Resident #35 had U-bars on both sides of his bed. The Ubars were not full-length side rails.

The following OT (occupational therapy) note dated 5/18/18, documented the following: "Resident completed bed mobility supine to sit with mod 1 without use of bed rail. Per resident, he does use bed rail when fatigued or due to lack of energy. Recommend use bilateral bed rail to optimize independence with bed mobility."

Review of Resident #35's care plan dated 5/12/18 documented in part, the following: "Bed mobility, I will continue to be independent with bed mobility daily. I need the following devices to be as independent as possible...U-bar right side U-bar left side."

There was no evidence in the clinical record that the right and left U-bars restricted his freedom of movement or normal access to his body.

On 6/8/18 at 9:04 a.m., an interview was conducted with RN (registered nurse) #4, the MDS coordinator. When asked the definition of a restraint, RN #4 stated that a restraint was anything physical that impedes movement to the body. RN #4 stated that restraints could be in different forms. When asked if U-bars were restraints, RN #4 stated that in the past, they were not classified as restraints. RN #4 stated that corporate was now calling U-bars side rails and that side rails were automatically considered restraints on the MDS. RN #4 stated that she was in the process of assessing all residents to see if they can use the U-bars for bed mobility. RN #4 stated they are taken off if the resident

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does not need them. RN #4 stated that if the U-bars are used for bed mobility, she does not consider them a restraint. RN #4 stated that she has to code them as a restraint on the MDS because they are side rails. When asked what she uses as a reference to complete Section P of the MDS, RN #4 stated that she uses the RAI (resident assessment instrument) manual. RN #4 stated that Resident #35 uses the U-bars for bed mobility especially on dialysis days when he is fatigued.

On 6/8/18 this writer reviewed the RAI's definition of restraints which documented, "Intent: The intent of this section is to record the frequency over the 7-day look-back period that the resident was restrained by any of the listed devices at any time during the day or night. Assessors will evaluate whether or not a device meets the definition of a physical restraint and code only the devices that meet the definition in the appropriate categories of Item P0100."

On 6/8/18 at approximately 12:00 p.m., ASM (administrative staff member) #2, the DON (Director of Nursing) was made aware of the above concerns.

No further information was presented prior to exit.

1b. For Resident #35, facility staff failed to reflect a fall that he had on 4/1/18 on his quarterly assessment with an ARD of 4/24/18.

Review of Resident #35's clinical record revealed that he had fallen on 4/1/18. The following nursing note was documented on 4/1/18: "The incident was reported to the writer by the wife of the resident. She stated, "(Name of Resident

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#35) fell." The resident stated that he was standing near the bed of his wife and tried to use the wheel chair sitting near the bed as support thinking the w/c was locked. Wheel chair moved and resident fell to the floor. Resident denies hitting head. He was not using walker at the time of the fall. The incident happened around 8:30 PM. ROM (range of motion) was done to all extremities and was WNL (within normal limits). No apparent injury was observed at that time. No skin changes were observed. Resident denies pain or discomfort. Neurochecks (neurological checks) in progress. Resident was encouraged to use walker while ambulating. Nursing will continue to monitor."

Review of Resident #35's quarterly assessment with an ARD of 4/24/18, failed to reflect this fall in Section J1800. (Falls). This was the most recent MDS assessment after the fall on 4/1/18.

On 6/8/18 at 9:14 a.m., an interview was conducted with RN (registered nurse) #4, the MDS nurse. RN #4 stated that she was responsible for completing Section J of the MDS. RN #4 stated that she would look back in the clinical record to see if the resident has had any falls during the look-back period and then document this information on the MDS. RN #4 was asked to check if Resident #35's fall on 4/1/18 was reflected on his 5/24/18 MDS.

On 6/8/18 at approximately 10:39 a.m., RN #4 stated that she had missed the fall on 4/1/18. RN #4 stated that she had modified the 5/24/18 MDS. RN #4 stated that she used the RAI manual as a reference when completing the MDS.

On 6/8/18 at approximately 12:00 p.m., ASM

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(administrative staff member) #2, the DON (Director of Nursing) was made aware of the above concerns. No further information was presented prior to exit.

The MDS RAI 3.0 manual documents the following:

"J1800: Any Falls Since Admission or Prior Assessment (OBRA or PPS), whichever is more recent
Item Rationale Health-related Quality of Life

· Falls are a leading cause of morbidity and mortality among nursing home residents.
· Falls result in serious injury, especially hip fractures.
· Fear of falling can limit an individual's activity and negatively impact quality of life.
J1800: Any Falls Since Admission or Prior Assessment (cont.)

Planning for Care
· Identification of residents who are at high risk of falling is a top priority for care planning. A previous fall is the most important predictor of risk for future falls.
· Falls may be an indicator of functional decline and development of other serious conditions such as delirium, adverse drug reactions, dehydration, and infections.
· External risk factors include medication side effects, use of appliances and restraints, and environmental conditions.
· A fall should stimulate evaluation of the resident's need for rehabilitation, ambulation aids, modification of the physical environment, or additional monitoring (e.g., toileting, to avoid incontinence).

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Steps for Assessment
1. If this is the first assessment (A0310E = 1), review the medical record for the time period from the admission date to the ARD.
2. If this is not the first assessment (A0310E = 0), the review period is from the day after the ARD of the last MDS assessment to the ARD of the current assessment.
3. Review all available sources for any fall since the last assessment, no matter whether it occurred while out in the community, in an acute hospital, or in the nursing home. Include medical records generated in any health care setting since last assessment.
4. Review nursing home incident reports, fall logs and the medical record (physician, nursing, therapy, and nursing assistant notes).
5. Ask the resident and family about falls during the look-back period. Resident and family reports of falls should be captured here whether or not these incidents are documented in the medical record.

Coding Instructions
· Code 0, no: if the resident has not had any fall since the last assessment. Skip to Swallowing Disorder item (K0100).
· Code 1, yes: if the resident has fallen since the last assessment. Continue to Number of Falls Since Admission or Prior Assessment (OBRA or PPS) item (J1900), whichever is more recent."

2. The facility staff failed to accurately code restraints on Resident #41's MDS (minimum data set), a 30 day assessment, with an ARD (assessment reference date) of 5/23/18.

Resident #41 was admitted to the facility on

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4/27/18 with diagnoses that included but were not limited to: fractured leg, high blood pressure, anemia, muscle weakness and anxiety.

The most recent MDS (minimum data set), a 30 day assessment, with an ARD (assessment reference date) of 5/23/18 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident\ was coded as requiring assistance from staff for all activities of daily living. The resident was coded as requiring extensive assistance of one staff member to move in bed and to get out of bed. The resident was coded as having restraints.

An observation was made on 6/6/18 at 10:30 a.m. of Resident #41. The resident was lying in bed. There were "U" shaped grab bars at the top of the bed level with the resident's head.

An interview was conducted on 6/6/18 at 11:05 a.m. wit Resident #41. When asked about the side rails, the resident stated, "I use those to help me move in the bed and to get out of bed. They really help me a lot." When asked if they get in her way, the Resident #41 stated, "No."

Review of the care plan initiated on 4/30/18 documented, "Bed Mobility - Functional Status" documented, "Goal(s): I need total assistance with bed mobility daily." "Transferring - Functional Status" documented, "I will need limited assistance to transfer daily." There was no evidence of documentation regarding restraints.

Review of the May 2018 physician's orders did not evidence an order for restraints or the use of

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grab bars for bed mobility.

An interview was conducted on 6/8/18 at 9:25 a.m. with RN (registered nurse) #4, the MDS coordinator. When asked what a restraint was defined as, RN #4 stated, "A restraint is anything physical that impedes movement or access to one's body." When asked why Resident #41 was coded as being restrained, RN #4 stated, "We always called them U bars not side rails. Then corporate said they were side rails, so now we have to code them as side rails. With the changes in MDS we have to code for side rails and then it's considered a restraint." When asked what document she used to determine how to code for restraints, RN #4 stated, "The RAI (resident assessment instrument)." A request for the restraint section of the RAI was requested.

An interview was conducted on 6/8/18 at 10:44 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked what was considered a restraint, ASM #2 stated, "A restraint is a device that prevents the resident from their range of mobility." When asked if there were, any residents restrained in the facility at that time, ASM #2 stated, "No. We are restraint free." When asked if the "U" bars were considered restraints, ASM #2 stated, "Those are used for repositioning and mobility in bed." When made aware of RN #4's statement that there was a corporate decision that "U" rails were considered side rails, ASM #2 stated, "There is nothing from corporate about that. We are assessing all the residents for entrapment risks." ASM #2 and this writer reviewed the RAI's definition of restraints which documented, "Intent: The intent of this section is to record the frequency over the 7-day look-back period that

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F 641	Continued From page 32 the resident was restrained by any of the listed devices at any time during the day or night. Assessors will evaluate whether or not a device meets the definition of a physical restraint and code only the devices that meet the definition in the appropriate categories of Item P0100." ASM #2 stated, "The "U" rails are not restraints." On 6/8/18 at approximately 12:00 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. On 6/8/18 at 12:22 p.m. RN #4, the MDS coordinator came to this writer and stated, "I checked the MDS and she wasn't coded for restraints on her admission and five day assessment. It was an error on my part." No further information was provided prior to exit.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		7/20/18

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F 656	Continued From page 33 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to develop and implement the comprehensive care plan for two of 15 residents in the survey sample, Resident #35 and #39. 1. The facility staff failed to check bruit and thrill to Resident #35's dialysis fistula on a daily basis per plan of care. 2. The facility staff failed to develop a comprehensive care plan for the care of Resident #39's right hip surgical site.	F 656	1. MD order obtained to check bruit and thrill for resident #35 on 6/8/18. Surgical site for resident #39 is healed as of 6/5/18. 2. DON or designee will review all residents with an AV fistula for documentation of assessment of bruit or thrill. DON or designee will review care plans for all residents with surgical sites. 3. SDC or designee will educate licensed nurses on assessment of bruit and thrill of AV fistula. SDC or designee will educate licensed nurses on developing a comprehensive care plan.	

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F 656	Continued From page 34 The findings include: 1. Resident #35 was admitted to the facility on 11/19/15 and readmitted on 5/12/18 with diagnoses that included but were not limited to pneumonia, end stage renal disease, heart failure, atrial fibrillation, and Chron's disease. Resident #35's most recent MDS (minimum data set) assessment was a 14 day scheduled assessment with an ARD (assessment reference date) of 5/24/18. Resident #35 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #15 was coded as requiring supervision to limited assistance with one staff member for ADLS (activities of daily living). Review of Resident #35's clinical record revealed that he had an A-V fistula (1) to his left arm. Review of Resident #35's "Special treatments, Procedures, and Programs" care plan dated 5/12/18, documented in part, the following: "I will receive dialysis three times a week...I need nurses to check my fistula for a bruit and thrill daily." Review of Resident #35's nursing noted failed to evidence daily monitoring of his A-V fistula. Further review of the clinical record failed to evidence daily monitoring of his A-V fistula. On 6/8/18 at 10:00 a.m., an interview was conducted with RN (registered nurse) #2, the unit manager. When asked the purpose of the care plan, RN #2 stated that the purpose was to serve as a plan of care for the resident. RN #2 stated	F 656	4. ADON or designee will monitor documentation of assessment of bruit and thrill monthly x3 months starting July 2018. Clinical Manager or designee will monitor 10% of comprehensive care plans monthly x 3 months starting July 2018.	

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that it was important for the care plan to be accurate. When asked who uses the care plan, RN #2 stated that the IDT (interdisciplinary team) used the care plan. When asked what should be monitored for a dialysis resident, RN #2 stated that the bruit and thrill of the shunt should be checked by nursing daily. RN #2 stated that this check should be documented in the nursing notes. RN #2 was asked to evidence any documentation that Resident #35's bruit and thrill was checked on a daily basis.

On 6/8/18 at 11:23 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked what nursing should be monitoring for dialysis residents, LPN #1 stated that nurses assess the dialysis site, check the shunt for bruit and thrill, weights etc. When asked how often bruit and thrill should be checked, LPN #1 stated, "Every shift." When asked if this check would be documented anywhere, LPN #1 stated that nurses should be documenting this information in a nursing note. When asked if she has ever worked with Resident #35, LPN #1 stated, "Sometimes." When LPN #1 was informed that daily documentation regarding Resident #35's bruit and thrill could not be found, LPN #1 stated if there was no documentation then it was not being done. When asked if Resident #35's care plan to check fistula for a bruit and thrill daily was followed, LPN #1 stated the care plan was not being followed.

On 6/8/18 at approximately 12:00 p.m., ASM (administrative staff member) #2, the DON (Director of Nursing) stated that she could not find evidence that bruit and thrill were being checked on a daily basis. ASM #2 stated that she had just received an order to check bruit and

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thrill daily so that it will be on the MAR (medication administration record) or TAR (treatment administration record).

On 6/8/18 at 12:30 p.m., an interview was conducted with LPN #4, Resident #35's nurse. When asked what was monitored for dialysis residents, LPN #4 stated that she checked bruit and thrill of the resident's shunt. When asked how often bruit and thrill are checked, LPN #4 stated that it used to be before the resident went to dialysis. LPN #4 stated that Resident #35 just received an order that day to check bruit and thrill daily. When asked what Resident #35's care plan documented regarding bruit and thrill, LPN #4 stated that she was not sure and would have to check.

On 6/8/18, Resident #35 was out at dialysis and could not be reached for an interview.

No further information was presented prior to exit.

Facility policy titled, "Care/Service Plans," documents in part, the following: "Each guest/resident will have an individualized care plan developed. Care Plans will include guest/resident preferences, strengths, routines, personal and cultural preferences, and choices as well as clinical needs." The policy did not address implementing the care plan.

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

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and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care..."

(1) A-V fistula- "The best type of long-term access is an AV fistula. A surgeon connects an artery to a vein, usually in your arm, to create an AV fistula. An artery is a blood vessel that carries blood away from your heart. A vein is a blood vessel that carries blood back toward your heart. When the surgeon connects an artery to a vein, the vein grows wider and thicker, making it easier to place the needles for dialysis. The AV fistula also has a large diameter that allows your blood to flow out and back into your body quickly. The goal is to allow high blood flow so that the largest amount of blood can pass through the dialyzer." This information was obtained from The National Institutes of Health. https://www.niddk.nih.gov/health-information/kidney-disease/kidney-failure/hemodialysis.

2. The facility staff failed to develop a comprehensive care plan for the care of Resident #39's right hip surgical site.

Resident #39 was admitted to the facility on 5/15/18 with diagnoses that included but were not limited to fracture of unspecified neck of right femur with routine healing, aftercare following joint replacement surgery, presence of artificial right hip joint, high blood pressure, and mild cognitive impairment. Resident #39's most recent MDS (minimum data set assessment) was a 14 day scheduled assessment with an ARD (assessment reference date) of 5/27/18. Resident #39 was coded as being cognitively intact in the ability to make daily decisions scoring

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15 out of 15 on the BIMS (Brief Interview for Mental Status) exam.

Resident #39's admission note dated 5/15/18 documented in part, the following: "He has diagnoses of right femoral neck fx (fracture) s/p (status/post) right hip hemi-arthoplasty...Report received that guest had a fall and surgery was done on 5/4/18...noted surgical site to right hip with 39 staples and measuring 20 x 0.8 cm (centimeters) with multiple opening area to left side...Guests weight bearing status is WBAT (weight bearing as tolerated) posterior hip precautions, abduction pillow when in bed, transfers with minimal assistance."

Review of Resident #39's June 2018 TAR (treatment administration record) revealed the following order: "Aquacel dressing to right hip daily." This order was initiated on 5/15/18 (time of admission) and discontinued on 6/5/18.

Review of Resident #39's comprehensive care plan dated 5/21/18, failed to evidence a care plan for Resident #39's right hip surgical site.

On 6/8/18 at 9:14 a.m., an interview was conducted with RN #4, the MDS nurse. When asked who was responsible for developing the care plan, RN #4 stated that IDT (interdisciplinary team) developed the care plan but that she was ultimately responsible to ensure the care plan was developed and completed. When asked who uses the care plan, RN #4 stated that nurses, nursing aides, social workers etc can use the care plan. When asked why residents have care plans, RN #4 stated that residents have care plans to make a determination and identify needs and strengths and how to care for the residents

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after an assessment. RN #4 stated the care plan was revised, quarterly, with any significant changes, or when she creates the comprehensive care plan. RN #4 stated that she would expect to see a surgical incision on the care plan.

On 6/8/18 at 10:00 a.m., an interview was conducted with RN (registered nurse) #2, the unit manager. When asked if a resident was admitted to the facility post surgical procedure and has a surgical incision, if she would expect to see that on the care plan, RN #2 stated that she would expect to see that. RN #2 was asked if she could find any information regarding Resident #39's surgical site on his care plan.

On 6/8/18 at approximately 1:30 p.m., ASM #2 stated that Resident #39's surgical site was on his interim care plan but it was never transferred to the comprehensive care plan. ASM #2 stated that it should have been on the comprehensive care plan.

Review of Resident #39's interim care plan dated 5/15/18 documented the following: "I have the following wound/uclers: Surgical incision: Number of wounds: 1 Site of wounds: right hip."

On 6/8/18 at approximately 12:00 p.m., ASM (administrative staff member) #2, the DON (Director of Nursing) was made aware of the above concerns.

Facility policy titled, "Facility policy titled, "Care/Service Plans," documents in part, the following: "Guests/residents admitted to the Post Acute/Long Term Care will have: a. A baseline care plan generated by nurse within 24 hours

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F 656	Continued From page 40 after admission. b. The baseline care plan will reflect resident's current goals and include interventions that address his or current needs in a language and format that the resident and/or representative, if applicable, will understand. c. The baseline care plan will include healthcare information necessary to properly care for a resident including, but not limited to i. initial goals based on admission orders. ii. Physician orders. iii. Dietary orders/instructions. iv. Therapy Services. v. social services. vi. PASARR recommendation if applicable. vii. Services and treatments to be administered by the community or personnel acting on behalf of the community...3. A comprehensive person centered care plan will be developed by the Interdisciplinary team and be completed within 72 hours of admission and will include measurable objectives, preferences, goals, any specialized services as a result of the PASARR evaluation, resident's discharge plan and will address the resident's medical, nursing, and mental and psychosocial needs as identified from the resident's comprehensive assessment."	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 657		7/20/18

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F 657	Continued From page 41 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review it was determined that facility staff failed to review and revise the comprehensive care plan for one of 15 residents in the survey sample, Resident #39. The facility staff failed to revise Resident #39's care plan after he developed cellulitis to his right hip surgical incision. The findings include: Resident #39 was admitted to the facility on 5/15/18 with diagnoses that included but were not limited to fracture of unspecified neck of right femur with routine healing, aftercare following joint replacement surgery, presence of artificial right hip joint, high blood pressure, and mild cognitive impairment. Resident #39's most recent MDS (minimum data set assessment) was a 14 day scheduled assessment with an ARD	F 657	1. Resident #39 cellulitis was resolved on 6/1/2018. 2. DON or designee will complete a 100% audit of resident will acute infections to ensure care plans have been reviewed and revised. 3. SDC or designee will educate licensed nurses on reviewing and revising care plans on an ongoing basis. 4. Clinical Manager will monitor care plans for revision monthly X 3 months. Any and corrections needed will be brought to our monthly QA/QI meeting.	

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(assessment reference date) of 5/27/18. Resident #39 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam.

Review of Resident #39's nursing notes revealed the following note dated 5/22/18 that documented in part, the following: "Guest surgical site noted with redness. Surgical site assessed by MD (medical doctor) and NP (nurse practitioner). New order received Keflex (1) 250 mg (milligrams) po (by mouth) bid (two times a day) x 10 days..."

Review of Resident #39's May 2018 MAR (medication administration record) and June 2018 MAR revealed the he received Keflex until 6/1/18.

Review of Resident #39's comprehensive care plan dated 5/21/18 failed to evidence that the care plan was revised after he developed cellulitis to his right hip surgical incision.

On 6/8/18 at 9:14 a.m., an interview was conducted with RN #4, the MDS nurse. RN #4 stated that the care plan was revised quarterly, with any significant changes, or when she creates the comprehensive care plan. RN #4 stated that any IDT staff can review/revise the care plan.

On 6/8/18 at 10:00 a.m., an interview was conducted with RN (registered nurse) #2, the unit manager. RN #2 stated that it was important for the care plan to be accurate. When asked who uses the care plan, RN #2 stated that the IDT (interdisciplinary team) used the care plan. When asked when the care plan was revised, RN #2 stated that the care plan was updated quarterly or with any new changes such as falls, pain, orders,

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F 657	Continued From page 43 etc. RN #2 stated that any part of IDT team can revise the care plan. On 6/8/18 at 12:00 p.m., ASM (administrative staff member) #2, the DON (Director of Nursing) was made aware of the above concerns. Facility policy titled, "Care/Service Plans," documents in part, the following: "Care Plans will be reviewed, revised if applicable, on an ongoing basis by the interdisciplinary team with any significant change in condition and after each assessment, including both comprehensive and quarterly review assessments." (1) Keflex is used to treat bacterial infections in many different parts of the body. It works by killing bacteria or preventing their growth. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009528/.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain professional standards of practice for two of 15 residents in the survey sample, Resident # 29, and #44.	F 658	1. Clarification order was received for resident #29 to change medication to a form that can be crushed. Clarification orders were received for all residents requiring crushed meds. Clarification for oxygen on resident #44	7/20/18

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F 658	Continued From page 44 1. The facility staff failed to administer medications according to the manufacturer's instruction to not crush or chew for Resident #29. 2. The facility staff failed to clarify a physician's order for oxygen for Resident #44. The findings include: 1. Resident #29 was admitted to the facility on 12/13/17 with diagnoses that included but were not limited to: Alzheimer's disease, high blood pressure, dementia, weakness and stroke. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 5/9/18 coded the resident as having a three out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance for all activities of daily living. A medication administration observation was made on 6/7/18 8:42 a.m. with RN (registered nurse) #1. RN #1 prepared the medications for Resident #29. RN #1 took one methylprednisolone (1) four milligrams (mg) out of the package with her finger, she then put the pill in applesauce and gave it to the resident. RN #1 then popped Prilosec (2) 20 milligrams delayed release from the package into her bare hand and placed it into a medication cup. Review of the medication's label documented, "DO NOT CRUSH OR CHEW." RN #1 then picked up the capsule with her bare hands, opened it up, put it into a small plastic bag and crushed the	F 658	was received on 6/8/18. 2. DON or designee will complete a 100% medication observation of licensed nurses. DON or designee will also complete a 100% audit of residents currently on oxygen to ensure accuracy of orders. 3. SDC or designee will educate licensed nurses on medications that cannot be crushed. SDS or designee will also educate nurses on the Erickson Living physician□s order policy. 4. Clinical Manager will complete a 10% audit of all residents X 3 months to ensure medications are administered according to manufactures instructions. Clinical Manger will also complete a 100% audit X 3 months of oxygen orders. All findings will be brought to our monthly QA/QI meetings for review.	

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medication. RN #1 then put the crushed medication into a medication cup, mixed it with applesauce and gave it to Resident #29. RN #1 next took a diltiazem 240 mg continuous dosing out of the package with her bare hands, opened the capsule deposited the medication within, into a medication cup and then poured the medication into a small plastic bag. RN #1 then crushed the medication, mixed it with applesauce and gave it to Resident #29. Review of the medication's label documented, "DO NOT CRUSH OR CHEW." RN #1 stated, "It's difficult to crush those little beads (the medication in the capsule)." RN #1 then washed her hands.

Review of the resident's care plan initiated on 5/15/18 documented, "Medications. Goal(s): The nurse and/or caregiver...will administer my medications as prescribed and monitor for side effects daily."

Review of the May 2018 physician's orders documented, "MethylPREDNISolone 4 mg tablets in a dose pack (1); omeprazole 20 mg, delayed release (1) CAPSULE DELAYED RELEASE (ENTERIC COATED). dilTIAZem CD 240 mg capsule, extended release 24 hr (1); Thera tablet (1 tab) TABLET Oral."

Review of the May 2018 medication administration record (MAR) documented, "MethylPREDNISolone 4 mg tablets in a dose pack (1); omeprazole 20 mg, delayed release (DR) (1) CAPSULE DELAYED RELEASE (ENTERIC COATED). dilTIAZem CD 240 mg capsule, extended release 24 hr [hour] (1); Thera tablet (1 tab) TABLET Oral." The medications were documented as being administered each

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day.

An interview was conducted on 6/7/18 at 2:16 p.m. with OSM (other staff member) #5, the pharmacist. When asked if a medication that has delayed release or continuous dosing can be crushed, OSM #5 stated, "Nine times out of ten they are not to be crushed." When asked about the Prilosec 20 mg DR and diltiazem 240 mg CD, OSM #5 stated, "The Prilosec can be opened and put into applesauce but it can't be crushed. The diltiazem can not be crushed." When asked why these medications could not be crushed, OSM #5 stated, "Because it's dose dumping. Instead of getting it over a 24 hour period they are getting it all at once."

An interview was conducted on 6/8/18 at 10:32 a.m. with RN (registered nurse) #1. When asked how staff knew if a medication could not be crushed or chewed, RN #1 stated, "It should be in the (name of software)." When asked if it would be on the medication package label, RN #1 stated, "Yes." When asked which kinds of medications could not be chewed or crushed, RN #1 stated, "Enteric coated." When asked if delayed release or continuous dosing medications could be crushed, RN #1 stated, "I don't think they are to be crushed." When asked why, RN #1 stated, "It won't be effective." When informed of the observation above of her crushing Prilosec and diltiazem, RN #1 stated, "Well what are we supposed to do if the resident can't swallow a pill?"

An interview was held on 6/8/18 at 10:44 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked how staff knew if

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there were special instructions around giving a medication, ASM #2 stated, "It's on the orders that they have specific instructions and there is more information on the MAR (medication administration record." When asked if delayed release or a continuous dosing medication could be crushed, ASM #2 stated, "No." When asked why, ASM #2 stated, "Because it affects the absorption of the medication." ASM #2 was made aware of the findings at that time. ASM #2 was asked what profession standard the facility used, ASM #2 stated, "Lippincott."

An interview was conducted on 6/8/18 at 11:14 a.m. with LPN (licensed practical nurse) #1. When asked how staff knew if a medication can be crushed or chewed, LPN #1 stated, "We have a reference guide in the med (medication) room. There are some medications that can't be crushed." When asked if a delayed release or a continuous dosing medication, could be crushed, or chewed, LPN #1 stated, "No." When asked what staff would do if a resident could not swallow a pill that could not be chewed or crushed, LPN #1 stated, "We need to call the doctor to accommodate that."

On 6/8/18 at approximately 12:00 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the policy titled, "Medication Administration, Receipt, Storage & Disposal" documented, "POLICY. Medication management in the Continuing Care (CC) will include ordering, receiving, proper storage and safe administration of residents' medications by authorized staff consistent with state requirements All medications will be administered honoring a resident's choice

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and activities, as much as possible consistent with the person center comprehensive care plan. (Holistic Care Plan). PROCEDURE: Medication Administration/Assistance. 2. Medications are administered in accordance with Nursing Standards of practice and in concordance with state law to include using the appropriate infection prevention & control practices for mediation assistance/administration. a. Staff designated to administer medications will verify that he/she is administering medications using the 5 Rights and all medications assisted with/administered will be document (sic) immediately following completion of task for each resident. 3. Right resident. 4 ii) Right medication. 5 iii) Right dose. 6 iv) Right time. 7 v) Right Route."

Review of the manufacturer's package insert documented, "OMEPRAZOLE DELAYED-RELEASE CAPSULE - ORAL" documented in part, "HOW TO USE: Swallow the capsules whole. If you have trouble swallowing the capsule, you may open the capsule if it is not sealed and carefully sprinkle its contents on a spoonful of soft, cool applesauce."

Review of the manufacturer's package insert documented, "DILTIAZEM 24 -HOUR SUSTAINED-ACTION CAPSULE. COMMON BRAND NAME(S): Cardizem CD. HOW TO USE: Do not crush or chew the capsule. Doing so can release all of the drug at once and my increase your risk of side effects.

According to "Fundamentals of Nursing", Seventh Edition, 2009: by Perry and Potter Chapter 35 "Medication Administration" Pg. 705; read: "Box 35-5 Steps to Take to Prevent Medication Errors"

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included: Follow the six rights of medication administration. Be sure to read the label at least three times ... before administering the medication ... Question unusually large or small doses ..."

According to "Fundamentals of Nursing", Seventh Edition, 2009: by Perry and Potter Chapter 35 "Medication Administration" Chapter 35, pg 707 read: "Professional standards, such as the American Nurses Association's Nursing: Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights medication administration consistently every time you administer medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication, 2. The right dose, 3. The right client, 4. The right route, 5. The right time, and 6. The right documentation."

No further information was provided prior to exit.

1. Methylprednisolone -- MEDROL Tablets are indicated in the following conditions: 1. Endocrine Disorders - Primary or secondary adrenocortical insufficiency (hydrocortisone or cortisone) This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=39d5270b-d957-4821-93d6-501b7b9f02d4

2. Prilosec DR -- Omeprazole delayed-release capsules should be taken before eating. In the clinical trials, antacids were used concomitantly with omeprazole. Patients should be informed

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that the omeprazole delayed-release capsule should be swallowed whole. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=c6bc8fb7-2862-464a-b7c9-e409034f072a

3. Diltiazem CD -- CARDIZEM CD is indicated for the treatment of hypertension. It may be used alone or in combination with other antihypertensive medications. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=1042fa13-e6af-46b9-8008-6c941f0978b1

2. The facility staff failed to clarify a physician's order for oxygen for Resident #44.

Resident #44 was admitted to the facility on 4/9/18 and readmitted on 4/29/18 with diagnoses that included but were not limited to: urinary retention, pneumonia, seizures, difficulty swallowing, feeding tube, communication deficit and difficulty walking.

The most recent MDS (minimum data set), a 30 day assessment, with an ARD (assessment reference date) of 5/25/18 coded the resident as having a six out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living. The resident was coded as receiving oxygen therapy.

An observation was made on 6/6/18 at 10:40 a.m.

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of Resident #44. The resident was sitting up in the wheelchair next to the bed. The resident had oxygen running at two liters via nasal cannula (soft plastic prongs that fit into the nose to deliver oxygen) from the oxygen tank attached to the back of the resident's wheelchair.

An observation was made on 6/7/18 08:17 a.m. of Resident #44. The resident was in bed with two liters of oxygen via nasal cannula from the oxygen concentrator.

Review of the resident's care plan initiated on 6/7/18 documented, "Respiratory and Cardiac. Goal(s) I will need assistance in keeping my 02 on and maintain prescribed liters of administration at all times daily. Oxygen Therapy LPM (liters per minute) 3L/min."

Review of the May 2018 physician's orders documented, "O2 ORDER: 2 Liters per NC (nasal cannula). NOTES: Oxygen 3L via NC continuously."

Review of the May 2018 medication administration record documented, "O2 ORDER: 2 Liters per NC (nasal cannula). NOTES: Oxygen 3L via NC continuously." The oxygen was documented as being administered every day.

An interview was conducted on 6/8/18 at 9:55 a.m. with RN (registered nurse) #2, the unit manager. When asked what staff do if they have a conflicting order, RN #2 stated, "They need to call the doctor and get a clarification order." RN #2 was asked to review Resident #44's oxygen order. When asked what the oxygen administration rate, RN #2 stated, "three liters." When asked to review the order again, RN #2

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stated, "Oh that needs to be clarified."

An interview was conducted on 6/8/28 at 10:44 A.M. with ASM (administration staff member) #2 the director of nursing. ASM #2 was asked to review the resident's oxygen order. When asked what rate the oxygen was to be administered at, ASM #2 stated, three liters. ASM #2 was asked to review Resident #44's physician order for oxygen again. ASM #2 stated, "If orders are not clear they should be clarified." ASM #2 stated, "I'll check the original order."

An interview was conducted on 6/8/18 at 11:14 p.m. with LPN (licensed practical nurse) #1. LPN #1 was asked about the process staff follows if they have a question about a physician's order. LPN #1 stated call the physician to get a clarification. LPN #1 was asked to review Resident #44's oxygen order. When asked what rate the oxygen should be administered, LPN #1 stated, "Three liters." When asked to review the order again, LPN #1 stated, "Oh that needs to be clarified." A policy on clarifying physicians' orders was requested at that time. No policy was received by the end of the survey.

On 6/8/18 at approximately 12:00 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

On 6/18/18 at 1:50 p.m., ASM #2 returned and stated, "I couldn't find an order so I got it clarified."

Review of the facility's policy titled, "Respiratory Equipment" did not evidence documentation regarding physician's order for oxygen.

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F 658	Continued From page 53 No further information was obtained prior to exit.No further information was obtained prior to exit.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and clinical record review it was determined the facility staff failed ensure one of 15 sampled residents, (Resident #19), received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. The facility staff failed to administer Resident #19 medications per the physician's order. The findings include: Resident #19 was admitted to the facility on 11/19/15 with diagnoses that included but were not limited to Parkinson's disease, high blood pressure and muscle weakness. Resident #19's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/1/18.	F 684	1. Physician was notified of medication hold for resident #19 on 6/2/18, 6/3/18, 6/4/18, 6/6/18 and 6/7/18. 2. ON or designee will complete 100% audit of residents with missed doses of medications beginning 6/8/2018. 3. SDC or designee will educate licensed nurses on refusal of medication or treatment policy. 4. ADON or designee will complete 10% audit of residents with missed doses of medications X 3 months starting July 2018. All findings will be brought to our monthly QA/QI meetings for review.	7/20/18

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Resident #19 was coded as being intact in cognitive function scoring 14 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.

On 6/7/18 at approximately 3:30 p.m., an interview was conducted with Resident #19. Resident #19 stated that she was concerned that she does not receive her Sinemet (1) every three hours like she is supposed to. Resident #19 stated that she has told the nurses when she is supposed to receive her sinemet.

Review of Resident #19's most recent POS (physician order sheet) revealed the following order: "Carbidopa 25 mg (milligrams)-levadopa 100 mg tablet (Sinemet) Tablet Oral Six times daily. Schedule: 6:00 a.m., 9:00 a.m., 12:00 p.m., 3:00 p.m., 6:00 p.m., 9:00 p.m." This order was initiated on 5/23/18.

Review of Resident #19's June 2018 MAR (medication administration record) revealed that she did not receive her Carbidopa-Levadopa on the following dates and times:

- 6/2/18 at 12:00 p.m.
- 6/3/18 at 6:00 p.m.
- 6/6/18 at 12:00 p.m.
- 6/7/18 at 12:00 p.m.

The following notes were documented on the MAR: "Not administered (see note)."

Review of Resident #19's June 2018 nursing notes failed to evidence why the Carbidopa-Levadopa was not administered on 6/2/18, 6/6/18 and 6/7/18. A was written on 6/3/18 documenting that the resident was

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sleeping. There was no evidence that the physician was notified of the missed doses of the Carbidopa-Levadopa.

On 6/8/18 at 10:32 a.m., an interview was conducted with RN (registered nurse) #1, the nurse who did not administer the Carbidopa-Levadopa on all the above dates. When asked if she was familiar with Resident #19's Sinemet, RN #1 stated, "Yes, she takes it six times." When asked what would be some reasons why Resident #19 did not receive her Sinemet, RN #1 stated that most of the time Resident #19 was sleeping. RN #1 stated that she was told when she first started working at the facility, not to wake the residents up to take their medications. RN #1 stated that when Resident #19 is awake, she would give the Sinemet. RN #1 stated that she usually gives the next scheduled dose because she receives the medication so frequently, it is usually time for the next dose by the time Resident #19 is awake. RN #1 stated she has not notified the doctor of the missed medication because the medication was her regular scheduled medication. RN #1 stated that missed medication should be documented in a nursing note. RN #1 was not sure if she documented for all above dates.

On 6/8/18 at 10:39 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). When asked what the nurses should do if a resident was consistently missing their scheduled medication because they were sleeping, ASM #2 stated that she would expect her nurses to notify the physician to see if he wants nursing staff to wake the resident, or for a schedule change. ASM #2 stated she would expect to see

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F 684	Continued From page 56 documentation on a nursing note or on the MAR, every time a resident misses their scheduled dose. In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc.; Page 419 "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients." On 6/8/18 at approximately 12:00 p.m., ASM #2 was made aware of the above concerns. (1) Sinemet (Carbidopa/Levadopa) used to treat symptoms of Parkinson's disease. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009448/?report=details	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an	F 690		7/20/18

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F 690	Continued From page 57 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined facility staff failed to appropriate treatment and services for a urinary catheter for one of 15 residents in the survey sample, Resident #44. The facility staff failed to maintain the urinary catheter below the level of the bladder for Resident #44. The findings include: Resident #44 was admitted to the facility on 4/9/18 and readmitted on 4/29/18 with diagnoses that included but were not limited to: urinary	F 690	1. Placement of catheter drainage bag for resident #44 was corrected on 6/7/2018. 2. DON or designee will complete a 100% audit of all residents with Foley catheters to ensure catheter bag is below the level of the bladder. 3. SDC or designee will educate licensed nurses to the Erickson Living urinary catheter policy. 4. Clinical Manager will complete 100% audit of residents with Foley catheters for bladder bag location X 3 months starting July 2018. All findings will be brought to our monthly QA/QI meetings for review.	

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retention, pneumonia, seizures, difficulty swallowing, feeding tube, communication deficit and difficulty walking.

The most recent MDS (minimum data set), a 30 day assessment, with an ARD (assessment reference date) of 5/25/18 coded the resident as having a six out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living. The resident was coded as having a urinary catheter.

An observation was made on 6/6/18 at 10:40 a.m., of Resident #44. The resident was sitting up in the wheelchair next to the bed. The urinary catheter bag was covered in a blue privacy bag and lying on the arm of the wheelchair above the bladder of the resident's bladder. There were no staff in the room. The resident was observed for ten minutes and no staff entered the room.

Review of the resident's care plan initiated on 6/7/18 documented, "Assistance in Bathroom - Functional Status/Continence" documented, "I use a (n) indwelling catheter." There was no evidence of documentation regarding how to manage the catheter.

Review of the May 2018 physician's orders documented, "Indwelling Urinary Foley (catheter)."

Review of the May 2018 treatment administration record documented, "Indwelling Urinary Foley (catheter)." There was documentation of nurse's initials for each shift and day of the month.

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An interview was conducted on 6/7/18 at 5:28 p.m. with RN (registered nurse) #1, the resident's nurse. When asked how a catheter bag should be positioned, RN #1 stated, "It depends on what side the Foley catheter is on. If it's on (taped to) the left leg then I put it on the left side of the bed and hanging it on the bed rail, I bring the bed down but make sure the Foley is still draining." When asked if the catheter bag could be placed above the resident's bladder, RN #1 stated, "No." When asked why, RN #1 stated, "If it goes above the bladder you don't want it to back up and go into the bladder you could have issues." When asked what issues, RN #1 stated, "Fullness, pain." When informed of the observation made of the catheter bag above the level of Resident #44's bladder, RN #1 stated, "I did see that. I think the aide did it."

An interview was conducted on 6/8/18 at 11:14 a.m. with LPN (licensed practical nurse) #1. When asked how a urinary catheter bag should be positioned, LPN #1 stated, "It has to be below the level of the bladder and kept in a privacy bag." When asked why it needed to be below the level of the bladder, LPN #1 stated, "So it keeps the urine from flowing back up into the bladder."

On 6/8/18 at approximately 12:00 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, "Urinary Catheter" documented, "Purpose/Scope: To provide urinary catheter for a guest/resident in accordance with nursing standards of practice and minimize the spread of infection. Procedure:

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F 690	Continued From page 60 1. Catheter Care g. Keep collection bag below the level of the bladder." No further information as provided prior to exit.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide care and services for oxygen therapy for one of 15 residents in the survey sample, Resident #44. The facility staff failed to store the oxygen cannula in a plastic bag when not in use and to keep the oxygen cannula off the floor for Resident #44. The findings include: Resident #44 was admitted to the facility on 4/9/18 and readmitted on 4/29/18 with diagnoses that included but were not limited to: urinary retention, pneumonia, seizures, difficulty swallowing, feeding tube, communication deficit and difficulty walking.	F 695	1. Oxygen cannula for resident #44 was placed in a plastic bag on 6/7/2018. 2. DON or designee will audit 100% of residents with oxygen tubing for proper storage when not in use. 3. SDC will educate licensed nurses on the Erickson Living respiratory equipment policy. 4. Clinical Manager or designee will audit 100% of residents with oxygen tubing for proper storage when not in use. All findings will be brought to our monthly QA/QI meetings for review.	7/20/18

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The most recent MDS, a 30 day assessment, with an ARD of 5/25/18 coded the resident as having a six out of 15 on the BIMS indicating the resident was severely cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living. The resident was coded as receiving oxygen therapy.

An observation was made on 6/6/18 at 10:40 a.m. of Resident #44. The resident was sitting up in the wheelchair next to the bed. The resident had oxygen running at two liters via nasal cannula (soft plastic prongs that fit into the nose to deliver oxygen) from the oxygen tank attached to the back of the resident's wheelchair. There was an oxygen concentrator in the room. An oxygen cannula tubing was coiled up and pushed through the handle of the concentrator. The tubing was dated 6/5/18. The cannula tubing was not in a bag.

An observation was made on 6/7/18 8:17 a.m. of Resident #44. The resident was in bed with two liters of oxygen via nasal cannula from the oxygen concentrator. The tubing was dated 6/5/18. There was nasal cannula tubing wrapped around the top of the oxygen tank on the back of the resident's wheelchair. There was no bag on the tubing.

An observation was made on 6/7/18 at 3:33 p.m. The resident was sitting up in his wheelchair with oxygen on via nasal cannula from the oxygen concentrator. There was an oxygen tank on the back of the resident's wheelchair and the oxygen tubing was wrapped uncovered around the neck of the tank. RN (registered nurse) #1 was putting the resident to bed with the assistance of another

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staff member. RN #1 took the resident's nasal cannula tubing off and laid it over the concentrator. The tubing fell onto the floor. After the resident was put into bed, RN #1 picked up the tubing from the floor and placed it on the resident.

Review of the resident's care plan initiated on 6/7/18 documented, "Respiratory and Cardiac. Goal(s) I will need assistance in keeping my 02 on and maintain prescribed liters of administration at all times daily."

Review of the May 2018 physician's orders documented, "O2 ORDER: 2 Liters per NC (nasal cannula)."

Review of the May 2018 medication administration record documented, "O2 ORDER: 2 Liters per NC (nasal cannula)." The oxygen was documented as being administered every day.

An interview was conducted on 6/7/17 at 5:28 p.m. with RN #1. When asked how oxygen tubing was to be stored when not in use, RN #1 stated, "It should be in a plastic bag with his name on it and the date." When asked what staff did if the tubing fell onto the floor, RN #1 stated, "I'm a germaphobe. You want to trash it and get a new one." When asked how Resident #44's oxygen tubing was stored, RN #1 stated, "I know, I know it's been wrapped around his tank and on the concentrator and the nasal cannula goes in the nose. It's infection control."

An interview was conducted on 6/8/18 at 11:14 p.m. with LPN (licensed practical nurse) #1. When asked how oxygen tubing was to be stored when not in use, LPN #1 stated, "In a bag, with a

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F 695	Continued From page 63 date on the bag so you know when you changed it." When asked what staff should do if tubing fell on the floor, LPN #1 stated, that they should get a new one. When asked why, LPN #1 stated, "For infection control." On 6/8/18 at approximately 12:00 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, "Respiratory Equipment" documented, "Policy: To provide appropriate equipment and supplies to prevent transmission of respiratory infection. Oxygen Equipment. 3. Oxygen tubing, when not in use, will be placed in a plastic bag and kept off the floor." No further information was provided prior to exit.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide treatment and services for a dialysis shunt for one of 15 residents in the survey sample, Resident #35.	F 698	1. MD order obtained to check bruit and thrill for resident #35 on 6/8/18 2. DON or designee will review all residents with an AV fistula for documentation of assessment of bruit or thrill. 3. SDC or designee will educate licensed	7/20/18

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F 698	Continued From page 64 The facility staff failed to check bruit and thrill to Resident #35's A-V fistula (1) on a daily basis. The findings include: Resident #35 was admitted to the facility on 11/19/15 and readmitted on 5/12/18 with diagnoses that included but were not limited to pneumonia, end stage renal disease, heart failure, atrial fibrillation, and Chron's disease. Resident #35's most recent MDS (minimum data set) assessment was a 14 day scheduled assessment with an ARD (assessment reference date) of 5/24/18. Resident #35 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #15 was coded as requiring supervision to limited assistance with one staff member for ADLS (activities of daily living). Review of Resident #35's clinical record revealed that he had an A-V fistula (1) to his left arm. Review of Resident #35's "Special treatments, Procedures, and Programs" care plan dated 5/12/18, documented in part, the following: "I will receive dialysis three times a week...I need nurses to check my fistula for a bruit and thrill daily." Review of Resident #35's nursing noted failed to evidence daily monitoring of his A-V fistula. Further review of the clinical record failed to evidence daily monitoring of his A-V fistula. On 6/8/18 at 10:00 a.m., an interview was conducted with RN (registered nurse) #2, the unit manager. When asked what should be	F 698	nurses on assessment of bruit and thrill of AV fistula. 4. ADON or designee will complete 100% audit of residents with AV fistula for documentation of assessment of bruit or thrill X 3 months. All findings will be brought to our monthly QA/QI meetings for review.	

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monitored for a dialysis resident, RN #2 stated that the bruit and thrill of the shunt should be checked by nursing daily. RN #2 stated that this check should be documented in the nursing notes. RN #2 was asked to evidence any documentation that Resident #35's bruit and thrill was checked on a daily basis.

On 6/8/18 at 11:23 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked what nursing should be monitoring for dialysis residents, LPN #1 stated that nurses assess the dialysis site, check the shunt for bruit and thrill, weights etc. When asked how often bruit and thrill should be checked, LPN #1 stated, "Every shift." When asked if this check would be documented anywhere, LPN #1 stated that nurses should be documenting this information in a nursing note. When asked if she has ever worked with Resident #35, LPN #1 stated, "Sometimes." When LPN #1was informed that daily documentation could be found regarding Resident #35's bruit and thrill, LPN #1 stated that if there was no documentation then it was not being done.

On 6/8/18 at approximately 12:00 p.m., ASM (administrative staff member) #2, the DON (Director of Nursing) stated that she could not find evidence that bruit and thrill were being checked on a daily basis. ASM #2 stated that she had just received an order to check bruit and thrill daily so that it will be on the MAR (medication administration record) or TAR (treatment administration record).

On 6/8/18 at 12:30 p.m., an interview was conducted with LPN #4, Resident #35's nurse. When asked what was monitored for dialysis

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F 698	Continued From page 66 residents, LPN #4 stated that she checked bruit and thrill of the resident's shunt. When asked how often bruit and thrill are checked, LPN #4 stated that it used to be before the resident went to dialysis. LPN #4 stated that Resident #35 just received an order that day to check bruit and thrill daily. When asked what Resident #35's care plan documented regarding bruit and thrill, LPN #4 stated that she was not sure and would have to check. On 6/8/18, Resident #35 was out at dialysis and could not be reached for an interview. The facility policy titled, "Dialysis," did not address the above concerns. No further information was presented prior to exit. (1) A-V fistula: "The best type of long-term access is an AV fistula. A surgeon connects an artery to a vein, usually in your arm, to create an AV fistula. An artery is a blood vessel that carries blood away from your heart. A vein is a blood vessel that carries blood back toward your heart. When the surgeon connects an artery to a vein, the vein grows wider and thicker, making it easier to place the needles for dialysis. The AV fistula also has a large diameter that allows your blood to flow out and back into your body quickly. The goal is to allow high blood flow so that the largest amount of blood can pass through the dialyzer." This information was obtained from The National Insitutes of Health. https://www.niddk.nih.gov/health-information/kidney-disease/kidney-failure/hemodialysis.	F 698		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)	F 759		7/20/18

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F 759	Continued From page 67 §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to ensure the facility was free of a less than 5% (five percent) medication error rate. There were 26 opportunities for error, and two medication errors were observed involving one of nine residents in the medication administration observation, Resident #29. This resulted in a medication error rate of 7.69%. The findings include: Resident #29 was admitted to the facility on 12/13/17 with diagnoses that included but were not limited to: Alzheimer's disease, high blood pressure, dementia, weakness and stroke. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 5/9/18 coded the resident as having scored a three out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance for all activities of daily living. A medication administration observation was made on 6/7/18 at 8:42 a.m. with RN (registered nurse) #1. RN #1 was observed administering the	F 759	1. Physician notified omeprazole and diltiazem were crushed and administered. 2. DON or designee will review orders of residents receiving crushed meds to ensure appropriate form of medication is administered. 3. SDC or designee to educate licensed nurses on medications that should not be crushed. 4. Clinical Manager will audit medication orders for residents requiring crushed medications to ensure medication is administered per manufacture□s guidelines. All finding will be brought to our monthly QA/QI meeting for review.	

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following medications to Resident #29:

Methylprednisolone (1) four milligrams (mg) one tablet, the tablet was put in applesauce whole; Omeprazole (2) 20 milligrams DR (delayed release) which RN #1 crushed and mixed into applesauce, review of the medication's label documented, "DO NOT CRUSH OR CHEW."; Diltiazem 240 mg (3) CD (continuous dosing) which RN #1 crushed and mixed with applesauce, review of the medication's label documented, "DO NOT CRUSH OR CHEW"; Tera (4) 400 mg crushed and mixed in applesauce.

Review of the May 2018 physician's orders documented, "MethylPREDNISolone 4 mg tablets in a dose pack (1); omeprazole 20 mg, delayed release (1) CAPSULE DELAYED RELEASE (ENTERIC COATED). dilTIAZem CD 240 mg capsule, extended release 24 hr (1); Thera tablet (1 tab) TABLET Oral."

Review of the May 2018 medication administration record (MAR) documented, "MethylPREDNISolone 4 mg tablets in a dose pack (1); omeprazole 20 mg, delayed release (1) CAPSULE DELAYED RELEASE (ENTERIC COATED). dilTIAZem CD 240 mg capsule, extended release 24 hr [hour] (1); Thera tablet (1 tab) TABLET Oral." The medications were documented as being administered each day.

An interview was conducted on 6/7/18 at 2:16 p.m. with OSM (other staff member) #5, the pharmacist. When asked if a medication that has delayed release or continuous dosing can be crushed, OSM #5 stated, "Nine times out of ten they are not to be crushed." When asked about

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the prilosec 20 mg DR and diltiazem 240 mg CD, OSM #5 stated, "The prilosec can be opened and put into applesauce but it can't be crushed. The diltiazem can not be crushed." When asked why these medications could not be crushed, OSM #5 stated, "Because it's dose dumping. Instead of getting it over a 24 hour period they are getting it all at once."

On 6/8/18 at 9:15 a.m. ASM (administrative staff member) #2, the director of nursing was made aware of the medication error rate.

An interview was conducted on 6/8/18 at 10:32 a.m. with RN (registered nurse) #1. When asked how staff knew if a medication could not be crushed or chewed, RN #1 stated, "It should be in the (name of software)." When asked if it would be on the medication package label, RN #1 stated, "Yes." When asked which kinds of medications could not be chewed or crushed, RN #1 stated, "Enteric coated." When asked if delayed release or continuous dosing medications could be crushed, RN #1 stated, "I don't think they are to be crushed." When asked why, RN #1 stated, "It won't be effective." When informed of the observation above of her crushing prilosec and diltiazem, RN #1 stated, "Well what are we supposed to do if the resident can't swallow a pill?"

An interview was conducted on 6/8/18 at 11:14 a.m. with LPN (licensed practical nurse) #1. When asked how staff knew if a medication could be crushed or chewed, LPN #1 stated, "We have a reference guide in the med (medication) room. There are some medications that can't be crushed." When asked if a medication that was a delayed release or a continuous dosing would be

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crushed or chewed, LPN #1 stated, "No." When asked what staff would do if a resident could not swallow a pill that could not be chewed or crushed, LPN #1 stated, "We need to call the doctor to accommodate that."

On 6/8/18 at approximately 12:00 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the manufacturer's package insert documented, "OMEPRAZOLE DELAYED-RELEASE CAPSULE - ORAL" documented in part, "HOW TO USE: Swallow the capsules whole. If you have trouble swallowing the capsule, you may open the capsule if it is not sealed and carefully sprinkle its contents on a spoonful of soft, cool applesauce."

Review of the manufacturer's package insert documented, "DILTIAZEM 24 -HOUR SUSTAINED-ACTION CAPSULE. COMMON BRAND NAME(S): Cardizem CD. HOW TO USE: Do not crush or chew the capsule. Doing so can release all of the drug at once and my increase your risk of side effects.

Review of the policy titled, "Medication Administration, Receipt, Storage & Disposal" documented, "POLICY. Medication management in the Continuing Care (CC) will include ordering, receiving, proper storage and safe administration of residents' medications by authorized staff consistent with state requirements All medications will be administered honoring a resident's choice and activities, as much as possible consistent with the person center comprehensive care plan. (Holistic Care Plan). PROCEDURE: Medication Administration/Assistance. 2. Medications are

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administered in accordance with Nursing Standards of practice and in concordance with state law to include using the appropriate infection prevention & control practices for medication assistance/administration. a. Staff designated to administer medications will verify that he/she is administering medications using the 5 Rights and all medications assisted with/administered will be document (sic) immediately following completion of task for each resident. 3. Right resident. 4 ii) Right medication. 5 iii) Right dose. 6 iv) Right time. 7 v) Right Route."

No further information was obtained prior to exit.

According to "Fundamentals of Nursing", Seventh Edition, 2009: by Perry and Potter Chapter 35 "Medication Administration" Pg. 705; read: "Box 35-5 Steps to Take to Prevent Medication Errors" included: Follow the six rights of medication administration. Be sure to read the label at least three times ... before administering the medication ... Question unusually large or small doses ..."

According to "Fundamentals of Nursing", Seventh Edition, 2009: by Perry and Potter Chapter 35 "Medication Administration" Chapter 35, pg 707 read: "Professional standards, such as the American Nurses Association's Nursing: Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights medication administration consistently every time you administer medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of

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medication administration include the following: 1. The right medication, 2. The right dose, 3. The right client, 4. The right route, 5. The right time, and 6. The right documentation." Under the subheading Right Route (on pg. 708) " ...When administering injections, precautions are necessary to ensure the nurse gives the medications correctly ..."

1. Methylprednisolone -- MEDROL Tablets are indicated in the following conditions: 1. Endocrine Disorders - Primary or secondary adrenocortical insufficiency (hydrocortisone or cortisone) This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=39d5270b-d957-4821-93d6-501b7b9f02d4

2. Prilosec DR -- Omeprazole delayed-release capsules should be taken before eating. In the clinical trials, antacids were used concomitantly with omeprazole. Patients should be informed that the omeprazole delayed-release capsule should be swallowed whole. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=c6bc8fb7-2862-464a-b7c9-e409034f072a

3. Diltiazem CD -- CARDIZEM CD is indicated for the treatment of hypertension. It may be used alone or in combination with other antihypertensive medications. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=1042fa13-e6af-46b9-8008-6c941f0978b1

4. Theragran -- Americans have been taking

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F 759	Continued From page 73 multivitamin/mineral (MVM) supplements since the early 1940s, when the first such products became available [1]. MVMs are still popular dietary supplements and, according to estimates, more than one-third of all Americans take these supplements [1, 2]. This information was obtained from: https://ods.od.nih.gov/factsheets/MVMS-HealthProfessional/	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and 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	F 761		7/20/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 74 by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to secure medications for two of ten medication cabinets. The facility staff failed to lock the medication cabinet when out of the line of sight of the cabinet during the medication administration. The findings include: A medication administration observation was conducted on 8/7/18 at 8:32 a.m. with RN (registered nurse) #1. RN #1 was in an ante-room with a resident's room to the right and left of the medication cabinets. Each resident had their own cabinet that was positioned outside the resident's room. RN #1 obtained a medication for one of the residents and entered the resident's room leaving the medication cabinet open and out of her line of sight. RN #1 repeated this process three more times taking in medications one at a time into the resident's room leaving the cabinet open and out of line of sight. During this observation, a nursing assistant came into the anteroom, spoke to the nurse, and left the area. RN #1 then went to the other medication cabinet in the ante-room and obtained a medication for the other resident; RN #1 closed the cabinet but did not lock it before entering the resident's room. RN #1 was out of sight of the resident during that time. An interview was conducted on 6/8/18 at 9:55 a.m. with RN #2, the unit manager. When asked what staff should do if they will be out of line of sight of their medication cabinets, RN #2 stated,	F 761	1. Locking of the medication cabinet was immediately locked 6/7/18. 2. DON or designee will complete a 100% audit of medication cabinets in ante-rooms during med pass to ensure medications cabinets are kept locked and secured. 3. SDC or designee will educate licensed nurses to the Erickson Living medication administration receipt, storage and disposal policy. 4. Clinical Manager will complete a 100% audit of medication cabinets in ante-rooms during med pass to ensure medications cabinets are kept locked and secured X 3 months starting July 2018. All findings will be brought to our monthly QA/QI meetings for review.	

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F 761	Continued From page 75 "They need to lock it. It might put a resident at risk because they could have access to it. Any visitor and staff could have access to it. An interview was conducted on 6/8/18 at 10:32 a.m. with RN #1. When asked the process staff follow if they are out of sight of their medication cabinets, RN #1 stated, "I should closed the door and lock it." When asked why, RN #1 stated, "For safety and the other residents." On 6/8/18 at 12:00 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings at that time. Review of the facility's policy titled, ""Medication Administration, Receipt, Storage & Disposal" documented, "POLICY. Medication management in the Continuing Care (CC) will include ordering, receiving, proper storage and safe administration of residents' medications by authorized staff consistent with state requirements All medications will be administered honoring a resident's choice and activities, as much as possible consistent with the person center comprehensive care plan. (Holistic Care Plan). Medication Storage." The policy did not specifically address securing medication cabinets when out of the sight of the nurse. No further information was obtained prior to exit.	F 761		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		7/20/18

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F 812	Continued From page 76 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that facility staff failed to prepare and serve food in a sanitary manner. 1. In the main dining room, the facility staff failed to ensure bare fingers were free from touching the rim of the residents' plates. 2. The facility staff failed to properly wear hair restraints while in the kitchen. The finding include: 1. On 6/6/18 at 11:50 a.m., observation of the main dining room was conducted. On 6/6/18 at 11:58 a.m., CNA (certified nursing assistant) #3, was observed removing plastic wrap off a salad plate. CNA #3 then held the salad plate with her bare fingers on the rim of the plate. CNA's fingers were almost touching a tomato that was in the	F 812	1. Facility unable to correct hair net and handling of food because facility was not informed at time of incident. 2. Dining Manager will complete a 100% audit of all three meal service for proper handling of food plates and hair nets. 3. Dining Manager or designee will educate dining and nursing staff on proper handling of resident food and procedures for wearing hairnets. 4. NHA or designee will complete meal service audits once a month X 3 months and report findings to monthly QA/QI starting in July 2018.	

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F 812	Continued From page 77	F 812		

salad. CNA #3 then served this plate to a resident. CNA #3 was then observed to wash her hands.

On 6/6/18 at 12:04 p.m., CNA #3 was observed serving another salad plate to another resident eating in the dining room. CNA #3's bare fingers were on the rim of the plate. Her fingers were almost touching the lettuce on the plate. CNA #3 was then observed to wash her hands.

On 6/8/18 at 10:21 a.m., an interview was conducted with CNA (certified nursing assistant) #3. When asked how to maintain infection control while serving residents meals, CNA #3 stated that she would wash hands in-between serving meals to residents and that she should not touch the side of the plates. When asked how she should serve a plate, CNA #3 held a plate with her hands underneath the plate. When asked why she should not touch the plate by the rim, CNA #3 stated, "Because don't want hands inside the resident's plate."

On 6/8/18 at approximately 12:00 p.m., ASM (administrative staff member) #2, the DON (Director of nursing was made aware of the above concerns.

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

2. The facility staff failed to properly wear hair restraints while in the kitchen.

On 6/6/18 at 11:50 a.m., observation of the dining room was conducted. The dietician, OSM (other staff member #7) was observed serving food in

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F 812	Continued From page 78 the dining room. OSM #7 had her hair restraint on while serving food. Large strands of her hair were coming out of the hair net. At 12:17 p.m., OSM #7 was observed walking into the kitchen. Large strands of hair were still observed to be hanging out of her hair net. On 6/8/18 at 11:30 a.m., an interview was conducted with OSM #7. When asked how to maintain infection control in the kitchen, OSM #7 stated that she should always put a hair net on before walking into the kitchen and then she should wash her hands. When asked how the hair net should be worn, OSM #7 stated that all her hair must be contained by the hair net. When asked if all her hair was restrained by the hair net on 6/8/18 during lunch, OSM #7 stated that she was not sure. When told OSM #7 about this writer's observations, OSM #7 stated that she tries to restrain all her hair. OSM #7 stated that it was hard. On 6/8/18 at approximately 12:00 p.m., ASM (administrative staff member) #2, the DON (Director of Nursing) was made aware of the above concerns. No further information was presented prior to exit. A policy was requested on hair restraints but not provided by facility staff.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information	F 842		7/20/18

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F 842	Continued From page 79 except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for-	F 842		

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F 842	Continued From page 80 (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for one of 15 residents in the survey sample, Resident #19. The facility staff failed to document why Carbiodpa-Levadopa was not administered to Resident #19 on 6/2/18, 6/6/18 and 6/7/18. The findings include: Resident #19 was admitted to the facility on 11/19/15 with diagnoses that included but were not limited to Parkinson's disease, high blood pressure and muscle weakness. Resident #19's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/1/18.	F 842	1. Facility cannot document reason for missed dosages for resident #19 on 6/2/18, 6/6/18, 6/8/18. 2. DON or designee will complete a 100% audit of missed dosages on residents from 6/8/18 to present to ensure a reason why medication was not administered is documented. 3. SDC or designee will educate licensed nurses on refusal of medication/treatment policy. 4. ADON will review 10% of residents will missed dosages of medications monthly X 3 months to ensure a reason was documented. Findings of audit will be reported to our monthly QA/QI meeting starting July 2018.	

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Resident #19 was coded as intact for cognitive function scoring 14 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #19 was coded as requiring total dependence on staff with most ADLS (activities of daily living).

On 6/7/18 at approximately 3:30 p.m., an interview was conducted with Resident #19. Resident #19 stated that she was concerned that she does not receive her Sinemet (1) every three hours like she is supposed to. Resident #19 stated that she has told the nurses when she is supposed to receive her sinemet.

Review of Resident #19's most recent POS (physician order sheet) revealed the following order: "Carbidopa 25 mg (milligrams)-levadopa 100 mg tablet (Sinemet) Tablet Oral Six times daily. Schedule: 6:00 a.m., 9:00 a.m., 12:00 p.m., 3:00 p.m., 6:00 p.m., 9:00 p.m." This order was initiated on 5/23/18.

Review of Resident #19's June 2018 MAR (medication administration record) revealed that she did not receive her Carbidopa-Levadopa on the following dates and times:

- 6/2/18 at 12:00 p.m.
- 6/3/18 at 6:00 p.m.
- 6/6/18 at 12:00 p.m.
- 6/7/18 at 12:00 p.m.

The following notes were documented on the MAR: "Not administered (see note)."

Review of Resident #19's June 2018 nursing notes failed to evidence why the Carbidopa-Levadopa was not administered on

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6/2/18, 6/6/18 and 6/7/18. A was written on 6/3/18 documenting that the resident was sleeping. There was no evidence that the physician was notified of the missed doses of the Carbidopa-Levadopa.

On 6/8/18 at 10:32 a.m., an interview was conducted with RN (registered nurse) #1, the nurse who did not administer the Carbidopa-Levadopa on all the above dates. When asked if she was familiar with Resident #19's Sinemet, RN #1 stated, "Yes, she takes it six times." When asked what would be some reasons why Resident #19 did not receive her Sinemet, RN #1 stated that most of the time Resident #19 was sleeping. RN #1 stated that she was told when she first started working at the facility, not to wake the residents up to take their medications. RN #1 stated that when Resident #19 is awake, she would give the Sinemet. RN #1 stated that she usually gives the next scheduled dose because she receives the medication so frequently, it is usually time for the next dose by the time Resident #19 is awake. RN #1 stated she has not notified the doctor of the missed medication because the medication was her regular scheduled medication. RN #1 stated that missed medication should be documented in a nursing note. RN #1 was not sure if she documented for all above dates.

On 6/8/18 at 10:39 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing). When asked what the nurses should do if a resident was consistently missing their scheduled medication because they were sleeping, ASM #2 stated that she would expect her nurses to notify the physician to see if he wants nursing staff to

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F 842	Continued From page 83 wake the resident, or for a schedule change. ASM #2 stated she would expect to see documentation on a nursing note or on the MAR, every time a resident misses their scheduled dose. On 6/8/18 at approximately 12:00 p.m., ASM #2 was made aware of the above concerns. No further information was presented prior to exit. The following quotation is found in Potter and Perry's Fundamentals of Nursing 6th edition (2005, p. 477): "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to the clients." (1) Sinemet (Carbidopa/Levadopa) used to treat symptoms of Parkinson's disease. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009448/?report=details.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		7/20/18

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

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

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

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

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F 880	Continued From page 85 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility policy review and clinical record review, it was determined that the facility staff failed to follow infection control practices for three of nine residents in the medication administration observation, (Resident # 29, #25, and Resident #149). 1. The facility staff failed to administer medications in a sanitary manner to Resident #29. 2. The facility staff failed to administer medication in a sanitary manner to Resident #25.	F 880	1. Facility is unable to correct medication administration to resident #29 and #25 in an unsanitary manner. Facility is unable to correct medications administered to resident #149 without maintaining infection control. 2. DON or designee to will observe medication administration practice to ensure medications are administered in a sanitary manner and infection control is maintained. 3. SDC or designee will educate licensed nurses on the Erickson Living medication administration/receipt/storage policy.	

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F 880	Continued From page 86 3. The facility staff failed to maintain infection control during the medication administration observation for Resident # 149. The findings include: 1. The facility staff failed to administer medications in a sanitary manner to Resident #29. Resident #29 was admitted to the facility on 12/13/17 with diagnoses that included but were not limited to: Alzheimer's disease, high blood pressure, dementia, weakness and stroke. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 5/9/18 coded the resident as having scored a three out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. A medication administration observation was made on 6/7/18 8:42 a.m. with RN (registered nurse) #1. RN #1 prepared the medications for Resident #29. RN #1 took one methylprednisolone (1) four milligrams (mg) out of the package with her finger, she then put the pill in applesauce and gave it to the resident. RN #1 then popped Prilosec (2) 20 milligrams delayed release from the package into her bare hand and placed it into a medication cup. RN #1 then opened the capsule with her bare hands, put the medication into a small plastic bag, and crushed the medication. RN #1 next took a diltiazem 240 mg continuous dosing out of the package with her hands, opened up the capsule into a medication cup and then poured the	F 880	4. Clinical Manager will complete with audit medication administration practices ensuring they are administered in a sanitary manner and infection control is maintained. All findings will be brought to our monthly QA/QI Meetings.	

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medication into a small plastic bag. RN #1 then crushed the medication, mixed it with applesauce and gave it to Resident # 29. RN #1 took a Thera (4) 400 mg out of the package with her hand, put it into a small bag and crushed it and gave it to Resident # 29.

Review of the resident's care plan initiated on 5/15/18 documented, "Medications. Goal(s): The nurse and/or caregiver...will administer my medications as prescribed and monitor for side effects daily."

Review of the May 2018 physician's orders documented, "MethylPREDNISolone 4 mg tablets in a dose pack (1); omeprazole 20 mg, delayed release (DR) (1) CAPSULE DELAYED RELEASE (ENTERIC COATED). dilTIAZem CD 240 mg capsule, extended release 24 hr (1); Thera tablet (1 tab) TABLET Oral."

Review of the May 2018 medication administration record (MAR) documented, "MethylPREDNISolone 4 mg tablets in a dose pack (1); omeprazole 20 mg, delayed release (1) CAPSULE DELAYED RELEASE (ENTERIC COATED). dilTIAZem CD 240 mg capsule, extended release 24 hr (1); Thera tablet (1 tab) TABLET Oral." The medication as documented as being administered every day.

An interview was conducted on 6/8/18 at 10:32 a.m. with RN (registered nurse) #1. When asked if a nurse's bare, hand should handle medications, RN #1 stated, "No." When informed of the above observations with her holding medications with her bare hands, RN #1 stated, "Well, sometimes the pills fall on the table instead of into the cup and you have to throw them away.

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My hands were clean."

An interview was conducted on 6/8/18 at 10:44 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked when it was appropriate for staff to hold the resident's pills in their bare hands, ASM #2 stated, "Never." When asked why, ASM #2 stated, "For infection control."

An interview was conducted on 6/8/18 at 11:14 a.m. with LPN (licensed practical nurse) #1. When asked when it was appropriate for staff to hold resident's medications with their bare hands, LPN #1 stated, "It's never okay." When asked why, LPN #1 stated, "its infection control."

On 6/8/18 at approximately 12:00 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the policy titled, "Medication Administration, Receipt, Storage & Disposal" documented, "POLICY. Medication management in the Continuing Care (CC) will include ordering, receiving, proper storage and safe administration of residents' medications by authorized staff consistent with state requirements All medications will be administered honoring a resident's choice and activities, as much as possible consistent with the person center comprehensive care plan. (Holistic Care Plan). PROCEDURE: Medication Administration/Assistance. 2. Medications are administered in accordance with Nursing Standards of practice and in concordance with state law to include using the appropriate infection prevention & control practices for mediation assistance/administration."

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No further information was provided prior to exit.

1. Methylprednisolone -- MEDROL Tablets are indicated in the following conditions: 1. Endocrine Disorders - Primary or secondary adrenocortical insufficiency (hydrocortisone or cortisone) This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=39d5270b-d957-4821-93d6-501b7b9f02d4

2. Prilosec DR -- Omeprazole delayed-release capsules should be taken before eating. In the clinical trials, antacids were used concomitantly with omeprazole. Patients should be informed that the omeprazole delayed-release capsule should be swallowed whole. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=c6bc8fb7-2862-464a-b7c9-e409034f072a

3. Diltiazem CD -- CARDIZEM CD is indicated for the treatment of hypertension. It may be used alone or in combination with other antihypertensive medications. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=1042fa13-e6af-46b9-8008-6c941f0978b1

4. Theragran -- Americans have been taking multivitamin/mineral (MVM) supplements since the early 1940s, when the first such products became available [1]. MVMs are still popular dietary supplements and, according to estimates, more than one-third of all Americans take these supplements [1, 2]. This information was obtained from:

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https://ods.od.nih.gov/factsheets/MVMS-HealthProfessional/

2. The facility staff failed to administer medication in a sanitary manner to Resident #25.

Resident #25 was admitted to the facility on 4/23/18 with diagnoses that included but were not limited to: Parkinson's disease (1), kidney disease, slurred speech and weakness.

The most recent MDS (minimum data set), an admission MDS, with an ARD (assessment reference date) of 4/23/18 coded the resident as having scored a 4 out of 15 on the BIMS (breif interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living.

A medication administration observation for Resident #25 was conducted on 6/7/18 at 9:10 a.m. with RN (registered nurse) #1. RN #1 took the carbidopa 25 mg - levodopa 250 mg (2), one and a half pills out of the package and put it into her hand, put it into a small plastic bag, crushed it, mixed it with applesauce and gave it to the resident.

Review of the May 2018 physician's orders documented, "carbidopa 25 mg-levodopa 250 (2) tablet (1 and 1/2) TABLET Oral."

Review of the May MAR documented, "carbidopa 25 mg-levodopa 250 (2) tablet (1 and 1/2) TABLET Oral." The medication was documented as being given every day.

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An interview was conducted on 6/8/18 at 10:32 a.m. with RN (registered nurse) #1. When asked if a nurse's bare, hand should handle medications, RN #1 stated, "No." When informed of the above observations with her holding medications with her bare hands, RN #1 stated, "Well, sometimes the pills fall on the table instead of into the cup and you have to throw them away. My hands were clean."

An interview was conducted on 6/8/18 at 10:44 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked when it was appropriate for staff to hold the resident's pills in their bare hands, ASM #2 stated, "Never." When asked why, ASM #2 stated, "For infection control."

An interview was conducted on 6/8/18 at 11:14 a.m. with LPN (licensed practical nurse) #1. When asked when it was appropriate for staff to hold resident's medications with their bare hands, LPN #1 stated, "It's never okay." When asked why, LPN #1 stated, "its infection control."

On 6/8/18 at approximately 12:00 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.
3. The facility staff failed to maintain infection control during the medication administration observation for Resident # 149.

Resident #149 was admitted to the facility on 5/31/18 with diagnoses that included but were not limited to compression fracture of the third lumbar vertebrae, Parkinson's disease, high blood pressure, dementia with Lewy Bodies, and mild

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cognitive impairment. Resident #149 did not have a completed MDS (minimum data set) assessment at the time of the survey. Resident #149 was documented in the clinical record as being alert and oriented x 3 (person, place, time).

On 6/7/18 at 5:13 p.m., medication administration observation was conducted with LPN (licensed practical nurse) #2. LPN #2 first washed her hands, grabbed a Styrofoam cup and filled it with water, and opened a straw wrapper. LPN #2 grabbed the straw by the mouthpiece as she was removing the wrapper. Her bare hands touched the mouthpiece as she placed the straw into the cup. LPN #2 placed the cup on the medication cart and then prepared the following medications for Resident #149:

1) Coumadin 3 mg (milligrams): 1 tablet
2) Myrbetriq 50 mg: 1 tablet
3) Tylenol 325 mg; 2 tablets to equal 650 mg

On 6/7/18 at 5:20 p.m., Resident #149 was administered the medication. Resident #149 drank his water from the straw that was touched by LPN #2's bare hands.

On 6/8/18 at 11:00 a.m., an interview was conducted with LPN #2. When asked how to maintain infection control during medication pass, LPN #2 stated that hand washing was the major thing. LPN #2 stated that hands should be washed before and after medication pass. When asked if it was ever okay to touch the resident's straw with bare hands, LPN #2 stated, "Oh no. I usually leave the top part with the paper." LPN #2 stated that she usually leaves the mouthpiece with the paper on top so that the residents can remove it themselves. When asked if she did that

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F 880	Continued From page 93 on 6/7/18 with Resident #149, LPN #2 stated that she had made a mistake and did not do that. On 6/8/18 at approximately 12:00 p.m., ASM (administrative staff member) #2, the DON (Director of Nursing) was made aware of the above concerns. No further information was presented prior to exit. 1) Coumadin is a blood thinner used to prevent blood clots. May lower the risk of serious complications after a heart attack. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012678/?report=details. 2) Myrbetriq is used for the treatment of overactive bladder. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=ba9e9e15-e666-4c56-9271-2e24739cfa2d. 3) Tylenol- Treats minor aches and pains and also reduces fever. This information was obtained from The National Insitutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008785/?report=details.	F 880		