STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495105	A. BUILDING _____ B. WING _____	C 04/13/2017

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

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 04/11/17 through 04/13/17. Significant corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. Four complaints were investigated. The Life Safety Code survey/report will follow. The census in this 180 bed facility was 141 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents # 1 through #21) and 3 closed record reviews (Residents # 22 through #24).	F 000		
F 252 SS=D	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident	F 252		5/22/17

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

Electronically Signed | 04/28/2017

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F 252	Continued From page 1 independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to ensure a safe and clean environment for two of 24 residents in the survey sample. Resident #2's wheelchair was dirty and had loose brake handles. Resident #21's wheelchair had loose brake handles with one handle missing a protective cap exposing a rough metal surface. The findings include: 1. Resident #2's wheelchair was dirty and had loose brake handles. 2. The facility staff failed to ensure Resident # 21's wheelchair was in good repair for safe operation. Resident #2 was admitted to the facility on 12/1/16 with a re-admission on 2/24/17. Diagnoses for Resident #2 included femur fracture, artificial hip replacement, pneumonia, depression, peripheral vascular disease, diabetes and anemia. The minimum data set (MDS) dated 3/8/17 assessed Resident #2 as cognitively intact. On 4/11/17 at 1:35 p.m. Resident #2 was observed seated in his wheelchair in his room. During an interview at this time about quality of life in the facility Resident #2 stated his only issue was concerning his wheelchair. Resident #2	F 252	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain incompliance with all state and federal regulations, the center has taken or will take the actions set forth in this Plan of Correction. In addition, the following plan constitutes the center□s allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated. F252 1. Resident #2□s wheelchair was cleaned and brakes were replaced while surveyors were onsite. Resident #21□s brakes were tightened and protective cap was placed while surveyors were onsite. 2. The maintenance director or designee will conduct an audit of the entire facility to ensure wheelchair brakes are in good repair and safe for operation and wheelchairs will be inspected to ensure they are appropriately cleaned. 3. Staff development coordinator or designee will educate all nursing and maintenance staff on proper cleaning of wheelchairs and assessing if they are in safe, operational order. 4. Maintenance department or designee will monitor residents□ wheelchairs on a weekly basis for 12 weeks to ensure they	

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F 252	Continued From page 2 stated about two days ago he got a new wheelchair. The resident stated the wheelchair was dirty when he got it and the brake handles were loose. Resident #2 stated he did not want to put his hands on the chair because it looked like it had not been cleaned. Resident #2 stated the loose brake handles hung on his covers and furniture as he moved about his room. When asked why he got a new wheelchair Resident #2 stated, "They told me my other chair was a rental." Resident #2's wheelchair was inspected at this time. The chair had crumbs and debris on the horizontal support bars and on the wheels. Both brake levers were loose. The gearing and mechanisms attaching the handles to the brake lever at the wheels were loose. On 4/11/17 at 1:45 p.m. the registered nurse (RN #3) caring for Resident #2 was interviewed about the dirty wheelchair with loose brakes. RN #3 stated the rehabilitation (rehab) department was responsible for wheelchairs. On 4/11/17 at 1:50 p.m. accompanied by rehab director, Resident #2's wheelchair was observed with the dirty surfaces and loose brake handles. The rehab director stated he would investigate and advise about the chair. On 4/11/17 at 3:05 p.m. the rehab director was interviewed about Resident #2's wheelchair. The rehab director stated Resident #2 got a different chair last Thursday (4/6/17) because his previous chair was a rental and had to be returned. The rehab director stated concerning the dirt/debris on the wheelchair, "I think that came from him [Resident #2]." Concerning the loose brake	F 252	are clean and are in safe, operational order. Discrepancies will be brought to the QA committee and addressed as needed.	

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handles/gearing, the rehab director stated he thought the resident may have locked the chair and then tried to propel with the brakes on. The rehab director stated, "He [Resident #2] has poor cognition."

On 4/11/17 at 3:35 p.m. the facility's assistant maintenance director was interviewed about the loose brake levers on Resident #2's wheelchair. The assistant maintenance director stated he was not aware of any issues with the resident's current chair and had received no work order concerning the brake levers. The assistant maintenance director stated the third shift aides were responsible for routine cleaning of wheelchairs. When asked about the loose brake levers on Resident #2's wheelchair, the assistant maintenance director stated this usually was the result of worn bearings. When asked if the resident could have worn the bearings out since last Thursday (4/6/17), the assistant maintenance director stated the bearings would not wear out that quickly.

These findings were reviewed with the administrator, director of nursing and nursing consultants during a meeting on 4/12/17 at 11:30 a.m.

2. The facility staff failed to ensure Resident # 21's wheelchair was in good repair for safe operation.

Resident # 21 was admitted to the facility 1/7/13 with diagnoses to include, but not limited to: history of stroke with residual right sided weakness, diabetes, high blood pressure, GERD,

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and mild cognitive impairment.

The most recent MDS (minimum data set) was an annual review dated 2/1/17. Resident # 21 was coded as having moderate cognitive impairment with a total summary score of 09 out of 15.

On 4/12/17 at 2:30 p.m. Resident # 21 was sitting in her room in a wheelchair. This surveyor knocked and was given verbal consent to enter the room. It was observed immediately that the brake on the left side of the wheelchair did not have a cap on the end of the handle, exposing the bare metal edge which was uneven and slightly rough and sharp. The right brake had a bright yellow rubber cap on the end. (It should be noted here the resident used the left side due to the weakness on the right side from the stroke). Upon closer inspection, the brake was extremely loose as well. Resident # 21 was asked how long her wheelchair had been in that condition, and she stated "For quite some time."

On 4/12/17 at 2:35 p.m. this surveyor went to the nurses' station and asked for the charge nurse. LPN (licensed practical nurse) # 3 came out of her office and stated she was the unit manager. This surveyor asked if she was familiar with Resident # 21, and she stated she was. This surveyor then asked LPN # 3 to accompany me to the resident's room to observe the wheelchair. Upon knocking and with permission, entering the resident's room, LPN # 3 looked around the room and asked the resident how she was doing. This surveyor pointed out the missing cap on the end of the brake, and demonstrated the looseness of it as well. LPN # 3 stated she did know the wheelchair was in disrepair, and that she would

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F 252	Continued From page 5	F 252		

contact maintenance. LPN # 3 was then asked who should notice if items such as a wheelchair was in need of repair. LPN # 3 stated "Well, the CNA's (certified nursing assistants) should notice it since they are with the residents more and see more; they should tell me or another charge nurse and we would put in a work order for the maintenance department to fix it. If maintenance can repair it, then they will; otherwise they would get therapy involved. I'll get (name of maintenance person) to come and look at it right now and we'll get that fixed. I'm sure maintenance can tighten the brake, but therapy may have to get a new cap for it."

On 4/13/13 at 7:50 a.m. this surveyor returned to Resident # 21's room. Resident # 21 was in bed with her eyes closed, and the wheelchair was sitting against the wall at the bottom of the bed. It was observed the wheelchair was without a cap on the metal edge. This surveyor then went to the nurses' station and LPN # 3 was in her office. This surveyor then asked LPN # 3 about the wheelchair. LPN # 3 stated "Oh, (name of maintenance person) came and got it yesterday evening to fix it; he gave (name of Resident # 21) a wheelchair to use while he fixed hers." This surveyor then informed LPN # 3 of the observation of the same wheelchair sitting in the resident's room. LPN # 3 and this surveyor then went to the resident's room, and LPN # 3 stated "I have no idea how this got back in her room; it was taken to be fixed yesterday. Let me page maintenance and see what happened." LPN # 3 then took the wheelchair from the resident's room, and instructed a CNA to go and get a wheelchair for the resident to use. LPN # 3 then parked the defective wheelchair in the nurses' station. This surveyor observed the pillows in the

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wheelchair and stated they looked very comfortable; were they able to be removed and put in the loaner wheelchair for the resident until her wheelchair was repaired? LPN # 3 stated they were removable, and that the cushions could be put in the loaner wheelchair stating "Yes, we could do that." LPN # 3 and this surveyor could see the maintenance person at the end of the hall. This surveyor told LPN # 3 that I would go and talk to maintenance and inquire as to what happened. LPN # 3 was writing on a piece of paper and replied "OK, I'll go with you." LPN # 3 and this surveyor then went down the hall where the maintenance person was conversing with another surveyor. LPN # 3 handed the maintenance person the folded piece of paper and left. The maintenance person, along with the new maintenance director was then asked about the Resident # 21's wheelchair, and what had happened about the repair. The maintenance person and new maintenance director looked at each other, and indicated they had no knowledge of what I was talking about. I then informed them of the observation on 4/12/17, and at that time the maintenance person unfolded the paper handed him by LPN # 3 and stated "Well, I know now..... she (LPN # 3) just handed me a note about that."

On 4/13/17 at 8:00 a.m. this surveyor and the maintenance person along with the director walked down the hall to the hall toward the resident's room, and this surveyor informed them the defective wheelchair was now at the nurses' station. The maintenance person and director looked at the wheelchair, and the director stated "I've never seen a blue wheelchair!" The maintenance person then inspected the brake, noting the looseness and stated "I can probably tighten that up and get a new cap. I'll come and

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F 252	Continued From page 7 get you when I'm done." On 4/13/17 at 8:05 a.m. as this surveyor was returning to the conference room, the therapy director was walking from the front lobby. This surveyor stopped him and asked if we could discuss an issue if he had time. He stated he did, and he was asked about the wheelchair for Resident # 21. The therapy director stated "(name of LPN # 3) mentioned it yesterday and I said I probably had a rubber cap to put on the end of it but (name of maintenance person) could tighten the brake." On 4/13/17 at approximately 9:15 a.m. the maintenance person came to the conference room and requested this surveyor to come and see the wheelchair. The wheelchair had been repaired and now had a black cap on the exposed end of the left brake, but was still slightly loose. On 4/13/17 at 9:30 a.m. the maintenance person returned to the conference room and showed this surveyor the final repairs. The wheelchair now had matching black caps, and the brake was no longer loose and functioned properly. On 4/13/17 beginning at 9:45 a.m. during a meeting with facility staff, the administrator and DON (director of nursing) were informed of the above observations and findings. No further information was provided prior to the exit conference.	F 252		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		5/22/17

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F 279	Continued From page 8 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 279		

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F 279	Continued From page 9 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on, staff interview and clinical record review, the facility staff failed to develop comprehensive care plan for one of 24 residents, Resident # 4. Resident #4 did not have a comprehensive care plan to include incontinence or cognition. Findings include: 1. Resident #4 was admitted 4/25/16 with a readmission on 6/25/16 with diagnoses including dysphasia, depression, and anxiety. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/15/17. Resident #4 was assessed as being moderately impaired	F 279	1. Resident #4□s comprehensive careplan was corrected to include impaired cognition and incontinence. 2. The MDS coordinator or designee will conduct an audit of all current residents□ most recent CAA triggers to ensure any resident assessed and coded as cognitively impaired and/or incontinent has a corresponding comprehensive careplan in place. 3. Staff development coordinator or designee will educate MDS coordinator on proper initiation of comprehensive careplans for impaired cognition and/or incontinence based on the MDS review. 4. MDS coordinator or designee will monitor to ensure all triggers for impaired cognition and/or incontinence are being	

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F 279	Continued From page 10 cognitively. Resident #4's medical record was reviewed on 4/4/17 and evidenced, via comprehensive (significant change) MDS dated 12/21/16 section "C" indicated that Resident #4 was cognitively intact with a score of 15 of 15. The MDS was then compared with the most current MDS dated 3/15/17 and indicated (section "C") that Resident #4 was coded as a 1-1 (long and short-term impairment) and "2" under section "C/1000" as modified independence. It was also documented on the comprehensive MDS dated 12/21/16 under section "H" Resident #4 had frequent bladder incontinence and "Always incontinent" of bowel, this was also triggered in section "V" as to be care planned. Resident #4's care plan was then reviewed and did not evidence a care plan for cognition or incontinence. On 4/12/17 at 10:30 a.m. the MDS (Registered nurse, RN #2) coordinator was interviewed concerning the above mentioned care plans. RN #2 verbalized that she had done the assessments on Resident #4 at that time. RN #2 verbalized, in reviewing and comparing the two MDS's a care plan should have been developed for cognition due to the change of cognition. RN #2 also reviewed the care plan for incontinence and verbalized that a care plan should have been done but was missed. On 4/12/17 at 11:45 a.m. the above finding was brought to the attention of the director of nursing and administrator.	F 279	properly added to the comprehensive careplan at the time of the MDS review. This will be completed weekly for 12 weeks. Discrepancies will be brought to the QA committee and addressed as needed.	

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F 279	Continued From page 11 No further information was presented prior to exit conference on 4/13/17.	F 279		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's	F 280		5/22/17

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F 280	Continued From page 12 strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 280		

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F 280	Continued From page 13 (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to review and revise a comprehensive care plan for three of 24 residents, Resident #15, Resident #6, and Resident #3. 1. Resident #15 did not have his comprehensive care plan updated to include interventions for a port-a-cath inserted on 04/05/2017. 2. Resident #6 did not have her Kardex care plan updated to include the application of TED (thrombo-embolitic) hose. 3. Resident #3's care plan was not updated with interventions for significant weight loss. Findings were: 1. Resident #15 did not have his comprehensive care plan updated to include interventions for a port-a-cath inserted on 04/05/2017. Resident #15 was most recently readmitted to the facility on 08/22/2016. His diagnoses included but were not limited to: Morbid obesity, Colon Cancer, Type II DM (diabetes mellitus) heart disease, hypertension, atrial fibrillation, anxiety and gout. The most recent MDS was a quarterly assessment with an ARD (assessment reference date) of 03/15/2017. Resident #15 was assessed	F 280	1. Resident #15□s comprehensive careplan was updated to include the port-a-cath and interventions. Resident #6□s TED (thrombo-embolitic) hose were discontinued due to non-use. Resident #3□s careplan was updated to include specific interventions for weight loss. 2. The director of nursing of designee will conduct an audit of all current residents with a port-a-cath, TED hose, or Med plus 2.0 (nutritional supplement) to ensure they are included in the comprehensive careplan. 3. Staff development coordinator or designee will educate licensed staff on proper updating of comprehensive careplans to include port-a-caths, TED hose, and nutritional supplements. 4. Unit manager or designee will monitor to ensure all new orders for port-a-caths, TED hose, and Med plus 2.0 (nutritional supplement) are updated on the comprehensive careplan 5 times a week for 12 weeks. Discrepancies will be brought to the QA committee and addressed as needed.	

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as having a cognitive summary score of "15", indicating he was cognitively intact.

The clinical record was reviewed on 04/12/2017. Observed in the nurse's note section was an entry dated 04/05/2017 which stated that Resident #15 had been sent to a surgeon to have a port-a-cath inserted. The entry also stated that port-a-cath instructions had been placed in the chart and a copy given to the oncoming nurse. The POS (physician order sheet) was then reviewed. There were no orders on the POS or directions for care regarding the newly inserted port-a-cath. The hard copy chart was obtained from the nurse's station. Observed in the paper chart were the following instructions: "Port Catheter Care Instructions: Do not remove the glue covering the incision; Keep the incision site from getting wet. Avoid taking showers or swimming. You may take a bath, but do not get the incision site wet for at least one week after placement...; Watch for signs and symptoms of infections such as redness, fever, pain, swelling or drainage; Discontinue the use of Probiotics."

There was no interventions on the care plan addressing the port-a-cath.

At approximately 2:15 p.m., this surveyor went to the DON (director of nursing) office to ask about the port-a-cath. The DON was asked if the instructions from the surgeon should have been incorporated into the orders on the electronic clinical record and the care plan. The DON stated, "Yes."

The unit manager, LPN #3 was interviewed at 2:35 p.m., she was asked about the port-a-cath. She stated, "I am putting the orders in the

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computer now." LPN #3 was asked what the nurse's should be doing in regard to the port-a-cath. She stated, "They should be assessing the site and documenting it in the progress notes." LPN #3 was asked how the nurse's would know to do that if it wasn't on the orders, the treatment record, or the care plan." She stated, "I am putting those in now."

The above information was discussed with the DON and the corporate nurse consultants at approximately 4:00 p.m. on 04/12/2017.

No further information was obtained prior to the exit conference on 04/13/2017.

2. Resident #6 did not have her Kardex care plan updated to include the application of TED (thrombo-embolitic) hose.

Findings were:

Resident #6 was most recently readmitted to the facility on 11/25/2016 with the following diagnoses, but not limited to: myocardial infarction, multiple rib fractures, acute kidney failure, dementia, hypertension, atrial fibrillation and Alzheimer's Disease.

The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/01/2017, assessed Resident #6 as having a cognitive status of "12", indicating moderate impairment with her cognitive status.

The clinical record was reviewed on 04/11/2017. Interventions on her care plan included, "TED

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hose on in AM off in PM, as tolerated."

On 04/12/2017 at approximately 11:30 a.m., Resident #6 was observed sitting in her wheelchair. She was asked what kind of socks she was wearing. She stated, "White." She pulled up her pants leg at this surveyors request, revealing short, white, cotton socks.

At approximately 11:45 a.m., CNA (certified nursing assistant) #4 was interviewed. She stated, "Oh God, I haven't looked at her Kardex [care plan for CNAs] today, I don't know if she is suppose to have them or not." CNA #4 went to the computer and pulled up Resident #6's Kardex. There were no entries on the Kardex regarding the use of the TED hose.

During a meeting with the DON (Director of Nursing), the administrator and corporate nurse consultants the above information was discussed.

A Kardex was presented to this surveyor at approximately 2:00 p.m. The interventions for the application of TED hose had been added.

During a meeting with the facility staff on 04/13/2017 at approximately 11:00 a.m., this surveyor asked why the TED hose had not connected to the Kardex from the electronic care plan. The nurse consultant stated, "It has to be linked manually and that hadn't been done."

No further information was obtained prior to the exit conference on 04/13/2017.

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3. Resident #3's care plan was not revised with individualized interventions regarding significant weight loss.

Resident #3 was admitted to the facility on 4/27/16 with a re-admission on 6/27/16. Diagnoses for Resident #3 included osteoporosis, hip fracture, chronic kidney disease, diabetes, heart failure and anemia. The minimum data set (MDS) dated 2/22/17 assessed Resident #3 with moderately impaired cognitive skills.

Resident #3's clinical record documented MDS assessments dated 11/23/16 and 2/22/17. Both of these assessments documented the resident had experienced a significant weight loss (5% or more in last month or loss of 10% or more in last 6 months).

The registered dietitian's (RD's) note dated 3/1/17 documented, "Met w/ [with family member] in CP [care plan] meeting on this date. She [family member] was made aware of weight hx [history] of fluctuations w/ [with] current wt. [weight] loss trend..." A RD note dated 3/7/17 documented the resident weighed 120.4 lbs. and listed this was a loss of 21.6 lbs. (15.2%) loss in the last six months. This note stated, "...High nutritional risk w/ hx [with history] of sig [significant] wt changed and current wt. loss." (sic) The clinical record documented the resident was prescribed a regular diet with shakes and "Med Plus" supplements three times per day

Resident #3's care plan (revised 3/22/17) made no mention of the resident's significant weight loss and had not been revised with individualized interventions to address the weight loss. The plan stated the resident had increased nutritional

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risk due to advanced age, healing needs, requested small portions and had weight change along with nausea/vomiting and a poor appetite. Interventions to avoid significant weight loss included administer medications as ordered, labs as ordered, monthly weights, supplements as ordered, diet as ordered and RD to evaluate and make diet change recommendations. These interventions had not been revised since 6/20/16. No revisions to the care plan had been made since 10/6/16 when weekly weights were added to the plan. The care plan made no mention of the shakes, Med Plus supplement or any other individualized interventions regarding the resident's weight/nutrition.

On 4/12/17 at 10:35 a.m. the registered nurse (RN #2) responsible for MDS and care plans was interviewed about Resident #3. RN #2 stated care plans were reviewed and updated by the entire interdisciplinary team and this included the dietitian.

On 4/12/17 at 2:30 p.m. the RD was interviewed about the lack of updates to Resident #3's care plan regarding her recent weight loss. The RD stated she already had on the care plan the resident had weight changes. When asked about the resident's most recent issue with significant weight loss documented in her notes and on MDS assessments (November 2016 and February 2017), the RD stated, "She's [Resident #3] gone up and down." When asked why Resident #3's interventions to avoid weight loss had not been updated since 6/20/16, the RD stated the care plan listed "supplements as ordered" and she did not list specific supplements on care plans. The RD stated, "We don't do that [list specific supplements] here."

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F 280	Continued From page 19 On 4/13/17 at 8:50 a.m. the dietary manager was interviewed about Resident #3's weight loss. The dietary manager stated the resident was on a regular diet and had requested small portions. The dietary manager stated the resident was served "house" shakes at each meal. The dietary manager stated the resident recently was served soup for lunch and dinner as this helped with the resident's ongoing nausea. These findings were reviewed with the administrator, director of nursing and nursing consultants during a meeting on 4/12/17 at 11:30 a.m.	F 280		
F 281 SS=E	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, and staff interview, the facility staff failed, for three of 24 residents in the survey sample (Residents # 7, 15 and 18), to follow professional standards of nursing practice. 1. Facility staff failed to check systolic blood pressure prior to administering an antihypertensive medication to Resident # 7. 2. During medication pass and pour observation	F 281	1. Resident #7□s blood pressure parameter for the antihypertensive medication was discontinued per MD order. Resident #15□s medication cards for lamictal and metformin were labeled with direction change stickers while surveyors were onsite. Resident #18□s miralax that was administered per standing order on 4/11/2017 was added as a current order and documented on the electronic MAR as administered on stated	5/22/17

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to Resident # 15 on 4/12/17, six medication cards (two Metformin and four Lamictal) were labeled with inaccurate medication administration information as compared with the physician orders on the electronic medication record.

3. A nurse administered Miralax to Resident # 18 without entering a physician's order for the medication. The nurse failed to document the Miralax given on the resident's Medication Administration Record (MAR) and documented no rationale for administering Miralax instead of previously ordered medications/treatment for constipation.

The findings include:

1. The facility staff failed to check Resident # 7's blood pressure prior to administering an antihypertensive medication.

Resident # 7 in the survey sample, a 74 year-old male, was admitted to the facility on 6/14/12, and readmitted on 6/24/13 with diagnoses that included hypertension, edema, chronic obstructive pulmonary disease, depression, idiopathic neuropathy, left above the knee amputation, peripheral vascular disease, generalized muscle weakness, hypothyroidism, rheumatoid arthritis, dementia, hyperlipidemia, gastroesophageal reflux disease, osteoarthritis, insomnia, and dysphagia. According to a Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/4/16, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 10 out of 15.

date.
2. Director of nursing or designee will conduct an audit of all current residents on antihypertensive medications to ensure if a parameter is ordered that the blood pressure is indicated to be documented prior to administration. All orders for lamictal and metformin will be audited to compare medication cards to ensure for matching instructions in the electronic system, if directions have changed, a corresponding direction change sticker will be placed on the medication card. An audit will be conducted of any resident that was administered miralax to ensure corresponding documentation is present in the electronic MAR.
3. Staff development coordinator or designee will educate all licensed staff on appropriate documentation of blood pressure prior to administering an anti-hypertensive medication if parameters are ordered, on applying direction change stickers to medication cards if directions for medications in the electronic MAR have changed, and on appropriate documentation of miralax in the electronic MAR upon administration.
4. Unit manager or designee will monitor to ensure all blood pressures are documented prior to administration of anti-hypertensive medications if parameters are ordered, all lamictal and metformin orders to ensure if directions have changed there is a corresponding direction change sticker present on medication card, and ensure if miralax was administered it is appropriately documented on the electronic MAR. This

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F 281	Continued From page 21 According to the most recent Quarterly MDS with an ARD of 2/1/17, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 13 out of 15. Resident # 7 had the following physician's medication order, dated 8/8/15: Lisinopril Tablet 10 mg (milligrams). Give 10 mg by mouth one time a day for hypertension. Hold if systolic blood pressure is < (less than) 100. (NOTE: Lisinopril is an antihypertensive used in the treatment of mild to moderate hypertension. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 714.) (NOTE: Systolic pressure is the highest arterial blood pressure of a cardiac cycle. Ref. Langenscheidt's Merriam-Webster Medical Dictionary, Copyright 2002, page 684.) At approximately 9:20 a.m. on 4/12/17, LPN # 1 (Licensed Practical Nurse) was observed passing medications to Resident # 7. Included in the medications administered was the Lisinopril. LPN # 1 did not check Resident # 7's blood pressure prior to administering his Lisinopril. A thorough review of Resident # 7's paper clinical record and electronic clinical record, including the E-MAR (Electronic Medication Administration Record), the E-TAR (Electronic Treatment Administration Record), and the Progress (Nurses) Notes failed to reveal any documentation that the resident's blood (systolic) pressure was ever checked prior to the administration of Lisinopril during the month of	F 281	will be completed 5 times a week for 12 weeks. Discrepancies will be brought to the QA committee and addressed as needed.	

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April 2017, up to and including 4/12/17, the day of medication observation.

At 2:40 p.m. on 4/12/17, LPN # 1 was asked if there were any blood pressure parameters associated with the use of Lisinopril administered to Resident # 7. "There are no parameters," LPN # 1 said. The surveyor then asked LPN # 1 if she would check the Lisinopril order to verify there were no parameters listed. After checking the order and reading the notation "Hold if systolic blood pressure is < 100," LPN # 1 said, "I guess I missed it. I'll check with the NP (Nurse Practitioner) about it."

The Potter-Perry Fundamentals of Nursing notes the following about assessment before administering a medication: "The nurse is also responsible for any preassessment data required of certain drugs, such as a blood pressure measurement for antihypertensive medications...before giving the drug." (Ref. Potter-Perry Fundamentals of Nursing, Seventh Edition, page 709.)

The finding was discussed during a meeting at 10:30 a.m. on 4/13/17 that included the Administrator, Director of Nursing, two Corporate Nurse Consultants, and the survey team.

2. During medication pass and pour observation on 04/12/2017, six medication cards (two Metformin and four Lamictal) were labeled with inaccurate medication administration information as compared with the physician orders on the electronic medical record.

A medication pass and pour observation was

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conducted on 04/12/2017 beginning at approximately 8:20 a.m. LPN (licensed practical nurse) # 4 was observed preparing medications for Resident #15.

Resident #15 was most recently readmitted to the facility on 08/22/2016. His diagnoses included but were not limited to: Morbid obesity, Colon Cancer, Type II DM (diabetes mellitus) heart disease, hypertension, atrial fibrillation, anxiety and gout.

The most recent MDS was a quarterly assessment with an ARD (assessment reference date) of 03/15/2017. Resident #15 was assessed as having a cognitive summary score of "15", indicating he was cognitively intact.

During the preparation of medications for Resident #15, the medication card for Lamictal was pulled by LPN #4. Directions on the card were listed as Lamictal 25 mg, give three tabs for total of 75 mg LPN #4 stated, "The order on the computer is for 50 mg, so I am going to just give two tabs." LPN #4 was asked how she knew which source was correct, the medication card or the computer. She stated, "I always go by the computer... it is the most updated order." She was asked when the medication cards were changed to reflect the correct order. She stated, "When the next medicines come... usually the pharmacy will tell us to finish the medicines we have, if we can." There were 5 cards of Lamictal in the medication cart. LPN #4 looked through the cards and stated, "Here is one that is changed." A handwritten note was observed on the card, "2 tabs New Order". The other four cards were labeled with the original order for 75 mg (3 tablets) to be given. LPN #4 continued

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preparing medications. When she pulled the card for Metformin she stated, "This is 1000 mg tablets... the order is for 500 mg." She located a second Metformin card that also contained 1000 mg tablets. Both cards were labeled for Resident #15 to be given one 1000 mg every morning. She stated, "This is a scored tablet so I am going to break it in half to get the 500 mg."

The DON (Director of Nursing) was coming up the hall and stopped at the medication cart. This surveyor asked her about the difference between orders on the medication cards and the computer. She stated, "The computer is correct... there should be a sticker on medication cards if the order has changed, so the nurse knows." The DON was asked who puts the change sticker on the medication cards. She stated, "The nurse who takes the order should do that." The two Metformin cards and the four Lamictal cards were shown to the DON. She stated, "They should all be labeled that there is a change." She looked in the medication cart with LPN #4. She stated, "The stickers should be in each cart, I don't see any in here, I'll be back." The DON returned with a roll of stickers. She stated, "These are the stickers." The sticker contained the following information : "DIRECTIONS CHANGED REFER TO CHART".

A policy/procedure regarding the use of the medication label stickers was requested and received. The policy "Reordering, Changing, and Discontinuing Orders", contained the following information: "Change Orders: ...If pharmacy receives a new order that changes the strength or dose of a medication previously ordered, and there is adequate supply on hand: ...Facility should notify Pharmacy not to send the

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medication and attach a "Change in Directions" sticker to the existing quantity of medications."

The clinical record was reviewed. The electronic physician order sheet was reviewed. The order for the decrease in Lamictal occurred on 04/05/2017 and the order for the decrease in Metformin occurred on 02/14/2017. This information was shared with the DON. She stated, "The stickers should have been placed on the cards when the orders changed."

The above information was discussed during meeting with the DON and the administrator on 04/12/2017 at approximately 11:45 a.m.

No further information was obtained prior to the exit conference on 04/13/2017.

3. A nurse administered the medication Miralax to Resident #18 without entering a physician's order for the medication. The nurse failed to document the Miralax on the resident's medication administration record (MAR) and documented no rationale for administering Miralax instead of medications already ordered for constipation.

Resident #18 was admitted to the facility on 3/21/17 with diagnoses that included heart failure, chronic kidney disease, anemia and diabetes. The minimum data set (MDS) dated 3/28/17 assessed Resident #18 as cognitively intact.

Resident #18's clinical record documented a nursing note dated 4/11/17 at 5:59 p.m. stating, "...C/O [complained of] not being able to have a BM [bowel movement], he was given a cup of warm prune juice 1st shift that was non effective.

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He was also given another cup this shift with myrlax [Miralax] due to no results..."

Resident #18's clinical record documented no physician's order for the Miralax. The resident's MAR for April 2017 had no entry for Miralax and documented no administration of Miralax on 4/11/17. The resident had a physician's order dated 3/21/17 for Bisacodyl 5 mg (milligrams) to be administered every 24 hours as needed for constipation and an order dated 3/28/17 for Colace 100 mg to be administered every 12 hours as needed for constipation. There was no documented rationale of why the Miralax was administered instead of the ordered Bisacodyl or Colace.

On 4/12/17 at 3:10 p.m. the licensed practical nurse (LPN #8) caring for Resident #18 was interviewed about the Miralax administered on 4/11/17. LPN #8 looked at the resident's clinical record and stated there was no physician's order in the system for Miralax. LPN #8 stated Miralax was listed as part of the facility's "standing orders" for constipation but if given an order was supposed to be entered. LPN #8 stated the Miralax administered should have been documented on the MAR. LPN #8 stated she did not know why the Miralax was given instead of the Bisacodyl or Colace.

On 4/12/17 at 4:00 p.m. the director of nursing (DON) was interviewed about Resident #18's Miralax administered on 4/11/17. The DON stated there was no order entered into the record prior to the nurse giving the Miralax. The DON stated Miralax was listed on the standing orders to be given for constipation but a physician's order was supposed to be entered into the

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system prior to giving any medication. The DON stated medications given were supposed to be documented on the MAR. The DON stated she had not been able to contact the nurse that gave the Miralax and did not have an explanation of why the Miralax was administered instead of the already ordered Bisacodyl or Colace. When asked if the facility had a policy or procedure addressing this situation the DON stated, "I don't think so." The DON stated it was just basic nursing practice to get an order prior to giving medication and to document medications in the clinical record.

The Nursing 2017 Drug Handbook on page 1603 states concerning safe drug administration, "Applying the nursing process (assessment, nursing diagnoses, planning, intervention, and evaluation) during drug therapy enables the nurse to systematically identify the drug therapy needs of each patient, thereby reducing the number of adverse events and providing safe patient care...Administer medication utilizing the 'eight rights'...Right patient...Right drug...Right dose...Right time...Right route...Right reason...Right response...Right documentation..." This reference on page 1650 describes Miralax as a laxative given for short-term treatment of occasional constipation and lists the dose as 1 heaping tablespoon of powder dissolved in 4 to 8 ounces of a beverage once daily. (1)

The Lippincott Manual of Nursing Practice 10th edition on page 16 states, "A deviation from the protocol should be documented in the patient's chart with clear, concise statements of the nurse's decisions, actions, and reason for the care provided, including any apparent deviation. This should be done at the time the care is

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F 281	Continued From page 28 rendered because passage of time may lead to a less than accurate recollection of the specific events." (2) These findings were reviewed with the administrator, director of nursing and nursing consultants during a meeting on 4/13/17 at 9:45 a.m. (1) Rader, Janet, Dorothy Terry and Leigh Ann Trujillo. Nursing 2017 Drug Handbook. Philadelphia: Wolters Kluwer, 2017. (2) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.	F 281		
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including	F 309		5/22/17

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F 309	Continued From page 29 but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to implement orders for, and assess a newly inserted port-a-cath, and failed to assess a skin rash for one of 24 residents, Resident #15. Facility staff also failed to follow physician orders for one of 24 residents, prior to the administration of a anti-hypertensive medication, Resident #7 1. Resident #15 had a port-a-cath inserted on 04/05/2017. Orders were sent to the facility from the surgeon, but were not added to the electronic record and the facility's physician order sheet. There were no assessments documented by the nursing staff that the newly inserted port-a-cath site was being assessed or that the care orders had been implemented. Also, there was no assessment done to treatment obtained for a raised, red, itching rash on Resident #15's face, neck, and chest. 2. Facility staff failed to follow physician orders to	F 309	1. Appropriate assessments were completed and orders were obtained and placed to assess resident #15□s port-a-cath as well as for treatment of a rash while surveyors were onsite. Resident #7□s blood pressure parameter for the antihypertensive medication was discontinued per MD order 2. Director of nursing or designee will conduct an audit of all current residents with port-a-cath in place to ensure appropriate orders are written to monitor the site, all residents with a rash to ensure appropriate orders are being followed, and all current residents on antihypertensive medications to ensure if a parameter is ordered that the blood pressure is indicated to be documented prior to administration. 3. Staff development coordinator or designee will educate licensed staff on the appropriate transferring of orders for new	

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F 309	Continued From page 30 check a blood pressure prior to the administration of an anti-hypertensive medication to Resident #7. Findings were: 1. Resident #15 had a port-a-cath inserted on 04/05/2017. Orders were sent to the facility from the surgeon, but were not added to the electronic record and the facility's physician order sheet. There were no assessments documented by the nursing staff that the newly inserted port-a-cath site was being assessed or that the care orders had been implemented. Also, there was no assessment done to treatment obtained for a raised, red, itching rash on Resident #15's face, neck, and chest. Resident #15 was most recently readmitted to the facility on 08/22/2016. His diagnoses included but were not limited to: Morbid obesity, Colon Cancer, Type II DM (diabetes mellitus) heart disease, hypertension, atrial fibrillation, anxiety and gout. The most recent MDS was a quarterly assessment with an ARD (assessment reference date) of 03/15/2017. Resident #15 was assessed as having a cognitive summary score of "15", indicating he was cognitively intact. The clinical record was reviewed on 04/12/2017. Observed in the nurse's note section was an entry dated 04/05/2017 which stated that Resident #15 had been sent to a surgeon to have a port-a-cath inserted. The entry also stated that port-a-cath instructions had been placed in the chart and a copy given to the oncoming nurse. The POS (physician order sheet) was then	F 309	port-a-cath assessment and care to the electronic MAR for proper documentation, following orders for any resident with a rash, and on appropriate documentation of blood pressure prior to administering an anti-hypertensive medication if parameters are ordered. 4. Unit manager or designee will monitor for new port-a-caths to ensure appropriate orders are transferred into the electronic MAR for proper documentation, all resident□s with a rash have appropriate orders written, and all blood pressures are documented prior to administration of anti-hypertensive medications if parameters are ordered. This will be completed 5 times a week for 12 weeks. Discrepancies will be brought to the QA committee and addressed as needed.	

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reviewed. There were no orders on the POS or directions for care regarding the newly inserted port-a-cath. The hard copy chart was obtained from the nurse's station. Observed in the paper chart were the following instructions: "Port Catheter Care Instructions: Do not remove the glue covering the incision; Keep the incision site from getting wet. Avoid taking showers or swimming. You may take a bath, but do not get the incision site wet for at least one week after placement...; Watch for signs and symptoms of infections such as redness, fever, pain, swelling or drainage; Discontinue the use of Probiotics."

There was no additional documentation in either the paper clinical record or the electronic record regarding the port-a-cath. There were no assessments documented of the insertion site, nor were there any entries on the care plan addressing the port-a-cath.

The ADL sheets were reviewed. Per the documentation completed by the CNA (certified nursing assistant) staff who cared for Resident #15, he had received three baths since the port-a-cath insertion.

At approximately 2:15 p.m., this surveyor went to the DON (director of nursing) office to ask about the port-a-cath. Concerns were voiced that there were no orders on the electronic record regarding the port-a-cath, there were no documented assessments of the site, and the CNA documentation that Resident #15 had received baths since the insertion. The DON was asked if the instructions from the surgeon should have been incorporated into the orders on the electronic clinical record. The DON stated, "Yes." The DON also stated that unit manager, LPN

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(licensed practical nurse) #3 would have information regarding the port-a-cath.

The unit manager, LPN #3 was interviewed at 2:35 p.m., she was asked about the port-a-cath. She stated, "I am putting the orders in the computer now." LPN #3 was asked what the nurse's should be doing in regard to the port-a-cath. She stated, "They should be assessing the site and documenting it in the progress notes." LPN #3 was asked how the nurse's would know to do that if it wasn't on the orders, or the treatment record, She stated, "I am putting those in now."

At approximately 2:40 p.m., LPN #3 was asked to accompany this surveyor to Resident #15's room to look at the port-a-cath site. The site incision line was covered with glue. A raised, red rash was observed on Resident #15's neck, face and down his chest. LPN #3 asked the resident about the rash. He stated, "It started night before last, I told the CNA, she told the nurse but they didn't come down here to look at it. [Name of CNA # 4] told the nurse yesterday morning but nobody came to look at it...it itches." LPN #3 stated, "You're having an allergic reaction to something. It's probably from where they cleaned you off before they inserted the port-a-cath."

At approximately 2:45 p.m., LPN # 4 who had been caring for Resident #15 that day (04/12/2017) was interviewed. She was asked if she knew Resident #15 had a port-a-cath. She stated, "I was in there yesterday when the CNAs were doing his care and I saw it then." LPN #4 was asked if she had done assessments regarding the site. She stated, "No, when I was in there yesterday it was incidental to being in the

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room when they were changing his clothes....it looked okay....It had tegaderm over it." LPN #4 was asked if she knew the port-a-cath had recently been inserted, She stated, "Like I said earlier, I am an agency nurse... I've only been here a few days... there isn't anything on the orders that I have seen to be checking it." LPN #4 was asked if she had noticed a rash on Resident #15 when she was in the room or if it had been reported to her. She stated, "No."

At approximately 2:50 p.m., the DON and two CNA's (CNA #1 and CNA #2) spoke with this surveyor. They stated that they had provided care to Resident #15. Both stated that when they checked off bath on the ADL sheet they were checking that they had given bed baths, not showers or tub baths. CNA #1 was asked if she had given Resident #15 a bed bath the previous day. She stated, "Yes." She was asked if she had reported that to her nurse. She stated, "The CNA I took report from told me about it, she said she told her nurse...I saw it, but I got busy and didn't think to tell anyone about it."

The above information was discussed with the DON and the corporate nurse consultants at approximately 4:00 p.m. on 04/12/2017.

On 04/13/2017 at approximately 8:00 a.m., this surveyor spoke with Resident #15. He was asked if any treatment had been done to the rash on his face, neck and chest. He stated, "No one has looked at it except the aides since I told them about it." He was asked if it was still itching and did it feel any better since the previous day. He stated, "Maybe a little."

At approximately 8:15 a.m., spoke with the DON

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about Resident #15's rash. She stated that the Nurse Practitioner had been notified but she didn't know if she had been in or not.

At approximately 10:30 a.m., the DON reported that the nurse practitioner had assessed the rash on Resident #15. She was asked when the Nurse Practitioner had been in. She went to Resident #15 who was seated in the hallway and asked him. He stated, "She just looked at it a few minutes ago." The DON stated, "She ordered Benadryl cream which is available over the counter. I am going to go get it from [name of pharmacy near the facility].

No further information was obtained prior to the exit conference on 04/13/2017.

2. The facility staff failed to follow physician's orders to check a blood pressure prior to the administration of an antihypertensive medication to Resident # 7.

Resident # 7 in the survey sample, a 74 year-old male, was admitted to the facility on 6/14/12, and readmitted on 6/24/13 with diagnoses that included hypertension, edema, chronic obstructive pulmonary disease, depression, idiopathic neuropathy, left above the knee amputation, peripheral vascular disease, generalized muscle weakness, hypothyroidism, rheumatoid arthritis, dementia, hyperlipidemia, gastroesophageal reflux disease, osteoarthritis, insomnia, and dysphagia. According to a Significant Change Minimum Data Set (MDS)

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with an Assessment Reference Date (ARD) of 4/4/16, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 10 out of 15.

According to the most recent Quarterly MDS with an ARD of 2/1/17, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 13 out of 15.

Resident # 7 had the following physician's medication order, dated 8/8/15:

Lisinopril Tablet 10 mg (milligrams). Give 10 mg by mouth one time a day for hypertension. Hold if systolic blood pressure is < (less than) 100.

(NOTE: Lisinopril is an antihypertensive used in the treatment of mild to moderate hypertension. Ref. Mosby's 2017 Nursing Drug Reference, 30th Edition, page 714.)

(NOTE: Systolic pressure is the highest arterial blood pressure of a cardiac cycle. Ref. Langenscheidt's Merriam-Webster Medical Dictionary, Copyright 2002, page 684.)

At approximately 9:20 a.m. on 4/12/17, LPN # 1 (Licensed Practical Nurse) was observed passing medications to Resident # 7. Included in the medications administered was the Lisinopril. LPN # 1 did not check Resident # 7's blood pressure prior to administering his Lisinopril.

At 2:40 p.m. on 4/12/17, LPN # 1 was asked if there were any blood pressure parameters associated with the use of Lisinopril administered

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F 309	Continued From page 36 to Resident # 7. "There are no parameters," LPN # 1 said. The surveyor then asked LPN # 1 if she would check the Lisinopril order to verify there were no parameters listed. After checking the order and reading the notation "Hold if systolic blood pressure is < 100," LPN # 1 said, "I guess I missed it. I'll check with the NP (Nurse Practitioner) about it." The Potter-Perry Fundamentals of Nursing notes the following about assessment before administering a medication: "The nurse is also responsible for any preassessment data required of certain drugs, such as a blood pressure measurement for antihypertensive medications...before giving the drug." (Ref. Potter-Perry Fundamentals of Nursing, Seventh Edition, page 709.) The finding was discussed during a meeting at 10:30 a.m. on 4/13/17 that included the Administrator, Director of Nursing, two Corporate Nurse Consultants, and the survey team.	F 309		
F 312 SS=E	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview and clinical record review, the facility staff failed to provide ADL (activities of daily living) care for one of 24 residents, Resident #15. Resident # 15 was not receiving showers or tub	F 312	1. Resident #15 was taken to the shower room and given a full shower on 4/12/2017, while surveyors were onsite. 2. Director of nursing or designee will conduct an audit, by way of individual interview of all bariatric patients to ensure	5/22/17

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F 312	Continued From page 37 baths at the facility due to his size. Findings were: Resident #15 was most recently readmitted to the facility on 08/22/2016. His diagnoses included but were not limited to: Morbid obesity, Colon Cancer, Type II DM (diabetes mellitus) heart disease, hypertension, atrial fibrillation, anxiety and gout. The most recent MDS was a quarterly assessment with an ARD (assessment reference date) of 03/15/2017. Resident #15 was assessed as having a cognitive summary score of "15", indicating he was cognitively intact. The weight record on the quarterly MDS was 348 pounds. The most recent weight in the clinical record was 343 pounds. The clinical record was reviewed on 04/12/2017. Observed in the nurse's note section was an entry dated 04/05/2017 which stated that Resident #15 had been sent to a surgeon to have a port-a-cath inserted. The entry also stated that port-a-cath instructions had been placed in the chart and a copy given to the oncoming nurse. The POS (physician order sheet) was then reviewed. There were no orders on the POS or directions for care regarding the newly inserted port-a-cath. The hard copy chart was obtained from the nurse's station. Observed in the paper chart were the following instructions: "Port Catheter Care Instructions: Do not remove the glue covering the incision; Keep the incision site from getting wet. Avoid taking showers or swimming. You may take a bath, but do not get the incision site wet for at least one week after placement...; Watch for signs and symptoms of	F 312	they are being taken to the shower room to receive full showers on their shower days. 3. Staff development coordinator or designee will educate nursing staff on importance of showers being given to bariatric residents on their shower days. 4. Unit manager or designee will monitor to ensure obese residents are being provided showers in the shower room on their shower days. This will be completed 2 times a week for 12 weeks. Discrepancies will be brought to the QA committee and addressed as needed.	

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infections such as redness, fever, pain, swelling or drainage; Discontinue the use of Probiotics."

The ADL sheets were reviewed. Per the documentation completed by the CNA (certified nursing assistant) staff who cared for Resident #15, he had received three baths since the port-a-cath insertion.

At approximately 2:15 p.m., this surveyor went to the DON (director of nursing) office to ask about the port-a-cath. Concerns were voiced that per the CNA documentation, Resident #15 had received baths since the insertion of the port-a-cath. The DON stated she would investigate.

At approximately 2:50 p.m., the DON and two CNA's (CNA #1 and CNA #2) spoke with this surveyor. They stated that they had provided care to Resident #15. Both stated that when they checked off bath on the ADL sheet they were checking that they had given bed baths, not showers or tub baths. CNA #2 stated, "He weighs like 500 pounds, we don't get him up to the shower." CNA #1 stated, "We never bathe him or give him a shower...he won't fit..."

The DON was asked if she was aware that Resident #15 was not receiving showers or tub baths. She shook her head side to side indicating, "No." The unit manager, LPN (licensed practical nurse) #3 was asked if she was aware that Resident #15 was not receiving baths or showers. She stated, "No."

The care plan was reviewed. The problem area: "The resident has an ADL self-care performance deficit r/t [related to] Limited Mobility", had the

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following interventions but not limited to: "BATING/SHOWERING: Provide sponge bath when a full bath or shower cannot be tolerated. Encourage to wash face and upper body. Staff to wash lower body." An additional intervention, "The resident is resistive to care (will not allow staff to change clothes/bed linens at times when soiled, refuses to turn to prevent skin impairment, and often will refuse meal tray-alternate options are offered and resident will often eat those and then later complain because he did not have his tray, refuses to have dressings changed/treatments performed at times) r/t anxiety and poor coping mechanisms." There was no mention of Resident #15 refusing baths on the care plan.

At approximately 3:20 p.m., this surveyor went to Resident #15's room. The door was closed and after entering the room, Resident #15's body odor was noted. Resident #15 was asked if the facility staff was offering him tub baths or showers. He stated, "No, they say it isn't safe." Resident #15 was asked how long it had been since he had been in the shower or tub. He stated, "It's been a good while....When I had the other wheelchair it worked pretty good...it was electric but they decided they didn't want to take that in there." Resident #15 was asked if it was considered safe for him to take a shower or tub bath would he be interested. He stated, "Yes."

At approximately 3:30 p.m., this surveyor went to the shower room. Both maintenance men (OS-other staff #4 and OS #6) were in the shower room working on a drain. They were asked if there was a whirlpool tub in the facility. This surveyor was directed to the other side of the shower room. A whirlpool tub was observed. The

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F 312	Continued From page 40 chair seat in the tub was measured. The seat measured 20 inches wide and 15 inches deep. This surveyor explained that Resident #15 was not getting baths or showers due to his size and asked if there was a bigger seat that could be used. OS #4 stated, "There is a bariatric shower chair on [name of wing]." This surveyor asked OS #4 to measure Resident #15's wheelchair seat size and compare to the bariatric shower chair. OS #4 and this surveyor went to Resident #15's room. Resident #15's wheelchair seat was measured, 29 1/2 inches wide and 18 1/2 inches deep. The bariatric shower chair was measured for comparison. The shower chair measured, 30 1/4 inches wide and 21 1/2 inches deep. OS #4 was asked if equipment was available to lift Resident #15 to the shower chair. He stated, "We have a lift that is about a year old that goes up to 1500 pounds." The above information was discussed with the DON, the administrator, and the corporate nurse consultants at approximately 4:00 p.m. on 04/12/2017. The corporate nurse consultant stated, "He'll be getting a bath today." On 04/13/2017 at approximately 8:00 a.m., this surveyor went to Resident #15's room. The odor from the day before was decreased. Resident #15 was asked if he had gotten a bath the previous afternoon (04/12/2017). He stated, "Oh yes, it felt good." No further information was obtained prior to the exit conference on 04/13/2017.	F 312		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		5/22/17

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F 314	Continued From page 41 (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and during the course of a complaint investigation, the facility staff failed to implement interventions for the prevention of pressure related ulcers for one of 24 residents in the survey sample (Resident # 23), as a result Resident #23 acquired pressure related areas resulting in harm to the resident. Resident # 23 had bilateral leg/knee braces for the prevention of contractures, the leg/knee braces were not removed daily for skin inspections and the resident acquired pressure related areas in the following locations: 1) Area to the right knee cap 2) Area to right heel 3) Area to left heel	F 314	1. Resident #23 is no longer a resident at the facility. 2. Director of nursing or designee will conduct an audit to identify any resident who wears a brace to ensure there are appropriate orders for removing the brace to monitor skin integrity. 3. Staff development coordinator or designee will educate licensed staff on appropriate monitoring of skin integrity for residents who wear a brace. 4. Unit manager or designee will monitor to ensure that all residents with a new order to wear a brace have appropriate orders in place for monitoring skin integrity. This will be completed 2 times a week for 12 weeks. Discrepancies will be brought to the QA committee and addressed as needed.	

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4) Area to top of right foot

On 11/10/16, Resident #23 was sent to the Emergency Department due to wounds not improving and a heavy odor associated with the areas.

Findings include:

Resident # 23, a 38 year old female was admitted originally to the facility on 12/15/2015. The resident had a readmission to the facility on 01/08/16, with the most current readmission being on 04/02/16; the resident was discharged from the facility on 11/10/16 and did not return to the facility.

Admitting diagnoses for Resident # 23 included, but were not limited to: persistent vegetative state, history of MI (myocardial infarction/heart attack), history of pneumonia, chronic respiratory failure with a tracheostomy, anoxic brain damage, high blood pressure, gastronomy tube (peg), dysphagia and DM (diabetes mellitus).

The most recent MDS (minimum data set) with CAAS (care area assessment summary) was a significant change assessment dated 10/26/16, which assessed Resident # 23 as being in a persistent vegetative state. This MDS also assessed the resident as requiring extensive assistance for all ADL's (activities of daily living). This MDS assessed the resident with 2 unstageable pressure ulcers that were suspected DTI (deep tissue injury).

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A quarterly MDS assessment was reviewed for comparison, dated 06/22/16. This MDS assessed the resident as being in a persistent vegetative state and also assessed the resident as requiring extensive assistance for all ADL's (activities of daily living). This MDS assessed the resident as having no pressure ulcers or skin impairment.

A PT (physical therapy) evaluation and plan of treatment (dated 02/28/16) was reviewed and documented, "...patient will safely wear a knee extension splint on left knee for up to 5 hours w/minimal s/s [signs and symptoms] of redness, swelling, discomfort or pain...will achieve normal anatomical alignment of the left knee... using a knee extension splint in order to prevent contractures and in order to reduce tone/promote mobility... Patient demonstrates good rehab potential as evidenced by strong family support and supportive caregivers/staff... Reason for Referral: Patient referred... increased need for assistance from others, joint instability, decreased coordination... decrease in range of motion indicating the need for PT to increase functional activity tolerance, increase coordination, improve tone in LE [lower extremity], facilitate motor control and establish and instruct in compensatory strategies... RLE [right lower extremity] ROM [within functional limits] (involuntary muscle movement noted) LLE [left lower extremity] [within functional limits] (spastic hamstrings resulting in left knee limited knee extension ROM)... To prevent BLE [bilateral lower extremity] contracture, decrease BLE spasm with use of dynamic knee brace, BLE PROM [passive range of motion] to increase ROM, and positioning to prevent contracture, bed ulcers and increase quality of life..."

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A PT therapy progress report dated 03/11/16, documented that the resident is tolerating the knee extension brace without any discomfort or redness on LE [lower extremity]... patient have [sic] demonstrated wearing tolerance from 30 minutes to 2.5 hours... is tolerating the knee extension brace without any discomfort or redness... building wearing tolerance then educate and train staff on proper donning [put on] and doffing [take off]..."

The PT discharge summary dated 03/28/16 documented: "...Patient now able to tolerate... 8-12 hours without any signs of redness or discomfort, left knee muscle tissue is demonstrating decrease muscle spasm activity and pt is able to relax and hold leg down in place without knee flexing maximally... Pt and caregiver training: caregiver education and training focused on proper positioning in bed for comfort, gentle PROM to LLE and donning and doffing of the left knee brace and skin inpection (sic) to monitor for redness and any adverse reaction..."

The resident was discharged to the hospital for UTI (urinary tract infection) sepsis on 03/29/16 and was readmitted back to the facility on 04/02/16.

The hospital history and physical dated 3/29/16 documented, "...she [resident] has braces for contractures on both upper extremities on the wrists and hands as well as on the left knee... she moves all extremities but again does not follow commands..."

The hospital discharge summary dictated 04/01/16 documented, "...pt has returned back to

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baseline status and she is felt stable for discharge back to [name of long term care facility]. The patient will resume previous care there..."

The resident was readmitted back to the long term care facility on 04/02/16.

A physician's progress note dated 04/04/16 (no time) documented, "...anoxic encephalopathy/persistent vegetative state... chronic trach/peg/foley-total care... cognitive impairment -anoxic brain injury and unable to answer questions... weakness... unresponsive exc [except] for some non-purposeful movements... total care... care plan/treatment/therapy: Total Care... [signature of physician]."

A physician's progress note dated 05/29/16 (no time) documented, "...60 day recert... hospitalized from 03/29 -04/02 UTI (urinary tract infection) sepsis. Stable since readmission [04/02/16] ... eyes closed and unresponsive to verbal stimuli exc [except] moves extremities a little only... total care with trach/peg/foley... [signature of physician]."

The resident's CCP (comprehensive care plan) from readmission (January 2016) to discharge (November 2016) was then reviewed and documented that the resident has potential for pressure ulcer development related to immobility, the resident will have intact skin, free of redness, blisters or discoloration (this was created on 04/12/16). The intervention to this problem was to educate the resident/family/caregivers as to causes of skin breakdown; including transferring/positioning requirements; importance

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of taking care during ambulating/mobility, good nutrition and frequent repositioning..."

Further review of Resident # 23's clinical record revealed Resident # 23 was seen again by PT therapy on 06/03/16 for bilateral leg braces related to contracture development.

The PT evaluation and plan of treatment (dated 06/03/16) documented, "...to increase LE ROM and prevent and decrease joint contracture, increase functional activity tolerance... improve tone LE and facilitate motor control in order to enhance patient's quality of life by improving ability to relieve pressure for decreased risk of skin breakdown and exhibit preserved skin integrity... due to documented physical impairments and associated functional deficits, the patient is at risk for:... increased dependency on caregivers ... limited functional movement... muscle atrophy and pressure sores..."

A PT therapy progress note dated 06/15/16 documented, "...Pt and caregiver training: instructed... primary caregivers in splinting/orthodic schedule in order to prevent decline from current level of skill performance with variable carryover demonstrated by caregivers... Patient is compliant with POT [plan of treatment] and patient's condition is improving as a result of skilled therapy services... Patient demonstrates good rehab potential as evidenced by strong family support and supportive staff..."

Resident # 23's physician's orders were reviewed for June 2016 and revealed three separate orders for the leg braces.

Order # 1- dated 06/23/16 documented, "Bilateral

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leg braces every evening shift for prevention remove leg braces at bedtime." This was documented on the TAR as evening and it was initialed from 06/23/16 through 06/29/16, there was not area to document the removal at bedtime.

Order # 2-dated 06/24/16 documented, "Bilateral leg braces one time a day for prevention apply bilateral leg braces on in AM and off in PM." This was documented on the TAR as 8:30 a.m. and was initialed from 06/24/16 through 06/29/16, there was no place on the TAR to document the removal of the braces in the PM.

Order # 3- dated 06/30/16 documented, "Bilateral leg braces every shift for prevention Bilateral leg braces on at all times." This was documented on the TAR as day/evening/night (every shift) and it was initialed for every shift from 06/30/16 through 08/14/16. The TAR was documented as continuous use of the leg braces for all three shifts from 06/30/16 through 08/014/16.

1) A nursing note dated 08/14/16 (timed 4:00 a.m.) documented, "...this nurse observed the resident moaning and grimace on face... made assessment and found... bruise to her right kneecap... removed the brace from the [sic] her legs... bed bath... reported to the next shift nurses..."

A nursing note dated 08/14/16 (timed 1:03 p.m.) documented, "Resident noted with wound to the right knee cap. Appearing as a blood filled blister/bruise... braces were removed from legs at nurse's discretion last night, as the wound has began by the knee braces rubbing against skin... MD [medical doctor] notified, order received for

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skin prep every shift to wound... Nurse explained to sister [of resident] how the wound was started on the knee and why the braces were removed. Sister states 'That's because they've been leaving them on too long'.... moonboots and positioning pillows remain in place"

A nursing note dated 08/14/16 and time 4:19 p.m. documented, "Braces removed on 11-7 shift this morning due to right knee wound..."

A nursing note dated 08/14/16 and timed 7:13 p.m. documented, "...wound appears as a bruise/blood filled blister measuring 3.8 cm [centimeters] in Width, 1.7 cm in Length... Resident had braces ordered by therapy for both legs due to contractures. Nurse attempted to explain to [name of family member] how braces could have been improperly placed..."

A nursing noted dated 08/15/16 and timed 4:47 a.m. documented, "resident has had a skin tear at the right knee cap, appears swollen and redden [sic]..."

A nursing note dated 08/15/16 (timed 11:03 a.m.) documented, "...concerns [from sister of resident] told [nurse] that patient has a sore on her right knee and that she believes that it came from staff not taking off her brace... has a circular area to right knee that appears as a skin tear..."

A nursing note dated 08/15/16 (timed 11:26 p.m.) documented, "resident continues with blister to right knee. Residents braces to bilateral legs have been discontinued..."

A wound record dated 08/14/16 documented, that the resident's wound to the right knee was

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'acquired... blood filled blister... purple/maroon... 1.7 by 3.8... irregular [wound edges]... first observation..."

The resident's CCP was reviewed and documented, "...resident has an abrasion to the right knee... identify potential causative factors and eliminate/resolve when possible..."

A physician's progress note dated 08/22/16 documented, "...total care... doesn't respond to verbal commands... arm extended above head. Legs flexed under buttocks, no edema, moving around in bed non-purposeful... one open area right knee now... orders reviewed/approved- no change..."

According to the clinical record documentation (TARs), the leg braces were not applied from 08/14/16 to 10/24/16 due to the wound. Restorative nursing was started [signed of as completed] on 08/15/16 for PROM to all extremities 5 sets of 10 reps 6-7 times per week.

A nursing note dated 10/01/16 (timed 2:47 p.m.) documented, "...patient has been tightening up muscles and moaning when going to apply braces to hands and legs are getting harder to move pillows between legs and heels..."

2 and 3) A nursing note dated 10/17/16 and timed 4:57 p.m. documented, "Resident noted to have SDTI [suspected deep tissue injury] to bilateral heels..."

A nursing note dated 10/24/16 and timed 2:30 p.m. documented, "Residents R [right] heel SDTI pressure ulcer observed with blood from ulcer... verbal order received to steri-strip skin that is still

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observed [sic] to heel, cover... continues with pressure ulcer to left heel as well, skin intact, purple in color..."

A nursing note date 10/24/16 (timed 7:49 p.m.) documented, "Knee braces on at all times except when taking a shower. every shift for prevention removed [sic]."

Wound records dated 10/16/16 documented for the right and left heel, both acquired and both pressure, both SDTI and this was the first observation.

A nursing note dated 10/28/16 (timed 2:41 p.m.) documented, "...new order for Ortho consult on 11/03/16 at 12:30 p.m...."

4) A nursing note dated 11/01/16 and timed 2:32 p.m. documented, "...Left heel with top layer of skin peeled back, slight odor... also observed new wound to top of residents right foot, measured 2 cm X 2 cm X 0 cm depth, no tunneling/undermining..."

An Ortho consult dated 11/03/16 documented, "...patient presents for evaluation of bilateral arm and bilateral leg pain... the patient has experienced bilateral upper and lower extremities contractures... has utilized braces of her lower extremities, which seemed to cause wounds on both heels. Her legs are fixed in a crossed position. She has increased pain when trying to move her... discussed patient's issue with... nurse... explained that any surgical intervention is a large undertaking... do not recommend this... bilateral lower extremity: fixed flexion contracture, no passive ROM... Eschar size of silver dollar on left heel small drainage...

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[signature of physician]."

A nursing note dated 11/10/16 and timed 11:52 a.m. documented, "...wounds assessed at this time, NP in to assess as well, gave this nurse verbal order to send resident to ED [emergency department] due to wounds not improving and odor to wounds...left foot measured 2 cm X 2 cm X 0 depth... Eschar observed to left heel... right heel observed purple in color, odor... area to right top of foot observed black in color, heavy odor, measured 4 xm [sic] X 4 cm X 0 depth... heavy odor..."

It was documented that the resident left the facility via EMT [emergency medical transport] at approximately 1:15 p.m.

The facility staff were informed of the above information regarding Resident # 23 in a meeting with the survey team on 04/13/17 at approximately 9:00 a.m. The facility staff were made aware that the resident had several wounds that were documented as acquired. Resident # 23's CCP did not have any interventions in place to address the use of the leg braces or any intervention to address the resident's skin in relation to the leg braces.

Assistance was requested from facility staff for any and all information and/or documentation to evidence that the resident had received appropriate care/services and interventions from facility staff for the prevention of pressure related ulcers.

At approximately 11:00 a.m., in a meeting with the survey team, the facility staff were again informed of serious concerns regarding Resident # 23 and

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F 314	Continued From page 52 the potential for harm for the resident who had acquired multiple wounds. The facility staff stated that they were aware of the concerns and stated that they (staff) were checking the resident's skin, but failed to document it. The facility staff was asked to present any information and/or documentation to evidence Resident #23's pressure ulcers were unavoidable. No further information and/or documentation was presented prior to the exit conference on 04/13/16 at 12:30 p.m., to evidence that Resident # 23 received adequate interventions for the preventions of pressure related ulcers or that the resident's pressure ulcers were unavoidable. The Lippincott Manual of Nursing Practice 10th edition on page 183 states, "Pressure ulcers (decubitus ulcers) are localized ulcerations of the skin or deeper structures. They most commonly result from prolonged periods of bed rest in acute- or long-term care facilities; however, they can develop within hours in the compromised individual..." Page 184 of this reference describes a stage 3 pressure ulcer as, "...full-thickness tissue loss, with subcutaneous fat that may be visible but bone, tendon, or muscle are not exposed; may include undermining and tunneling. Slough may be present but does not obscure the depth of tissue loss." (1) (1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014. This is a complaint deficiency.	F 314		
F 318	483.25(c)(2)(3) INCREASE/PREVENT	F 318		5/22/17

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F 318 SS=G	Continued From page 53 DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and during the course of a complaint investigation, the facility staff failed to prevent a significant decline in ROM (range of motion) for one of 24 residents in the survey sample (Resident # 23). Resident #23 did not receive range of motion exercises and/or interventions for the prevention of contractures and had a significant decline in range of motion in both lower extremities, resulting in harm. Resident # 23 was not provided restorative nursing ROM as recommended by therapy and was not provided physician ordered leg brace(s) for an extended period of time to prevent a significant decline in bilateral lower extremities mobility; the restorative nursing ROM recommendations were included in the resident's CCP (comprehensive care plan) beginning in January 2016, but was not implemented until August of 2016, a result the resident suffered irreversible bilateral (crossed) leg contractures.	F 318	1. Resident #23 is no longer a resident at the facility. 2. Director of nursing of designee will conduct an audit to identify any resident who is to be on a ROM restorative program to ensure documentation is entered accurately for CNA to document minutes and participation. 3. Staff development coordinator or designee will educate nurse management staff on appropriate entry of ROM restorative programs to ensure the CNA can document minutes and participation. 4. Director of nursing or designee will monitor to ensure that all residents who are on a ROM restorative program are being documented on appropriately by the CNA to include minutes and participation. This will be completed weekly for 12 weeks. Discrepancies will be brought to the QA committee and addressed as needed.	

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F 318	Continued From page 54 Findings include: Resident # 23, a 38 year old female was admitted originally to the facility on 12/15/2015. The resident had a readmission to the facility on 01/08/16, with the most current readmission being on 04/02/16; the resident was discharged from the facility on 11/10/16 and did not return to the facility. Admitting diagnoses for Resident # 23 included, but were not limited to: persistent vegetative state, history of MI (myocardial infarction/heart attack), history of pneumonia, chronic respiratory failure with a tracheostomy, anoxic brain damage, high blood pressure, gastronomy tube (peg), dysphagia and DM (diabetes mellitus). The most recent MDS (minimum data set) with CAAS (care area assessment summary) was a significant change assessment dated 10/26/16, which assessed Resident # 23 as being in a persistent vegetative state. This MDS also assessed the resident as requiring extensive assistance for all ADL's (activities of daily living). The resident's functional limitation in ROM (upper and lower extremities) was assessed as having no impairment in the upper extremities and as having impairment on both sides for lower extremities. A quarterly MDS assessment was reviewed for comparison, dated 06/22/16. This MDS assessed the resident as being in a persistent vegetative state and also assessed the resident as requiring extensive assistance for all ADL's (activities of daily living). The resident's functional limitation in ROM (upper and lower	F 318		

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extremities) was assessed as having no impairment in the upper or lower extremities.

A PT (physical therapy) evaluation and plan of treatment (dated 02/28/16) was reviewed and documented, "...patient will safely wear a knee extension splint on left knee for up to 5 hours w/minimal s/s [signs and symptoms] of redness, swelling, discomfort or pain... will achieve normal anatomical alignment of the left knee... using a knee extension splint in order to prevent contractures and in order to reduce tone/promote mobility... Patient demonstrates good rehab potential as evidenced by strong family support and supportive caregivers/staff... Reason for Referral: Patient referred... increased need for assistance from others, joint instability, decreased coordination... decrease in range of motion indicating the need for PT to increase functional activity tolerance, increase coordination, improve tone in LE [lower extremity], facilitate motor control and establish and instruct in compensatory strategies...RLE [right lower extremity] ROM [within functional limits] (involuntary muscle movement noted) LLE [left lower extremity] [within functional limits] (spastic hamstrings resulting in left knee limited knee extension ROM)...To prevent BLE [bilateral lower extremity] contracture, decrease BLE spasm with use of dynamic knee brace, BLE PROM [passive range of motion] to increase ROM, and positioning to prevent contracture, bed ulcers and increase quality of life..."

A PT treatment encounter note dated 02/28/16 documented, "Physician's order received, chart reviewed, history noted, evaluation completed... techniques to prevent contractures and techniques to normalize tone..."

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A PT therapy progress report dated 03/11/16, documented that the resident is tolerating the knee extension brace without any discomfort or redness on LE [lower extremity]... patient have [sic] demonstrated wearing tolerance from 30 minutes to 2.5 hours... is tolerating the knee extension brace without any discomfort or redness... building wearing tolerance then educate and train staff on proper donning [put on] and doffing [take off]..."

A physician's order dated 03/24/16 documented, "Leg brace to left leg every day and evening shift for leg brace Stretch residents leg 45 degrees and apply leg brace, apply leg brace to left leg and remove at bedtime."

The leg brace was documented as applied on the TAR (treatment administration orders) for March 24th through March 28th, 2016.

The PT discharge summary dated 03/28/16 documented: "...Patient now able to tolerate... 8-12 hours without any signs of redness or discomfort, left knee muscle tissue is demonstrating decrease muscle spasm activity and pt is able to relax and hold leg down in place without knee flexing maximally... Pt and caregiver training: caregiver education and training focused on proper positioning in bed for comfort, gentle PROM to LLE and donning and doffing of the left knee brace and skin inpection (sic) to monitor for redness and any adverse reaction. Unit Manager was educated and task demonstrated to her on the process of donning/doffing. She is in agreement and has signed the inservice form accordingly... discharge recommendations: ...to facilitate patient

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maintaining current level of performance and in order to prevent decline, development of and instruction in the following RNP [restorative nursing program] has been completed with the IDT [interdisciplinary team]: ROM (passive) and knee brace care...."

The resident was discharged to the hospital for UTI (urinary tract infection) sepsis on 03/29/16 and was readmitted back to the facility on 04/02/16.

The hospital history and physical dated 3/29/16 documented, "...she [resident] has braces for contractures on both upper extremities on the wrists and hands as well as on the left knee... she moves all extremities but again does not follow commands..."

The hospital discharge summary dictated 04/01/16 documented, "...pt has returned back to baseline status and she is felt stable for discharge back to [name of long term care facility]. The patient will resume previous care there..."

The resident was readmitted back to the long term care facility on 04/02/16.

A physician's progress note dated 04/04/16 (no time) documented, "...anoxic encephalopathy/persistent vegetative state... chronic trach/peg/foley-total care... cognitive impairment -anoxic brain injury and unable to answer questions... weakness... unresponsive exc [except] for some non-purposeful movements... total care... care plan/treatment/therapy: Total Care...[signature of physician]."

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A nursing note dated 05/27/16 (3:32 a.m.) documented, "...extremely fidgety and screaming out. Both legs and hands are contracted...NP [nurse practitioner] notified to assess resident..."

05/27/16 (6:30 p.m.) "NP gave instructions to medicate with PRN [as needed] Tylenol as pain persist."

A physician's progress note dated 05/29/16 (no time) documented, "...60 day recert... hospitalized from 03/29 -04/02 UTI (urinary tract infection) sepsis. Stable since readmission [04/02/16] ...eyes closed and unresponsive to verbal stimuli exc [except] moves extremities a little only... total care with trach/peg/foley...[signature of physician]."

No other information and or documentation could be located throughout Resident # 23's clinical record to indicate that the resident had any prior issues with bilateral leg contractures prior to the nursing note dated 05/27/16. No information could be located to evidence the resident was assessed by the physician and/or the NP for documented concerns related to contractures on 05/27/16.

TARs (treatment administration records) and Restorative records were reviewed for the months of April and May of 2016. According to the restorative records, Resident # 23 did not receive any restorative ROM exercises for either month and no records could be located for the leg/knee brace for the either month.

On 04/13/17 at 9:30 a.m., the corporate nurse consultants were made aware of the above

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information and was asked for assistance in locating records for the use of the leg/knee brace for Resident # 23 for April and May (2016). The corporate nurse stated that if you don't have them in the copies that were presented to you, then they are not there and further stated that it (the leg/knee brace) starts back up in June (2016). The corporate nurse was asked if the resident went without the leg/knee brace for over 2 months. No further information or response was provided at this time.

The resident's CCP (comprehensive care plan) from readmission (January 2016) to discharge (November 2016) was then reviewed and documented that the resident had, limited physical mobility and for staff to provide gentle range of motion as tolerated with daily care (this was created on 12/16/15). The CCP also documented for, nursing rehab/restorative care to provide passive ROM with passive ROM to all extremities to include 5 sets of 10 repetitions, 6-7 times per week (this was created on 01/19/16).

Resident # 23's restorative nursing records were reviewed from January 2016 through November 2016.

The restorative records included the following: "Nursing rehab/restorative Passive ROM to all extremities 5 sets of 10 reps 6-7 times per week..." The restorative records had slots for day, evening and night shifts to initial as completed; none were marked from January 2016 through July 2016, all were blank.

According to the restorative records, the resident did not receive any ROM exercises from January 2016 through July 2016. The resident began

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receiving restorative passive ROM on August 15, 2016 according to the documentation.

Further review of Resident # 23's clinical record revealed Resident # 23 was seen again by PT therapy on 06/03/16.

The PT evaluation and plan of treatment (dated 06/03/16) documented, "...Short-term Goals will achieve and maintain good anatomical alignment while in bed using a side wedge and inclined wedge place between feet/ankles... will achieve anatomical alignment of the right ankle, right knee and right hip... using a knee extension splint in order to reduce tone/promote mobility and in order to prevent contractures... will safety wear a knee extension splint on left foot, left hip, left knee and left ankle... in order to reduce tone/promote mobility and in order to prevent contractures... Long-term Goals Patient will be positioned in bed using cushion placed between fee/ankles... maintain joint integrity and prevent contractures..."

As documented above, the resident went from wearing one leg/knee brace in March which was for the left knee, to now requiring two braces, one on each leg.

The PT eval and treat (dated 06/03/16) also documented the reason for the referral as, "Pt referred to PT secondary to decreased ROM in BLE [bilateral lower extremities], BLE muscle stiffness and contractures in all joints... increase LE [lower extremity] ROM and prevent and decrease joint contracture..."

A PT therapy progress note dated 06/15/16 documented, "...Pt and caregiver training:

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instructed... primary caregivers in splinting/orthodic schedule in order to prevent decline from current level of skill performance with variable carryover demonstrated by caregivers... Patient is compliant with POT [plan of treatment] and patient's condition is improving as a result of skilled therapy services... Patient demonstrates good rehab potential as evidenced by strong family support and supportive staff..."

A physician's progress note dated 06/20/16 documented, "...no subsequent visits since last recertification [05/29/16]... vegetative state... lower and upper extremity contractures noted. Spastic movement noted... continue current treatment plan... continues to require skilled nursing and rehab services...[signature of NP]."

The resident's PT discharge summary dated 06/24/16 documented, "...Contracture management... instructed... primary caregivers in splinting/orthodic schedule in order to preserve current level of function... patient tolerated PROM and gentle passive stretching of bilateral hamstrings, ankle PF/DF [plantar flexion/dorsal flexion] and hip aB/aD [abduction/adduction] well... Recommend con't [continued] use and application of bilateral dynamic knee braces to prevent or reduce significant BLE contractures... RNP [restorative nursing program]... facilitate patient maintaining current level of performance and in order to prevent decline, development of and instruction in the following RNP had been completed with the IDT [interdisciplinary team]: ROM (Passive) and splint brace care..."

Resident # 23's physician's orders were reviewed and evidenced three separate orders for the leg braces.

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Order # 1- dated 06/23/16 documented, "Bilateral leg braces every evening shift for prevention remove leg braces at bedtime." This was documented on the TAR as evening and it was initialed from 06/23/16 through 06/29/16, there was not area to document the removal at bedtime.

Order # 2-dated 06/24/16 documented, "Bilateral leg braces one time a day for prevention apply bilateral leg braces on in AM and off in PM." This was documented on the TAR as 8:30 a.m. and was initialed from 06/24/16 through 06/29/16, there was no place on the TAR to document the removal of the braces in the PM.

Order # 3- dated 06/30/16 documented, "Bilateral leg braces every shift for prevention Bilateral leg braces on at all times." This was documented on the TAR as day/evening/night (every shift) and it was initialed for every shift from 06/30/16 through 08/14/16.

According to the clinical records, Resident # 23 did not have the leg braces from 04/02/16 (readmission) through 06/23/16, there was not documentation that the resident had the leg braces for April and May. The leg braces were started again on June 23, 2016. The clinical record did not evidence that consistent restorative nursing services were provided until 08/15/16, after being recommended by therapy on two separate occasions. Clinical records revealed and demonstrated the formation of contractures for Resident 23 between 04/02/16 and 05/27/16 (identified by nurse) and was not seen by therapy again until 06/23/16.

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A nursing note dated 07/24/16 (timed 10:27 a.m.) documented, "...prepare to put patients braces on... opened eyes and started grimacing.. giving Tylenol for pain and will go back and apply braces to extremities..."

A nursing note dated 07/24/16 (timed 1:59 p.m.) documented, "...patient was very contracted... massaged legs and got them straightened out a lot..."

A physician's progress note dated 07/28/16 documented, "...seen due to staff request muscle relaxer to help with rigidity... lower and upper contractures noted... Contractures/spasticity: Will start Baclofen 5 mg [milligrams] TID [three times daily], can increase every 3 days, Max 80mg/day... [signature of NP]."

A nursing note dated 08/15/16 (timed 11:26 p.m.) documented, "...resident's braces to bilateral legs have been discontinued..."

According to the clinical record documentation (TARs), the leg braces were not applied from 08/14/16 to 10/24/16 due to the wound. Restorative nursing was started on 08/15/16.

A nursing note dated 10/01/16 (timed 2:47 p.m.) documented, "...patient has been tightening up muscles and moaning when going to apply braces to hands and legs are getting harder to move pillows between legs and heels..."

A nursing note date 10/24/16 (timed 7:49 p.m.) documented, "Knee braces on at all times except when taking a shower. every shift for prevention removed [sic]."

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A nursing note dated 10/28/16 (timed 2:41 p.m.) documented, "...new order for Ortho consult on 11/03/16 at 12:30 p.m...."

An Ortho consult dated 11/03/16 documented, "...patient presents for evaluation of bilateral arm and bilateral leg pain... the patient has experienced bilateral upper and lower extremities contractures... has utilized braces of her lower extremities, which seemed to cause wounds on both heels. Her legs are fixed in a crossed position. She has increased pain when trying to move her... discussed patient's issue with... nurse... explained that any surgical intervention is a large undertaking... do not recommend this... bilateral lower extremity: fixed flexion contracture, no passive ROM... [signature of physician]."

The Lippincott Manual of Nursing Practice 10th edition states on pages 172 and 173 concerning complications of immobility, "The goal of frequent position changes is to prevent contractures, stimulate circulation and prevent pressure sores, prevent thrombophlebitis and pulmonary embolism, promote lung expansion and prevent pneumonia, and decrease edema of the extremities ... The recommendation is to change body position at least every 2 hours, and preferably, more frequently in patients who have no spontaneous movement ... The goals of therapeutic exercise are to develop and retrain deficient muscles, to restore as much normal movement as possible to prevent deformity, to stimulate the functions of various organs and body systems, to build strength and endurance, and to promote relaxation ...Perform passive range-of-motion (ROM) exercise ... Carried out without assistance from the patient ... The

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purpose is to retain as much joint ROM as possible and to maintain circulation... Move the joint smoothly through its full ROM ... Do not push beyond the point of pain ..." (1)

The facility staff were informed of the above information regarding Resident # 23 in a meeting with the survey team on 04/13/17 at approximately 9:00 a.m. The facility staff were made aware that the resident's CCP included interventions from therapy for restorative nursing ROM exercises and there was no evidence that the exercises were being completed regularly until August of 2016, after the fact the resident had already acquired bilateral leg contractures. The facility staff were also made aware that according to the clinical record, the resident did not have any type of therapy and/or restorative nursing services from 04/02/16 through 06/23/16, when a nursing note had identified that the resident had contractures on 05/27/16. Assistance was requested from facility staff for any information and/or documentation to evidence that the resident had received appropriate care/services and interventions from facility staff for the prevention of contractures.

At approximately 11:00 a.m., in a meeting with the survey team, the facility staff were again informed of serious concerns regarding Resident # 23 and the potential for harm for the resident who had suffered a significant decline in ROM. The facility staff stated that they were aware of the concerns and stated that they (staff) did do exercises with the resident, but failed to document it. The facility staff was asked to present any information and/or documentation to evidence Resident #23 was receiving the care and services to prevent contractures.

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F 318	Continued From page 66 No further information and/or documentation was presented prior to the exit conference on 04/13/16 at 12:30 p.m., to evidence that Resident # 23 was receiving adequate interventions for the preventions of contractures. (1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.	F 318		
F 323 SS=D	This is a complaint deficiency. 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F 323		5/22/17

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F 323	Continued From page 67 (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on, observation, staff interview and clinical record review, the facility staff failed to implement safety interventions to prevent injury for one of 24 residents, Resident #4 and failed to ensure a wheelchair was in safe operating condition for one of 24 residents, Resident #21. 1. Resident #4 did not have hipsters in place as indicated on the care plan. 2. Resident #21's wheelchair brake handle was in ill repair. Findings include: 1. Resident #4 was admitted 4/25/16 with a readmission on 6/25/16 with diagnoses including dysphasia, depression, and anxiety. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/15/17. Resident #4 was assessed as being moderately impaired cognitively. Resident #4's medical record was reviewed on 4/4/17 and evidenced, via care plan under a goal to prevent injury, an intervention documented to place "Hipsters" (padding for hips to prevent injury) daily. This intervention was also documented on the certified nursing assistants (CNA's) kardex. On 4/12/17 at 9:00 a.m. Resident #4 was	F 323	1. Hipsters were retrieved from laundry department and were placed on resident #4 while surveyors were onsite. Resident #21□s wheelchair brake handle was repaired while surveyors were onsite. 2. Director of nursing or designee will conduct an audit to ensure all residents with hipsters noted on the careplan as an intervention are wearing them. Maintenance director or designee will conduct an audit to ensure all residents wheelchairs are in safe, operational condition. 3. Staff development coordinator or designee will educate nursing staff on ensuring hipsters are in place for residents who have them as an intervention. Staff development coordinator or designee will educate all nursing and maintenance staff on proper cleaning of wheelchairs and assessing if they are in safe, operational order. 4. Unit manager or designee will monitor to ensure all resident□s with hipsters as an intervention have them on. This will be completed 5 times a week for 12 weeks. Maintenance director or designee will monitor residents□ wheelchairs on a weekly basis for 12 weeks to ensure they are in safe, operational order. Discrepancies will be brought to the QA committee and addressed as needed.	

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observed sitting up in bed without hipsters in place. Resident #4 was again observed at 10:15 a.m. sitting in wheelchair and at 2:15 p.m. laying in bed without hipsters in place.

On 4/12/17 at 2:30 p.m. certified nursing assistant (CNA #7) was interviewed concerning Resident #4's hipsters. CNA #7 verbalized that Resident #4 was part of her (CNA #7) work load and had only worked with Resident #4 a couple of times. CNA #7 verbalized that she was unaware that hipsters were supposed to be in place for Resident #4.

At this time CNA #7 and this surveyor went to Resident #4's room and observed Resident #4 without hipsters in place. Resident #4's closet and draws were also looked through and was unable to produce the missing hipsters.

On 4/12/17 at 3:25 p.m. the evening shift had begun and CNA #2 was interviewed concerning Resident #4's hipsters. CNA #2 verbalized that he was not aware Resident #4 needed hipsters until it was reported to him (CNA #2) at shift change. CNA #2 also verbalized that the charge nurse was trying to locate a pair of hipsters for Resident #4.

On 4/13/17 at 11:00 a.m. the above finding was brought to the attention of the director of nursing and administrator.

No further information was presented prior to exit conference on 4/13/17.

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2. The facility staff failed to ensure Resident # 21's wheelchair was in good repair for safe operation.

Resident # 21 was admitted to the facility 1/7/13 with diagnoses to include, but not limited to: history of stroke with residual right sided weakness, diabetes, high blood pressure, GERD, and mild cognitive impairment.

The most recent MDS (minimum data set) was an annual review dated 2/1/17. Resident # 21 was coded as having moderate cognitive impairment with a total summary score of 09 out of 15.

On 4/12/17 at 2:30 p.m. Resident # 21 was sitting in her room in a wheelchair. This surveyor knocked and was given verbal consent to enter the room. It was observed immediately that the brake on the left side of the wheelchair did not have a cap on the end of the handle, exposing the bare metal edge which was uneven and slightly rough and sharp. The right brake had a bright yellow rubber cap on the end. (It should be noted here the resident used the left side due to the weakness on the right side from the stroke). Upon closer inspection, the brake was extremely loose as well. Resident # 21 was asked how long her wheelchair had been in that condition, and she stated "For quite some time."

On 4/12/17 at 2:35 p.m. this surveyor went to the nurses' station and asked for the charge nurse. LPN (licensed practical nurse) # 3 came out of her office and stated she was the unit manager. This surveyor asked if she was familiar with Resident # 21, and she stated she was. This

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surveyor then asked LPN # 3 to accompany me to the resident's room to observe the wheelchair. Upon knocking and with permission, entering the resident's room, LPN # 3 looked around the room and asked the resident how she was doing. This surveyor pointed out the missing cap on the end of the brake, and demonstrated the looseness of it as well. LPN # 3 stated she did know the wheelchair was in disrepair, and that she would contact maintenance. LPN # 3 was then asked who should notice if items such as a wheelchair was in need of repair. LPN # 3 stated "Well, the CNA's (certified nursing assistants) should notice it since they are with the residents more and see more; they should tell me or another charge nurse and we would put in a work order for the maintenance department to fix it. If maintenance can repair it, then they will; otherwise they would get therapy involved. I'll get (name of maintenance person) to come and look at it right now and we'll get that fixed. I'm sure maintenance can tighten the brake, but therapy may have to get a new cap for it."

On 4/13/13 at 7:50 a.m. this surveyor returned to Resident # 21's room. Resident # 21 was in bed with her eyes closed, and the wheelchair was sitting against the wall at the bottom of the bed. It was observed the wheelchair was without a cap on the metal edge. This surveyor then went to the nurses' station and LPN # 3 was in her office. This surveyor then asked LPN # 3 about the wheelchair. LPN # 3 stated "Oh, (name of maintenance person) came and got it yesterday evening to fix it; he gave (name of Resident # 21) a wheelchair to use while he fixed hers." This surveyor then informed LPN # 3 of the observation of the same wheelchair sitting in the resident's room. LPN # 3 and this surveyor then

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went to the resident's room, and LPN # 3 stated "I have no idea how this got back in her room; it was taken to be fixed yesterday. Let me page maintenance and see what happened." LPN # 3 then took the wheelchair from the resident's room, and instructed a CNA to go and get a wheelchair for the resident to use. LPN # 3 then parked the defective wheelchair in the nurses' station. LPN # 3 and this surveyor could see the maintenance person at the end of the hall. This surveyor told LPN # 3 that I would go and talk to maintenance and inquire as to what happened. LPN # 3 was writing on a piece of paper and replied "OK, I'll go with you." LPN # 3 and this surveyor then went down the hall where the maintenance person was conversing with another surveyor. LPN # 3 handed the maintenance person the folded piece of paper and left. The maintenance person, along with the new maintenance director was then asked about the Resident # 21's wheelchair, and what had happened about the repair. The maintenance person and new maintenance director looked at each other, and indicated they had no knowledge of what I was talking about. I then informed them of the observation on 4/12/17, and at that time the maintenance person unfolded the paper handed him by LPN # 3 and stated "Well, I know now..... she (LPN # 3) just handed me a note about that."

On 4/13/17 at 8:00 a.m. this surveyor and the maintenance person along with the director walked down the hall to the hall toward the resident's room, and this surveyor informed them the defective wheelchair was now at the nurses' station. The maintenance person then inspected the brake, noting the looseness and stated "I can probably tighten that up and get a new cap. I'll come and get you when I'm done."

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F 323	Continued From page 72 On 4/13/17 at 8:05 a.m. as this surveyor was returning to the conference room, the therapy director was walking from the front lobby. This surveyor stopped him and asked if we could discuss an issue if he had time. He stated he did, and he was asked about the wheelchair for Resident # 21. The therapy director stated "(name of LPN # 3) mentioned it yesterday and I said I probably had a rubber cap to put on the end of it but (name of maintenance person) could tighten the brake." On 4/13/17 at approximately 9:15 a.m. the maintenance person came to the conference room and requested this surveyor to come and see the wheelchair. The wheelchair had been repaired and now had a black cap on the exposed end of the left brake, but was still slightly loose. The maintenance person stated "I can probably tighten the brake up a little more...it is still kinda loose." On 4/13/17 at 9:30 a.m. the maintenance person returned to the conference room and showed this surveyor the final repairs. The wheelchair now had matching black caps, and the brake was no longer loose and functioned properly. On 4/13/17 beginning at 9:45 a.m. during a meeting with facility staff, the administrator and DON (director of nursing) were informed of the above observations and findings. No further information was provided prior to the exit conference.	F 323		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		5/22/17

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F 329	Continued From page 73 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 329		

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F 329	Continued From page 74 This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record reviews, and facility document reviews, the facility staff failed to ensure one of 24 Residents were free from unnecessary medications. Resident #22 was prescribed and administered the medication Seroquel four times without a clinical justification. The findings include: Resident #22 was admitted to the facility on 12/24/16 with diagnoses including, but not limited to enterocolitis secondary to clostridium difficile, muscle weakness, chronic kidney disease stage III, osteoarthritis, and gout. The admission minimum data set (MDS) with an assessment reference date (ARD) of 12/31/16 documented the resident with a brief interview for mental status (BIMS) score of 15 out of 15, meaning the resident was cognitively intact. The closed clinical record was reviewed on 4/12/17. Resident #22 was discharge from the facility on 2/1/17. A hospital discharge note dated 12/24/16 documented under the heading of "MEDICATION CHANGES 3. Seroquel 12.5 mg (milligrams) every six hours as needed for agitation. Of note she has been very cooperative here in the hospital and has not needed this but wanted to have an option just in case she became agitated. She does reportedly have episodes of sundowning according to the family." Seroquel is defined in Nursing 2012 drug handbook. (2012). Columbia: Lippincott.page	F 329	1. Resident #22 is no longer a resident in the facility. 2. Director of nursing or designee will conduct an audit to ensure all current residents receiving Seroquel have an appropriate clinical justification. 3. Staff development coordinator or designee will educate licensed staff on ensuring appropriate clinical justification of use of Seroquel. 4. Director of nursing or designee will monitor all orders for Seroquel to ensure that there is appropriate clinical justification. This will be completed weekly for 12 weeks. Discrepancies will be brought to the QA committee and addressed as needed.	

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1151 as an antipsychotic used to treat Schizophrenia, acute manic episodes associated with bipolar I disorder, depression associated with bipolar disorder, major depressive disorder, and obsessive-compulsive disorder. This medication has a black box warning - "Drug isn't indicated for use in elderly patients with dementia-related psychosis because of increased risk of death from CV (cardiovascular) disease or infection." An adverse effect of tardive dyskinesia (TD) is possible in approximately 5 - 10% of patients. TD can cause involuntary movements and has the potential of being irreversible.

The admission sheet, which is from the hospital that the facility uses for their admitting orders, documented under "As Needed Medications Quetiapine (generic name for Seroquel) 25 mg tablet (with the instructions) 0.5 tablet (half of a tablet) Oral (by mouth) every 6 hours as needed."

The January 2017 medication admission record (MAR) documented "Quetiapine Fumarate (full generic name for Seroquel) Tablet 25 mg Give 0.5 tablet by mouth every six hours as needed for agitation with a start date of 12/24/16 and D/C (discontinue date) of 2/1/17." The dates of 1/1/17, 1/6/17, 1/14/17, and 1/21/17 showed the nurse's initials, meaning the medication was given on those dates.

The nurse's notes documented "1/1/17 11:18 (am) - Type: Orders - Administration Note...agitated, convinced someone broke into room/house, unable to redirect." "1/1/17 14:38 (2:38 p.m.) - Type - Skilled Note... Became agitated during visit with family, insisted someone broke into her house last night, 1:1 (one person to one person) conversation ineffective, prn

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Seroquel admin. (administered) with some effectiveness."

"1/6/17 19:25 (7:25 p.m.) - Type: Skilled Note - Resident alert with confusion...Pt. becomes increasingly agitated/confused in the evening, redirected several times." "1/6/17 20:00 (8:00 p.m.) - Type: Orders - Administration Note - agitate/restless, pacing."

"1/14/17 20:43 (8:43 p.m.) - Type: Orders - Administration Note...Patient is agitated PRN (as needed) administered per MD order." "1/14/17 23:02 (11:02 p.m.) - Type: Skilled Note - patient observed walking in room and talking to roommate. Patient also observed walking in the hallway. Continues to work with therapy. Tolerated medications without difficulty..."

"1/21/17 16:28 (4:28 p.m.) - Type: Orders - Administration Note...very agitated, one on one ineffective."

The 14 day MDS, with an ARD of 1/6/17, and the 30 day MDS, with an ARD of 1/20/17 documented that the resident had a BIMS score of 15, meaning she was cognitive. All three MDS' showed that the resident had displayed no delirium and no behaviors during the seven day look back periods from the ARD.

A pharmacy review dated 12/27/16 documented "Req. (request to) D/C PRN Seroquel." A second pharmacy review dated 1/24/17 documented an arrow from the 12/27/17 documentation request to D/C PRN Seroquel to the word "Repeat" from the pharmacist. This surveyor was unable to locate any pharmacist consultation report requests.

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A discharge note dated 1/31/17 documented under "Assessment and Plan:...13. Agitation: Seroquel 12.5 mg Q6prn (every six hours as needed) utilized at intervals, will discharge with 30 doses/15 tabs (tablets). Continue current treatment plan and follow up with PCP (primary care physician)." This discharge (education, assessment, and plan) was signed by the resident's attending physician's nurse practitioner.

A 12/29/16 physician's subsequent note, and a 30 day recertification note dated 1/23/17 both showed no documentation of any behaviors displayed by the resident. The ROS (Review of Symptoms) documented "...Pt (patient) answers questions appropriately..." Both of these were signed by the same nurse practitioner from the discharge note.

On 4/12/17 at 4:00 p.m., this surveyor asked for the pharmacist's consultation report which includes recommendations.

On 4/12/17 at 4:45 p.m., this surveyor was provided with the pharmacist's recommendation to discontinue the prn Seroquel, dated 1/24/17. The recommendation was accepted and signed by the physician on 1/31/17, and then signed by the director of nurses on 2/3/17. This surveyor asked if there was one for the 12/27/16 pharmacy review. The corporate nurse consultant stated the facility would look to see if there was one.

On 4/13/17 at 8:05 a.m., licensed practical nurse (LPN) #8 was asked about the process when a resident is admitted with an order for prn antipsychotics, like Seroquel. LPN #8 stated that the psychiatrist will follow up with the resident.

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When asked how the psychiatrist is made aware of what residents to see, LPN #8 stated that any time a resident needs to be seen by the psychiatrist, their name is put into his book. This surveyor asked LPN #8 to look at the book to see if the resident's name was in the book to see the psychiatrist. LPN #8 looked and stated that Resident #22's name was not in the book for the psychiatrist. This surveyor asked LPN #8 if agitation was a clinical justification for the use of Seroquel. LPN #8 stated that it was not a reason to give Seroquel.

On 4/13/17 at 8:30 a.m., the director of nurses (DON) was asked about the process for pharmacy recommendations. The DON stated that the pharmacy recommendations are emailed from the pharmacist after the review, they are given to the doctor to review, then are given to the director of nurses to sign off then they are given to medical records and are scanned into the computer. This surveyor showed the DON the findings regarding Resident #22 being ordered and administered Seroquel for agitation. This surveyor asked the DON if this was a clinical justification for the use of Seroquel, to which the DON replied that it was not. The DON then stated that she expected the staff to use non pharmacological interventions before using an antipsychotic like Seroquel.

On 4/13/17 at 8:55 p.m., one of the clinical nurse consultants brought this surveyor, the copy of the 12/27/16 pharmacy recommendations, regarding the request to discontinue the as needed medication, Seroquel. The clinical nurse consultant stated the facility was unable to locate where the prior DON had placed her copies so the facility got this copy from the pharmacist. The

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clinical nurse consultant stated they do not have documentation of what the physician's response was. When asked if agitation is a clinical justification for the use of an antipsychotic, to which the clinical nurse consultant replied that it was not. This surveyor asked for the facility's policy for the use of antipsychotics.

On 4/13/17 at 9:43 a.m., the administrative team was made aware of the findings during a meeting with the survey team. This surveyor was provided with the facility's titled Chemical Restraints (as it covers Psychoactive Agents.) The other (second) clinical nurse consultant was asked if agitation was a clinical justification for the use of the antipsychotic medication, Seroquel, to which she replied that it was not. This surveyor was reviewing the facility's policy that was received earlier. The policy titled "Chemical Restraints" documented under Section "Policy:...'Psychoactive Medications'." stated that those medications "are any drug that is used to alter thought, mood, or mental capacity. The psychoactive agents are currently identified as: antipsychotic, anxiolytics, and sedatives." Under the section of "Procedure: 1. Upon initiation of psychoactive drug therapy, the physician will provide an appropriate diagnosis for the use of the drug... Antipsychotic drugs should not be used unless the clinical record contains documentation that the patient has one or more of the following specific conditions", none of which included agitation. Under section, "Procedure... 3. Non-drug interventions for the targeted behavior should have been attempted and documented onto the clinical record as ineffective. 4. Patients receiving ANY psychoactive medications regardless of the reason for use will be monitored for the

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F 329	Continued From page 80 occurrence of specific behavioral symptoms and adverse side effects by a licensed nurse, using the Behavior/Intervention Monitoring form." This surveyor did not see this form in either the paper, or electronic clinical record, so this surveyor asked to see this form for Resident #22. On 4/13/17 at 11:50 a.m., this surveyor was made aware that no Behavior/Intervention Monitoring form was located for Resident #22, and that this was never done. No other information was provided to this surveyor prior to the exit conference on 4/13/17.	F 329		
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on medication pass and pour observation, staff interview, clinical record review and facility document review the facility staff failed to ensure a medication error rate of less than five percent. Resident #16 did not receive two medications (Eliquis and Metamucil) during a morning medication pass observation on 04/12/2017 for Resident #15. There were 37 total opportunities with two medication errors (missed opportunities) resulting in a medication error rate of 5.40 percent. Findings were:	F 332	1. Resident #16□s medication orders for Metamucil and eliquis were placed on hold for the morning dose on 4/12/2017 per NP order and restarted on the evening dose after the medications arrived from pharmacy. 2. Director of nursing or designee will conduct an audit of all current residents receiving Metamucil and eliquis to ensure they have stock on the medication cart. 3. Staff development coordinator or designee will educate licensed staff on how to properly order medication refills from the pharmacy when stock becomes	5/22/17

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F 332	Continued From page 81 A medication pass and pour observation was conducted on 04/12/2017, beginning at approximately 8:10 a.m. with LPN (licensed practical nurse) #4. LPN #4 was observed preparing medications for Resident #15. Resident #15 was most recently readmitted to the facility on 08/22/2016. His diagnoses included but were not limited to: Morbid obesity, Colon Cancer, Type II DM (diabetes mellitus) heart disease, hypertension, atrial fibrillation, anxiety and gout. The most recent MDS was a quarterly assessment with an ARD (assessment reference date) of 03/15/2017. Resident #15 was assessed as having a cognitive summary score of "15", indicating he was cognitively intact. Resident #15 was ordered a total of 14 medications for the morning medication pass on 04/12/2017. LPN #4 prepared the medications and stated, "The Eliquis [anticoagulant] isn't here... I had some yesterday I can't find the card." She continued pulling medications and stated, "The Metamucil Packets aren't here either." LPN #4 was asked how often Resident #4 received those medications. She stated, "He gets them both twice a day...I am going to give the medications I have and then I'll see if the Eliquis is in the stock box, and the Metamucil." After LPN #4 gave the medications, she was asked how medications were ordered from the pharmacy. She stated, "We can do it right from the computer." The DON (Director of Nursing)	F 332	available for 7 days or less. 4. Unit manager or designee will monitor to ensure any resident□s receiving eliquis and Metamucil have at least 7 days worth of medication in the cart and ensure reorder has occurred at that point. This will be completed weekly for 12 weeks. Discrepancies will be brought to the QA committee and addressed as needed.	

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came up the hallway and stopped at the medication cart. LPN #4 told her about the medications that were not available for administration. The DON assisted the LPN to see if the medications had been ordered. Per the computer the Metamucil had been ordered from the pharmacy but had not been delivered, the Eliquis had not been ordered from the pharmacy. The DON was asked what the expectation was for ordering medications. She stated, "Once we are down to seven days they should be reordered." The DON was asked who reordered the medications from the pharmacy. She stated, "The nurses, it can be done right from the computer."

A policy regarding reordering medications was requested and received. The policy, "Reordering, Changing, and Discontinuing Orders", did not address when medications should be reordered to ensure that medications were always available for administration.

At approximately 10:30 a.m., LPN #4 spoke with this surveyor and stated, "Both of those medications are now ordered... they should be here today... I contacted the nurse practitioner and she said to just hold the morning dose of those two medicines and resume them this evening."

The DON and the administrator were notified of the medication error rate of 5.40% during a meeting on 04/12/2017 at approximately 11:45 a.m.

No further information was obtained prior to the exit conference on 04/13/2017.

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F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure staff members were knowledgeable of fire emergency procedures for 4 out of eight staff members interviewed. Contracted agency nurses did not know their role during a fire emergency and had not been trained on the facility's emergency procedures prior to working in the facility. The findings include: On 4/11/17 at 3:55 p.m. licensed practical nurse (LPN) #6 was interviewed about his role during fire drills and fire emergency protocols for the facility. LPN #6 stated he had never participated in a fire drill in the facility and did not know the specific protocol. When asked what actions needed to be taken if the fire alarm sounded, LPN #6 stated he did not know the protocol. When asked how he would know the location of a fire if the alarm sounded, LPN #6 stated he was not sure. When asked how long he had worked at the facility, LPN #6 stated he was a contracted "agency" nurse and had worked in the facility 4 to 5 times. LPN #6 stated he had not received any training on the facility's emergency procedures prior to working in the facility. Three other contracted "agency" nurses were	F 518	1. LPN #6, LPN #4, LPN #2, and RN #1 were educated on emergency preparedness while surveyors were onsite. 2. Staff development coordinator or designee will conduct an audit of all staff to ensure familiarity with emergency preparedness protocols. 3. Staff development coordinator or designee will educate all staff on emergency preparedness protocols. 4. All new staff will be educated on emergency preparedness protocols during the orientation process and will verbalize familiarity. This will be completed every other week with the current orientation schedule. Discrepancies will be brought to the QA committee and addressed as needed.	5/22/17

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interviewed and stated they were not familiar with the facility's emergency procedures and had received no prior training about protocols. These interviews included the following.

On 4/12/17 at 8:30 a.m. LPN #4 was interviewed and stated she was not familiar with the emergency protocols and had received no prior training on the facility's emergency procedures until last evening (4/11/17). On 4/12/17 at 8:45 a.m. LPN #2 was interviewed about emergency protocols. LPN #2 stated she was an "agency" nurse and had received no training on emergency procedures. LPN #2 stated she was given a "cheat sheet" this morning (4/12/17) about emergency codes but had no prior training or review of the facility's emergency protocols including fire safety. RN #1 was interviewed on 4/12/17 at 8:50 a.m. about emergency procedures. RN #1 stated she did not know the emergency procedures and had no prior training. When asked about actions to take for a fire emergency RN #1 stated she would ask another nurse or talk to the aides.

Four other facility hired employees were interviewed and found to be familiar with the fire and emergency procedures.

On 4/12/17 at 7:45 a.m. the assistant maintenance director was interviewed about employee training regarding fire and emergency protocols. The assistant maintenance director stated he reviewed procedures with new hires during their orientation and he re-educated as need based upon results of practice drills. The assistant maintenance director stated he provided no emergency procedure training for contracted "agency" staff. The assistant maintenance

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director stated fire drills were conducted once per month on rotating shifts. The assistant maintenance director stated nurses were responsible for announcing the fire location on the intercom system, calling 911 and directing aides and staff to clear hallways, secure and account for residents during an emergency and contacting administration in addition to taking fire extinguishers to the fire location.

On 4/12/17 at 8:30 a.m. the staff development coordinator was interviewed about the agency nurses' lack of knowledge regarding fire/emergency procedures. The staff development coordinator stated after LPN #6 was interviewed by the surveyor on 4/11/17 she started training with all the agency staff concerning the facility's emergency procedures. The staff development coordinator stated prior to yesterday (4/11/17) there was no documented training on emergency preparedness for contracted agency staff. The staff development coordinator stated facility hired employees had emergency training during formal orientation and annual training. The staff development coordinator stated the facility started using agency nurses approximately two to three week ago and there had been no prior training on emergency protocols until after LPN #6 was interviewed on the evening of 4/11/17.

On 4/12/17 at 8:50 a.m. the administrator was interviewed about any facility policy or procedures for training contracted "agency" staff members regarding emergencies. The administrator stated he called corporate yesterday (4/11/17) and there were no procedures or policies in place regarding training of agency staff.

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F 518	Continued From page 86 The facility policy titled Safety in the Environment of Care (undated) documented the following topics were reviewed during training regarding fire emergencies: smoking policy and designated smoking areas; code word use by facility to indicate a fire (code Red); fire suppression systems and how they are activated; evacuation plan; fire extinguisher operation using PASS (pull, aim, squeeze, sweep); RACE (rescue, alarm, confine, extinguish); frequency and nature of fire drills. An undated education sheet documented instructions during a fire emergency included, "You immediately rescue patients, visitors & disabled staff - Fire doors will close when alarm sounds, All carts have to be off the floor. Do not attempt to fight a fire before activating the fire alarm pull station & calling the fire department..." These findings were reviewed with the administrator, director of nursing and nursing consultants during a review on 4/12/17 at 11:30 a.m.	F 518		