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PINEY FOREST HEALTH AND REHABILITATION CENTER	450 PINEY FOREST RD DANVILLE, VA 24540

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey Inspection was conducted 10/3/17 through 10/5/17. Three complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was107 at the time of the survey. The survey sample consisted of 19 current Resident reviews (Resident #1 through Resident #19) and 5 closed record reviews (Resident #20 through Resident #24).	F 000		
F 253 SS=D	HOUSEKEEPING & MAINTENANCE SERVICES CFR(s): 483.10(i)(2) (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and in the course of a complaint investigation, facility staff failed to provide effective housekeeping services to maintain a clean bathroom for 2 of 24 residents in the survey sample (Residents #1 and 15) and four rooms were in need of housekeeping services. 1. For Resident #1, facility staff failed to maintain the toilet room clean and in good repair. Resident #1 was admitted to the facility on 9/27/16 with diagnoses including failure to thrive,depression, dementia, cardiopulmonary disease, gastroesophageal disease, and	F 253	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	11/19/17

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

Electronically Signed | 10/31/2017

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F 253	Continued From page 1 dysphagia. On the quarterly Minimum Data Set assessment with assessment reference date 9/12/17, the resident scored 11/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting others. The surveyor interviewed Resident #1 on 10/3/17 while investigating a complaint that the bathroom was filthy. The resident reported that it was occasionally dirty. The surveyor observed that the resident's bathroom smelled strongly of urine and there was a layer of dried dirt and debris along the wall and door jamb of the bathroom. The surveyor rolled a strip of debris out the bathroom door with the toe of her shoe. The surveyor also observed that several floor tiles were cracked. The surveyor toured resident rooms on 10/5/17 in the company of the heads of the maintenance and housekeeping departments. The surveyor pointed to the cracked tiles and what appeared to be streaked dirt along the baseboards and the toilet bowl. The maintenance director stated that tiles were being replaced as necessary and that several in the room had already been replaced. The surveyor reported the concern to the administrator and director of nursing during a summary meeting on 10/5/17. 2. For Resident #15, facility staff failed to maintain the toilet room clean and in good repair. Resident #15 was admitted to the facility on 7/20/11 with diagnoses including hypertension, human immunodeficiency virus, dysphagia,	F 253	1. Resident #1 and 15 toilet rooms were cleaned at the time of the survey 2. An audit was done of all current rooms to assess for dirt, odors and broken tiles by the Maintenance and Housekeeping Director by November 15, 2017 3. Education was provided by the Housekeeping Director to the housekeeping staff on cleaning of the toilet rooms and reporting broken tile by 11/15/17 4. Maintenance and Housekeeping Directors will detail clean and repair 4 toilet rooms per week for the next 90 days 5. Any non-compliance will be reported to the QA committee for tracking and trending and progressive disciplinary action as needed	

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dementia, depression, end stage renal disease with hemodialysis, and type two diabetes mellitus. On the annual Minimum Data Set assessment with assessment reference date 7/5/17, the resident scored 13/15 on the Brief Interview for Mental Status and was assessed as without signs of delirium, psychosis, or behaviors affecting others.

On 10/4/17, the surveyor entered the resident's room and smelled a strong odor of urine. The surveyor tracked the source of the odor to the bathroom. Several tiles appeared to be cracked and the bolts securing the toilet appeared rusted. During an interview on 10/5/17, the resident reported that the room and bathroom were frequently cleaned.

The surveyor toured resident rooms on 10/5/17 in the company of the heads of the maintenance and housekeeping departments. The surveyor pointed to the cracked tiles. The surveyor reported the concern to the administrator and director of nursing during a summary meeting on 10/5/17.

3. Room 48 had a dark, dirty-appearing streak along the lowest 1-1 1/2 inch of the baseboard. Room 50 appeared to have dirt an accumulation of dirt in one corner. Room 26 had cracked tiles, an odor of mildew, there was a 1/2 inch gap between the floor tiles and the baseboard behind the toilet, and the lower 3 feet of wall behind the toilet appeared to be bubbled as if from moisture. Room 24 had gaps between the tile and baseboard behind the toilet and in the corner opposite the door. The heads of maintenance and housekeeping were made aware of these additional concerns. The surveyor reported the

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F 253	Continued From page 3 observations to the administrator and director of nursing during a summary meeting on 10/5/17. This is a complaint deficiency.	F 253		
F 285 SS=D	PASRR REQUIREMENTS FOR MI & MR CFR(s): 483.20(e)(k)(1)-(4) (e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: (1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. (2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. (k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. (1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the	F 285		11/19/17

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F 285	Continued From page 4 State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. (2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-	F 285		

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F 285	Continued From page 5 (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. (3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. (k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) was completed for both level one and level two screenings for 1 of 24 residents;	F 285	F285 1. Resident # 7 PASRR form was completed and placed on the clinical record 2. An audit was completed by the	

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F 285	Continued From page 6 Resident (#7). Resident #7 was admitted to the facility on 3/5/13 and readmitted on 4/19/15. His diagnoses included, but were not limited to: diverticulitis, diabetes, glaucoma, thyroid disease, and depression. Resident #7's MDS (minimum data set) assessment, with an ARD (assessment reference date) of 7/18/17, was reviewed. The assessment scored the resident to be a 5 in section C for his cognitive pattern. He was coded in section g to require assistance with activities of daily living. A review of the Resident #7 clinical record failed to include a copy of the Level one or a level two screening for mental illness, mental retardation/intellectual disability, or related condition. On 10/3/17, the surveyors asked the social worker if the form had been completed. She was also asked to show the surveyor where Resident #7's form was. She said she would look for the forms for all residents in question. On 10/4/17 at 2:55pm, during a summary meeting with the facility administrator, director of nurses, and regional nurse consultant; the PASSAR forms were discussed. On 1/5/17 at 9:20 am, the regional nurse consultant was asked if the PASSAR's had been found. She stated, "We have not found that one." Prior to exit on 1/5/17 no further information was provided by the facility related to the PASSAR.	F 285	Medical Records Director to assure all PASRR forms are on the clinical record of current residents by 11/15/17 3. Education was provided to the Social Services Director and Medical Record on the policy for PASRR by Corporate Nurse Consultant by 11/15/17 4. All new admissions will be audited by the Medical Records to assure PASRR forms are present and scanned into the medical record 5. Any non- compliance will be reported to the QA committee for tracking and trending and progressive disciplinary action as needed	

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F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 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 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.	F 309		11/19/17

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F 309	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, facility staff failed to maintain the highest practicable well-being for 3 of 24 residents in the survey sample (Residents #15, 16, and 6). 1. For Resident #15, facility staff failed to monitor the resident's status after hemodialysis and per facility policy. Resident #15 was admitted to the facility on 7/20/11 with diagnoses including hypertension, human immunodeficiency virus, dysphagia, dementia, depression, end stage renal disease with hemodialysis, and type two diabetes mellitus. On the annual Minimum Data Set assessment with assessment reference date 7/5/17, the resident scored 13/15 on the Brief Interview for Mental Status and was assessed as without signs of delirium, psychosis, or behaviors affecting others. The resident had a physician order for hemodialysis 3 times a week on Monday, Wednesday, and Friday. The facility's Dialysis Communication Form Section C: Post-Dialysis (to be completed by the Health & Rehab Center) was blank the 11 forms started in the 30 days prior to the survey. There were post dialysis nursing notes for 6 of those dates. There were no post dialysis assessments for 9/8, 9/11, 9/18, 9/20, and 9/21. There was a post-dialysis nursing note for 9/15, but no Dialysis Communication form for that date. The surveyor informed the administrator and director of nursing of the concern with lack of	F 309	F 309 1. Resident # 15 and 16 Dialysis communication forms have been reviewed and scanned into the medical record Resident #6 physician was notified of accu-chek that was not obtained on 9/8/17 2. An audit was done for current residents receiving dialysis to assure that orders and dialysis communication sheets are in place and follow up assessments are completed Current residents with accu-chek orders were audited to assure that the orders are in place to show documentation of the test results 3. Education was provided by the Staff Development Coordinator on Assessments of Dialysis residents pre and post treatments using the dialysis communication form and also on complete documentation of accu chek results by 11/15/17 4. DON/Unit Manager/Designee will monitor dialysis documentation and Blood sugar monitoring at least 5 times per week times 4 weeks then 3 times per week for 2 weeks and then weekly for 2 weeks 5. Any non-compliance will be reported to the QA committee for tracking and trending and progressive disciplinary action	

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consistent post dialysis assessment during a summary meeting on 10/5/17.
2. The facility staff failed to ensure coordination of dialysis services with facility staff for Resident #16.

The clinical record of Resident #16 was reviewed 10/4/17 and 10/5/17. Resident #16 was admitted to the facility 3/27/17 with diagnoses that included but not limited to end stage renal disease, dependence on renal dialysis, dysphagia, dysarthria following cerebral infarction, hypertension, chronic atrial fibrillation, major depressive disorder, and dementia without behavioral disturbances.

Resident #16's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 9/25/17 assessed the resident with a BIMS summary score of 9 out of 15 in Section C BIMS Summary Score. Section O Special Treatments, Procedures and Programs assessed the resident was receiving dialysis while a resident of the facility.

Resident #16's current comprehensive care plan had a focus area that read "The resident needs dialysis (hemo) r/t (related to) renal failure., M-W-F (Monday, Wednesday, Friday), BLAIRS, weekly weights Created on: 03/27/17 Revision on: 09/15/2017. Interventions: Do not draw blood or take B/P (blood pressure) in RT (right) arm with graft. Monitor/document/report PRN (as needed) any s/sx (signs or symptoms) of infection to access site: redness, swelling, warmth or drainage."

The electronically signed physician orders included an order for hemodialysis three times a

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week Monday, Wednesday, Friday, 1230 Blairs. Orders also included to check AV (arteriovenous) fistula q (every) shift, bruit/thrill rt (right) arm every shift for protocol/placement.

The dialysis communication sheets used to share the flow of information between the facility and dialysis (three days a week) were reviewed from 9/1/17 through 10/4/17. These forms had a section for facility staff to fill out prior to transport to the dialysis center. This section included information on meal provided to take to dialysis, medication required before dialysis, and if there was a change in condition before going to dialysis. Also included on the form was the center nurse.

The dialysis section included pre- and post - weight for before and after dialysis, labs, if meal eaten, medications administered, vs (vital signs), occurrences during dialysis, and dialysis nurse signature and date.

The dialysis communication sheet included a section for post dialysis treatment upon Resident #16's return to the facility. Information to be completed included Vital Signs, assessment of dialysis site/AV fistula, pre and post weights, and skin assessment and receiving nurse's signature, and date.

Between 9/1/17 and 10/4/17, the surveyor observed a total of 15 communication sheets which were incomplete for either the facility information, the dialysis center information, contained a date but no information from either party or a note was not found.

The Hemodialysis Communication Records had

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the following issues:
9/4/17-There were no vital signs assessed upon return to the facility.
9/6/17 No vital signs upon return to the facility from dialysis.
9/8/17 No dialysis communication was found. No pre-dialysis assessment or dialysis section completed. No pre and post weights found.
9/11/17 No vital signs upon return from dialysis.
9/15/17 No vital signs upon return to facility from dialysis.
9/18/17 No vital signs upon return from facility from dialysis.
9/20/17 No vital signs upon return to facility from dialysis.
9/22/17 No dialysis communication note was found.
9/27/17 No dialysis communication note was found.
9/29/17 No dialysis communication note was found.
10/2/17 The dialysis communication sheet was not completed by facility staff pre-dialysis. Section B Dialysis was incomplete-the time dialysis started and completed was blank. There was no signature from the dialysis nurse or a date when completed.
10/4/17 No dialysis communication note was found.

The September 2017 electronic treatment administration records (eTAR) were reviewed. An entry to check AV Fistula q shift, bruit/thrill rt (right) arm every shift for protocol/placement had been placed on the eTAR. There was no documentation on 9/3/17 on night shift that the AV fistula had been checked.

The surveyor interviewed the unit manager

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licensed practical nurse #2 on 10/5/17 at 9:15 a.m. L.P.N. #2 stated nurses are expected to do vital signs and an assessment of their shunt and document these findings.

The surveyor requested the facility policy on dialysis from the director of nursing on 10/5/17 at 11:50 a.m.

The surveyor reviewed the facility policy titled "Hemodialysis." The policy titled "Hemodialysis" read "PROCEDURE 1. Palpate for the presence of the thrill over the shunt upon return from dialysis and daily. 2. Auscultate bruit per physician's order. 3. Leave pressure bandage in place for 24 hours or daily and PRN (as needed). 4. Monitor for signs of bleeding and signs and symptoms of infection every shift. 5. Document findings daily on the Treatment Administration Record, and document any unusual findings and notification of physician/responsible party in the Nurses Note. 6. NEVER ACCESS A SHUNT. 7. The Dialysis Communication Form will be initiated prior to sending patient for dialysis. A dialysis's center designated form may be used in place of MFA's Dialysis Communication Form."

The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above dialysis concerns in a meeting on 10/5/17 at 12:31 p.m.

No further information was provided prior to the exit conference on 10/5/17.

3. The facility staff failed to obtain a physician ordered accucheck on Resident #6.

The clinical record of Resident #6 was reviewed

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10/3/17 and 10/4/17. Resident #6 was admitted to the facility 6/12/17 and readmitted 7/10/17 with diagnoses that included but not limited to type 2 diabetes mellitus, pneumonia, dysphagia, cerebral infarction, ischemic cardiomyopathy, atrial fibrillation, gastroesophageal reflux disease, hypertension, acute coronary thrombosis, hyperlipidemia, peripheral vascular disease, acute and chronic respiratory failure, traumatic amputation at level between right hip and knee, and chronic kidney disease, stage 3.

Resident #6's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 9/6/17 assessed the resident with a BIMS (brief interview for mental status) as 5 out of 15 in Section C BIMS Summary Score.

Resident #6's current comprehensive care plan identified a focus area that read "The resident has Diabetes Mellitus Created on: 07/10/2017. Interventions: Monitor/document for side effects and effectiveness. Labs as ordered by doctor."

The 9/1/2017 through 9/30/2017 electronic physician's orders were reviewed. Resident #6 had an order that read "Accuchecks AC and HS (before meals and at bedtime) for DM (diabetes mellitus). Notify MD (medical doctor) if BS (blood sugar) < (less than) 60 or > (greater than) 400. Order date 7/10/17 Start date 7/10/17." The surveyor reviewed the September 2017 electric medication administration record. There were no recorded results for 9/8/17 at 6:30 a.m. The surveyor reviewed the blood sugar summary on the "Weights and Vitals Summary" flowsheet. There was no record blood sugar for 9/8/17 at 6:30 a.m. The surveyor reviewed the 9/8/17 progress notes. There was no recorded blood

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F 309	Continued From page 14 sugar result for 9/8/17 at 6:30 a.m. The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above issue on 10/4/17 at 3:35 p.m. and requested the facility policy on diabetic monitoring. The facility policy titled "Blood Testing" was reviewed 10/5/17. The policy read in part "4. Blood glucose checks will be documented on the eMAR (electronic medication administration record)." No further information was provided prior to the exit conference on 10/5/17.	F 309		
F 314 SS=D	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (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	F 314		11/19/17

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F 314	Continued From page 15 by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to follow infection control guidelines during wound care for 1 of 24 residents (Resident #6). The findings included: The facility staff failed to follow infection control guidelines for the cleaning of a pressure area during wound care and failed to wash hands for at least 15 seconds during wound care for Resident #6. The clinical record of Resident #6 was reviewed 10/3/17 and 10/4/17. Resident #6 was admitted to the facility 6/12/17 and readmitted 7/10/17 with diagnoses that included but not limited to type 2 diabetes mellitus, pneumonia, dysphagia, cerebral infarction, ischemic cardiomyopathy, atrial fibrillation, gastroesophageal reflux disease, hypertension, acute coronary thrombosis, hyperlipidemia, peripheral vascular disease, acute and chronic respiratory failure, traumatic amputation at level between right hip and knee, and chronic kidney disease, stage 3. Resident #6's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 9/6/17 assessed the resident with a BIMS (brief interview for mental status) as 5 out of 15 in Section C BIMS Summary Score. Resident #6's current comprehensive care plan included the focus area that read "Potential for skin impairment r/t (related to) incontinence, impaired mobility. Interventions: Atmos air 900, lotion to dry skin, bunny boot to left foot,	F 314	F314 1. The nurse that did the wound care received education on proper way to clean wounds and also on handwashing 2. Treatment orders for current residents with wounds were audited to assure cleaning step is written with the wound orders 3. Education was provided to licensed nurses on proper cleaning of wounds and proper handwashing by the staff development coordinator by 11/15/17 4. DON/Unit Manager/Designee will observe wound care and treatment pass observations at least 5 times per week times 4 weeks then 2 times per week times 2 weeks then weekly times 90 days 5. Any non-compliance will be reported to the QA committee for tracking and trending and progressive disciplinary actions as needed	

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gerisleeves."

Resident #6's physician orders included wound care to the left elbow, gluteal cleft, left buttock, and left lateral ankle.

The physician order dated 9/13//17 for wound care to the left elbow read "Clean area to left elbow with n.s. (normal saline) apply TAO (triple antibiotic ointment) and dry dressing prn (as needed)."

The physician order dated 8/25/17 for wound care to the left lateral ankle read "Skin prep left lateral ankle bid (twice a day)."

The surveyor observed wound care on 10/5/17 at 10:45 a.m. with licensed practical nurse #3. L.P.N. #3 stated the left ankle and the left elbow were the two sites that were to be dressed. L.P.N. #3 gathered the supplies for wound care at the treatment cart and carried them into Resident #6's room. L.P.N. #3 washed her hands for approximately two seconds, dried both hands and turned the faucet off with her dried bare hands. L.P.N. #3 then put gloves on both hands. L.P.N. #3 applied skin prep to the left lateral ankle of Resident #6 starting with the outer most edges and working inward. L.P.N. #3 replaced the sock that had been removed from Resident #6's left foot back on but left the soiled bunny boot off. L.P.N. #3 then removed gloves. L.P.N. #3 then washed hands for approximately 5 seconds, dried them and turned the faucet off with dried bare hands. L.P.N. #3 applied gloves and removed the soiled dressing from Resident #6's left elbow and discarded the soiled dressing. Gloves removed. L.P.N. #3 opened a bottle of normal saline and placed a gauze in the bottle. L.P.N. #3

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left the room, went to the treatment cart, removed triple antibiotic ointment from the treatment cart, put some of the ointment into a plastic cup, returned the triple antibiotic ointment to the treatment cart, and came back into the room. The surveyor did not observe L.P.N. #3 wash her hands or do hand hygiene after removing the soiled dressing. The surveyor did not observe L.P.N. #3 perform hand hygiene before opening the bottle of normal saline and placing the gauze in the bottle or when L.P.N. #3 left the room, obtained triple antibiotic ointment from the treatment cart, returned the triple antibiotic ointment to the treatment cart and returned to Resident #6's room.

L.P.N. #3 then applied gloves and cleaned the pressure area on Resident #6's left elbow. L.P.N. #3 removed the normal saline saturated gauze from the opened bottle. L.P.N. #3 first swiped the left outer edge of the wound, then swiped the right edge of the pressure area, and then swiped down the center of the wound 2-3 times. L.P.N. #3 applied the triple antibiotic ointment to the pressure area with her fingers. L.P.N. #3 removed her gloves. New gloves applied. L.P.N. #3 applied an Allevyn dressing to the left elbow. L.P.N. #3 applied Resident #6's elbow pad. Gloves were removed and L.P.N. #3 washed her hands for approximately 5 seconds. L.P.N. #3 carried the unused treatment supplies back to the treatment cart and stated she would throw them away.

Upon completion of the wound care completed by L.P.N. #3, the surveyor interviewed L.P.N. #3 of the observations made. L.P.N. #3 was asked what her nursing school had taught about how to do wound care. L.P.N. #3 stated clean the

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outside on one side, then clean the outside on the other side, and then clean down the center. When asked what L.P.N. #3 was taught about handwashing, L.P.N. #3 stated 15 seconds. When informed that the handwashing was less than 5 seconds, L.P.N. #3 stated "I thought I washed my hands long enough."

The surveyor interviewed the unit manager L.P.N. #2 on 10/5/17 at 11:10 a.m. The surveyor asked L.P.N. #2 what procedure was she taught for the cleaning of a wound. L.P.N. #2 stated start in the center which was the dirtiest and work outward which is the cleanest.

The surveyor interviewed registered nurse #1 on 10/5/17 at 11:30 a.m. R.N. #1 was asked the procedure for cleaning a wound. R.N. #1 stated clean from inner to outer. Also, take soiled dressing off and discard and then wash your hands and then put on clean glove.

The surveyor interviewed the corporate registered nurse on 10/5/17 at 11:50 a.m. the procedure for wound cleaning. The corporate registered nurse stated follow the physician order and to start from the center of the wound outward. The surveyor requested the following facility policies: wound care, dressing changes and handwashing.

The surveyor reviewed the facility policy titled "Handwashing Requirements" on 10/5/17. The policy read in part "PROCEDURE 1. Hand hygiene can consist of handwashing with soap and water or use of an alcohol based hand rub. A. Hand Hygiene 1. The following is a list of some situations that require hand hygiene: b. before and after direct patient contact, c. Before and after changing a dressing. B. Hand Washing

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F 314	Continued From page 19 with Antimicrobial Soap and Water f. Scrub for at least 15-20 seconds. 5. Dry hands thoroughly with a disposable towel, turning off the faucet on the hand sink with the disposable paper towel. Discard the towel into the trash can. D. Gloves 3. Change gloves during patient care if moving from a contaminated body site to a clean body site." The surveyor reviewed the facility policy titled "Wound Care" on 10/5/17. The policy read in part "Licensed nurses will follow recognized standards of practice regarding dressing change (s), including date and initials on dressing. The corporate registered nurse stated for their standard of practice for wound care, the facility referred to Lippincott. The surveyor informed the administrator, the director of nursing and the corporate registered nurse of the above concerns during wound care in a meeting on 10/5/17 at 12:31 p.m. No further information was provided prior to the exit conference on 10/5/17.	F 314		
F 333 SS=D	RESIDENTS FREE OF SIGNIFICANT MED ERRORS CFR(s): 483.45(f)(2) 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure 1 of 24	F 333	F333 1. Resident # 6 MD was notified of no	11/19/17

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F 333	Continued From page 20 residents (Resident #6) was free of a significant medication error. The findings included: The facility staff failed to document when insulin was administered to Resident #6 on 9/8/17. The clinical record of Resident #6 was reviewed 10/3/17 and 10/4/17. Resident #6 was admitted to the facility 6/12/17 and readmitted 7/10/17 with diagnoses that included but not limited to type 2 diabetes mellitus, pneumonia, dysphagia, cerebral infarction, ischemic cardiomyopathy, atrial fibrillation, gastroesophageal reflux disease, hypertension, acute coronary thrombosis, hyperlipidemia, peripheral vascular disease, acute and chronic respiratory failure, traumatic amputation at level between right hip and knee, and chronic kidney disease, stage 3. Resident #6's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 9/6/17 assessed the resident with a BIMS (brief interview for mental status) as 5 out of 15 in Section C BIMS Summary Score. Resident #6's current comprehensive care plan identified a focus area that read "The resident has Diabetes Mellitus Created on: 07/10/2017. Interventions: Monitor/document for side effects and effectiveness. Labs as ordered by doctor. Diabetes medication as ordered by doctor." The surveyor reviewed the September 2017 electronically signed physician orders. Included in the orders for Resident #6 was one that read "Levemir FlexPen Solution Pen-Injector 100 unit/ml (milliliter) (Insulin Detemir) Inject 10 unit	F 333	documentation for receiving insulin on 9/8/17 and no new orders 2. An audit was done on current residents for the last 30 days to assure that insulin dosage was documented as ordered and MD was notified as needed 3. Staff Development Coordinator educated licensed staff on proper documentation of medications by 11/15/17 4. DON/Unit Manager/Designee will monitor E-MAR report for missed administration at least 5 times a week for 4 weeks, then 2 times per week for 2 weeks to assure no missed documentation 5. Any non- compliance will be reported to the QA committee for tracking, trending, and progressive disciplinary action as needed.	

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F 333	Continued From page 21 subcutaneously two times a day for diabetes mellitus." The surveyor reviewed the September 2017 electronic medication administration record (eMAR). The eMAR contained an entry that read "Levemir FlexPen Solution Pen-Injector 100 unit/ml (milliliter) (Insulin Detemir) Inject 10 unit subcutaneously two times a day for diabetes mellitus." There was no documentation for 9/8/17 at 0600 that the physician ordered insulin had been administered to Resident #6. The progress notes for 9/8/17 did not provide evidence why the 0600 Insulin Detemir was not administered. There was no documentation the physician had been informed of the omission of the 0600 insulin on 9/8/17. Blood sugar was not obtained on 9/8/17 at 6:30 a.m. as well. The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the concern with diabetic management on 10/4/17 at 3:35 p.m. and again on 10/5/17 at 12:31 p.m. No further information was provided prior to the exit conference on 10/5/17.	F 333		
F 425 SS=E	PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH CFR(s): 483.45(a)(b)(1) (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425		11/19/17

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F 425	Continued From page 22 (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, the facility staff failed to ensure physician ordered medications were available for administration for 3 of 24 residents (Resident #3, Resident #17, and Resident #11). The findings included: 1. The facility staff failed to ensure the physician ordered medications were available for Resident #3. Famvir 250 mg (milligram) was not available for administration in October 2016, Zolpidem Tartrate ER (extended release) 6.25 mg and Temazepam 15 mg were not available in December 2016, Temazepam was not available in April 2017, and Advair Diskus inhaler was not available in May 2017 for administration. The clinical record of Resident #3 was reviewed 10/3/17 and 10/4/17. Resident #3 was admitted to the facility 10/3/16 with diagnoses that included but not limited to malignant neoplasm bronchus or lung, hypothyroidism, esophageal reflux disease, insomnia, palliative care, right femur fracture, major depressive disorder, rheumatoid arthritis, and cellulitis. Resident #3's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/8/17 assessed the resident with a	F 425	F425 1. Physician for residents # 3, 17, and 11 were notified of residents not getting ordered medications and no new orders 2. Current residents for the last 30 days were audited using the missed administration report to assure that no medications were missed and MD was made aware as indicated 3. Education was provided by the Staff Development Coordinator on how to obtain medications from the pharmacy and policy on what to do when medications have not been received from the pharmacy by 11/15/17 4. DON/Unit Manager/Designee will monitor the missed administration report at least 5 times per week for 4 week they 3 times per week for 2 weeks and then weekly for 90 days to assure no medications are missed and to assure policy is followed when medications have not arrived from the pharmacy and what to do to obtain them. 5. Any non- compliance will be reported to the QA committee for tracking and trending and progressive disciplinary action as needed	

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BIMS (brief interview for mental status) score of 10 out of 15 in Section C BIMS Summary Score.

The surveyor reviewed the October 2016 electronic medication administration record. The entry read "Famvir Tablet 250 mg (Famciclovir) Give 1 tablet by mouth three times a day for fever blister for 7 days-Order date-10/25/2016 at 0251-D/C (discontinue) Date-10/29/2016 at 0244." The entry for 10/25/16 at 0900 and 1300 (1:00 p.m.) had a "9" and initials. The entry on 10/28/16 at 0900 and 1300 was blank. The "Chart Codes/Follow-Up Codes" indicated 9=Other/See progress Notes.

The October 2016 physician's order read "Famvir Tablet 250 mg Give 1 tablet by mouth three times a day for fever blister for 7 days. Order and Start Date: 10/25/16 End date: 11/1/2016."

The surveyor reviewed Resident #3's progress notes for October 2016. The progress note dated 10/25/16 at 12:33 read "Famvir Tablet 250 mg Give 1 tablet by mouth three times a day for fever blister for 7 days awaiting on arrival from pharmacy. Medication not available in stat box."

Famvir was not available for 2 administrations for Resident #3 in October 2016.

The surveyor reviewed the December 2016 electronic medication administration records. The entry read "Zolpidem Tartrate ER Tablet Extended Release 6.25 mg Give 1 tablet by mouth at bedtime related to INSOMNIA (G47.00)-Order date-11/8/2016 1520 (3:20 p.m.)-D/C Date-12/29/2016 at 1418 (2:18 p.m.). The entry on 12/18/16 at 2100 9:00 p.m.) read "9" and initials. The entry for 12/25/16, 12/26/16, and

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12/27/16 at 2100 (9:00 p.m.) also had "9" and initials. The "Chart Codes/Follow-Up Codes" indicated 9=Other/See progress Notes.

The surveyor reviewed Resident #3's progress notes for December 2016. The progress note dated 12/18/16 at 21:20 (9:20 p.m.) read "Awaiting script from md (medical doctor)." The progress note dated 12/25/16 20:03 (10:03 p.m.) read "not available on order." The progress note dated 12/26/16 at 21:19 (9:19 p.m.) read "Zolpidem Tartrate ER Extended release 6.25 mg Give 1 tablet by mouth at bedtime related to INSOMNIA, UNSPECIFIED (G47.00) on order." The progress note dated 12/27/16 at 20:53 (8:53 p.m.) read "Zolpidem Tartrate ER Extended Release 6.25 mg Give 1 tablet by mouth at bedtime related to INSOMNIA, UNSPECIFIED (G47.00) Awaiting signature from MD."

The December 2016 physician's orders read "Zolpidem Tartrate ER Extended Release 6.25 mg Give 1 tablet by mouth at bedtime related to INSOMNIA, UNSPECIFIED (G47.00)-Order date-11/8/2016 1520 (3:20 p.m.)"

Resident #3 did not receive 3 doses of the medication Zolpidem Tartrate 6.25 mg as ordered in December 2016 due to the medication not available from the pharmacy.

The surveyor continued the review of Resident #3's December 2016 electronic medication administration records. An entry read "Temazepam Capsule 15 mg Give 1 capsule by mouth at bedtime related to INSOMNIA, UNSPECIFIED (G47.00)-Order date-12/29/16 at 1418 (2:18 p.m.) -D/C Date-05/01/2017 1606 (4:06 p.m.). The entry for Temazepam on

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12/29/16, 12/30/16, and 12/31/16 at 2100 (9:00p.m.) read "9" and initials. The "Chart Codes/Follow-Up Codes" indicated 9=Other/See progress Notes.

The surveyor reviewed the December 2016 progress notes. The progress note dated 12/29/16 at 21:34 (9:34 p.m.) read "Temazepam Capsule 15 mg Give 1 capsule at bedtime related to INSOMNIA, UNSPECIFIED (G47.00) awaiting medication from pharmacy." The progress note dated 12/30/16 at 21:49 (9:49 p.m.) read "Temazepam Capsule 15 mg Give 1 capsule at bedtime related to INSOMNIA, UNSPECIFIED (G47.00) unavailable from pharmacy." The progress note dated 12/31/16 at 20:59 (8:59 p.m.) read "Temazepam Capsule 15 mg Give 1 capsule at bedtime related to INSOMNIA, UNSPECIFIED (G47.00) waiting on script from md."

The December 2016 physician's order read "Temazepam Capsule 15 mg Give 1 capsule at bedtime related to INSOMNIA, UNSPECIFIED (G47.00) Order date and Start Date: 12/29/16."

Resident #3 did not receive 3 doses of the physician ordered medication Temazepam due to inability of the medication from the pharmacy in December 2016.

The surveyor continued the review of Resident #3's April 2017 electronic medication administration records. An entry read "Temazepam Capsule 15 mg Give 1 capsule by mouth at bedtime related to INSOMNIA, UNSPECIFIED (G47.00)-Order date-12/29/16 at 1418 (2:18 p.m.) -D/C Date-05/01/2017 1606 (4:06 p.m.). The entry for Temazepam on 4/19/17 at 2100 (9:00 p.m.) read "9" and initials.

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The "Chart Codes/Follow-Up Codes" indicated 9=Other/See progress Notes.

The surveyor reviewed the April 2017 progress notes. The progress note dated 4/19/17 at 22:12 (10:22 p.m.) read "Has not arrived from pharmacy at this time."

The April 2017 physician's order read "Temazepam Capsule 15 mg Give 1 capsule at bedtime related to INSOMNIA, UNSPECIFIED (G47.00) Order date and Start Date: 12/29/16."

Resident #3 did not receive one dose of the physician ordered medication Temazepam due to inability of the medication from the pharmacy in April 2017.

The May 2017 electronic medication administration records were reviewed. The entry read "Advair Diskus Aerosol Powder Breath Activated 100-50 mcg (micrograms)/dose (Fluticasone-Salmeterol) 1 puff inhale orally two times a day for COPD (chronic obstructive pulmonary disease)-Order date-05/04/2017 at 1049 -D/C date-05/15/2017 at 1615 (4;15 p.m.). The entry for 5/4/17 at 1700 (5:00p.m.) read "9"and initials. The "Chart Codes/Follow-Up Codes" indicated 9=Other/See progress Notes."

The surveyor reviewed the progress note for 5/4/17 at 22:20 (10:20 p.m.). The note read "Advair Diskus Aerosol Powder Breath activated 100-50 mcg (micrograms)/dose (Fluticasone-Salmeterol) 1 puff inhale orally two times a day for COPD Advir (sic) dickus (sic) has not arrived from pharmacy at this time. No c/o (complaints of) sob (shortness of breath)."

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The May 2017 physician's order read "Advair Diskus Aerosol Powder Breath Activated 100-50 mcg (micrograms)/dose (Fluticasone-Salmeterol) 1 puff inhale orally two times a day for COPD-Order date and Start Date 05/04/2017."

The Advair diskus inhaler was not available for administration to Resident #3 on 5/4/17 at 5:00 p.m.

The surveyor interviewed licensed practical nurse #1 on 10/5/17 at 0813 on the process for obtaining medications from the pharmacy. L.P.N. #1 stated first call the pharmacy and let the pharmacy know the medication isn't available, then see if you can get the medication from the back-up pharmacy, if you can't then call the doctor and document that in the progress notes. L.P.N. #1 stated that the pharmacy needs a script if the medication was a narcotic. The surveyor asked if Resident #3's medications were provided by the hospice caring for her. L.P.N. #1 stated Resident #3's medications came from the facility pharmacy.

The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the medications that were unavailable for Resident #3 in October 2016, December 2016, April 2017 and May 2017 in the end of the day meeting on 10/4/17 at 3:35 p.m. The surveyor requested the pharmacy manifest for Famvir, Temazepam, Zolpidem, and Advair Diskus, the facility stat box list, and the facility policy on obtaining medications from the pharmacy.

An unknown amount of Famvir was received 10/25/16 at 2:33 p.m.
An unknown amount of Zolpidem was received

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12/19/16 at 2:57 p.m.
No pharmacy manifest for Temazepam in December 2016 was received.
An unknown amount of Temazepam was received 4/19/17 at 10:51 p.m.
An unknown amount of Advair Diskus was received 5/4/17 at 10:59 p.m.

None of the medications that were ordered (Famvir, Zolpidem, Temazepam, and Advair Diskus) were in the stat box.

The surveyor reviewed the facility policy titled "7.0 Medication Shortages/Unavailable Medications" on 10/5/17. The policy read in part "2. If a medication shortage is discovered during normal Pharmacy hours: 2.1 Facility nurse should call Pharmacy to determine the status of the order. If the medication has not been ordered, the licensed Facility nurse should place the order or reorder for the next scheduled delivery. 2.2 If the next available delivery causes delay or a missed dose in the resident's medication schedule, Facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose. 2.3 If the medication is not available in the Emergency Medication Supply, Facility staff should notify Pharmacy and arrange for an emergency delivery. 3. If a medication shortage is discovered after normal Pharmacy hours: 3.1 A licensed Facility nurse should obtain the ordered medication from the Emergency Medication Supply. 3.2 If the ordered medication is not available in the Emergency Medication Supply, the licensed Facility nurse shall call Pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include: 3.2.1 Emergency delivery; or, 3.2.2 Use

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of an emergency (back-up) Third Party Pharmacy. 4. If an emergency delivery is unavailable, Facility nurse should contact the attending physician to obtain ordered or directions."

No further information was provided prior to the exit conference on 10/5/17.

2. The facility staff failed to ensure the physician ordered medication Polytrim Solution was available for Resident #17.

The surveyor reviewed Resident #17's clinical record on 10/4/17 and 10/5/17. Resident #17 was admitted to the facility 1/21/11 and readmitted 6/11/16 with diagnoses that included but not limited to hypokalemia, glaucoma, atherosclerotic heart disease, mood disorder, cerebrovascular disease, Alzheimer's disease, intracapsular fracture of left femur, anemia, hypertension, overactive bladder, and palliative care.

Resident #17's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 9/19/17 assessed the resident with short term memory problems, long term memory problems, and severely impaired cognitive skills for daily decision making.

The surveyor reviewed the electronic medication administration records (eMARS) for September 2017 and October 2017. The entry for Polytrim Solution 10000-0.1 unit/ml (milliliter)-% (Polymyxin B-Trimethoprim) Instill 1 drop in both eyes four times a day for eye infection for 1 week -Order date-09/27/2017 at 1246 -D/C (discontinue) date-09/29/2017 at 1006. The entry

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for 9/27/17 at 1300 (1:00p.m.) documented "9" and initials. The entry for 9/27/17 at 1700 (5:00 p.m.) and 2100 (9:00 p.m.) read "5" and initials. The entry for 9/28/17 at 0900 and 1300 (1:00 p.m.) documented "9" and initials. The entry for 9/28/17 at 1700 (5:00 p.m.) and 2100 (9:00 p.m.) read "5" and initials. The "Chart Codes/Follow-Up Codes" indicated 5=Hold/See Progress Notes and 9=Other/See progress Notes.

The surveyor reviewed the progress note dated 9/27/17 and timed 1307 (1:07 p.m.) The note read "Polytrim Solution 10000-0.1 unit/ml (milliliter)-% (Polymyxin B-Trimethoprim) Instill 1 drop in both eyes four times a day for eye infection for 1 week medication has not arrived from pharmacy new order." The progress note of 9/28/17 at 15:09 (3:09 p.m.) read "Polytrim Solution 10000-0.1 unit/ml (milliliter)-% (Polymyxin B-Trimethoprim) Instill 1 drop in both eyes four times a day for eye infection for 1 week-medication has not arrived from pharmacy new order."

The September 2017 physician orders read "Polytrim Solution 10000-0.1 unit/ml (milliliter)-% (Polymyxin B-Trimethoprim) Instill 1 drop in both eyes four times a day for eye infection for 1 week Start Date 9/27/2017 at 1300 (1:00 p.m.) Revision date 9/27/17, End date 9/29/2017."

Resident #17 did not have the Polytrim solution available and therefore the staff failed to administer the medication six (6) times from 9/27/17 through 9/28/17.

The surveyor informed the administrator, the director of nursing and the corporate registered

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nurse of the medication (polytrim eye drops) that was unavailable for administration to Resident #17 in September 2017 on 10/5/17 at 12:31 p.m.

No further information was provided prior to the exit conference on 10/5/17.

3. For Resident #11 the facility staff failed to ensure the medications Methadone and Xanax were available for administration.

Resident #11 was admitted to the facility on 07/01/17. Diagnoses included but not limited to gastroesophageal reflux disease, arthritis, anxiety, respiratory failure, fibromyalgia, dysphagia and chronic pain syndrome.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 07/08/17 coded the Resident as 13 of 15 in section C, cognitive status. This is an admission MDS. Resident's CCP (comprehensive care plan) was reviewed and contained a care plan for "Pain r/t (related to) RA (rheumatoid arthritis), dx (diagnosis) of chronic pain syndrome, fibromyalgia". Interventions for this care plan were listed as "medicate as ordered".

The Resident's clinical record was reviewed on 10/04/17. It contained signed POS's (physician's order summary) for the months of July, August and September which read in part "Methadone HCl Tablet 10mg. Give 40mg by mouth every 6 hours related to Rheumatoid Arthritis Unspecified; Fibromyalgia" and "Xanax Tablet 1mg (Alprazolam). Give 1mg by mouth every 6 hours related to anxiety disorder, unspecified".

The Resident's clinical record also contained

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MAR's (medication administration record) for the months of July, August and September which read in part "Methadone HCl Tablet 10mg. Give 40mg by mouth every 6 hours related to Rheumatoid Arthritis Unspecified; Fibromyalgia" and Xanax Tablet 1mg (Alprazolam). Give 1mg by mouth every 6 hours related to anxiety disorder, unspecified". For the month of July, the MAR for the Methadone had been coded with "9" and initialed on 07/03 at 1p, 07/19 at 6am, 07/23 at 6am and 07/28 at 6pm. Chart code indicated that '"9" was "other/see progress notes". Progress notes for these dates were reviewed and read in part "7/03/17 14:15 Methadone HCl Tablet 10mg Give 40mg by mouth three times a day related to Rheumatoid Arthritis, unspecified; Fibromyalgia medication not available", "7/23/2017 06:52 Methadone HCl Tablet 10mg. Give 40mg by mouth every 6 hours related to Rheumatoid Arthritis, unspecified; Fibromyalgia. Waiting on pharmacy refill today", and "7/28/2017 23:15 medication on the way from pharmacy dr..... (name omitted) notified on (sic) missed dose". For the Xanax, the MAR had been coded with "9" and initialed on 07/01 at 6p, 07/04 at 6p, 07/05 at 12a and 6a, and 07 13 at 6p. Progress notes for these dates read in part "7/1/2017 18:43 Xanax Tablet 1MG. Give 1 mg by mouth every 6 hours related to Anxiety Disorder, Unspecified medication not available in stat box pharmacy will have it delivered before 12am dose", "7/5/2017 00:04: Xanax Tablet 1mg Give 1 mg by mouth every 6 hours related to anxiety disorder, unspecified not given. Waiting on script", "7/5/2017 12:51 Awaiting on arrival from pharmacy", "7/5/2017 22:07 Xanax 1mg medication on way from pharmacy" and "7/13/2017 22:25 pharmacy notified".

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For the month of August 2017, the MAR for Methadone had been coded with "9" and initialed on 08/05 at 12p and 08/10 at 6p. Chart code indicated "other/see progress notes". Progress notes for these dates were reviewed and read in part "8/5/2017 12:02 on order from pharmacy" and "8/10/2017 Methadone HCl Tablet 10mg Give 40mg by mouth every 6 hours related to Rheumatoid Arthritis, Unspecified; Fibromyalgia on order from pharmacy". The MAR for Xanax had been coded with "9" and initialed on 08/12 and 08/13 at 12p and 6p. Progress notes for these dates read in part "8/12/2017 14:36 pharmacy notified", 8/12/2107 17:20 Xanax Tablet 1 mg called pharmacy needs ne (sic) script", 8/13/2107 00:02 Awaiting on arrival from pharmacy", 8/13/2017 14:54 pharmacy notified", 8/13/2107 21:00 script faxed to pharm awaiting to be received". There was also a progress note which read in part "8/15/2017 14:56 Dr. ...(name omitted) notified of Resident missing medication on 8/12, 8/13, 8/14/17. Resident has not shown any signs of anxiety, Resident is own RP (responsible party) and aware of doses missed. No new orders received at this time".

For the month of September 2017, the MAR for Methadone had been coded with "9" and initialed on 09/03 at 12p, 09/24 at 12p and 6p, and 09/28 at 6p. Progress notes for these dates read in part "9/3/2107 14:39 Methadone HCl Tablet 10mg Give 40mg by mouth every 6 hours related to Rheumatoid Arthritis not given unavailable. pharmacy aware", and "9/4/2017 13:27 pharmacy notified". The MAR for Xanax was coded with "9" and initialed on 09/04 at 12p, 09/05 at 12a and 6a, and 09/13 at 6p. The progress notes for these dates read in part "9/6/2017 02:49 Xanax Tablet 1mg Waiting on delivery from pharmacy", and

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"9/6/2107 06:20 Xanax Tablet 1mg Waiting on pharmacy to deliver". There were no progress notes for 09/13/17.

The surveyor spoke with LPN #1 on 10/04/17 at approximately 1350 regarding Resident #11's missing medication doses and the procedure followed when medication is not available. LPN #1 stated that pharmacy runs twice daily. Also stated that she reorders medications when there are 5-6 doses left in package, and that the packages have a sticker from pharmacy to alert when a new script is needed. LPN #1 also stated that the physician is in facility almost daily and will write a new script when needed.

The surveyor spoke with RN #1 on 1004/17 at approximately 1650 regarding Resident #11. RN #1 stated "We have a lot of issues getting meds from pharmacy. Resident #11 called 911 on me because I didn't have her meds".

Surveyor spoke with RN #2 regarding pharmacy procedures. RN#2 stated "We have a lot of trouble getting meds from pharmacy".

Surveyor spoke with Resident #11 on 10/04/17 at 1410. Resident stated that she went 3 days one time without her meds and she called the police. Surveyor asked her if bothered her or if she was in pain and Resident stated "I am always in pain. They gave me ibuprofen until they could get my regular pain meds, but it didn't help much".

Surveyor requested and was provided with a policy entitled "Medication Shortages/Unavailable Medications" which read in part " Procedure 1. Upon discovery that facility has an inadequate supply of a medication to administer to a

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F 425	Continued From page 35 Resident, facility staff should immediately initiate action to obtain the medication from pharmacy. If the medication shortage is discovered at the time of medication administration, facility staff should immediately take the action specified in Sections 2 or 3 of this Policy, as applicable. 3. If a medication shortage is discovered after normal Pharmacy hours: 3.1 A licensed facility nurse should obtain the ordered medication from the emergency medication supply. 3.2 If the ordered medication is not available in the emergency medication supply, the licensed facility nurse should call pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include: 3.2.1 Emergency delivery; or 3.2.2 Use of an emergency (back-up) third party pharmacy. 4. If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain orders or directions." The concern of the medications being unavailable for administration was discussed with the administrative staff during a meeting on 10/04/17 at approximately 1535. No further information was provided prior to exit.	F 425		
F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general	F 431		11/19/17

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supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

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

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the

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F 431	Continued From page 37 Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review the facility staff failed to ensure medications were stored properly for 1 of 2 units. The findings included: For North Unit, the facility staff failed to return medication cards to the cart prior to On 10/04/17 at approximately 0820, surveyor observed LPN (licensed practical nurse) #1 during a medication pass and pour on Unit of the facility. LPN #1 prepared unsampled Resident's medications, placed medication cards on top of med cart, locked the cart, then walked into Resident's room to administer the medications, leaving medication cards unattended. After returning to medication cart, surveyor asked LPN #1 if she normally left the medication cards on top of the cart, unattended, and LPN #1 stated that she did not. Surveyor requested and was provided with a copy of policy entitled "General Dose Preparation and Medication Administration", which read in part "Procedure: 3.9 Facility staff should not leave medications or chemicals unattended." The concern of leaving the medication cards on top of the med cart, unattended, was discussed with the administrative team during a meeting on	F 431	F431 1. Licensed Nurse was given education on proper storage of medications at the time of the survey 2. Licensed staff has received education by the staff development coordinator on not leaving medications on top of the medication cart unattended by 11/15/17 3. Current Licensed staff were audited by DON/Unit Manager/ Designee to assure proper storage of medications with a medication pass observation 4. New hires will have education of proper storage of medications at the time of hire and also will complete a medication pass observation prior to completing orientation 5. Any non-compliance will be reported to the QA committee for tracking and trending and progressive disciplinary action	

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F 431	Continued From page 38 10/04/17 at approximately 1535. No further information was provided prior to exit.	F 431		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 441		11/19/17

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F 441	Continued From page 39 (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, the facility staff failed to follow infection control guidelines/practice during a wound care observation on 1 of 2 units. The findings include:	F 441	F441 1. C NA that carried trash bag from one room to another received education at the time of the survey 2. Staff Development Coordinator will provide education to all C NA and licensed	

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F 441	Continued From page 40 The facility staff failed to follow infection control practices when transferring trash. On 10/04/17 at 1:40 pm, on the north unit the surveyor observed CNA #1 carry a bag of trash from room 54 into room 53. The surveyor followed the CNA into room #53 and observed her set the bag on a wheel chair that had pillows on it. The surveyor asked CNA #1 what was in the bag at first she said linen. She then put gloves on and picked up the bag off the wheel chair. The surveyor asked her again what was in the bag and she said "trash." The bag was clear and the surveyor could see that it contained soiled briefs and used gloves. The unit manager and the nurse educator were in the room at the time CNA #1 carried the trash into the room. The surveyor asked the unit manager if that was the normal procedure. The unit manager looked at the CNA and said "we don't do that". CNA #1 said "I apologize." During a meeting on 10/4/17 at 3:30 pm the above information was discussed with the administrator, director of nurses and the regional nurse consultant. On 10/5/17 at 9:45 am, the surveyor asked the nurse educator if the CNA should have brought the trash from one room to another. She said "She is a new CNA; it was a violation of infection control". The facility staff provide the requested infection control policy. Under manual section tiled Precautionary Measures it read in part: 1. Standard precautions, a. Hand Hygiene, b. Gloves; Wear gloves (clean non-sterile gloves are adequate) when touching body fluids,	F 441	staff on infection control and proper way to dispose of trash by 11/15/17 3. DON/Unit Managers/Designee will monitor for proper disposal of trash on rounds at least 5 times per week for 4 weeks, then 3 times per week for 2 weeks then weekly for 90 days to assure all staff are disposing of trash as educated 4. Any non- compliance will be reported to the QA committee for tracking and trending and progressive disciplinary action as needed	

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F 441	Continued From page 41 secretions, excretions and contaminated items. Put on clean gloves just before touching mucous membranes and non-intact skin. Change gloves between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces and before going to another patient. Perform hand hygiene upon removing gloves. Prior to exit on 10/5/17 no further information was provided by the facility staff related to the infection control issue.	F 441		
F 502 SS=D	ADMINISTRATION CFR(s): 483.50(a)(1) (a) Laboratory Services (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to obtain physician ordered laboratory testing for 2 of 24 Residents in the sample survey, Resident #9 and Resident #5. The Findings Included: 1. For Resident #9 the facility staff failed to obtain a physician ordered Hgb A1C on 8/29/17. Resident #9 was a 72 year old female who	F 502	F 502 1. Physician for residents # 9 and 5 were notified of missed labs 2. Current residents for orders for lab test of Hemoglobin A1C in the last 30 days were audited to assure that test were performed and lab results obtained 3. Staff Development Coordinator educated licensed staff on the lab tracking process and following Physician orders by 11/15/17 4. DON/Unit Manager/Designee will	11/19/17

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was originally admitted on 8/6/12 and readmitted on 5/21/16. Admitting diagnoses included, but were not limited to: diabetes mellitus, pressure ulcer on the sacrum, hypertension, hemiplegia/hemiparesis, osteomyelitis, chronic kidney disease, cerebrovascular accident (stroke) and anxiety.

The most current Minimum Data Set (MDS) assessment located in the clinical record was an Annual MDS assessment with an Assessment Reference Date (ARD) of 9/13/17. The facility staff coded that Resident #9 had a Cognitive Summary Score of 13. The facility staff also coded that Resident #9 required limited (2/2) to total nursing care (4/2) with Activities of Daily Living (ADL's).

On October 4, 2017 at 10:10 a.m. the surveyor reviewed Resident #9's clinical record. Review of the clinical record produced signed physician orders dated 8/14/17. Signed physician orders included, but were not limited to: "Hgb A1c one time only for diabetes related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS (E11.9) for 1 DAY." (sic) The order initiated on 8/29/17.

Continued review of the clinical record failed to produce the results of the physician ordered Hgb A1C for 8/29/17.

On October 4, 2017 at 2 p.m. the surveyor notified the Corporate Compliance Nurse (CCN) that Resident #9 had a physician order dated 8/29/17 to obtain a Hgb A1C. The surveyor notified the CCN that review of the clinical record failed to produce the results of the physician ordered Hgb A1C. The CCN stated that she

monitor the daily lab orders and the daily lab tracking log to assure that all labs were obtained as ordered at least 5 times per week for 4 weeks, then 3 times per week for 2 weeks then weekly for 90 days
5. Any non-compliance will be reported to the QA committee for tracking and trending and progressive disciplinary action as needed

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would attempt to locate the physician ordered Hgb A1C.

On October 4, 2017 at 2:20 p.m. the CCN informed the surveyor that she "couldn't find anything" in relationship to the missing physician ordered Hgb A1C.

On October 4, 2017 at 3:35 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON) and CCN. The surveyor notified the Administrative Team (AT) that Resident #9 had a physician order to obtain a Hgb A1C on 8/29/17. The surveyor notified the AT that review of the clinical record failed to produce the results of the physician ordered Hgb A1C.

No additional information was provided to the survey team prior to exiting the facility as to why the facility staff failed to obtain the physician ordered Hgb A1C on Resident #9.

2. The facility staff failed to obtain a hemoglobin A1C annually as ordered by the physician for Resident #5.

The surveyor reviewed Resident #5's clinical record on 10/3/17 and 10/4/17. Resident #5 was admitted to the facility 11/9/12 and readmitted 3/2/17 with diagnoses that included but not limited to infectious gastroenteritis, dementia without behavioral disturbances, hypertension, gastrostomy status, age related osteoporosis, Parkinson's disease, cleft palate, depressive disorder, unspecified psychosis, atherosclerotic heart disease, and dysphagia.

Resident #5's quarterly minimum data set (MDS) with an assessment reference date (ARD) of

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F 502	Continued From page 44 9/1/17 assessed the resident with a BIMS (brief interview for mental status) score of 9 out of 15 in Section C BIMS Summary Score. Resident #5's October 2017 physician's orders included an order that read "Hgb (hemoglobin) A1C yearly in August Order Status: Active Revision Date: 5/10/17." The surveyor reviewed both the electronic clinical record and the paper clinical record but was unable to locate the results of the Hgb A1C. The surveyor informed the administrator, the director of nursing and the corporate registered nurse of the above issue in the end of the day meeting on 10/4/17 at 3:35 p.m. and on 10/5/17 at 12:31 p.m. Prior to the exit meeting on 10/5/17, the corporate registered nurse informed the surveyor the laboratory test was not obtained.	F 502		
F 514 SS=E	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F 514		11/19/17

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F 514	Continued From page 45 (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility failed to ensure a complete and accurate clinical record for 2 of 24 Residents in the sample survey, Resident #13 and Resident #3. The Findings Included: 1. For Resident #13 the facility staff failed to ensure complete and accurate Physician Order Sheets (POS's) and October 2017 Medication Administration Records (MAR's). Resident #13 was a 78 year old male, who was originally admitted on 5/28/11 and readmitted on 12/22/14. Admitting diagnoses included, but	F 514	F514 1. Resident number 13 orders for medication routes were clarified MD for resident #3 was notified for holes in MAR documentation 2. Current residents with tube feeding orders were audited to assure proper medication routes were in place 3. Licensed staff were educated by the Staff Development Coordinator on proper documentation on the E-MAR and for following physician orders for proper medication administration routes by 11/15/17 4. DON/Unit Manager/Designee will monitor missed administration report at	

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F 514	Continued From page 46 were not limited to: bacterial pneumonia, vision loss, contracture of the right hand, hemiplegia, dementia without behaviors, hypertension, anemia and a cerebrovascular accident (stoke). The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 8/1/17. The facility staff coded that Resident #13 had a Cognitive Summary Score of 5. The facility staff also coded that Resident #13 required extensive (3/2) to total nursing care (4/2) with Activities of Daily Living (ADL's). In Section K. Swallowing/Nutritional Status the facility staff coded that Resident #13 was receiving a Mechanically Altered Diet. The facility staff did not code/capture that Resident #13 had a Percutaneous Endoscopic Gastrostomy (PEG) tube or was receiving PEG tube feedings. On October 3, 2017 at 2:10 p.m. the surveyor reviewed Resident #13's clinical record. Review of the clinical record produced signed Physician Order Sheets (POS's) dated 8/14/17. Signed physician orders included, but were not limited to: "Omeprazole Suspension Give 2mg/ml by mouth one time a day related to GASTROESOPHAGEAL REFLUX DISEASE WITHOUT ESOPHEGITIS (K21.9) Give 10 ml once daily via PEG TUBE. Culturelle one twice a day for supplement (Resident receives meds (medications) through G-Tube). Potassium Give 10 mEq via G-Tube one time a day for hypokalemia." (sic) The surveyor noted that all of Resident #13's other medications were ordered to be administered by mouth. Continued review of the clinical record produced	F 514	least 5 times per week times 4 week then 3 times per week times 2 weeks and they weekly for 90 days to assure no holes in documentation on the E-MAR. Unit Manager will review new admissions with tube feeding to assure that medication routes are correct for medication administration 5. Any non- compliance will be reported to the QA committee for tracking, trending, and progressive disciplinary action as needed.	

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the October 2017 Medication Administration Records (MAR's). The October 2017 MAR's documented that the Omeprazole, Culturelle and Potassium were being administered by a PEG tube.

On October 3, 2017 at 3:35 p.m. the surveyor walked to the medication cart that was parked outside of Resident #13's room. The surveyor observed a Licensed Practical Nurse (LPN #1) standing at the medication cart. The surveyor asked if LPN (#1) was Resident #13's nurse. LPN (#1) stated that she was Resident #13's regular nurse. The surveyor asked LPN (#1) how Resident #13 received his medications. LPN (#1) stated that Resident #13 received all of his medications by mouth. The surveyor informed LPN (#1) that several of Resident #13's medications were ordered to be administered by PEG tube. LPN (#1) stated that Resident #13 did not have a PEG tube. LPN (#1) stated that Resident #13's PEG tube had been removed a long time ago.

On October 3, 2017 at 3:40 p.m. the surveyor walked up to the Director of Nursing's (DON's) office. The surveyor knocked on the door and the door was partially open. The surveyor noted that the DON, Corporate Compliance Nurse (CCN) and Administrator (ADM) were sitting in the DON's office. The surveyor notified the Adm, DON and CCN that Resident #13's POS's and MAR's were incorrect. The surveyor notified the Administrative Team (AT) that several of Resident #13's medications were ordered to be administered by PEG tube. The surveyor informed the AT that Resident #13 no longer had a PEG tube and received all of his medications by mouth.

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No additional information was provided to the survey team prior to exiting the facility as to why the facility staff failed to ensure complete and accurate POS's and October 2017 MAR's for Resident #13.
2. Resident #3's October 28, 2016 electronic medication administration record (eMAR) contained "holes", times when there was no documentation that the ordered medications had been given.

The clinical record of Resident #3 was reviewed 10/3/17 and 10/4/17. Resident #3 was admitted to the facility 10/3/16 with diagnoses that included but not limited to malignant neoplasm bronchus or lung, hypothyroidism, esophageal reflux disease, insomnia, palliative care, right femur fracture, major depressive disorder, rheumatoid arthritis, and cellulitis.

Resident #3's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/8/17 assessed the resident with a BIMS (brief interview for mental status) score of 10 out of 15 in Section C BIMS Summary Score.

On 10/28/16, there were no initials for the administration of the following 9:00 a.m. medications on the electronic medication administration records: Aspirin 81 mg (milligrams), Loratadine 10 mg, Miralax Powder, Colace 100 mg, Med Plus 2.0 supplement, Oxycontin ER (extended release) 20 mg (milligrams), Symbicort inhaler, and Famvir. There were no initials for the administration of the 1:00 p.m. medication Famvir. There were no initials for the monitoring of antianxiety medications, anticoagulants, behaviors,

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F 514	Continued From page 49 psychotropic interventions, sedatives/hypnotics on day shift. The surveyor informed the corporate registered nurse of the missing documentation on 10/4/17 at 3:35 p.m. When asked if the nurse was still employed, the corporate registered nurse stated no and then stated that nurse gave the medication. No further information was provided prior to the exit conference on 10/5/17. The surveyor reviewed the facility policy on medication administration documentation. The policy titled "6.0 General Dose and Medication Administration" read in part "6. After medication administration, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following: 6.1 Document necessary medication administration/treatment information on appropriate forms."	F 514		
F 526 SS=D	Hospice CFR(s): 483.70(o)(1)-(4) (o) Hospice services. (1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for	F 526		11/19/17

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the provision of hospice services when a resident requests a transfer.

(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:

(i) Ensure that the hospice services meet professional standards and principles that apply to
individuals providing services in the facility, and to the timeliness of the services.

(ii) Have a written agreement with the hospice that is signed by an authorized representative of the
hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:

(A) The services the hospice will provide.

(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.

(C) The services the LTC facility will continue to provide based on each resident's plan of care.

(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.

(E) A provision that the LTC facility immediately

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notifies the hospice about the following:

(1) A significant change in the resident's physical, mental, social, or emotional status.

(2) Clinical complications that suggest a need to alter the plan of care.

(3) A need to transfer the resident from the facility for any condition.

(4) The resident's death.

(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.

(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.

(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.

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(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.

(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.

(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.

The designated interdisciplinary team member is

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responsible for the following:

(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.

(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.

(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.

(iv) Obtaining the following information from the hospice:

(A) The most recent hospice plan of care specific to each patient.

(B) Hospice election form.

(C) Physician certification and recertification of the terminal illness specific to each patient.

(D) Names and contact information for hospice personnel involved in hospice care of each patient.

(E) Instructions on how to access the hospice's 24-hour on-call system.

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F 526	Continued From page 54 (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. (4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.20. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to coordinate Hospice Services for 1 of 24 residents in the survey sample. (Resident #17) The findings included: The facility staff failed to ensure there was coordination of care between the facility and the contracted hospice agency for Resident #17. Resident #17's clinical records (electronic and paper) did not have documentation of care provided by the hospice aide or a plan of care for each discipline. The surveyor reviewed Resident #17's clinical record on 10/4/17 and 10/5/17. Resident #17	F 526	F526 1. Documentation of care provided by the Hospice aid was obtained for resident # 17 2. An audit was done of current hospice residents to assure hospice documentation was in place. Meeting held with Hospice administration to develop communication guidelines for services provided. 3. Education was provided by the staff development coordinator on the documentation requirements from the hospice company to us and how to obtain this documentation from the hospice agency by 11/15/17 4. DON/Unit Manager/ Designee will	

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F 526	Continued From page 55 was admitted to the facility 1/21/11 and readmitted 6/11/16 with diagnoses that included but not limited to hypokalemia, glaucoma, atherosclerotic heart disease, mood disorder, cerebrovascular disease, Alzheimer's disease, intracapsular fracture of left femur, anemia, hypertension, overactive bladder, and palliative care. Resident #17's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 9/19/17 assessed the resident with short term memory problems, long term memory problems, and severely impaired cognitive skills for daily decision making. Section O Special Treatments, Procedures, and Programs was marked for hospice care. The surveyor reviewed Resident #17's clinical record on 10/4/17 and 10/5/17. The electronically signed physician orders included an order dated 6/14/17 for hospice services. The surveyor noted during this review that there was no plan of care generated from the hospice agency with frequency of visits for each discipline or hospice aide notes scanned in the electronic clinical record or in the paper clinical record. The surveyor asked registered nurse #2 where the hospice services notes were for the visits that they had made since the resident had been admitted to hospice. R.N. #2 stated the notes were in the clinical record. The surveyor reviewed the hospice information titled "Clinical and Hospice Aide Documentation." The notes were dated 5/30/17, 6/9/17, 6/12/17, 6/20/17, 6/29/17, 7/3/17, 7/11/17, 7/21/17, 7/25/17, 7/31/17, 8/8/17, 8/15/17, 8/23/17, and 8/31/17. There were no notes for September 2017 and October 2017 in the paper clinical record or	F 526	monitor hospice care with each visit to obtain documentation of services provided and to scan this into the medical record. 5. Any non-compliance will be reported to the QA committee for tracking, trending, and progressive disciplinary action as needed.	

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scanned in the electronic clinical record. Each of the entries on the Clinical and Hospice Aide Documentation read "Routine SN (skilled nurse) visit." There were no hospice aide entries found in the paper or electronic clinical record.

The surveyor interviewed registered nurse #1 on 10/5/17 at 11:30 a.m. R.N. #1 stated there was no frequency protocol found in Resident #17's clinical record for hospice visits by each discipline or hospice aide visits. R.N. #1 stated she would call the hospice agency.

The surveyor was provided a copy of the hospice contract on 10/5/17. In Section 1.12 of the contract it reads in part " ...Plan of care means with respect to each Hospice patient, a written care plan established, maintained, reviewed, and modified, as necessary, at intervals established by the applicable Interdisciplinary Team, which includes (a) an assessment of such Hospice Patient's needs; (b) identification of the Hospice Services, including management of discomfort and symptom relief, appropriate to meet such Hospice patient's needs and the related needs of the Hospice patient's family; and (c) details concerning the scope and frequency of Hospice Services to be provided. IV Hospice Obligations 4.1.1 Establishment of Plan of Care. Hospice shall designate an Interdisciplinary Team to establish, or modify as necessary an appropriate Plan of Care for each Hospice patient resident in the facility. 4.1.2 Coordination with Facility Staff Hospice shall ensure that its Interdisciplinary teams coordinate with and include members of the Facility staff to develop a Plan of Care for an individual Resident that integrates Hospice philosophy with the needs of the Resident. The Plan of Care shall identify the care and services

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that the Facility will provide to resident and the Services that will be provided directly by Hospice employees or others under contract to Hospice. 4.1.3 Modifications Hospice shall modify the Plan of Care in coordination with Facility as necessary and shall ensure that the Plan of Care is reviewed by the Resident's attending physician as often as necessary but at least every 60 days. A copy of the Resident's current Plan of Care shall be maintained at both Facility and Hospice, and Hospice shall inform Facility in writing of any modification. 4.1.3 Medical Records Hospice shall ensure that its staff make timely, accurate, and legible entries in Resident's medical record at facility. V Facility Obligation 5.3.3 Maintain records of all care and services provided by facility. 5.3.4 Provide space in resident's Facility medical records for Hospice staff to document visits and care rendered by hospice." The contract was signed by the facility 3-25-08 and by hospice on 3/7/08.

The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above missing information from Resident #17's clinical record with respect to hospice services on 10/5/17 at 12:31 p.m.

No further information was provided prior to the exit conference on 10/5/17.