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	495105	A. BUILDING _____ B. WING _____	C 03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNCHBURG HLTH & REHAB CNTR	5615 SEMINOLE AVENUE LYNCHBURG, VA 24502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted on 3/22/16 through 3/24/16. Two complaints were investigated. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 180 certified bed facility was 149 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents # 1 through 21) and three closed record reviews (Residents # 22 through 24).	F 000		
F 167 SS=C	RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE CFR(s): 483.10(g)(1) A resident has the right to 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. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and resident interview the facility failed to post notice of location and ensure readable form and without devices readily available of the survey results report.	F 167	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain	4/19/16

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

Electronically Signed | 04/07/2016

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F 167	Continued From page 1 The survey result book did not have posted notice and was observed in small print without devices to enhance readability. Findings: Throughout the survey process conducted 3/22/16 through 3/24/16 general observations were performed. The most recent survey report book was located in the main entrance lobby on a table next to the administrator's office. There was no evidence of notice as to where the survey book was located, except for the survey book itself. Review of the survey book revealed the print to be small approximately 10 to 12 font and without any devices to enhance readability, such as a magnifying glass. On 3/24/16 at 8:45 a.m. a certified nursing assistant (identified as CNA #10) working on the east wing of the facility was interviewed concerning the location of the survey book. CNA #10 verbalized that the book was at the nurses station and proceeded to look for the survey book. After not being able to locate the survey book, CNA #10 verbalized that she thought it (survey book) was up in the front lobby. On 3/24/16 at 9:15 a.m. the Resident council president was interviewed concerning the location of the survey book. The Resident council president verbalized that the book might be up front somewhere. When asked if he (Resident council president) had ever reviewed the survey book, the Resident president council verbalized, no.	F 167	in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F167 1. A notice is posted in the front lobby that identifies the location of the survey book. A magnifying page has been placed inside the survey book cover to enhance readability. 2. Current facility staff and residents will be educated regarding notice and location of the survey book. 3. The front desk receptionist will ensure that the notice and survey book with magnifying page is in place daily 5X weekly X one month and weekly X 2 months. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters.	

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F 167	Continued From page 2 The above finding was brought to the attention of the Administrator and Director of nursing on 3/24/16 at 10:30 a.m. No other information was given to the survey team prior to the exit conference on 3/24/16.	F 167		
F 241 SS=D	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.15(a) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility staff failed to promote dignity for three of 24 residents, Resident #9, Resident #7 and Resident #10. 1. Resident #9's ileostomy bag was not covered by a privacy bag. 2. Resident #7 was not provided a dignified dining experience during breakfast in the East Wing Restorative Dining Room. 3. Resident #10 was not provided a dignified dining experience during breakfast in the West Wing Dining Room. Findings were: 1. Resident # 9 was originally admitted to the facility on 02/22/2016 with the following diagnoses, but not limited to: Critical Illness	F 241	F241 1. Resident #9 no longer resides at the facility. Residents #7 and #10 are currently being provided a dignified dining experience. Residents seated at the same table are served meals at the same time. 2. Current residents meal preference location and tray times will be reviewed to ensure consistency with being able to serve residents at the same table at the same time. Adjustments will be made as indicated. 3. Current facility direct care staff will be educated regarding a dignified dining experience to include serving residents seated at the same table at the same time. Nursing and Dietary leadership will observe dining areas daily 5X weekly X one month then 3X weekly X 2 months to ensure residents seated at the same table are being served at the same time. Any	4/19/16

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F 241	Continued From page 3 Myopathy, hypertension, severe protein-calorie malnutrition (requiring TPN -total parental nutrition), congestive heart failure, chronic kidney disease, gastroduodenitis with bleeding, gastritis with bleeding, ileostomy and COPD (chronic obstructive pulmonary disease). The most recent MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 02/29/2016. Resident #9 was assessed as having a cognitive summary score of "08", indicating moderate impairment with her cognitive status. Initial tour of the facility was conducted on 03/22/2015 at approximately 10:30 a.m. Resident #9 was observed lying in bed, supine, eyes closed, nasal cannula in place. A large round tube was observed coming out from under the sheet and down the side of the bed, the tube entered into a large rectangular container. The tube and the container contained brown liquid. The container was not in any type of privacy bag and was propped up and visible inside of a pink basin normally used for bed baths. LPN (licensed practical nurse) # 1 was in the hallway and was asked to accompany this surveyor to the room. This surveyor asked what the tubing coming from under the sheet was. LPN #1 stated, "That is her rectal tube." LPN #1 was asked why Resident #9 had a rectal tube. She stated, "She has an ileostomy, the rectal tube catches what doesn't come out of the ostomy." LPN #1 asked why the resident had both a rectal tube and an ileostomy. She stated, "She has it [feces] coming from both places. They put in the rectal tube to keep her from getting any skin breakdown."	F 241	issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters.	

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After reviewing the clinical record, this surveyor asked LPN #1 to accompany her to Resident #9's room. LPN #1 stated, "I told you wrong. She doesn't have a rectal tube. The tube is from her ileostomy bag." LPN #1 showed the ileostomy bag to this surveyor. The ostomy bag was open at the bottom and connected to the tubing which then connected to the rectangular container. The container was observed to have been placed inside of a black privacy bag and remained propped up in the pink basin. She stated, "This is how she and her husband had it hooked up at home and they wanted us to continue it." LPN #1 was asked what the black bag was for. She stated, "It's a privacy bag, the container should have been in there."

The above information was discussed during an end of the day meeting with the administrative staff on 03/23/2016 at approximately 3:50 p.m.

No further information was obtained prior to the exit conference on 03/24/2016.

2. Resident #7 was not provided a dignified dining experience during breakfast in the East Wing Restorative Dining Room.

Resident #7 was most recently readmitted to the facility on 01/08/2015 with the following diagnoses, but not limited to: Hypoglycemia, hypertension, type II diabetes mellitus, Alzheimer's, seizures, psychosis, and anemia.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 03/14/2016. Resident #7 was assessed as having a cognitive summary score

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of "08", indicating moderate impairment with her cognitive status.

On 03/23/2016 a breakfast meal observation was conducted in the East wing restorative dining room beginning at approximately 7:35 a.m. There were four tables in the dining room with a total of nine residents seated around the tables.

Resident #7 was observed sitting at a table with two other residents. Resident #7 was seated looking across the table and out of the window. One of the residents seated at the table was eating breakfast. Resident #7 and another resident did not have a tray. There were no staff members in the room.

At approximately 7:45 a.m., two CNAs (Certified nursing assistants) entered the room. CNA #2 was asked why all of the residents were not eating. She stated, "We are waiting on the trays." CNA #2 was asked if the residents who were not eating minded watching others eat. She stated, "They don't mind, they sit and watch the cars go by outside...I am just in here to deserve [observe] them...their food is on the second cart." CNA #2 was asked if she was a restorative aid. She stated, "No, I am just a plain CNA...I am only here to deserve [observe] them."

Two nurse consultants came down the hall while this surveyor was standing outside of the dining room. They were asked why no staff had been in the room earlier and why all residents had not been served. The corporate QI (quality improvement) nurse went into the dining room and spoke to CNA #2, stating, "Go get her tray now." The corporate QI nurse stated, "They know better than that...I have been working on

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this."

Resident #7's tray was served at approximately 8:00 a.m. Resident #7 was asked if she was hungry, she stated, "I'm always hungry."

The above information was discussed with the administrative staff during an end of the day meeting on 03/23/2016 at approximately 3:50 p.m.

No further information was obtained prior to the exit conference on 03/24/2016.

3. The facility staff failed to promote a dignified dining experience for Resident # 10. The resident sat at a table for approximately 45 minutes while two other residents were served, and were fed their breakfast.

Resident # 10 in the survey sample, a 78 year-old female, was originally admitted to the facility on 7/10/14, and most recently readmitted on 2/3/15 with diagnoses that included a history of femoral neck fracture, hypertension, osteoporosis, anxiety disorder, dementia, hypokalemia, anemia, gastroesophageal reflux disease, hyperlipidemia, generalized muscle weakness, and difficulty walking. According to the most recent Annual MDS, with an ARD of 7/13/15, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired, with a Summary Score of 3 out of 15.

According to the most recent Quarterly MDS, with an ARD of 3/14/16, the resident was assessed under Section C (Cognitive Patterns) as having short and long term memory problems with severely impaired daily decision making skills.

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At approximately 7:50 a.m. on 3/23/16, an observation of the breakfast meal in the West Wing Day Room was started. Resident # 10 was seated at a table with two other female residents, one on her right, and the other across the table from her.

At approximately 7:55 a.m., the resident seated across from Resident # 10 was served her breakfast. After the tray was set-up, the resident's daughter, who was present at the time, began feeding her. At about 8:20 a.m., the resident finished her breakfast. Her daughter left the day room and the resident remained seated at the table with Resident # 10. When asked later, CNA # 1 (Certified Nursing Assistant) said the resident's daughter "...comes in and feeds her mother almost everyday."

At about 8:25 a.m., the resident seated on Resident # 10's right was served her breakfast. After the tray was set-up, the resident was fed by CNA # 1. At about 8:35 a.m., the resident finished breakfast. CNA # 1 removed the resident's tray and the resident remained seated at the table.

At approximately 8:45 a.m., CNA # 1 brought Resident # 10's breakfast tray. After the tray was set-up, CNA # 1 began feeding the resident. While Resident # 10 was fed breakfast, the resident on her right and the resident across from her continued to sit at the table and watch her eat.

Resident # 10 sat at the table for approximately 45 minutes watching the other two residents eat while she waited for her breakfast tray.

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F 241	Continued From page 8 The observations were discussed with the administrative staff during an end of day meeting at 4:00 p.m. on 3/23/16.	F 241		
F 271 SS=D	ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE CFR(s): 483.20(a) At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain orders for the immediate care of a central line for one of 24 residents, Resident #9. Resident #9 was admitted with a tunneled central line into her upper left chest. No orders were written at the time of the admission for the care of the insertion site. Findings were: Resident # 9 was originally admitted to the facility on 02/22/2016 with the following diagnoses, but not limited to: Critical Illness Myopathy, hypertension, severe protein-calorie malnutrition (requiring TPN -total parental nutrition), congestive heart failure, chronic kidney disease, gastroduodenitis with bleeding, gastritis with bleeding, ileostomy and COPD (chronic obstructive pulmonary disease). The most recent MDS (minimum data set) was an admission assessment with an ARD	F 271	F271 1. Resident #9 no longer resides at the facility. 2. Current residents with central venous access devices were reviewed to ensure physician orders were in place at the time of admission for immediate care and are currently active. Corrections were made immediately as indicated. 3. Licensed nursing staff were educated by nursing leadership regarding the need for physician orders at the time of admission for residents immediate care. Licensed nursing staff will ensure orders are in place at the time of admission for care of central venous access devices. Unit managers or designees will review new admissions daily 5X weekly X 3 months to ensure accuracy of orders. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters.	4/19/16

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(assessment reference date) of 02/29/2016. Resident #9 was assessed as having a cognitive summary score of "08", indicating moderate impairment with her cognitive status.

Initial tour of the facility was conducted on 03/22/2015 at approximately 10:30 a.m. Resident #9 was observed lying in bed, supine, eyes closed, nasal cannula in place. A large IV (intravenous bag) was observed attached to an infusion pump at her bedside, the pump was off.

LPN (licensed practical nurse) # 1 was in the hallway and was asked to accompany this surveyor to the room..This surveyor asked what the bag was hanging at the bedside. She stated, "Her TPN [total parenteral nutrition], it is through infusing, I am going to take it down."

The clinical record was reviewed on 03/22/2016 beginning at approximately 1:00 p.m. The POS (Physician order sheet) contained the following orders: "Normal Saline Flush 10 ml (milliliters) intravenously one time per day for tunneled catheter" and "Heparin lock flush 10 units/ml use 5 ml intravenously one time a day for tunneled catheter." There were also orders for TPN, different mixtures to infuse on different days.

The care plan was then reviewed. A focus area: "Is on TPN IV" was observed. Goals were: "To ensure that 2 lumen catheter is flushed as ordered and patent." Interventions listed were: "Make sure dressing is changed as ordered, make sure site is free from infection while at facility, make sure site on left chest is dry and intact."

The physician orders were again reviewed, there

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were no orders on the POS for dressing changes to the catheter site.

This surveyor asked LPN #1 to accompany her to Resident #9's room. LPN #1 showed this surveyor the catheter insertion site on Resident #9's left chest. LPN #1 was asked how often the dressing was changed. She stated, "We change them on admission and every seven days." This surveyor asked LPN #1 how she knew when the seven days were up. She stated, "I look at the date on the dressing when I disconnect the TPN."

LPN #1 was asked if there were any orders on the TAR (treatment administration record) or the MAR (medication administration record) to indicate dates that the dressing was changed. LPN #1 reviewed the MAR, TAR and progress notes and stated, "I don't see where it is documented." LPN #1 was asked if there should be a physician order on the record regarding the dressing change. She stated, "Yes."

A copy of the POS was requested. When the POS was obtained new orders had been added which read: "IV Dressing change every 7 days and PRN as needed for dressing coming off or any part of occlusive seal not sealed" and "IV Dressing change every 7 days and PRN every day shift every 7 days for protocol change dressing and adapters." The corporate nurse consultant was asked where the new orders had come from. She stated [Name of LPN #1] got them from the physician....we should have had them."

The above information was discussed during an end of the day meeting with the administrative staff on 03/23/2016 at approximately 3:50 p.m.

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F 271	Continued From page 11 No further information was obtained prior to the exit conference on 03/24/2016.	F 271		
F 279 SS=E	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d), 483.20(k)(1) A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for three of 24 residents in the survey sample. 1. Resident #19 had no care plan developed regarding antipsychotic medication.	F 279	F279 1. Resident #19□s care plan was corrected to address antipsychotic medication. Resident #9 no longer resides in the facility. Resident #13□s care plan was corrected to address swallowing problems and the use of therapeutic devices for eating/drinking.	4/19/16

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F 279	Continued From page 12 2. Resident #9 had no care plan for care of an ileostomy. 3. Resident #13 had no care plan regarding swallowing problems and the use of therapeutic devices for eating/drinking. The findings include: 1. Resident #19 had no care plan developed regarding her use of antipsychotic medication. Resident #19 was admitted to the facility on 11/2/13 with a re-admission on 2/21/15. Diagnoses for Resident #19 included bipolar disorder, dysphagia, anxiety, osteoporosis, chronic kidney disease, tremors, irritable bowel syndrome and hypothyroidism. The minimum data set (MDS) dated 1/25/16 assessed Resident #19 as cognitively intact. Resident #19's clinical record documented a physician's order for the antipsychotic medication Ziprasidone 60 milligrams (mg) to be administered twice per day for the management of bipolar disorder. The resident's medication administration records documented the medication was administered as ordered. An annual MDS assessment dated 11/2/15 listed psychotropic drug use as a triggered concern that required a plan of care. Resident #19's current plan of care (revised 3/2/16) included no problems, goals and/or interventions regarding the resident's daily use of the antipsychotic medication Ziprasidone. On 3/23/16 at 2:00 p.m. the registered nurse (RN #1) responsible for care plans was interviewed	F 279	2. Nursing and dietary leadership will review current residents that receive antipsychotic medications, ileostomy care, have swallowing problems, and use therapeutic devices for eating/drinking. Care plans will be corrected immediately as indicated. 3. Current licensed nursing staff will be educated regarding developing comprehensive care plans to meet the active care needs of the residents. Licensed nursing staff will make daily updates to care plans as applicable. Unit managers or designees will review care plans weekly X 3 months based on MDS assessment schedule to ensure accuracy of the care plan. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters.	

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about Resident #19. After reviewing the care plan RN #1 stated she did not see anything listed about the resident's use of antipsychotic medication. RN #1 stated problems related to the resident's antipsychotic use were previously on the care plan but she did not know why it was no longer listed. RN #1 stated the problems, goals and interventions regarding Resident 19's antipsychotic use had been removed from the care plan in error.

These findings were reviewed with the administrator and director of nursing during a meeting on 3/23/16 at 4:00 p.m.
2. Facility staff to develop a comprehensive care plan for Resident #9's ileostomy.

Resident # 9 was originally admitted to the facility on 02/22/2016 with the following diagnoses, but not limited to: Critical Illness Myopathy, hypertension, severe protein-calorie malnutrition (requiring TPN -total parental nutrition), congestive heart failure, chronic kidney disease, gastroduodenitis with bleeding, gastritis with bleeding, ileostomy and COPD (chronic obstructive pulmonary disease).

The most recent MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 02/29/2016. Resident #9 was assessed as having a cognitive summary score of "08", indicating moderate impairment with her cognitive status.

Initial tour of the facility was conducted on 03/22/2015 at approximately 10:30 a.m. Resident #9 was observed lying in bed, supine, eyes closed, nasal cannula in place. A large IV (intravenous bag) was observed attached to an

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infusion pump at her bedside, the pump was off. A large round tube was observed coming out from under the sheet and down the side of the bed, the tube entered into a large rectangular container. The tube and the container contained brown liquid. The container was not in any type of privacy bag and was propped up and visible inside of a pink basin normally used for bed baths.

LPN (licensed practical nurse) # 1 was in the hallway and was asked to accompany this surveyor to the room. This surveyor asked what the tubing coming from under the sheet was. LPN #1 stated, "That is her rectal tube." LPN #1 was asked why Resident #9 had a rectal tube. She stated, "She has an ileostomy, the rectal tube catches what doesn't come out of the ostomy." LPN #1 asked why the resident had both a rectal tube and an ileostomy. She stated, "She has it [feces] coming from both places. They put in the rectal tube to keep her from getting any skin breakdown."

Orders were observed to "Change ostomy appliance once a week and PRN as needed..." and for "Ostomy care every shift for ileostomy care. Clean around ostomy bag and empty bag every shift and as needed." There were no orders observed for a rectal tube on the POS.

The care plan was then reviewed. There were no interventions on the care plan for care of the ostomy or for a rectal tube.

This surveyor asked LPN #1 to accompany her to Resident #9's room. LPN #1 stated, "I told you wrong. She doesn't have a rectal tube. The tube is from her ileostomy bag." LPN #1 showed the

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ileostomy bag to this surveyor. The ostomy bag was open at the bottom and connected to the tubing which then connected to the rectangular container. The container was observed to have been placed inside of a black privacy bag and remained propped up in the pink basin. She stated, "This is how she and her husband had it hooked up at home and they wanted us to continue it."

On 03/24/2016 at approximately 8:30 a.m., this surveyor informed the corporate nurse consultant that there were no interventions on the comprehensive care plan for the care of Resident #9's ileostomy. She stated, "It is on her orders, but it should also be on the care plan. We will fix it."

No further information was obtained prior to the exit conference on 03/24/2016.

3. The facility staff failed to develop a CCP (comprehensive care plan) for Resident # 13 for the restorative dining, for a divided plate and for dysphagia and/or any special drinking recommendations related to the dysphagia.

Resident # 13 was readmitted to the facility on 12/06/15. Diagnoses for Resident # 13 included, but were not limited to: TBI (traumatic brain injury) resulting from a MVA (motor vehicle accident), depression, spastic hemiplegia, impulsiveness and dysphagia (difficulty swallowing).

The most current MDS (minimum data set) dated 01/18/16, assessed the resident as having a cognitive score of 15, indicating the resident was

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cognitively intact. The resident was also assessed as requiring supervision, with set-up help only for food and beverage consumption. The resident was assessed as requiring extensive assistance from staff for all other ADL's (activities of daily living) .

Resident # 13 was observed eating breakfast, in the assisted (restorative) dining room, on 03/23/16 at approximately 7:30 a.m. The resident was sitting at a table with a food plate in front of him and 4 small, (approximately 4 ounce) blue cups lined up. Each cup was approximately half full. The resident was asked what was in the 4 cups; the resident stated, "Orange juice." The resident was then asked why he had the 4 small cups. The resident voiced that he didn't know why they were like that and further voiced that one of the CNA's (certified nursing assistant) had set it up like that for him. The resident voiced that he did not like having 4 small cups and voiced that he liked a big cup. The resident's meal ticket was beside the meal tray. The meal ticket documented: "...Restorative...Regular Divided Plate...Cinnamon French Toast DIVIDED PLATE...Sausage Patty DIVIDED PLATE...Orange juice..." The resident's food plate was had a regular, porcelain type plate; the plate was not divided. The meal ticket did not document anything about the resident's liquids related to the 4 small cups.

Resident # 13's clinical record was then reviewed. The current/active POS (physician's order set) documented: "...Regular diet..." No physician orders were found related to restorative dining, the divided plate, dysphagia, and/or recommendations related to the resident's beverage consumption or use of 4 small cups.

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The resident's CCP (comprehensive care plan) was then reviewed and documented: "...ADL (activities of daily living) self-care performance deficit r/t (related to) Musculoskeletal impairment, contracture...EATING: The resident is able to feed self after set up except for salads. Staff to feed resident salad when provided (created on : 01/07/15)...Increased nutritional risk r/t history of weight changes...Provide, serve diet as ordered...RD to evaluate and make diet changes..." The CCP did not address the resident's 'restorative dining', did not address the resident's 'divided plate' and did not address any information related dysphagia or to any recommendations related to the resident's beverage consumption or the use of the 4 small cups for drinking.

Resident # 13's therapy records were then reviewed. A "Speech Therapy SLP (Speech Language Pathology) Evaluation & Plan of Treatment", dated 08/18/15 was reviewed for Resident # 13.

The SLP documented: "...Start of Care: 8/18/15...Personal history of traumatic brain injury...DYSPHAGIA, UNSPECIFIED...Dysphagia unspecified...EVALUATION ONLY...electronic signature SLP (speech therapist) # 1...I certify the need for these medically necessary services furnished under this plan of treatment while under my care from 8/18/15 through 8/18/15...signature [of] PA (physician's assistant) 8/19/15...Patient referred...due to exacerbation of dysphagia characterized by increased coughing and wet voice at meals...spastic hemiplegia...patient consuming regular texture/thin liquid diet with minimal overt s/s (signs/symptoms) aspiration

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(e.g. coughing, wet voice)...exacerbation of dysphagia...patient assessed with...6 oz thin liquids via cup. Patient presents with full body convulsions, negatively impacting patient's ability to prepare bolus...nursing reports patient typically impulsive and utilizes large bolus size with occasional packing behaviors...moderate pharyngeal dysphagia when consuming thin liquids as evidenced by mild coughing and wet "gurgly" voice post swallow...required moderate cues to utilize throat clear and cough/swallow to clear pharyngeal residue...Clinician recommends patient receive close supervision during all meals. Clinician also recommends patient trial Provale cup with meals to reduce liquid bolus size and increase safety of swallow. Clinician unable to trial at time of evaluation due to no availability of Provale cup. Clinician will re-educate at future time to determine whether utilizing Provale cup increased safety of swallow...Precautions: Aspiration...Swallow precautions in place...Self feeds with mild difficulty controlling cup/bolus with utensil...Cup = Moderate; Clinical S/S Dysphagia: Wet voice (x 3) [three times] with several attempts to clear with cough/throat clear/reswallow (sic); mild coughing (x2)...behaviors impacting safety; full body convulsions...Risk Factors: Due to the documented physical impairments and associated functional deficits, the patient is at risk for: aspiration...electronic signature [3:36 p.m.] SLP # 1.

Resident # 13's progress notes were then reviewed from August 2015 to present.

A nursing progress note dated 08/18/15 and timed 9:30 a.m. documented: "...At 0920 [9:20 a.m.] house keeping came to get this writer and

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reported that resident was choking and needed assistance...assessed resident...sounds very gurglie (sic)...trying to talk saying "help and it sounds as if he was in water drowning as he held his throat. (sic) Lungs assessed, not clear...called ST [speech therapy] and made them aware. ST stated tht (sic) it took 5 minutes for pt [patient] to drink 1/2 cup of water. [Name of Nurse Practitioner] was also make aware V/O [verbal order] obtained to suction pt now and PRN [as needed]...Resident was suctioned...ST will be coming out to see this afternoon..."

A nursing progress note dated 08/18/15 and timed 2:43 p.m. documented: "...After hearing adventitious [abnormal] sounds in lungs this am ST was made aware...ST worked with resident during lunch...ST reported that this was "typical" of this resident...suggested that resident remains on...thin liquids but pt MUST BE SUPERVISED! (sic)..."

At 2:10 p.m. on 03/23/16, the RD presented an "Activity Log Report." The RD voiced that this report documented when the divided plate was initiated for Resident # 13, which was 04/27/13. The RD voiced, it was initiated because the resident shakes and has spastic movements and that the resident should have had a divided plate this morning.

The administrator, DON (director of nursing) and CN (corporate nurse) # 1 and # 2 were made aware of the above in a meeting with the survey team on 03/23/16 at 3:50 p.m. The facility staff was asked for any information related to the resident's dysphagia and/or the use of the 4 small, blue cups. The facility staff agreed that all of the above information should have been

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F 279	Continued From page 20 included in the resident's CCP. No further information or documentation was presented prior to the exit conference on 03/24/16.	F 279		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.20(d)(3), 483.10(k)(2) The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan for one of 24 residents in the survey sample. Resident #1's care plan was not updated with interventions for	F 280	F280 1. Resident #1□s care plan was corrected to address interventions for injury prevention following a skin tear and bruise.	4/19/16

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F 280	Continued From page 21 injury prevention following bruising and a skin tear during a shower. The findings include: Resident #1 was admitted to the facility on 10/16/14 with diagnoses that included diabetes, chronic kidney disease, osteoarthritis, chronic obstructive pulmonary disease, cerebrovascular accident (stroke), hypertension, anxiety and insomnia. The minimum data set (MDS) dated 3/16/16 assessed Resident #1 as cognitively intact. Resident #1's clinical record documented a nursing note dated 3/17/16 stating the resident experienced a skin tear on her right arm from a lift pad while the resident was on a shower bed. The note documented, "CNA [certified nurses' aide] pulled resident using her Hoyer pad for assistance and the Hoyer pad tore her skin..." The resident was treated for a skin tear and bruising on her right arm. The resident's plan of care (revised 3/18/16) documented the resident had a skin tear on her right elbow. Care plan goals related to the skin tear stated, "The resident will be free from skin tears through the review date." The care plan included no interventions for prevention of injury during showers or of any preventive actions implemented concerning use of the Hoyer lift pad with Resident #1. The only care plan intervention listed to prevent skin tears was, "Identify potential causative factors and eliminate/resolve when possible." On 3/23/16 at 9:45 a.m. the licensed practical nurse (LPN #3) unit manager was interviewed	F 280	2. Current residents with identified skin tears and bruises were reviewed to ensure care plan interventions are in place to prevent further injuries. Care plans were corrected immediately as indicated. 3. Licensed nursing staff were educated by nursing leadership regarding care plan accuracy to include interventions for injury prevention following skin tears and bruises. Licensed nursing staff will make daily updates to care plans as applicable. Unit managers or designees will review care plans weekly X 3 months based on MDS assessment schedule to ensure accuracy of the care plan. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters.	

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F 280	Continued From page 22 about any interventions implemented to prevent skin tears from the lift pad for Resident #1. LPN #3 stated the aides no longer used the lift pad to reposition the resident when on the shower bed. LPN #3 stated instead of using the pad to move the resident they now rolled the resident with the assistance of two people to prevent skin contact with the edges of the lift pad. LPN #3 stated the interventions implemented needed to be added to the care plan. These findings were reviewed with the administrator and director of nursing during a meeting on 3/23/16 at 4:00 p.m.	F 280		
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.20(k)(3)(i) The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed to follow professional standards of nursing practice for one of 24 residents in the survey sample. Nurses failed to clarify duplicate orders entered for Resident #1's cough medication Guaifenesin. A nurse documented duplicate doses of the Guaifenesin were administered to Resident #1 on 3/9/16. The findings include: Resident #1 was admitted to the facility on 10/16/14 with diagnoses that included diabetes,	F 281	F281 1. Resident #1□s guaifenesin order was clarified with the physician and the resident currently receives the correct dose and dose is documented accurately. 2. Current residents receiving guaifenesin will be reviewed to ensure no duplicate order and no duplicate dose documented. 3. Licensed nursing staff will be educated regarding duplicate orders, administering medications at the correct dose, and documenting accurately. Medication pass observations will be	4/19/16

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F 281	Continued From page 23 chronic kidney disease, osteoarthritis, chronic obstructive pulmonary disease, cerebrovascular accident (stroke), hypertension, anxiety and insomnia. The minimum data set (MDS) dated 3/16/16 assessed Resident #1 as cognitively intact. Resident #1's clinical record documented two current physician orders for medication Guaifenesin. The record documented a physician's order dated 1/2/16 for Guaifenesin Liquid 100 mg (milligrams) per 5 ml (milliliters); give 10 ml every 4 hours as needed (prn) for cough. The record also documented a physician's order dated 3/8/16 for Guaifenesin ER (extended release) tablet 600 mg to be given every 12 hours as needed for sinus congestion. Resident #1's medication administration record (MAR) documented on 3/9/16 a 10 ml dose of the liquid Guaifenesin was administered at 8:51 a.m. and a 600 mg tablet of Guaifenesin was administered at 8:52 a.m. There were no notes documented regarding the duplicate doses. Both doses were entered/signed off on the MAR by licensed practical nurse (LPN) #6. On 3/22/16 at 3:30 p.m. LPN #6 was interviewed about Resident #1's duplicate orders for Guaifenesin and the duplicate administration documented on 3/9/16. LPN #6 stated she gave only the 600 mg tablet of Guaifenesin to Resident #1 on 3/9/16 and not the liquid. LPN #6 stated she did not know why both the liquid and tablet dose of Guaifenesin were marked as given on 3/9/16. LPN #6 stated Resident #1 takes her medications whole. LPN #6 stated she did not know why Resident #1 had two current orders for as needed Guaifenesin. LPN #6 stated she saw	F 281	conducted 3x weekly X one month and weekly X 2 months to validate no duplicate orders and accurate documentation of medication administration time and doses. Any issues will be addressed immediately at the time of identification. MD will be notified promptly as indicated. 4. Process will be reviewed in QA committee for two quarters.	

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no clarification order regarding the duplicate Guaifenesin orders.

On 3/22/16 at 4:20 p.m. accompanied by LPN #6, Resident #1's Guaifenesin supply was observed in the medication cart. LPN #6 stated the tablet form of Guaifenesin was supplied in bulk form from a bottle sent by pharmacy. LPN #6 displayed Resident #1's bottle of liquid Guaifenesin. The liquid Guaifenesin was labeled from the pharmacy for Resident #1 and was marked as opened on 3/9/16. When asked about why the bottle was opened on 3/9/16 if the liquid Guaifenesin was not given, LPN #6 had no response.

Resident #1's MAR documented no other doses of Guaifenesin were administered on 3/9/16 except for the two marked by LPN #6 at 8:51 a.m. and 8:52 a.m.

On 3/22/16 at 3:45 p.m. unit manager (LPN #3) was interviewed about Resident #1's duplicate orders for Guaifenesin and duplicate doses listed as given on 3/9/16. LPN #3 stated did not know why duplicate doses were marked given. Concerning the duplicate orders, LPN #3 stated it was possible that the order for the Guaifenesin tablet on 3/8/16 was entered when the resident already had an order for the liquid Guaifenesin.

On 3/23/16 at 9:40 a.m. the director of nursing (DON) was interviewed about the duplicate order and duplicate doses of Guaifenesin marked for Resident #1. The DON stated LPN #3 said she gave only the 600 mg tablet on 3/9/16 and not the liquid. The DON stated she had no explanation why the bottle of liquid Guaifenesin was opened on 3/9/16 if not given. The DON stated, "I don't

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have any explanation for that whatsoever. I don't know."

The facility's policy titled General Dose Preparation and Medication Administration (revised 1/1/13) stated, "Prior to administration of medication, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following...Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident...Confirm that the MAR reflects the most recent medication order...After medication administration...Document necessary medication administration/treatment information (e.g., when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN medications, application sight) on appropriate forms..."

The Drug Information Handbook for Nursing 13th edition on page 12 states, "Safe administration is grounded in the five 'Right' principles: Right Drug, Right Dose, Right Patient, Right Route, Right Time... Right Drug - involves checking the drug dispensed with the written prescription...caution must be used to determine the exact drug prescribed... Right route should also include knowledge about whether the dispensed oral drug form can be changed..." Page 586 of this reference describes Guaifenesin as an expectorant used to help loosen phlegm and to thin bronchial secretions making coughs more productive. (1)

The Lippincott Manual of Nursing Practice 10th edition on pages 16 and 17 states, "Legal claims

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F 281	Continued From page 26 most commonly made against professional nurses include the following departures from appropriate care: failure to assess the patient properly or in a timely fashion, follow physician orders, follow appropriate nursing measures, communicate information about the patient, adhere to facility policy or procedure, document appropriate information in the medical record, administer medications as ordered, and follow physician's orders that should have been questioned or not followed, such as orders containing medication dosage errors." (2) These findings were reviewed with the administrator and director of nursing during a meeting on 3/23/16 at 4:00 p.m. (1) Turkoski, Beatrice B., Brenda R. Lance and Elizabeth A. Tomsik. Drug Information Handbook for Nursing. Hudson, Ohio: Lexi-Comp, 2011. (2) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.	F 281		
F 282 SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.20(k)(3)(ii) The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to implement	F 282	F282 1. Resident #2 is currently receiving	4/19/16

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F 282	Continued From page 27 interventions in the care plan related to pain for one of 24 residents in the survey sample, Resident #2 and failed to ensure staff was knowledgeable regarding care of a catheter and regarding the functionality of an ileostomy for one of 24 residents in the survey sample, Resident #9. 1. Resident #2's Care Plan (CP) was not implemented for alternative interventions related to pain control 2. Facility staff was not knowledgeable regarding the type of catheter and the care needed for the catheter, nor was facility staff knowledgeable regarding the functionality of Resident #9's ileostomy. The findings include: 1. Resident #2 was admitted to the facility on 5/24/15 with, but not limited to, the following diagnoses: coronary artery disease, hypertension, chronic obstructive pulmonary disease, seizure disorder, chronic pain, unspecified myalgia and myositis. The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/23/16, the assessment was incomplete during the time of the survey. The comparison MDS with an ARD of 2/22/16, which was a quarterly assessment was reviewed; the resident was assessed as a nine (9) for cognitive impairment, moderately impaired in decision-making skills. On 3/23/16 at approximately 8:00 a.m., Resident #2 was observed sitting in the hallway, at the medication cart and on a rollator; the medication nurse who was a licensed practical nurse and will	F 282	interventions to treat pain as stated in the care plan. Resident #9 no longer resides at the facility. 2. Current residents receiving a scheduled pain management regimen will be reviewed by nursing leadership to ensure interventions in the care plan are being implemented to treat pain. Current licensed nursing staff caring for residents with ostomies and intravenous lines were interviewed by nursing leadership to ensure knowledge of specific care needs. 3. Current nursing staff will be educated regarding pain management strategies to include assessment and implementation of interventions to treat pain. Current licensed nursing staff will be educated regarding identification and care of ostomies and intravenous lines. Licensed nurses will observe current residents for signs of pain daily and if indicated will provide interventions and follow up. Unit Manager or designee will review current residents pain scale documentation daily 5X weekly X 3 months to determine the need for further interventions. Current residents will also be interviewed by licensed nurses regarding pain with weekly care plan schedules to determine the residents current pain status and need for further pain management regimens. Nursing leadership will validate knowledge of current nurses caring for residents with ostomies and intravenous lines. Three nurses per week will be validated X 3 months to ensure competency. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA	

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be identified as LPN #2 was administering the resident her morning medications, which consisted of Gabapentin 600 milligrams (mg). The resident was wearing a Fentanyl patch that was placed on 3/21/16 on the right side of the resident's person.

This Surveyor upon completion of the medication observation for the resident, asked if the resident would like to talk. Resident #2 agreed to an interview. As this Surveyor and Resident #2 started to her room, Resident #2 stated that she was not "feeling well" when asked. Resident #2 stated that she was in pain. This Surveyor proceeded to ask the resident how bad her pain was on the pain scale of 0-10; Resident #2 stated, "It's an eight (8). This Surveyor turned to go to the medication cart to make LPN #2 aware of the resident's complaint of pain, when the resident's daughter in law approached this Surveyor and stated, "If you are going in the room to talk to my mother-in-law, you may want to find someone else; she is not going to be bias and she will blame everything on the nurses and staff here at the facility (Sic)." This Surveyor asked Resident #2 if she felt like being interviewed due to her complaint of pain, Resident #2 stated, "Yes, I can talk to you."

On 3/23/16 at approximately 8:30 a.m., after the interview was completed, Resident #2 was interviewed and asked if the pain was still present. Resident #2 stated, "Yes, I hurt all the time in my legs." This Surveyor left the resident's room; the medication nurse, who was a licensed practical nurse and will be identified as LPN #2 was standing at the medication cart. LPN #2 was made aware that Resident #2 was complaining of pain. LPN #2 stated, "We can't give her anything

committee for two quarters.

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for pain, her family does not want her to have anything(sic)." LPN #2 was interviewed and asked the reasoning for the resident not being able to have anything for pain per the family's request, and if the resident was in pain, how was it being managed. LPN #2 stated, "I don't know other than her regular medicines. I wondered the same thing, I don't know why she can't have Tylenol for in between pain."

On 3/23/15 at approximately 9:00 a.m., Resident #2's clinical record was reviewed to include the following:

A Pain Care Plan (CP) created on 5/23/15 and revised on 6/11/15 was reviewed to include the following:
"Focus: The resident has chronic pain r/t (related to) myalgia and myositis...Goal: The resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date...Interventions: Administer analgesia as ordered...Encourage to try different pain relieving methods i.e. positioning, relaxation therapy, progressive relaxation, bathing, heat and cold application, muscle stimulation, ultrasound. Monitor/record/report to Nurse any s/sx of non-verbal pain. Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM (range of motion), withdrawal or resistance to care..." There were no new updates to the care plan regarding pain.

A Physician's Progress Note dated 5/26/15 was reviewed to include the following:
"CC: Resident seen for pain assessment S: Resident reports pain in left leg from mid-thigh down to foot 10/10. "My pain comes every day

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and night." Reports pain also in left buttock, and over left ileosacral joint. Unable to give quality of pain; when asked whether pain is sharp or dull, replied, "both". Report's some numbness and tingling left lower leg and foot, no numbness or tingling right leg and foot...Also stated today, that she has been told that she has "nerve pain", and that she cannot be operated on as she runs the risk of "being in a wheelchair"...A/P: chronic pain: fentanyl patch 75 mcg (microgram) / hour, oxymorphone 10 mg Q (every) 6 hours prn, with 8 doses requested and received since admission, Percocet 5-325 mg Q 4 hours prn pain, with 4 doses requested and received since admission...but despite a patchy history and pain inconsistent with sciatica on SLR (straight leg raise), she describes a neurogenic pain...She seems to have a tolerance to high dose narcotics, so will start gabapentin 100 mg BID (twice a day) with 300 mg QHS (at bedtime /night), titrate up as needed. Discussed with [Physician named], who would like to schedule oxymorphone for now, so will schedule 10 mg Q6 hours for now."

On 3/23/16 at approximately 9:47 a.m., the unit manager, who was a licensed practical nurse and will be identified as LPN #3 was interviewed regarding the resident complaining of pain and the family's request for the resident not to have pain medication. LPN #3 stated, "I was not aware of this; the family does not know if she is in pain and they should not control if she can have pain medications. I will dig around and see what I can come up with." LPN #3 was made aware that during the Resident Interview, Resident #2 complained of pain and stated, when asked, that it was an eight (8) on the pain scale level of 0-10. LPN #3 was interviewed and asked if the Resident had any other medications to control

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breakthrough pain other than Neurontin and a Fentanyl patch. LPN #3 stated, "I don't know, I have to check."

On 3/23/16 at approximately 10:30 a.m., LPN #3 stated to this Surveyor, "I went to the room and talked with [Resident named], she said her pain was an eight (8)." When interviewed and asked what interventions were put in place to alleviate the resident's pain. LPN #3 stated, "She said the Neurontin helps some and she goes to Bingo three times a week." During the interview with LPN #3 the director of nursing (DON) was present and stated, in regards to the resident receiving pain medications, "She was on Oxycontin and the family asked that we discontinue it because it was causing her to have behaviors. The DON was interviewed and asked if anything else was ordered to help control the pain that would not cause the resident to have behaviors but alleviate the pain. The DON stated, "When they are admitted, we go over the orders with [Physician named] and if he want to make changes he does based on knowing the patient. He discontinued the Oxycontin because the family was against her having it and because of her behaviors."

On 3/23/15 at approximately 10:35 a.m., the DON and LPN #3 was made aware of the Psychology evaluation in that it was documented that the resident's behaviors were contributed a medication (Risperdal) change and pain, in which Oxycodone IR was added to manage the resident's pain. The DON and LPN #3 was interviewed regarding the Oxycodone and the reason the resident was not on it as recommended by the Psychologist. The DON stated, "Her son did not want her to have it so he

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asked the doctor to discontinue it." When interviewed regarding the location of other non-pharmacological interventions that was provided to relieve the resident's pain, the DON stated, "It should be documented in the nursing notes."

On 3/23/15 at approximately 1:00 p.m., Resident #2's Pain Level Summary from May 2015 through March 2016 was presented to this Surveyor, the Summary indicated that the resident's pain level for the month of February and March was as follows:

3/19/16 (4)
3/17/16 (9)
3/16/16 (6)
3/10/16 (5)
3/6/16 (7)
3/5/16 (4)
3/4/16 (6)
2/29/16 (4)
2/20/16 (8)
2/19/16 (5)
2/18/16 (5)
2/16/16 (8)
2/15/16 (5)
2/12/16 (9)
2/11/16 (5)
2/9/16 (5)
2/8/16 (5)
2/7/16 (9)
2/6/16 (9)
2/5/16 (5)
2/4/16 (6)
2/3/16 (6)
2/2/16 (7)
2/1/16 (6)

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On 3/23/16 at approximately 1:10 p.m., Resident #2's nursing notes from February 2016 through March 2016 was reviewed in the clinical record, the nursing notes did not address any pharmacological or non-pharmacological interventions as documented on the CP to decrease the resident's pain.

On 3/23/16 at approximately 1:20 p.m., the DON was interviewed regarding the pain level summary and the follow up to determine the interventions used to manage the resident's pain. The DON reviewed the Pain Level Summary and stated, "If they are getting scheduled pain meds (medicines) it (the computer) does not default to do a follow up; it only does that if the resident is taking prn (as needed/necessary) narcotics." When interviewed and asked how did staff know that the resident's pain was managed if there was no follow up or documentation to show that interventions were put in place, the DON stated, "If the resident does not complain of pain anymore, we assume that they are not in pain. (sic)" The DON was interviewed regarding the facility's expectations related to assessing and then following up to ensure pain is managed. The DON stated, "There should be a follow up. Let me see what I can find."

On 3/23/16 at approximately 2:29 p.m., the regional nurse consultants, who will be identified as Administrator (Admin) #1 and #4 entered the conference room and requested that this Surveyor explain to them what was going on regarding Resident #2's pain. This Surveyor made Admin #1 and #4 aware of the resident stating she was in pain and the pain assessment follow up not being done to determine if the resident's pain was relieved or that the

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interventions were being offered as CP'd. Admin #1 stated, "The follow up documentation for pain is not there; there is no documentation for pain I can tell you that now."

No further information was provided during the course of the survey regarding, care plan interventions, pain management and following up on pain level assessments.
2. Facility staff was not knowledgeable regarding the type of catheter and the care needed for the catheter, nor was facility staff knowledgeable regarding the functionality of Resident #9's ileostomy.

Resident #9 was originally admitted to the facility on 02/22/2016 with the following diagnoses, but not limited to: Critical Illness Myopathy, hypertension, severe protein-calorie malnutrition (requiring TPN -total parental nutrition), congestive heart failure, chronic kidney disease, gastroduodenitis with bleeding, gastritis with bleeding, ileostomy and COPD (chronic obstructive pulmonary disease).

The most recent MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 02/29/2016. Resident #9 was assessed as having a cognitive summary score of "08", indicating moderate impairment with her cognitive status.

Initial tour of the facility was conducted on 03/22/2015 at approximately 10:30 a.m. Resident #9 was observed lying in bed, supine, eyes closed, nasal cannula in place. A large IV (intravenous bag) was observed attached to an infusion pump at her bedside, the pump was off. A large round tube was observed coming out

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from under the sheet and down the side of the bed, the tube entered into a large rectangular container. The tube and the container contained brown liquid. The container was not in any type of privacy bag and was propped up and visible inside of a pink basin normally used for bed baths.

LPN (licensed practical nurse) # 1 was in the hallway and was asked to accompany this surveyor to the room..This surveyor asked what the bag was hanging at the bedside. She stated, "Her TPN, it is through infusing, I am going to take it down." This surveyor also asked what the tubing coming from under the sheet was. LPN #1 stated, "That is her rectal tube." LPN #1 was asked why Resident #9 had a rectal tube. She stated, "She has an ileostomy, the rectal tube catches what doesn't come out of the ostomy." LPN #1 asked why the resident had both a rectal tube and an ileostomy. She stated, "She has it [feces] coming from both places. They put in the rectal tube to keep her from getting any skin breakdown."

The clinical record was reviewed on 03/22/2016 beginning at approximately 1:00 p.m. The POS (Physician order sheet) contained the following orders: "Normal Saline Flush 10 ml (milliliters) intravenously one time per day for tunneled catheter" and "Heparin lock flush 10 units/ml use 5 ml intravenously one time a day for tunneled catheter." There were also orders for TPN, different mixtures to infuse on different days.

There were no orders observed for a rectal tube on the POS.

The care plan was then reviewed. A focus area:

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"Is on TPN IV" was observed. Goals were: "To ensure that 2 lumen catheter is flushed as ordered and patent." Interventions listed were: "Make sure dressing is changed as ordered, make sure site is free from infection while at facility, make sure site on left chest is dry and intact."

There were no interventions on the care plan for care of the ostomy or for a rectal tube.

This surveyor asked LPN #1 to accompany her to Resident #9's room. Before arriving to the room, LPN #1 stated, "I told you wrong. She doesn't have a rectal tube. The tube is from her ileostomy bag." LPN #1 showed the ileostomy bag to this surveyor. The ostomy bag was open at the bottom and connected to the tubing which then connected to the rectangular container. The container was observed to have been placed inside of a black privacy bag and remained propped up in the pink basin. She stated, "This is how she and her husband had it hooked up at home and they wanted us to continue it."

LPN #1 showed this surveyor the catheter insertion site on Resident #9's left chest. LPN #1 was asked what kind of line was in Resident #9's chest. She stated, "It is a PICC [Peripherally inserted central catheter]. A double lumen catheter was observed extending from Resident #9's upper left chest. One lumen was clamped, the other was not. The lumen that was clamped had a port on the end. The lumen that was not clamped did not have a port/cap. LPN #1 was asked to if the lumens were suppose to be clamped. She stated, "Yes, I forgot to clamp it when I took the TPN down this morning around 10:00." LPN #1 was asked if the port was

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suppose to have a cap on it. She stated, "Yes, but I didn't hang the TPN, I'm not sure where the cap is."

Two nurse consultants and the DON (director of nursing) were at the nurse's station and was asked about the protocol for the line, should it be clamped, and what about caps on the ports.

The medical director was interviewed on 03/22/2016 at approximately 3:45 p.m. He stated, "I contacted the radiologist that puts those lines in. He said that the system is closed and there is no back flow, it doesn't need to be clamped or capped." The medical director was asked what kept bacteria from sitting in the end of the port if the port was not capped. He left the room and returned. He stated, "I called the radiologist back and he said as long as the nurse's clean the port before infusing anything, it is okay."

The above information was discussed with the DON (director of nursing) on 03/22/2016 at approximately 4:00 p.m. Information obtained was that they catheter was a double lumen tunneled Hohn Catheter, not a PICC as verbalized by LPN #1.

On 03/23/2016 at approximately 9:00 a.m., the DON came to the conference room to speak with this surveyor. She presented information regarding the Hohn catheter and stated, "We changed the ports out when the resident got her and placed these. She presented ports/adapters as observed on the ends of Resident #9's lumen. She stated, "The system is closed with these adapters, it is a needleless system. The lumens are clamped when we change these adapters

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F 282	Continued From page 38 weekly." The above information was discussed during an end of the day meeting with the administrative staff on 03/23/2016 at approximately 3:50 p.m. Concerns were voiced that the LPN caring for Resident #9 had not known the type of central line she was taking care of, what the care for the line was, and had voiced that Resident #9 had a rectal tube as well as an ileostomy. No further information was obtained prior to the exit conference on 03/24/2016.	F 282		
F 309 SS=E	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.25 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, family interview and clinical record review, the facility staff failed to assess and implement interventions for the management of chronic pain for one of 24 residents in the survey sample, Resident #2. Resident #2 was diagnosed with chronic pain syndrome and other unspecified myalgias and myositis. The resident was not assessed or	F 309	F309 1. Resident #2 is currently being assessed for pain and is receiving interventions to treat pain. 2. Current residents receiving a scheduled pain management regimen will be reviewed by nursing leadership to ensure pain is being assessed and interventions are being implemented to treat pain.	4/19/16

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F 309	Continued From page 39 provided interventions to alleviate chronic pain symptoms. The findings include: Resident #2 was admitted to the facility on 5/24/15 with, but not limited to, the following diagnoses: coronary artery disease, hypertension, chronic obstructive pulmonary disease , seizure disorder, chronic pain, unspecified myalgia and myositis. The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/22/16, which was a quarterly assessment was reviewed. The resident was assessed as a nine (9) for cognitive impairment, moderately impaired in decision-making skills. On 3/23/16 at approximately 8:00 a.m., Resident #2 was observed sitting in the hallway, at the medication cart and on a rollator; the medication nurse who was a licensed practical nurse and will be identified as LPN #2, was administering the resident her morning medications, which consisted of Gabapentin 600 milligrams (mg). The resident was wearing a Fentanyl patch that was placed on 3/21/16 on the right side of the resident's person. This Surveyor upon completion of the medication observation for the resident, asked if the resident would like to talk. Resident #2 agreed to an interview. As this Surveyor and Resident #2 started to her room, Resident #2 stated that she was not "feeling well" when asked. Resident #2 stated that she was in pain. This Surveyor proceeded to ask the resident how bad her pain was on the pain scale of 0-10; Resident #2 stated, "It's an eight (8). This Surveyor turned to go to the medication cart to make LPN #2 aware	F 309	3. Current nursing staff will be educated regarding pain management strategies to include assessment and implementation of interventions to treat pain. Licensed nurses will observe current residents for signs of pain daily and if indicated will provide interventions and follow up. Unit Manager or designee will review current residents□ pain scale documentation daily 5X weekly X 3 months to determine the need for further interventions. Current residents will also be interviewed by licensed nurses regarding pain with weekly care plan schedules to determine the residents□ current pain status and need for further pain management regimens. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters.	

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of the resident's complaint of pain, when the resident's daughter-in-law approached this Surveyor and stated, "If you are going in the room to talk to my mother-in-law, you may want to find someone else; she is not going to be bias and she will blame everything on the nurses and staff here at the facility (Sic)." This Surveyor asked Resident #2 if she felt like being interviewed due to her complaint of pain, Resident #2 stated, "Yes, I can talk to you."

On 3/23/16 at approximately 8:30 a.m., after the interview was completed, Resident #2 was interviewed and asked if the pain was still present. Resident #2 stated, "Yes, I hurt all the time in my legs." This Surveyor left the resident's room; the medication nurse,LPN #2, was standing at the medication cart. LPN #2 was made aware that Resident #2 was complaining of pain. LPN #2 stated, "We can't give her anything for pain, her family does not want her to have anything(sic)." LPN #2 was interviewed and asked the reasoning for the resident not being able to have anything for pain per the family's request, and if the resident was in pain, how was it being managed. LPN #2 stated, "I don't know other than her regular medicines. I wondered the same thing, I don't know why she can't have Tylenol for in between pain."

On 3/23/15 at approximately 9:00 a.m., Resident #2's clinical record was reviewed to include the following:

A Psychology evaluation dated 8/10/15 was reviewed in the clinical record to include the following:

"8/10/15...Hospital Course: According to the

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facility she had become quite difficult to redirect after being quarantined for several weeks...in the context of being quarantined and also the discontinuation of her Risperdal that her behaviors became problematic, out of control according to the records...Although her behaviors may seem intentional during her stay on a geri-psych unit, and from reports from the facility, much of what she has been doing is not willful, but is in the context of her decline and her dementing illness. During her stay on the Geri-psych we simply restarted her Risperdal at 2 mg daily. We also added a low dose of Lexapro and continued with her Cymbalta in hopes of managing her depression which is related to the pain that she has in her legs and back...In addition we are making changes with her pain medication as she was on Neurontin 300 mg tid (three times a day) and we have increased that to 600 mg t.i.d and changed her prn (as needed/necessary) pain medications to Oxycodone IR 15 mg every three hours as needed for pain.

[Resident named] also has a Fentanyl patch which is to be applied every 72 hours in managing the pain as well. At the time of discharge, [Resident named] is quite, safe, stable...As noted above, she has really not displayed any type of aggressive behaviors...Ultimately the intervention that we found successful with [Resident named] was to restart the Risperdal that had been discontinued...Disposition and Followup Plans: [Resident named] is discharging to [Facility named]. Her son who serves as her power of attorney agrees with the disposition..."

A Pain Care Plan (CP) created on 5/23/15 and

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revised on 6/11/15 was reviewed to include the following:
"Focus: The resident has chronic pain r/t (related to) myalgia and myositis...Goal: The resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date...Interventions: Administer analgesia as ordered...Encourage to try different pain relieving methods i.e. positioning, relaxation therapy, progressive relaxation, bathing, heat and cold application, muscle stimulation, ultrasound. Monitor/record/report to Nurse any s/sx of non-verbal pain. Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM (range of motion), withdrawal or resistance to care..." There were no new updates to the care plan regarding pain.

A Physician's Progress Note dated 5/26/15 was reviewed to include the following:
"CC: Resident seen for pain assessment S: Resident reports pain in left leg from mid-thigh down to foot 10/10. "My pain comes every day and night." Reports pain also in left buttock, and over left ileosacral joint. Unable to give quality of pain; when asked whether pain is sharp or dull, replied, "both". Report's some numbness and tingling left lower leg and foot, no numbness or tingling right leg and foot...Also stated today, that she has been told that she has "nerve pain", and that she cannot be operated on as she runs the risk of "being in a wheelchair"...A/P: chronic pain: fentanyl patch 75 mcg (microgram) / hour, oxymorphone 10 mg Q (every) 6 hours prn, with 8 doses requested and received since admission, Percocet 5-325 mg Q 4 hours prn pain, with 4 doses requested and received since admission...but despite a patchy history and pain

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inconsistent with sciatica on SLR (straight leg raise), she describes a neurogenic pain...She seems to have a tolerance to high dose narcotics, so will start gabapentin 100 mg BID (twice a day) with 300 mg QHS (at bedtime /night), titrate up as needed. Discussed with [Physician named], who would like to schedule oxymorphone for now, so will schedule 10 mg Q6 hours for now."

On 3/23/16 at approximately 9:47 a.m., the unit manager, who was a licensed practical nurse and will be identified as LPN #3 was interviewed regarding the resident complaining of pain and the family's request for the resident not to have pain medication. LPN #3 stated, "I was not aware of this; the family does not know if she is in pain and they should not control if she can have pain medications. I will dig around and see what I can come up with." LPN #3 was made aware that during the Resident Interview, Resident #2 complained of pain and stated, when asked, that it was an eight (8) on the pain scale level of 0-10. LPN #3 was interviewed and asked if the Resident had any other medications to control breakthrough pain other than Neurontin and a Fentanyl patch. LPN #3 stated, "I don't know, I have to check."

On 3/23/16 at approximately 10:30 a.m., LPN #3 stated to this Surveyor, "I went to the room and talked with [Resident named], she said her pain was an eight (8)." When interviewed and asked what interventions were put in place to alleviate the resident's pain. LPN #3 stated, "She said the Neurontin helps some and she goes to Bingo three times a week." During the interview with LPN #3 the director of nursing (DON) was present and stated, in regards to the resident receiving pain medications, "She was on

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Oxycontin and the family asked that we discontinue it because it was causing her to have behaviors. The DON was interviewed and asked if anything else was ordered to help control the pain that would not cause the resident to have behaviors but alleviate the pain. The DON stated, "When they are admitted, we go over the orders with [Physician named] and if he want to make changes he does based on knowing the patient. He discontinued the Oxycontin because the family was against her having it and because of her behaviors."

On 3/23/15 at approximately 10:35 a.m., the DON and LPN #3 was made aware of the Psychology evaluation in that it was documented that the resident's behaviors were contributed a medication (Risperdal) change and pain, in which Oxycodone IR was added to manage the resident's pain. The DON and LPN #3 was interviewed regarding the Oxycodone and the reason the resident was not on it as recommended by the Psychologist. The DON stated, "Her son did not want her to have it so he asked the doctor to discontinue it." When interviewed regarding the location of other nonpharmalogical interventions that was provided to relieve the resident's pain, the DON stated, "It should be documented in the nursing notes."

On 3/23/15 at approximately 1:00 p.m., Resident #2's Pain Level Summary from May 2015 through March 2016 was presented to this Surveyor, the Summary indicated that the resident's pain level for the month of February and March was as follows:

3/19/16 (4)
3/17/16 (9)

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F 309	Continued From page 45 3/16/16 (6) 3/10/16 (5) 3/6/16 (7) 3/5/16 (4) 3/4/16 (6) 2/29/16 (4) 2/20/16 (8) 2/19/16 (5) 2/18/16 (5) 2/16/16 (8) 2/15/16 (5) 2/12/16 (9) 2/11/16 (5) 2/9/16 (5) 2/8/16 (5) 2/7/16 (9) 2/6/16 (9) 2/5/16 (5) 2/4/16 (6) 2/3/16 (6) 2/2/16 (7) 2/1/16 (6) On 3/23/16 at approximately 1:10 p.m., Resident #2's nursing notes from February 2016 through March 2016 was reviewed in the clinical record, the nursing notes did not address any pharmalogical or nonpharmalogical interventions as documented on the CP to decrease the resident's pain. On 3/23/16 at approximately 1:20 p.m., the DON was interviewed regarding the pain level summary and the follow up to determine the interventions used to manage the resident's pain. The DON reviewed the Pain Level Summary and stated, "If they are getting scheduled pain meds (medicines) it (the computer) does not default to do a follow up; it only does that if the resident is	F 309		

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taking prn (as needed/necessary) narcotics." When interviewed and asked how did staff know that the resident's pain was managed if there was no follow up or documentation to show that interventions were put in place, the DON stated, "If the resident does not complain of pain anymore, we assume that they are not in pain. (sic)" The DON was interviewed regarding the facility's expectations related to assessing and then following up to ensure pain is managed. The DON stated, "There should be a follow up. Let me see what I can find."

On 3/23/16 at approximately 1:30 p.m., Resident #2's Nursing Notes in the clinical record was reviewed to include the following:

"10/14/15 7:11 a.m. Son [named] called and stated that he does not want his mother to have the new pill that was prescribed "Oxycontin" because he feels its making her non functional." "10/14/15 13:13 (1:13 p.m.) Resident's oxycontin 30 mg has been discontinued per MD (doctor). Resident to start oxycodone 10 mg q12 hrs with Ibuprofen. Resident also has an appointment set up with the pain center on November 18, [Son named] notified of change in medication orders." "11/9/15 17:30 (5:30 p.m.) This nurse received a telephone call from [person named] (11:35) from the Pain Management Center. [person named] stated that [Physician named] will not be in the office on tomorrow and they will have to cancel [Resident named] appt that is scheduled with him for tomorrow. [Person named] states that they have rescheduled her appt for December 23, 2015 at 11:00 am..."

A review of the resident's clinical record did not evidence that the resident was sent out to the

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F 309	Continued From page 47 Pain Management Clinic on 12/23/15. On 3/23/16 at approximately 2:00 p.m., the DON entered the conference room and stated, "[Nurse named] talked to [Physician named] and as stated earlier he does not want to give her anything additional for pain. When interviewed and asked the reasoning, the DON stated, "He said he did not feel comfortable (Sic)." When asked about the pain clinic consult, the DON stated, "We tried to get her in today (3/23/16) but they can't see her today. We asked her, the resident, since we could not control her pain, if she wanted to go to the hospital; she said 'No.' The DON further stated, [Nurse named] did get her some prn (as needed/necessary) Tylenol and the son agreed to her having it." When interviewed and asked the reason the resident was not sent to the pain clinic as previously recommended, the DON stated, "I have the documentation from the pain clinic, when she was first scheduled for an appointment the pain clinic called and canceled the appointment, because the doctor was on vacation. The next appointment the daughter-in-law called and canceled the appointment because the facility was managing her, the resident's, pain and she told them if she needed them in the future she would call them." On 3/23/16 at approximately 2:29 p.m., the regional nurse consultants, who will be identified as Administrator (Admin) #1 and #4 entered the conference room and requested that this Surveyor explain to them what was going on regarding Resident #2's pain. This Surveyor made Admin #1 and #4 aware of the resident stating she was in pain and the pain assessment follow up not being done to determine if the	F 309		

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F 309	Continued From page 48 resident's pain was relieved. Admin #1 stated, "The follow up documentation for pain is not there; there is no documentation for pain I can tell you that now." On 3/24/16 at approximately 9:30 a.m., the resident's son and daughter requested to meet with this Surveyor, a meeting was held in the conference room in the presence of other Surveyors with the family. The son stated that he did not want his mother to take pain medications because of her past addiction. The son further stated that the resident can be very manipulative in trying to get pain medications. The daughter-in-law stated that the resident's appointment was canceled because she felt the resident was being treated for pain at the facility and it was under control. On 3/24/16 at approximately 10:00 a.m., the clinical record was thoroughly reviewed and a diagnosis of drug addiction was not documented in the clinical record as a diagnosis. The clinical record did evidence that the resident, prior to coming to the facility on 8/10/15 was treated at another facility from May 4, 2015 through May 8, 2015 for pain control and the documentation evidenced that the resident's pain was being controlled. No further information was provided during the course of the survey regarding the resident pain management and following up on pain level assessments.	F 309		
F 311 SS=D	TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS CFR(s): 483.25(a)(2)	F 311		4/19/16

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F 311	Continued From page 49 A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to provide restorative services per the care plan for one of 24 residents, Resident #15. Resident #15 was not provided restorative dining interventions during the breakfast meal on 03/23/2016. Findings were: Resident #15 was admitted to the facility on 07/22/2014. Her diagnoses included but were not limited to: Parkinson's dysphagia, type II diabetes mellitus, hypertension, psychosis, schizophrenia and dementia with behaviors. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 02/02/2016. Resident #15 was assessed as having a cognitive summary score of "09", indicating moderate impairment with her cognitive status. On 03/23/2016 a breakfast meal observation was conducted in the west wing restorative dining room beginning at approximately 7:35 a.m. There were four tables in the dining room with a total of nine residents seated around the tables. Resident # 15 was observed sitting at a table with two other residents. She was eating her	F 311	F311 1. Resident #15 is currently receiving restorative dining interventions per the care plan. 2. Current residents receiving restorative dining services were reviewed to ensure interventions are implemented per the care plan. 3. Nursing staff will be educated regarding restorative dining interventions and implementation. Unit managers and/or designees will review residents receiving restorative dining daily 5X weekly X one month then weekly X 2 months to ensure interventions are implemented per the care plan. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters.	

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F 311	Continued From page 50	F 311		

breakfast. The two other residents at the table did not have trays. There were no staff members in the room.

The corporate QI nurse came to speak with this surveyor at approximately 8:20 a.m. She stated, "There weren't any staff in there because the nurse forgot to assign anyone to the dining room." A list of all residents in the room that were ordered restorative dining was requested. Resident #15 was the only resident on the list.

LPN (licensed practical nurse) #8 was in charge of the west unit and was interviewed on 03/23/2016 at approximately 9:30 a.m. regarding staff in the dining room. She stated, "The nurse on third shift normally does the assignment for day shift... the nurse here last night doesn't normally work over here... I didn't look at the assignment and I didn't notice that no one was in there..."

Resident #15's care plan was reviewed. The focus area: "The resident has an ADL (activity of daily living) self-care performance deficit r/t [related to] limited mobility. Interventions listed included but were not limited to: "Nursing Rehab/restorative: Eating/swallowing Program #1 Pt will consume at least 50 % of meals with supervision without becoming distracted for 3 meals a day daily 6-7 days per week."

The above information was discussed with the administrative staff during an end of the day meeting on 03/23/2016 at approximately 3:50 p.m. Information was requested regarding why Resident #15 needed restorative dining services.

On 03/24/2016 at approximately 9:15 a.m. the

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F 311	Continued From page 51 DON (director of nursing) was again asked why Resident #15 needed restorative dining services. She stated, "She gets off track easily and she is a wanderer...she gets up and rambles around. She need direction...someone should have been in there with her yesterday while she was eating." No further information was obtained prior to the exit conference on 03/24/2016.	F 311		
F 323 SS=E	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(h) The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and in the course of a complaint investigation, facility staff failed to promptly respond to resident call lights. Facility staff failed to promptly answer resident call lights on the East and West units of the facility. Findings included: During the survey conducted 03/22/2016 through 03/24/2016 residents and staff were interviewed by the survey team regarding timeliness of call lights being answered. The interview responses are documented below.	F 323	F323 1. Residents call lights on the East and West wing, including Resident #1 and #16, are currently being answered promptly. 2. Current facility residents on each unit will be reviewed to ensure call lights are being answered promptly. Corrections will be made immediately as indicated. 3. Current facility staff will be educated regarding procedures for answering call lights promptly. Leadership staff will round daily 5X weekly X 3 months to ensure call lights are being answered promptly. Any	4/19/16

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F 323	Continued From page 52 On 3/22/16 at 2:25 p.m. Resident #1 was interviewed about quality of life in the facility. During this interview Resident #1 stated she frequently experienced slow call bell response from the aides. Resident #1 stated the call bell response was slowest during the day shift when the aides were busy with other residents. Resident #1 stated many times when she activated the call bell an aide or nurse would come, turn the light off and say they were coming back but never return. Resident #1 stated the facility was short of staff especially aides and call bells were slow because there were not enough aides at times to respond to everyone timely. On 03/23/2016 at 8:50 a.m. the Resident Council President was interviewed. During this interview he was asked about the timeliness of call lights being answered. The Resident Council President stated, "There often isn't enough CNA's (certified nursing assistants) on the unit, especially if there are only three. If they are busy in another room, they often can't answer call lights timely." Resident #16 was interviewed on 03/23/2016 at 9:45 a.m. Resident #16 stated, "Often times there isn't enough staff to answer call lights. Three aides cannot take care of sixty people. Call lights ring on average 10-15 minutes before they are answered. I feel that is too long. Sometimes lights are answered, but the aide will say I'll be back in a minute and don't ever return until I call again. There has been two instances where I messed myself, once in the bed, once in the wheelchair. Both times a clean towel was placed over the feces until I could be cleaned up...This goes back to not enough staff."	F 323	issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters.	

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The DON (director of nursing) was interviewed on 2:55 p.m. regarding CNA staffing. The DON stated, "Unit directors do daily schedule. I oversee the master schedule. It's a rotating schedule every two weeks. Ideally on 7-3 shift, five CNA's on both the East and West units is preferred, 3-11, four to five CNA's on each unit, depending on call outs and people leaving. People leaving usually don't even call out, they just don't show up. Other facilities are offering bonuses and such and people leave. Call offs have been a problem the past few months. We have been big time recruiting the last one and one-half months. We have advertised different ways...with good results. We are having orientation weekly.

Review of the Resident Council Meeting Minutes at approximately 4:15 p.m. revealed the following: 01/08/16 - "...Concern a/b (about) East wing CNA...Resident's informed that all nursing management positions are posted & (and) accepting applications..." 02/08/16 - "Administrative Response to Resident Council...East wing residents state that 3rd shift (11-7 shift) CNA (Name) frequently turns off call light without addressing concerns of the resident needing help..." 03/04/16 - "...Residents have staffing concerns..."

At approximately 4:40 p.m. CNA #5 was interviewed regarding staffing. CNA #5 stated, "Most of the time staffing is good. Call outs cause a problem. A wonderful day is 5-6 aides, bad day is 3-4 aides. Decreased staffing contributes to answering call lights slower."

CNA #6 was interviewed at approximately 4:45 p.m. CNA #6 stated, "We usually work with 3-4

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F 323	Continued From page 54 aides. Four to five aides would be good. The last couple of months have been rough. Decreased staff definitely contributes to untimeliness of call lights being answered." CNA #8 was interviewed on 03/24/2016 at approximately 8:40 a.m. CNA #8 stated, "Normally we have three aides. Ideally 5-6 aides are needed. People are leaving all the time. They say the workload is too much. Taking care of 18-20 residents is too much. Decreased aide staffing does affect how quickly call lights are answered." CNA #9 was interviewed at approximately 8:50 a.m. CNA #9 stated, "We normally work with 3-4 aides. Five to six aides would be ideal. Decreased staff directly affects call lights being answered. People come and go all the time." While out on the units on 03/24/2016 a resident on the East unit requested this surveyor to come into their room. The resident asked what the CNA to resident staffing ratio was in Virginia. This surveyor explained to this resident there is no staffing ratio in the regulations. The resident stated, "Three aides with twenty people apiece is too much. They can't do everything. It isn't fair to them or us." The Administrator and DON were informed of the above information during a meeting with the survey team on 03/24/2016 at approximately 10:00 a.m. No further information was received prior to the exit conference.	F 323		
F 325 SS=D	MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE CFR(s): 483.25(i)	F 325		4/19/16

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F 325	Continued From page 55 Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to maintain nutritional status for one of 24 residents, Resident #7. Resident #7 suffered a weight loss of 15.2 pounds or 11.9% from 12/09/2015 to 12/17/2015. From 12/09/2015 until 03/08/2016 she lost a total of 14.9 pounds or 11.7 percent. There were no new interventions to address the weight loss from 12/17/2015 until 02/25/2016. Findings were: Resident #7 was most recently readmitted to the facility on 01/08/2015 with the following diagnoses, but not limited to: Hypoglycemia, hypertension, type II diabetes mellitus, Alzheimer's, seizures, psychosis, and anemia. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 03/14/2016. Resident #7 was	F 325	F325 1. Resident #7□s weight is currently stable and the goal to not experience further significant weight loss remains active. 2. Current residents□ weights will be reviewed to ensure significant weight loss has been identified and interventions are in place and documented in the plan of care. 3. Current nursing and dietary leadership staff will be educated by corporate consultant regarding significant weight loss identification and implementation of interventions. Interdisciplinary team will meet weekly to review significant weight changes and weight change trends. Residents who trigger for subsequent weight change trends will continue to be reviewed for efficacy of interventions. Care plan goals and new interventions will be implemented as indicated by the interdisciplinary team.	

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F 325	Continued From page 56 assessed as having a cognitive summary score of "08", indicating moderate impairment with her cognitive status. On 03/23/2016 a breakfast meal observation was conducted in the west wing restorative dining room beginning at approximately 7:35 a.m. There were four tables in the dining room with a total of nine residents seated around the tables. Resident #7 was observed sitting at a table with two other residents. Resident #7 was seated looking across the table and out of the window. One of the residents seated at the table was eating breakfast. Resident #7 and another resident did not have a tray. There were no staff members in the room. Resident #7's tray was served at approximately 8:00 a.m. Resident #7 was asked if she was hungry, she stated, "I'm always hungry." The clinical record was reviewed. Weight recorded from December until time of survey were: 12/09/2015: 126.9 (wheelchair) 12/17/2015: 111.7 12/29/2015: 110.0 (wheelchair) 01/06/2016: 113.7 01/13/2016: 112.5 01/20/2016: 116 01/27/2016: 114.1 02/04/2016: 115 02/17/2016: 114.5 02/24/2016: 109.3 03/02/2016: 115.6 (wheelchair) 03/08/2016: 112 03/15/2016: 113	F 325	Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters.	

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F 325	Continued From page 57 03/22/2016: 112.6 (wheelchair) Resident #7 was noted to have a significant weight loss of 15.2 pounds or 11.9% from 12/09/2015 to 12/17/2015. From 12/09/2015 until 03/08/2016 she lost a total of 14.9 pounds or 11.7 percent. Interventions were reviewed. According to the facility documentation on 12/17/2015 Resident #7's son was contacted by a nurse at the facility to discuss Resident #7's weight loss. According to the documentation, Resident #7's son voiced that he was "worried that his Mother had lost so much weight". The nurse offered interventions that could be implemented to address the weight loss. The son agreed to Med Pass, Chocolate Ice Cream, chocolate milk and the resident going to the dining room for lunch. The son felt this would help his mother gain some of her weight back. The RD (registered dietitian) was notified of the conversation. There were two RD notes for 12/17/2016. The second note written at 12:37 p.m. contained the following: "Sig [significant] 15.2 [pound] wt [weight] loss X [times] one week. Observed weight verification and chair weight verification. Pt with hx [history] of sig wt fluctuations r/t [related to] dx [diagnoses] High nutritional risk r/t minimal po [by mouth] at times with rebound intake and wt gain cycling. Pt may accept chocolate ice cream which will be started at lunch and dinner daily, Weekly weights ongoing for close monitoring." An RD noted dated 1/11/2016 contained the following: "Pt with weight loss despite being fed by staff. Meals in DR [dining room] w/o [without]	F 325		

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consistent success. Pt can [sic] very combative with staff trying to help or encourage her to eat. High risk for weight changes r/t hx of sig wt changes r/t dxs including psychosis. Following routinely."

An RD note dated 1/21/2016 read: "3.5# weight gain X one week. Wt gain desirable. HX of wt gain and loss r/t dxs and behaviors. Staff to continue to encourage intake as tolerated by pt. Weekly wts ongoing."

On 2/17/2016 the RD made the following entry: "Weight review Wt more stable X 2 months...med plus TID [three times per day]...weekly weights ongoing..."

On 2/25/2016 the RD made the following entry: "Weekly weights reflect further weight loss. Pt weights obtained in broda chair as pt tolerates this better but it is not the best way to obtain an accurate weight. Pt takes PO as desired. If encouraged or assisted pt will attempt to bite or strike staff per their report. Dementia with psychosis. Pt tolerating med plus but staff does not feel she would accept increased volume. Will add shakes to trays to monitor response to change."

The RD was interviewed on 03/23/2016 regarding interventions to address Resident #7's weight loss. The RD was asked why no further interventions had been implemented between the weight loss noted on 12/17/2015 and the additional weight loss of 5.2 pounds (4.5%) in one week on 02/24/2016. The RD stated, "I am at a loss as to what to do with [name of resident] and suggestions you can given me would be appreciated." The RD continued, "Her weight

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was stable after she had the loss in December, she fluctuates...there are weight discrepancies." The RD was asked if the weight discrepancies had been discussed with staff and what was the normal protocol for someone with a sustained weight loss. She stated, "We added the med pass and the chocolate ice cream and chocolate milk in December and the milk shakes in February."

On 03/23/2016 at approximately 12:00 p.m., Resident #7 was observed in the west wing restorative dining room. She had her lunch tray in front of her. She was eating her chocolate ice cream. She stated, "Do you know why I get chocolate ice cream?...because the doctor thinks I am losing weight to fast."

The RD and the corporate RD came to the conference room to speak with this surveyor on 03/23/2016 at approximately 3:15 p.m. The RD stated, "I spoke with the resident and her son...the resident is very proud that she has a flat stomach after having six kids, she is happy with her weight and she likes the food...I spoke with her son and he is Okay with her weight, he said the most she has weighed is around 135 pounds...she did eat her chocolate ice cream at lunch, and her milkshake and she ate two peanut butter crackers while I was in the room talking to her."

A record of Resident #7's BMI (body mass index) was presented by the RD. The RD stated that based on the BMI the resident was not underweight, and that the BMI was a more accurate indicator.

The above information was discussed with the

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administrative staff during an end of the day meeting on 03/23/2016 at approximately 3:50 a.m. Concerns were voiced that interventions implemented for Resident #7's weight loss in December 2015 were initiated by the nurse who contacted the son. Orders for med pass indicated the supplement was "Per the sons request". Concerns were also voiced that the no further interventions were implemented after 12/17/2015 until Resident #7 lost additional weight in February 2016. The RD's comment regarding weight discrepancies was also discussed. The admin team was asked what they would expect if weight discrepancies were identified. The corporate nurse consultant stated, "I would expect staff to weigh her the same way and document it." The administrative team was also asked if weight loss was only treated if the BMI indicated the resident was underweight. Also discussed was that the RD had not documented that any discussion regarding the resident's weight loss had occurred with the resident or the son until questioned by this surveyor.

On 03/24/2016 the RD and the corporate RD came to the conference room to speak with this surveyor. The RD stated, "It is hard for elderly people to regain lean body weight once they have had a weight loss... the BMI shows that she is not underweight." The RD was asked if interventions were only implemented if the BMI indicated that the resident was underweight. She stated, "No, we look at weights but after the weight loss we try to maintain the weight so they don't lose more." The RD was again asked, what the facility had done to address the weight loss after the interventions were put into place on 12/17/2015. She stated, "We maintained her weight so she didn't lose more."The RD was asked why the

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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 325	Continued From page 61 information presented during survey, i.e. her BMI is within normal limits, as well as discussion with the resident and her son had not been implemented and documented prior to the survey. The corporate RD stated, "I see your perspective." The Corporate RD was asked if those things should have been documented. She stated, "Yes, somewhere." No further information was obtained prior to the exit conference on 03/24/2016.	F 325		
F 369 SS=E	ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS CFR(s): 483.35(g) The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to provide special equipment for one of 24 residents in the survey sample, Resident # 13. Resident # 13 was not provided a divided plate and/or a provale cup to assist the resident with eating and consuming liquids at a controlled rate. Findings include: Resident # 13 was readmitted to the facility on 12/06/15. Diagnoses for Resident # 13 included, but were not limited to: TBI (traumatic brain injury) resulting from a MVA (motor vehicle accident), depression, spastic hemiplegia,	F 369	F369 1. Resident #13 currently is receiving a divided plate for all meals and was reevaluated for a Provale cup for fluids but refused. Resident is currently being provided small cups to drink fluids. 2. Current residents will be reviewed to ensure special equipment for eating and drinking is provided. Corrections will be made as necessary. 3. Nursing staff will be educated regarding identification and use of specialized equipment for residents that need assistance with eating and drinking. Nursing staff will observe meal tickets daily to ensure special equipment is available at the time of the meal. Any	4/19/16

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F 369	Continued From page 62 impulsiveness and dysphagia (difficulty swallowing). The most current MDS (minimum data set) dated 01/18/16, assessed the resident as having a cognitive score of 15, indicating the resident was cognitively intact. The resident was also assessed as requiring supervision, with set-up help only for food and beverage consumption. The resident was assessed as requiring extensive assistance from staff for all other ADL's (activities of daily living) . Resident # 13 was observed eating breakfast, in the assisted (restorative) dining room, on 03/23/16 at approximately 7:30 a.m. The resident was sitting at a table with a food plate in front of him and 4 small (approximately 4 ounce) blue cups lined up. Each cup was approximately half full. The resident was asked what was in the 4 cups; the resident stated, "Orange juice." The resident was then asked why he had the 4 small cups. The resident voiced that he didn't know why they were like that and further voiced that one of the CNA's (certified nursing assistant) had set it up like that for him. The resident voiced that he did not like having 4 small cups and voiced that he liked a big cup. The resident's meal ticket was beside the meal tray. The meal ticket documented: "...Restorative...Regular Divided Plate...Cinnamon French Toast DIVIDED PLATE...Sausage Patty DIVIDED PLATE...Orange juice..." The resident's food plate was a regular porcelain type plate; the plate was not divided. The meal ticket did not document anything about the resident's liquids related to the 4 small cups. Resident # 13's clinical record was then reviewed.	F 369	issues will be addressed immediately at the time of identification. Unit managers and Dietary leadership will review residents receiving special eating and drinking equipment weekly X 3 months to ensure implementation. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters.	

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The current/active POS (physician's order set) documented: "...Regular diet..." No physician orders were found related to the divided plate or the resident's beverage consumption or use of 4 small cups.

The resident's CCP (comprehensive care plan) was then reviewed and documented: "...ADL (activities of daily living) self-care performance deficit r/t (related to) Musculoskeletal impairment, contracture...EATING: The resident is able to feed self after set up except for salads. Staff to feed resident salad when provided (created on : 01/07/15)...Increased nutritional risk r/t history of weight changes...Provide, serve diet as ordered...RD to evaluate and make diet changes..." The CCP did not address the resident's 'restorative dining', did not address the resident's 'divided plate' and did not address any information related to the resident's beverage consumption or the use of the 4 small cups for drinking.

Resident # 13's therapy records were then reviewed. A "Speech Therapy SLP (Speech Language Pathology) Evaluation & Plan of Treatment", dated 08/18/15 was reviewed for Resident # 13.

The SLP documented: "...Start of Care: 8/18/15...Personal history of traumatic brain injury...DYSPHAGIA, UNSPECIFIED...Dysphagia unspecified...EVALUATION ONLY...electronic signature SLP (speech therapist) # 1...I certify the need for these medically necessary services furnished under this plan of treatment while under my care from 8/18/15 through 8/18/15...signature [of] PA (physician's assistant) 8/19/15...Patient referred...due to exacerbation of dysphagia

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characterized by increased coughing and wet voice at meals...spastic hemiplegia...patient consuming regular texture/thin liquid diet with minimal overt s/s (signs/symptoms) aspiration (e.g. coughing, wet voice)...exacerbation of dysphagia...patient assessed with...6 oz thin liquids via cup. Patient presents with full body convulsions, negatively impacting patient's ability to prepare bolus...nursing reports patient typically impulsive and utilizes large bolus size with occasional packing behaviors...moderate pharyngeal dysphagia when consuming thin liquids as evidenced by mild coughing and wet "gurgly" voice post swallow...required moderate cues to utilize throat clear and cough/swallow to clear pharyngeal residue...Clinician recommends patient receive close supervision during all meals. Clinician also recommends patient trial Provale cup with meals to reduce liquid bolus size and increase safety of swallow. Clinician unable to trial at time of evaluation due to no availability of Provale cup. Clinician will re-educate at future time to determine whether utilizing Provale cup increased safety of swallow...Precautions: Aspiration...Swallow precautions in place...Self feeds with mild difficulty controlling cup/bolus with utensil...Cup = Moderate; Clinical S/S Dysphagia: Wet voice (x 3) [three times] with several attempts to clear with cough/throat clear/reswallow (sic); mild coughing (x2)...behaviors impacting safety; full body convulsions...Risk Factors: Due to the documented physical impairments and associated functional deficits, the patient is at risk for: aspiration...electronic signature [3:36 p.m.] SLP # 1.

Resident # 13's progress notes were then reviewed from August 2015 to present.

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A nursing progress note dated 08/018/15 and timed 9:30 a.m. documented: "...At 0920 [9:20 a.m.] house keeping came to get this writer and reported that resident was choking and needed assistance...assessed resident...sounds very gurglie (sic)...trying to talk saying "help and it sounds as if he was in water drowning as he held his throat. (sic) Lungs assessed, not clear...called ST [speech therapy] and made them aware. ST stated tht (sic) it took 5 minutes for pt [patient] to drink 1/2 cup of water. [Name of Nurse Practitioner] was also make aware V/O [verbal order] obtained to suction pt now and PRN [as needed]...Resident was suctioned...ST will be coming out to see this afternoon..."

A nursing progress note dated 08/018/15 and timed 2:43 p.m. documented: "...After hearing adventitious [abnormal] sounds in lungs this am ST was made aware...ST worked with resident during lunch...ST reported that this was "typical" of this resident...suggested that resident remains on...thin liquids but pt MUST BE SUPERVISED! (sic)...can be suctioned as needed...machine at bedside..."

Physician progress notes were then reviewed from August 2015 to present. No information related to the above was found or addressed in the physician's progress notes.

On 03/23/16 at 1:45 p.m., the RD (Registered Dietitian) was interviewed regarding Resident # 13's meal ticket for a divided plate. The RD viewed Resident # 13's meal ticket and was asked, based on the ticket was the resident supposed to have a divided plate. The RD stated, "Yes, based on the ticket." And then

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asked, did he not have a divided plate? This surveyor informed the RD of the breakfast observation. The RD voiced that she would attempt to find information regarding when the divided plate was initiated. The RD was asked if there has to be a physician's order for the divided plate. The RD voiced that basically anyone could ask to have a divided plate, if a resident can gain benefit from it and again voiced that no physician's order is needed.

On 03/23/16 at 2:00 p.m., SLP # 1 was interviewed regarding the above information. SLP # 1 voiced that the Provale cup is something that has to be ordered [we don't just have them here] and it measures "sip size." The SLP voiced that she did make that recommendation and the resident got the Provale cup. The SLP was made aware that no information or documentation could be located to evidence the resident received the recommendation. The SLP voiced, yes he got it. The SLP was asked for the evaluation and documentation regarding the above statement. The SLP then voiced that she didn't actually remember if the resident was 'trialed' on the Provale cup or not, that was a long time ago. The SLP then voiced that she did remember the resident telling her that he did not want the Provale cup. The SLP was asked, when was that. The SLP voiced that she didn't remember. The SLP was asked, how the resident could say he didn't want the cup if he had not tried it, the SLP voiced that is what the resident told her. The SLP was asked if that was documented. The SLP stated that she did not document that because she was not evaluating him at the time [when the resident told her that] and she does not document unless she is doing an evaluation and that the resident was only evaluated by her one

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time.

At approximately 2: 05 p.m., Resident # 13 was interviewed in his room. The resident was asked about the breakfast observation with the 4 small, blue cups. The resident again voiced that he did not like those cups and pointed to a larger cup on his BST (bedside table), that had lid and straw and voiced that he liked the big cup. The resident was asked if he remembered trying a Provale cup. The resident asked, what is a provale cup? The resident was informed that it was a special cup that had handles, and delivered a measured amount to allow easier swallowing and help to prevent getting too much liquid at one time and help prevent choking. The resident stated that no, he had not tried one. The resident was then asked if he would be opposed to trying it. The resident voiced that he didn't mind to try it, but wouldn't say that he would like it and again voiced that he liked the larger cup and pointed to the cup sitting on BST.

At 2:10 p.m., the RD presented an "Activity Log Report." The RD voiced that this report documented when the divided plate was initiated for Resident # 13, which was 04/27/13. The RD voiced, it was initiated because the resident shakes and has spastic movements and that the resident should have had a divided plate this morning.

The administrator, DON (director of nursing) and CN (corporate nurse) # 1 and # 2 were made aware of the above in a meeting with the survey team on 03/23/16 at 3:50 p.m. The staff were asked for any information related to the above.

On 03/24/16 at approximately 9:00 a.m., CN # 1

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F 369	Continued From page 68 voiced that no physician's order could be located to suction the resident back in August, when the resident got choked, but there was an order for speech therapy and voiced that it would be presented. At approximately 9:15 a.m. CN # 1 presented a physician's order, which documented: "...Speech to Eval and treat one time only for possible aspiration..." No further information or documentation was presented prior to the exit conference on 03/24/16.	F 369		
F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.60(b), (d), (e) The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to	F 431		4/19/16

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F 431	Continued From page 69 have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to properly store a medication subject to abuse on one of three nursing units. Nine vials of injectable Lorazepam were stored with other medications in the West unit's refrigerator and were not in the separately locked affixed box. The findings include: On 3/23/16 at 7:50 a.m. accompanied by license practical nurse (LPN) #2, the medication room on the West unit was inspected. In the unit's medication refrigerator were nine vials of injectable Lorazepam. The vials of Lorazepam were stored with other medications in the refrigerator and were not in the separately affixed lock box. LPN #2 was interviewed at this time about the storage of the Lorazepam. LPN #2 stated Lorazepam was counted each shift and since the Lorazepam was stored in the narcotic box on the medication cart she thought it should be in the mounted locked box in the refrigerator.	F 431	F431 1. Lorazepam injectable vials are currently stored in a separately locked affixed box inside the West wing unit refrigerator. 2. Medication refrigerators on each unit were inspected to ensure appropriate storage of Schedule II injectable vials. Each unit medication room refrigerator is currently equipped with a permanently affixed locked box. 3. Licensed nursing staff will be educated regarding proper storage of refrigerated Schedule II injectable vials. Nursing leadership will observe medication room refrigerators daily 5X weekly X one month then weekly X 2 months to ensure proper storage of Schedule II vials. Any issues will be corrected immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters.	

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F 431	Continued From page 70 On 3/23/16 at 8:00 a.m. LPN #3 unit manager was interviewed about the storage of the injectable Lorazepam. LPN #3 stated there was a separately mounted lock box in the refrigerator and the Lorazepam was supposed to be stored in the affixed lock box. The facility's policy titled Storage and Expiration of Medications, Biologicals, Syringes and Needles (revised 1/1/13) stated, "After receiving controlled substances and adding to inventory, Facility should ensure that Schedule II - V controlled substances are immediately placed into a secured storage area (i.e., a safe, self-locked cabinet, or locked room, in all cases in accordance with Applicable Law." The Drug Information Handbook for Nursing 13th edition on pages 743 through 745 describes Lorazepam as a benzodiazepine used for the management of anxiety disorders or anxiety associated with depression. This reference on page 744 states "Use with caution in patients with a history of drug dependence, alcoholism, or significant personality disorders. Benzodiazepines have been associated with dependence and acute withdrawal symptoms on discontinuation or reduction in dose." Page 745 of this reference states under nursing actions, "Assess for history of addiction; long-term use can result in dependence, abuse, or tolerance... For inpatient use, institute safety measures... Drug may cause physical and/or psychological dependence." (1) These findings were reviewed with the administrator and director of nursing during a meeting on 3/23/16 at 4:00 p.m.	F 431		

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F 431	Continued From page 71 (1) Turkoski, Beatrice B., Brenda R. Lance and Elizabeth A. Tomsik. Drug Information Handbook for Nursing. Hudson, Ohio: Lexi-Comp, 2011.	F 431		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.65 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		4/19/16

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F 441	Continued From page 72 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to perform hand hygiene during a medication pass on the East unit. A nurse administered medications to a resident, touching his armband, wheelchair and the cup previously held by the resident and then prepared medications for the next resident in the pass without performing hand hygiene. The nurse also directly touched two of the resident's pills with her fingertips during the preparation of medications. The findings include: On 3/22/16 at 3:50 p.m. a medication pass observation was conducted with licensed practical nurse (LPN) #4. LPN #4 prepared and administered oral medications to the first resident in the pass. While administering the medications to the first resident, LPN #4 touched the resident's armband, wheelchair and the cup previously held by the resident when taking his medications. On 3/22/16 at 3:55 p.m. and without any prior hand hygiene, LPN #4 prepared medications for Resident #19. During this preparation LPN #4 poured two Tylenol tablets in the bottle cap then picked them out of the cap with her bare fingertips and placed them into the medicine cup prior to administration to the resident.	F 441	F441 1. Resident #19 is currently receiving medications during medication pass according to appropriate infection control practices specific to hand washing. 2. Current licensed nurses will be observed by nursing leadership staff during a medication pass administration to ensure hand washing practices are being followed. Any issues will be immediately corrected at the time of observation. 3. Licensed nursing staff will be educated regarding infection control procedures specific to hand washing during medication pass. Medication pass observations will be performed 3X weekly X one month then weekly X 2 months by nursing leadership. Any issues will be corrected immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters.	

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F 441	Continued From page 73 On 3/23/16 at 2:50 p.m. LPN #4 was interviewed about the lack of hand hygiene between residents during the medication pass observation and about touching Resident #19's Tylenol tablets with her fingers. LPN #4 stated she did not wash her hands between the residents. LPN #4 stated, "We are told to wash or use hand sanitizer between residents." LPN #4 stated she took the Tylenol tablets out of the bottle cap because they were stuck. The facility's policy titled Handwashing Requirements (effective 2/1/15) stated, "Employee will wash hands at appropriate times to reduce the risk of transmission and acquisition of infections...Hand hygiene can consist of handwashing with soap and water or use of an alcohol based hand rub..." This policy stated situations that require hand hygiene included before and after direct patient contact and after handling soiled equipment or utensils. The policy titled General Dose Preparation and Medication Administration (revised 1/1/13) stated facility staff should perform handwashing prior to preparing and administering medications. This policy documented, "Facility staff should not touch the medication when opening a bottle or unit dose package." These findings were reviewed with the administrator and director of nursing during a meeting on 3/23/16 at 4:00 p.m.	F 441		