STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495303	A. BUILDING _____ B. WING _____	10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE CONVALESCENT CNTR WE	2960 CHELSEA ROAD WEST POINT, VA 23181

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted on 10/17-19/2017. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The Life Safety Survey/Report will follow. The census in this 60 certified bed facility was 51 at the time of the survey. The survey sample consisted of 12 current resident reviews (Resident #1- #12) and 3 closed record reviews (Resident #13-#15)	F 000		
F 156 SS=B	NOTICE OF RIGHTS, RULES, SERVICES, CHARGES CFR(s): 483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting	F 156		11/22/17

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

Electronically Signed | 11/03/2017

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personal funds, under paragraph (f)(10) of this section;

(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.

(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and

(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42

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U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)
[§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]

(iii) Information regarding Medicare and Medicaid eligibility and coverage;
[§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]

(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;
[§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]

(v) Contact information for the Medicaid Fraud Control Unit; and
[§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]

(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:

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(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and

(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.

(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.

(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and

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regulations governing resident conduct and responsibilities during the stay in the facility.

(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.

(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;

(g)(17) The facility must--

(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.

(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the

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F 156	Continued From page 5 facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on observation and resident interview the facility staff failed to ensure contact information for the Ombudsman and the state agency were accessible to all residents.	F 156	1. Contact information for the Ombudsman and the state agency were lowered to a level that was easily visible to resident #11 who is wheelchair bound on 10/20/17.	

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F 156	Continued From page 6 The posted contact information was inaccessible to residents who were wheel chair bound. The findings included: Resident #11, a 79 year old, was admitted to the facility on 5/21/09. Her diagnoses included hemiplegia, mood disorder, and diabetes. The most recent Minimum Data Set assessment was a significant change assessment with an assessment reference date of 9/11/17. She has a Brief Interview of Mental Status score of 15 indicating no cognitive impairment and required extensive assistance with activities of daily living. During an interview on 10/19/17 at 10:00 a.m., Resident #11 was asked if she knew how to contact the Ombudsman and the state agency. She stated that she knew the phone numbers were located over the water fountain, but stated that they were posted too high up and she could not see them from her wheel chair. On 10/19/17 at 10:30 a.m., the phone numbers were observed posted above the water fountain, inaccessible to residents who were wheel chair bound. The issue was reviewed with the Administrator, Director of Nursing and Corporate Nurse at the end of day meeting on 10/19/17.	F 156	2. All residents that are wheelchair bound are at risk for not having contact information for the Ombudsman and the state agency visibly accessible. The contact information was lowered on 10/20/17 to be visibly accessible. 3. Residents will be provided education to the location and ability to access the contact information for the Ombudsman and the state agency by social services or designee during Resident Council by the Activity Director by 11/22/17. 4. The administrator/designee will audit location of Ombudsman and state agency contact information twice weekly for 4 weeks to ensure that contact information remains at an easily visible level for residents that are wheel chair bound. Accessibility of contact information for the Ombudsman and the state agency will be reported at the QAPI meeting by Administrator/designee for evaluation of compliance. 5. All corrective actions will be completed by 11/22/17.	
F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes.	F 157		11/22/17

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(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).

(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.

(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-

(A) A change in room or roommate assignment as specified in §483.10(e)(6); or

(B) A change in resident rights under Federal or

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F 157	Continued From page 8 State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on clinical record review the facility staff failed for 1 resident (Resident #4) of 15 residents in the survey sample to notify the doctor regarding unsuccessful blood draws. For Resident #4, staff were unable to draw blood in order to retest potassium levels. The physician was not notified. The findings included: Resident #4, a 60 year old, was admitted to the facility on 2/10/00. Diagnoses included cerebral palsy, hypertension, depression, intellectual disability and mood disorder. The most recent Minimum Data Set assessment was a comprehensive assessment with an assessment reference date of 7/18/17. Resident #4 was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment. He required extensive assistance with activities of daily living. On 8/15/17, the physician wrote a progress note "His most recent laboratory data revealed an improvement in his low potassium though it remains below normal." Plan: "Laboratory testing will be repeated this week to check his electrolytes and magnesium."	F 157	1. DON notified the provider that staff was unable to obtain specimen during blood draw on resident #4 to retest the potassium levels new orders were obtained and resident had blood drawn on 9/8/17 for a potassium level. 2. An audit was completed on all current residents 10/20/17 to ensure that the provider was notified of all delays in obtaining lab specimens. No other incidents were identified. 3. Licensed nurses will be provided additional education by DON or designee by 11/22/17 regarding notification of provider for delays or inability to obtain lab specimens. 4. The DON/designee will audit 3 lab orders per week times 4 weeks, and then 2 lab orders per week for 4 weeks to ensure that notification is made to the provider regarding delays or inability to obtain lab specimens. The results of the audits will be reported at the QAPI meeting by the DON/Designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis.	

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F 157	Continued From page 9 The following unsuccessful attempts at drawing blood were documented in the nursing notes: 8/18/17 "Lab draw unsuccessful, will pass on to next nurse". 8/21/17 nursing note "Unable to obtain blood from right A/C, unable to find another site. Oncoming nurse aware." 8/30/17 nursing note "Unable to draw blood from right a/c for BMP and magnesium. Day shift nurse notified." The Administration was notified of the issue at the end of day meeting on 10/19/17.	F 157	5. All corrective actions will be completed by 11/22/17.	
F 241 SS=D	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and clinical record review, the facility staff failed to provide a dignified living experience for one Resident (Resident #1) in a survey sample of 15 Residents. 1. For Resident #1, call bells were not answered promptly and the resident had an incontinent episode. 2. LPN (A) entered Resident #10's and Resident #11's room without knocking. The findings included:	F 241	1. Staff was educated on 10/17/17 for the need to knock on resident doors prior to entering for resident #11 room and the need to answer call bells promptly for resident #1. 2. An audit was completed by the DON/designee to ensure the staff is knocking prior to entering the resident room and that call bells are answered promptly. Education was provided and observations were made to ensure that staff were compliant.	11/22/17

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F 241	Continued From page 10 Resident #1, a female, was admitted to the facility 8/22/16. Her diagnoses included high blood pressure, Alzheimer's dementia, low vision both eyes and hearing loss bilaterally. Resident #1's most recent MDS (minimum data set) with an ARD (assessment reference date) of 7/28/17 was coded as a quarterly assessment. Resident #1 was coded as having a BIMS (brief interview of mental status) of "15" out of 15, or no cognitive loss. She was coded as requiring extensive to total assistance of one to two staff members to perform her activities of daily living. She was coded as being continent of bowel and occasional urinary incontinence. On 10/17/17 at 1:50 PM, during the initial tour, Resident #1 was observed sitting in the wheelchair. The private sitter stated, "She's been waiting to talk to you." Resident #1 made several comments about the staff being slow to answer the call bells. She stated, "No one will come and I have to wet the bed. I don't like that." Several observations were made of staff response to call bells during the survey, and the call bells were answered within 11 minutes. However, on 10/18/17, a meeting with the resident council, 100 % of the residents in the meeting complained of slow call bell response. Review of the Resident Council minutes for August, September and October revealed residents had complaints regarding the call bell response time. 2. LPN (A) entered Resident #10's and Resident #11's room without knocking. Resident #11, a 79 year old, was admitted to the facility on 5/21/09. Her diagnoses included hemiplegia, mood disorder, and diabetes.	F 241	3. All departments will be educated by the DON/designee regarding knocking prior to entering resident□s room and ensuring call bells are answered promptly completed by 11/22/17. 4. The DON or designee will audit call bell response times and staff knocking prior to resident room entry 3 times per week for 4 weeks then 2 times per week for 4 weeks. The results of the audits will be reported at the QAPI meeting by the DON/Designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis. 5. All corrective actions will be completed by 11/22/17.	

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F 241	Continued From page 11 The most recent Minimum Data Set assessment was a significant change assessment with an assessment reference date of 9/11/17. She has a Brief Interview of Mental Status score of 15 indicating no cognitive impairment and required extensive assistance with activities of daily living. Resident #10, a female, was admitted to the facility 8/22/16. Her diagnoses included high blood pressure, Alzheimer's dementia, low vision both eyes and hearing loss bilaterally. Resident #10's most recent MDS (minimum data set) with an ARD (assessment reference date) of 7/28/17 was coded as a quarterly assessment. Resident #1 was coded as having a BIMS (brief interview of mental status) of "15" out of 15, or no cognitive loss. She was coded as requiring extensive to total assistance of one to two staff members to perform her activities of daily living. She was coded as being continent of bowel and occasional urinary incontinence. On 10/17/17 at 3:50 PM, LPN (A) entered Resident #10's room without knocking. On 10/17/17 at 4:05 PM, LPN (A) entered Resident #11's room without knocking. On 10/17/17 at 4:30 PM, LPN (A) stated, "I do know I forget to knock." On 10/19/17, at approximately 12:00, the Administrator and DON (director of nursing) were notified of above findings.	F 241		
F 246 SS=E	REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	F 246		11/22/17

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F 246	Continued From page 12 CFR(s): 483.10(e)(3) 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on resident interview, family interview, group interview, staff interview and facility documentation review the facility staff failed to ensure call bells were answered and mechanical lifts were functional. 1. Individual residents, resident council group and family members stated that it was regular practice for staff to come into a resident room, turn off the call bell and not address the resident concern. 2. Individual residents and resident council group stated that the mechanical lifts are often times not charged, resulting in long wait times to get in and out of bed. The findings included: 1. Individual residents, resident council group and family members stated that it is regular practice for staff to come into a resident room, turn off the call bell and not address the resident concern. Resident #11 was interviewed on 10/19/17 at 10:00 a.m.	F 246	1. Staff was educated on 10/17/17 by DON/designee to ensure call bells are answered promptly for residents #11, #2 and #5. An audit of all mechanical lifts by maintenance to ensure they were functional was completed on 10/17/17. All lifts were found to be functional. Staff was provided education by maintenance on 10/18/17 to keep lifts plugged in when not in use. 2. An audit was completed by the DON/designee to ensure staff are answering call bells. Education was provided and staff observations were completed to ensure compliancy. To maintain continuing functional lifts for resident use, staff will keep lift plugged in between use. 3. All Departments will have education provided by DON/designee on call bell response time, utilizing proper sling size and keeping lifts plugged in while not in use by 11/22/17. DON/designee will review all Transfer Mobility Status	

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F 246	Continued From page 13 Resident #11, a 79 year old, was admitted to the facility on 5/21/09. Her diagnoses included hemiplegia, mood disorder, and diabetes. The most recent Minimum Data Set assessment was a significant change assessment with an assessment reference date of 9/11/17. She has a Brief Interview of Mental Status score of 15 indicating no cognitive impairment and required extensive assistance with activities of daily living. Resident #11 stated that when she rings the call bell, staff come in and turn it off and do not assist her with her needs. She stated that this happens 3-4 times per week. In addition, she stated that she has to wait 45 minutes to get help after ringing the call bell. Resident #5 was interviewed on 10/17/17 at 3:05 p.m. Resident #5, a 72 year old, was admitted to the facility on 2/4/16. Her diagnoses included colon cancer, diabetes, hypertension, dementia, and lupus. The most recent Minimum Data Set assessment was a comprehensive assessment with an assessment reference date of 9/15/17. She has a Brief Interview of Mental Status score of 15 indicating no cognitive impairment and required assistance with activities of daily living. Resident #5 stated that the staff shut the call bells off and do not provide assistance. She stated that the weekends are the worst time, stating that she often has to wait for 45 minutes and ring the call bell multiple times to get help. Resident #2 was interviewed on 10/18/17 at 2:00 p.m. Resident #2, a 73 year old, was admitted to the facility on 1/24/17. His diagnoses included	F 246	Evaluations to assure the correct sling is identified and placed on the resident profile for nursing staff reference. 4. The DON or designee will audit call bell response time 3 times weekly for 4 weeks and then 2 times weekly for 4 weeks. The DON/designee will audit all lifts not in use are plugged in 3 times weekly for 4 weeks and then 2 times weekly for 4 weeks. The maintenance director or designee will audit mechanical lifts are functional weekly for 4 weeks and then monthly. The results of the audits will be reported at the QAPI meeting by the DON/Designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis. 5. All corrective actions will be completed by 11/22/17.	

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hemiplegia, multiple sclerosis, hypertension and depression. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 7/28/17. He has a Brief Interview of Mental Status score of 15 indicating no cognitive impairment and required extensive assistance with activities of daily living.

Resident #2 stated that he felt that his call bell did not work at times. It was pressed by this surveyor after the interview and was functional at this time. After pressing the call bell, the survey team stood in the hall to record response time. Staff responded to the call bell in 9 minutes. While standing in the hall, two separate family members approached the survey team. Both family members expressed concern about staffing and the answering of call bells.

A group meeting was held on 10/18/17 at 3:00 p.m. Seven residents were in attendance. The group unanimously agreed that call bells do not get answered in a timely manner, approximately 20-45 minute wait. The staff come in, shut the call bell off and do not provide care. The group reports that this happens often at night time and the weekends are the worst.

Concern regarding call bell wait times have been documented as follows in the Resident Council monthly meeting notes:
August 2017: "Call bell response time what is the policy? because they will come in ask what you want, turn call bell off then say I will be right back and never come back"
September 2017: "Call bell wait times waiting too long"
October 2017: "-Call bell wait times too long -why can't the call light stay on until they address

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our needs? -when we need to go the bathroom, an aide will answer call light by coming in and turning off call light and then state I will get your aide 'I'm not your aide'."

2. Individual residents and resident council group stated that the mechanical lifts are often times not charged, resulting in long wait times to get in and out of bed.

Resident #11 stated that the facility staff do not use the appropriate sling for her when she is transferred using the mechanical lift. Residents in the group meeting stated that the lifts are a problem. They stated that they can not go to the bathroom because they are waiting too long for the lift. The group stated that there are only two lifts for all the residents. They stated that often times the lifts are not charged. Everyone at the group agreed this was an issue. They stated that this was an everyday problem.

On 10/19/17 at 11:15 a.m., five lifts were observed in the facility hallways. One of the five lifts were plugged in at this time.

On 10/19/17 at 11:30 a.m., Registered Nurse A (RN A) was interviewed. RN A stated the facility had six lifts, three sit to stand and three hoyer. She stated that as far as she knew, all were functional. When asked who was responsible for charging the lifts, she stated that the night staff were supposed to plug them in at night to be sure they were charged. RN A stated that the lifts takes about two hours to charge.

The issues with the call bells and lifts were reviewed with the Administrator, Director of Nursing and Corporate Nurse at the end of day

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F 246	Continued From page 16 meeting on 10/18/17 at 4:30 p.m. When asked if it was ok that the staff turned off the call bells without addressing the resident's needs, the Administrator stated that the Certified Nursing Assistants should address issues when they turn the call bell lights off.	F 246		
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure services met professional standards of care for 1 resident (Resident #4) of 15 residents in the survey sample. For Resident #4, the facility staff failed to clarify an order for Calcitonin (for osteoporosis). The findings included: Resident #4, a 60 year old, was admitted to the facility on 2/10/00. Diagnoses included cerebral palsy, hypertension, depression, intellectual disability and mood disorder. The most recent Minimum Data Set assessment was a comprehensive assessment with an assessment reference date of 7/18/17. Resident	F 281	1. Resident #4's physician order was clarified on 9/9/17 to ensure proper documentation of which nares to administer the Calcitonin. 2. An audit was completed on 10/20/17 by the DON to ensure all medication orders are written correctly to ensure proper route of the medications. 3. Licensed nursing staff will be educated by the DON/ designee to validate physician orders are completed to include proper route locations of administering the medications completed by 11/22/17. 4. The DON or designee will audit new orders for proper route of the medication for 3 residents for 4 weeks and 2	11/22/17

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F 281	Continued From page 17 #4 was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment. He required extensive assistance with activities of daily living. Resident #4 had the following order for Calcitonin: 7/13/17- Calcitonin (salmon) 200 unit nasal spray, 1 spray to each nare daily. A Medication Regimen Review (MRR) was completed by the pharmacist on 8/2/17. The review identified an issue with the Calcitonin administration. The "Note to Attending Physician/ Prescribe" read "(Resident #4) has a current order for calcitonin nasal spray into each nostril daily for osteoporosis Recommendation: Please note that per manufacturer for indication OP: Intranasal: 200 units (1 spray) in one nostril once daily Please change current order to 200 units (1 spray) in alternating nostrils daily" The nurse practitioner checked "Agree" and signed the recommendation on 8/3/17. A new order for Calcitonin was written: 8/5/17- Calcitonin (salmon) 200 unit nasal spray both nostrils. Instructions: Alternate nostrils daily. While the order was changed to reflect the need to alternate nostrils, the August 2017 Medication Administration Record (MAR) documentation did not change to include documentation of administration in the right or left nostril. Another MRR was completed by the pharmacist on 9/6/17. The review identified an issue with the Calcitonin administration. The "Note to Attending Physician/ Prescribe" read "(Resident #4) has a	F 281	residents for 4 weeks. The results of the audits will be reported at the QAPI meeting by the DON/Designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis. 5. All corrective actions will be completed by 11/22/17.	

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current order for calcitonin nasal spray daily". "Per (computer system) Dosage to administer is BOTH nostrils daily, but INSTRUCTIONS indicate alternating nostrils daily". "Recommendation(s): Please clarify order entry to indicate alternating nostrils daily, in both the DOSAGE TO ADMINISTER section as well as INSTRUCTIONS to avoid confusion".

The nurse practitioner checked "Agree" and signed the recommendation on 9/9/17.

The order was rewritten as two separate orders, one for the left nostril and one for the right nostrils. Dates of administration alternated as ordered on the September 2017 MAR.

The issue was reviewed with the Corporate Nurse on 10/19/17 at 11:30 a.m. The Calcitonin documentation on the August 2017 MAR was reviewed. As there was no place to document which nostril medication was administered on which day, the Corporate Nurse was asked how a nurse would know in which nostril to administer medication. The Corporate Nurse stated that the nurse would not know.

Fundamentals of Nursing, 6th Edition, Potter-Perry, p. 419, provides the following guidance regarding physicians' orders, "The physician is responsible for directing medical treatment. Nurses are obligated to follow physicians' orders unless they believe the orders are in error or would harm the clients. Therefore all orders must be assessed, and if one is found to be erroneous or harmful, further clarification from the physician is necessary."

The facility used Mosby's for their standards of

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F 281	Continued From page 19 nursing reference.	F 281		
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	F 309		11/22/17

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F 309	Continued From page 20 preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review the facility staff failed to provide the highest possible well-being for 2 Residents (#3 and #4) of 15 residents in the sample. 1. For Resident #3, the facility staff failed to institute planned interventions after a fall, to prevent a second fall. 2. For Resident #4, the facility staff failed to A) implement a bowel protocol and B) failed to treat a low potassium level. The findings included: 1. For Resident #3, the facility staff failed to institute planned interventions after a fall, to prevent a second fall. Resident #3, a 90 year-old female was admitted to the facility on 5/7/2008. Her diagnoses included colon cancer, dementia, psychosis with delusions, Alzheimer's, osteoporosis, hypothyroidism, hypertension, chronic kidney disease, anxiety, and peripheral vascular disease. Resident #3's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/8/2017 was coded as a significant change assessment. Resident #3 was coded a BIMS (Brief Interview of Mental Status) score of 12/15 indicating moderate cognitive impairment. Resident #3 was coded as needing moderate assistance of one person for her activities of daily living and as being always continent of bowel and	F 309	1. Interventions were implemented for prevention of falls on 8/8/17 for Resident #3. A bowel regimen was established for resident #4 on 7/12/17. A potassium level was completed on 9/8/17 and new orders were received for the potassium level for resident #4. 2. Fall care plans were reviewed with resident observations completed to validate interventions were in place on 10/30/17. All discrepancies were immediately corrected. An audit was completed to ensure that all residents had a bowel movement within the last three days on 10/21/17. All concerns were immediately addressed. DON/designee completed a review of lab results received within last 30 days on all current residents to ensure out of range results were addressed on 10/30/17. None were noted. 3. Nursing staff will be educated by DON/designee on initiating fall prevention interventions post fall, monitoring no BM in 72 hour report and ensuring treatment initiated as needed, and notifying provider for delays or inability to obtain lab specimens by 11/22/17. 4. The DON or designee will audit for implementation of fall interventions for 3 residents per week for 4 weeks and then 2 residents per week for 4 weeks. DON or designee will review the No BM in 72 hour report to identify residents whom do	

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F 309	Continued From page 21 occasionally incontinent of bladder. On 10/17/2017 at 3:00 PM a clinical record review was conducted, and it revealed that Resident #3 experienced falls on 8/1/2017 and 8/8/2017. The record indicated that Resident #3 fell on 8/1/2017 while ambulating to the bathroom. She fell backward hitting her back and head on the floor. She was found by staff who used a Hoyer lift to pick her up. She was assessed after the fall and it was determined that there was no injury. The fall investigation stated, "Interventions now in place to monitor Resident closely. New interventions for a bed alarm to alert staff of Resident's attempts to get up without supervision." On 8/8/2017 Resident #3 again fell while ambulating to the bathroom. Progress Note of 8/8/2017 stated "Resident attempting to use rest room calling for her son. Dizzy, lost balance fell backward landing on back and hit head. Got up without assistance and complained of back and head pain. X-ray revealed fracture." The X-ray report dated 8/8/2017 for a "Spine, Lumbrosacral" stated "Multilevel compression fractures are noted of uncertain age". The clinical record also contained a TAR (Treatment Administration Record) showing that the bed alarm was instituted on 8/8/2017, subsequent to both falls. An interview was conducted on 10/18/2017 at 9:00 AM with Employee B, Director of Nursing. She did not know why the implementation of the bed alarm did not take place after the first fall, as	F 309	not have a bowel movement within three days for proper treatment for 3 residents per week for 4 weeks and then 2 residents per week for 4 weeks. The DON/designee will audit 3 lab orders per week for 4 weeks, 2 lab orders per week for 8 weeks to ensure that notification is made to the provider regarding delays or inability to obtain lab specimens. The results of the audits will be reported at the QAPI meeting by the DON/Designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis. 5. All corrective actions will be completed by 11/22/17.	

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was outlined in the initial fall investigation.

Administration was informed of findings on 10/19/2017 at 4:30 PM.
2. For Resident #4, the facility staff failed to A) implement a bowel protocol and B) failed to treat a low potassium level.
A) Failed to implement a bowel protocol

Resident #4, a 60 year old, was admitted to the facility on 2/10/00. Diagnoses included cerebral palsy, hypertension, depression, intellectual disability and mood disorder.

The most recent Minimum Data Set assessment was a comprehensive assessment with an assessment reference date of 7/18/17. Resident #4 was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment. He required extensive assistance with activities of daily living.

During the May 2017, Resident #4's bowel movements were documented as follows:
5/2/17: soft, large
5/3/17: loose, medium
5/4/17: loose, large
5/5/17: loose, extra large
5/6/17: none
5/7/17: none
5/8/17: none
5/9/17: soft, medium
5/9/17: loose, small
5/10/17: loose, medium

Resident #4 did not have a bowel movement for 3 days (5/6/17- 5/8/17).

A review of the May 2017 Medication

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Administration Record (MAR) revealed that Resident #4 had an order for Milk of Magnesia give 30 milliliters as needed one time daily for constipation (give with prune juice). This medication was not administered during the month.

On 10/19/17 at 11:05 a.m., the Corporate Nurse was asked if the facility had a bowel management protocol policy. The Corporate Nurse stated that there was no policy. When asked how the nursing staff were supposed to treat constipation, the Corporate Nurse stated the nursing staff was supposed to administer whatever medication was included in the resident's orders after 3 days without a bowel movement.

The following nursing notes were documented in the clinical record:
5/11/17 at 10:41 a.m. "Resident's abdomen appears distended and hard. No bowel sounds this am (morning) but could hear thin faint bowel sounds this pm (evening) with NP (nurse practitioner) in to assess and xray ordered. Resident denies discomfort and bowels are moving however, his stool is looser than normal."

5/12/17 at 12:15 a.m. "Spoke to hospital with the resident admitted."

Resident #4 was admitted to the hospital from 5/11/17- 5/20/17. The hospital discharge summary read "A CT (CAT scan) of the abdomen was performed which revealed significant pancolonic distension with fecal impaction and diffuse wall thickening in the rectum down towards the anus. He was admitted to the hospital for treatment of severe constipation and hypokalemia." The summary also read "1.

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Constipation. CT did reveal a large-bowel obstruction. He was given enemas and Miralax, and this eventually did resolve. This was followed by frequent loose stooling which is improving." Discharge medications included Milk of Magnesia give 30 milliliters oral daily as needed for constipation.

Resident was re-admitted to the facility on 5/20/17. He was sent back to the emergency room on 5/30/17. The nursing note read "Residents x-ray showed there is a diffuse ileus. Residents abdomen is distended, and painful. RR (responsible party) notified, requested resident be sent to ED (emergency department). MD (doctor) gave order to transfer resident for further evaluation."

While Resident #4 was at the facility from 5/20/17-5/30/17, he did not receive any medication for constipation or bowel management.

Resident #4 was in the hospital from 5/30/17-7/12/17. He was admitted to Hospital #1 from 5/30/17-6/24/17 and transferred to Hospital #2 from 6/24/17- 7/12/17.

The following documentation is from the Hospital #2 admission note dated 6/24/17 "Patient again developed abdominal distension, x-ray was obtained that showed intestinal obstruction. Patient was admitted to (Hospital #1) on 5/31/17 for progressive abdominal distension. CT scan showed colonic wall thickening, diffuse gas distension with findings suggestive of inflammatory colitis vs. ileus, r/o (rule out) toxic megacolon. PT (patient) also noted to have severe hypokalemia and mild hypomagnesemia.

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He was started on ciprofloxacin and metrodiazole and aggressive electrolytes replacement (po and IV KCL) (by mouth and intravenous). His stool exam was benign and he was having constipation and occasional explosive bowel movement. No nausea, vomiting or fever or chills. No clear etiology of the hypokalemia was identified. Despite daily replacement his potassium level remained low. Given prolonged hospital stay and unresolving abdominal distension, poor oral intake, PICC (peripherally inserted central catheter) line was placed and started on TPN (total parental nutrition) also for malnutrition. He was evaluated by GI (gastrointestinal), surgery and Nephrology (kidney) (for hypokalemia, low urine K, low urine phos and hypocalciurea, high urine chloride level, no significant metabolic alkalosis or hyperchloremic alkaosis, hypokalemia felt to be from colonic potassium sequestration). GI and Surgery felt that abdominal distension is from pseudo-obstruction/ ileus (Ogilive syndrome) due to hypokalemia and suggested no acute invasive procedure. GI recommended transferring patient to tertiary level of care for further management."

Resident #4 returned to the facility on 7/12/17. Currently, Resident #4 receives scheduled Bisacodyl 10 milligram rectal suppository one time daily (ordered 7/17/17). He has received this medication per the MAR documentation. He also had an order for Milk of Magnesia 30 cc as needed every day.

A physician progress note from the surgeon dated 9/21/17 read "The physicians at (Hospital #2) concur with my current impression, which is that surgical intervention (a colon resection) should be reserved as a last resort for (Resident #4). The

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risks of the operation and long-term problems associated with him having a colectomy are significant. Thus, if he is able to eat and maintain adequate nutrition, he will likely always have colonic distension." In addition, the note read "I spoke with (Resident #4's) father during the last office visit, he also felt that his son would likely not do well with a big operation and certainly would not handle having a colostomy."

Resident #4 had a care plan for constipation. It is not dated. Goal: "Resident will maintain a pattern of bowel elimination of no less than every 3-4 days." Interventions included consult with dietitian, consume fluids, monitor bowel elimination, administer medications per bowel protocol. See MAR, notify nurse of signs and symptoms of fecal impaction (fever, acute abdominal pain, nausea, vomiting, watery discharge).

At the end of day meeting on 10/19/17, it was reviewed with the Administrator, Director of Nursing and Corporate Nurse that there was no bowel protocol initiated prior to or after the first hospitalization.

B) Failed to treat a low potassium level

During the 5/11/17 hospital stay, Resident #4 was identified to have low potassium (hypokalemia). The discharge summary read "He was admitted to the hospital for treatment of severe constipation and hypokalemia."

Upon return to the facility on 5/20/17, Resident #4 was started on the potassium supplement Klor-Con 20 milliequilivants (mEq), extended release one tablet daily.

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Resident #4 was in the hospital from 5/30/17-7/12/17. The 6/24/17 admission note from Hospital #2 documented "severe hypokalemia".

The following information about hypokalemia was accessed at the Mayo Clinic website on 10/25/17 at 9:19 a.m.:
https://www.mayoclinic.org/symptoms/low-potassium/basics/definition/SYM-20050632.
"Low potassium (hypokalemia) refers to a lower than normal potassium level in your bloodstream. Potassium helps carry electrical signals to cells in your body. It is critical to the proper functioning of nerve and muscles cells, particularly heart muscle cells. Normally, your blood potassium level is 3.6 to 5.2 millimoles per liter (mmol/L). A very low potassium level (less than 2.5 mmol/L) can be life-threatening and requires urgent medical attention."

The following is a timeline of the hypokalemia management:

7/13/17 (return to facility), potassium chloride 40 mEq every six hours.
8/1/17 Lab: potassium level= 3.1 (low)
8/4/17- Lab: potassium level= 2.5 (nursing note)
8/6/17 potassium chloride 40 mEq- give extra dose at 9:00 a.m. one time
8/7/17 potassium chloride 40 mEq every six hours discontinued according to MAR (last does at 3:00 p.m.)
8/7/17 potassium chloride 20 mEq- one time does in evening
8/8/17 Lab: potassium level= 3.0 (low)
8/8/17 potassium chloride 20 mEq (2 tabs) every day ordered
8/9/17 Lab: potassium level= 2.8 (critical)

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F 309	Continued From page 28 8/9/17 potassium chloride 20 mEq (2 tabs) administered this day and then discontinued this day 8/9/17 potassium chloride 20 mEq (2 tabs) administered 8/9/17 NP note "K was 2.5 and now at 3. Have increased K (potassium) to 40 meq qd (daily)" 8/10/17 potassium chloride 20 mEq (2 tabs) discontinued 8/10/17 potassium chloride 20 mEq (2 tabs) two times daily for five days 8/15/17 last does of potassium chloride 20 mEq (2 tabs) administered 8/15/17 MD note: "His most recent laboratory data revealed an improvement in his low potassium though it remains below normal." Plan: "Laboratory testing will be repeated this week to check his electrolytes and magnesium." 8/15/17- 9/5/17 NO POTASSIUM ORDERED 8/18/17 nursing note "Lab draw unsuccessful, will pass on to next nurse" (Physician was not notified). 8/21/17 nursing note "Unable to obtain blood from right A/C, unable to find another site. Oncoming nurse aware." 8/30/17 nursing note "Unable to draw blood from right a/c for BMP and magnesium. Day shift nurse notified." 9/5/17 potassium chloride 20 mEq two times daily ordered 9/6/17 Pharmacy recommendation: "Recent K+ 2.8 Currently not on a K+ supplement. Should he restart the K+ supplement? NP response: "yes on 40 mEq + recheck". 9/8/17 Lab: potassium level= 2.0 (critical) 9/8/17 nursing note "Received call from pharmacy for critical potassium level. RP (responsible party) notified. On call doc notified. New orders entered."	F 309		

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9/8/17 NP note: "Called by nursing for critical K+ 2.0 Review of labs seem to indicate this is not a new issue for this gentleman". "Will treat with 40 extra potassium tonight for total of 60 po Then 40 mEq BID (twice daily) until Monday with repeat BMP (lab) on Monday".
9/8/17 potassium chloride 20 mEq two times daily discontinued
9/8/17 potassium chloride 20 mEq (2 tabs) one time ordered critical low potassium
9/8/17 potassium chloride 20 mEq one time, critical low potassium give now with 40
9/8/17 potassium chloride 20 mEq (2 tabs) two times daily ordered
9/11/17 Lab: potassium level= 2.5 (critical)
9/11/17 nursing note "Lab called and communicated critical K (potassium) value of 2.5. This is an improvement from 2.0 on 9/8/17. Dosage remains 40 mEq BID (twice daily). NP (nurse practitioner) notified of critical lab value. This is a normal trend for resident."
9/11/17 NP note: "being seen for follow up low K. He has been in and out of hospitals and ER d.t. (due to) his ABD (abdominal) distension and ileus and has had multiple med changes. Upon his last return, he was not on any potassium." "Hypokalemia- Primary Will repeat labs next Monday".
9/18/17 Lab: potassium level= 2.7 (critical)
9/18/17 nursing note "Lab called to advise that resident's potassium level was 2.7. Prior potassium level was 2.5. Current dosage is 2.5 Provider aware of value. Will continue to monitor for signs/ symptoms of hypokalemia.
9/20/17 potassium chloride 20 mEq (2 tabs) two times daily discontinued
9/21/17 potassium chloride 20 mEq (2 tabs) three times daily ordered
9/25/17 NP note: "Also his K level had been low

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F 309	Continued From page 30 and had been given extra K". "Labs to be done on 9/27 to re-evaluate the K level. As his K was 2.7. Given extra K but have now started lasix". 9/28 17 nursing note "2 unsuccessful attempts at drawing labs on top of left hand. Will pass on. Fluids encouraged." 9/29/17 Lab: potassium level= 2.5 (critical) 9/29/17 nursing note "Received report from (nurse) that resident's potassium level is 2.5 PC (primary care) to NP (nurse practitioner) who ordered 40 mEq potassium chloride stat and 40 mEq potassium chloride 40 mEq tomorrow morning. Order input." 9/29/17 potassium chloride 10 mEq (4 tabs) give one time 9/30/17 potassium chloride 10 mEq (4 tabs) give one time 10/5/17 Lab: potassium level= 2.5 (critical) 10/18/17 Lab: potassium level= 4.1 (WNL) On 8/15/17, the physician ordered a repeat lab draw. The lab draw was not completed and the physician was not notified. From 8/15/17-9/5/17, Resident #4 did not receive a potassium supplement. On 9/8/17, the lab completed most recent to the 8/15/17 order, the potassium level was 2.0, a critical low level. Throughout September 2017, Resident #4 continued with a critical low level of potassium. On 10/18/17, the potassium level was 4.1, which is within normal limits. At the end of day meeting on 10/19/17, the facility Administration was notified of the issue.	F 309		
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3)	F 323		11/22/17

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F 323	Continued From page 31 (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed for one resident, (Resident #7) in a survey sample of 15 residents, to provide a safe living environment. Resident #7 did not have on non skid socks. The findings included: Resident #7, was admitted to the facility 5/4/16. Diagnoses included high blood pressure, dementia with psychotic disorder, and diabetes.	F 323	1. Resident #7 nonskid socks were applied on 10/19/17 by charge nurse. 2. An audit of residents for fall interventions was completed by the RN supervisor on 10/29/17 to ensure that interventions were correct on resident profile and in place for the residents. 3. Nursing staff will be educated by DON/designee on necessity of fall interventions remaining in place	

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F 323	Continued From page 32 Resident #7's most recent MDS (minimum data set) with an ARD (assessment reference date) of 9/14/17 was coded as a quarterly assessment. Resident #7 was coded as having a BIMS (brief interview of mental status) of "3" out of 15, or severe cognitive loss. He was coded as requiring extensive to total assistance of one to two staff members to perform activities of daily living, such as walking and locomotion. He was coded as having two falls without injury and one fall with minor injury. On 10/17/17 at 2:00 PM, during the initial tour, Resident #7 was observed in his low bed, with a mat alarm in place. Resident #7 was not wearing non skid socks, but had on regular socks. On 10/18/17 at 8:20 AM, Resident #7 was observed in his bed, wearing the same socks as the day before. On 10/18/17 at 2:55 PM, Resident #7 had been to the shower. He was observed back in his room in bed, wearing regular socks. On 10/18/17 at at 3:45 PM, CNA (certified nursing assistant) A was questioned if the resident had any non skid socks. She stated, "All his socks are regular socks. He does wear shoes." On 10/19/17 at 9:30 AM, Resident #7 was observed in the dining room, wearing non skid socks and shoes. Review of the clinical record revealed the following falls: 8/23/17: Found on floor, sustained a skin tear.	F 323	completed by 11/22/17. 4. The DON or designee will audit 3 residents weekly times 4 weeks and then 2 residents weekly for 4 weeks for compliance with fall interventions. The results of the audits will be reported at the QAPI meeting by the DON/Designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis. 5. All corrective actions will be completed by 11/22/17.	

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The resident stated, "I have to (sh..)." The intervention for this fall was to "use the call bell."

9/8/17: Found on floor in bath room. The resident was placed on the toilet and the staff left him. The intervention was to not leave resident unattended.

9/30/17: The resident was sitting on the toilet (had taken himself to the bath room) yelling, "Help, help." The alarm was sounding. Before the staff could get to him, he had fallen forward onto the floor, sustaining a 7 centimeter (2.75 inches) laceration, requiring sutures. There have been no further falls since this incident. A fall assessment risk assessment dated 9/21/17 revealed the resident was at high risks for falls.

Review of the care plan dated 8/17/16 to present included that the resident "was at risk for falls related to ataxic gait, vascular dementia and history of falls." Interventions included, but not limited to:

11/11/16:Mattress pad
3/9/17: Place floor alarm at bedside
4/3/17: Toileting program
No date: Encourage resident to use call bell and ask for assistance
9/17/17: Verbal education to staff to cut on all alarms to prevent falls
No date: Encourage resident to wear non skid shoes or socks

Review of the facility's Policy/Procedure for Falls Prevention and Management revealed:

PT (physical therapy) OT (occupational therapy) screen for functional status. Assess for proper

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F 323	Continued From page 34 adaptive equipment already in use (wheel chair, walkers, canes, shoes, gripper socks, etc." On 10/18/17 at the end of the day exit, the Administrator and DON (director of nursing) were notified of above findings.	F 323		
F 329 SS=D	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the	F 329		11/22/17

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F 329	Continued From page 35 medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure 1 resident (Resident #4) of 15 residents was free from unnecessary medications. Resident #4 was administered duplicate doses of Depakote (for mood disorder). The findings included: Resident #4, a 60 year old, was admitted to the facility on 2/10/00. Diagnoses included cerebral palsy, hypertension, depression, intellectual disability and mood disorder. The most recent Minimum Data Set assessment was a comprehensive assessment with an assessment reference date of 7/18/17. Resident #4 was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment. He required extensive assistance with activities of daily living. According to the October 2017 Medication Administration Record (MAR), Resident # 4 had the following orders for Depakote (Divalproex) to be administered in the morning:	F 329	1. Resident #4 medication was clarified by RN supervisor on 10/4/17 to ensure resident did not receive duplicate doses of medication. RP was also notified. 2. An audit was completed by the RN supervisor on all current residents on 10/21/17 to ensure residents were not receiving duplicate doses of medications. No issues were noted. 3. Licensed staff will be educated by DON/designee to ensure residents do not receive duplicate medications by 11/22/17. 4. DON or designee will audit new orders to ensure there are no duplicate doses of medications for 3 residents per week for 4 weeks and then 2 residents per week for 4 weeks. The results of the audits will be reported at the QAPI meeting by the DON/Designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis. 5. All corrective actions will be completed by 11/22/17.	

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1. Depakote Extended Release 500 milligram. Ordered 7/13/17, discontinued 10/4/17. Administered 10/3/17 and 10/4/17.

2. Divalproex 125 milligram capsule, 4 capsules (500 milligram) delayed release sprinkles. Ordered 10/2/17, discontinued 10/4/17. Administered 10/3/17 and 10/4/17.

3. Depakote Sprinkles 125 milligram 125 milligram capsule, delayed release 4 capsules (500 milligram). Ordered 10/4/17. Administered 10/4/17.

In summary, on the morning of 10/3/17, Resident #4 was administered a duplicate dose of 500 milligrams of Depakote. On the morning of 10/4/17, Resident #4 was administered a triplicate dose of 500 milligrams of Depakote.

A Medication Regimen Review (MRR) was completed on 10/4/17. The MRR read "New order for Depakote sprinkles in addition to current ER (extended release) 500 mg (milligram) AM (morning) and 1000 mg PM (evening)?" In addition to the MRR, on 10/4/17 the pharmacist sent a "Note to Attending Physician/ Prescriber" to the nurse practitioner. This note read "Reviewing (Resident #4) chart, noticed a new order for Depakote Sprinkles 125 mg (milligram) x 4 (500 mg) sprinkled on food q (every) AM (morning). He is alsohas (sic) concurrent orders for Depakote ER (extended release) 500 mg (milligram) q AM (morning) and 1000 mg (milligram) q (every) HS (evening). Is the new order for sprinkles to replace the am (morning) 500 ER (extended release) dose, or in addition? Just wanted to clarify as it looks like he's receiving all of the above."

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F 329	Continued From page 37 The nurse practitioner marked "Agree" and wrote "Done" on the form. Two of the three Depakote orders were discontinued on 10/4/17. On 10/19/17 at 11:30 a.m., the Depakote issue was reviewed with the Corporate Nurse. She was asked to clarify whether all three orders for morning Depakote were supposed to be active or if a new order was written without the old order being discontinued. The Corporate Nurse stated that she was aware that the pharmacist, nurse practitioner and mental health practitioner had been in contact by email regarding the Depakote orders. It was reviewed with the Corporate Nurse that it appeared that the pharmacist identified the duplicate orders during the MMR. The Corporate Nurse stated she was going to contact the nurse practitioner for clarification. On 10/19/17 during the afternoon, the Corporate Nurse stated that she was unable to reach the nurse practitioner. At 3:58 p.m., the Director of Nursing stated that the facility did not have any further information regarding the issue.	F 329		
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	F 333	1. Resident #4 medication was clarified	11/22/17

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F 333	Continued From page 38 review the facility staff failed to ensure 1 resident (Resident #4) of 15 residents was free from a significant medication error. Resident #4 was administered duplicate doses of Depakote (for mood disorder). The findings included: Resident #4, a 60 year old, was admitted to the facility on 2/10/00. Diagnoses included cerebral palsy, hypertension, depression, intellectual disability and mood disorder. The most recent Minimum Data Set assessment was a comprehensive assessment with an assessment reference date of 7/18/17. Resident #4 was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment. He required extensive assistance with activities of daily living. According to the October 2017 Medication Administration Record (MAR), Resident # 4 had the following orders for Depakote (Divalproex) to be administered in the morning: 1. Depakote Extended Release 500 milligram. Ordered 7/13/17, discontinued 10/4/17. Administered 10/3/17 and 10/4/17. 2. Divalproex 125 milligram capsule, 4 capsules (500 milligram) delayed release sprinkles. Ordered 10/2/17, discontinued 10/4/17. Administered 10/3/17 and 10/4/17. 3. Depakote Sprinkles 125 milligram 125 milligram capsule, delayed release 4 capsules (500 milligram). Ordered 10/4/17. Administered	F 333	on 10/4/17 to ensure resident did not receive duplicate doses of medication. RP was notified by unit nurse. 2. An audit was completed by the DON on all current residents on 10/21/17 to ensure residents were not receiving duplicate doses of medications no issues were noted. 3. Licensed staff will be educated by DON/designee to ensure residents do not receive duplicate medications completed on 11/22/17. 4. DON or designee will audit new orders to assure no duplicates on 3 residents per week for 4 weeks and then 2 residents per week for 4 weeks. The results of the audits will be reported at the QAPI meeting by the DON/Designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis. 5. All corrective actions will be completed by 11/22/17.	

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10/4/17.

In summary, on the morning of 10/3/17, Resident #4 was administered a duplicate dose of 500 milligrams of Depakote. On the morning of 10/4/17, Resident #4 was administered a triplicate dose of 500 milligrams of Depakote.

A Medication Regimen Review (MRR) was completed on 10/4/17. The MRR read "New order for Depakote sprinkles in addition to current ER (extended release) 500 mg (milligram) AM (morning) and 1000 mg PM (evening)?" In addition to the MRR, on 10/4/17 the pharmacist sent a "Note to Attending Physician/ Prescriber" to the nurse practitioner. This note read "Reviewing (Resident #4) chart, noticed a new order for Depakote Sprinkles 125 mg (milligram) x 4 (500 mg) sprinkled on food q (every) AM (morning). He is alsohas (sic) concurrent orders for Depakote ER (extended release) 500 mg (milligram) q AM (morning) and 1000 mg (milligram) q (every) HS (evening). Is the new order for sprinkles to replace the am (morning) 500 ER (extended release) dose, or in addition? Just wanted to clarify as it looks like he's receiving all of the above."

The nurse practitioner marked "Agree" and wrote "Done" on the form. Two of the three Depakote orders were discontinued on 10/4/17.

On 10/19/17 at 11:30 a.m., the Depakote issue was reviewed with the Corporate Nurse. She was asked to clarify whether all three orders for morning Depakote were supposed to be active or if a new order was written without the old order being discontinued. The Corporate Nurse stated that she was aware that the pharmacist, nurse

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F 333	Continued From page 40 practitioner and mental health practitioner had been in contact by email regarding the Depakote orders. It was reviewed with the Corporate Nurse that it appeared that the pharmacist identified the duplicate orders during the MMR. The Corporate Nurse stated she was going to contact the nurse practitioner for clarification. On 10/19/17 during the afternoon, the Corporate Nurse stated that she was unable to reach the nurse practitioner. At 3:58 p.m., the Director of Nursing stated that the facility did not have any further information regarding the issue.	F 333		
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	F 441		11/22/17

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possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(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.

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F 441	Continued From page 42 (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation review, the facility failed for one resident (Resident #10) in a survey sample of 15 residents, to ensure there was an effective prevention infection control program. LPN (licensed practical nurse) A did not wash her hands correctly and placed a barrier (foil) on the medication cart after it had been placed on the resident's bedside table. The findings included: Resident #10, was admitted to the facility 8/16/16. Diagnoses included high blood pressure, dementia, congestive heart failure and stroke. Resident 10's most recent MDS (minimum data set) with an ARD (assessment reference date) of 8/9/17 was coded as an annual assessment. Resident #10 was coded as having a BIMS (brief interview of mental status) of "8" out of 15, or moderate cognitive loss. She was coded as requiring extensive to total assistance of one to two staff members to perform activities of daily living, eating. The resident was coded as having a gastrostomy tube (tube inserted into the stomach for feeding and medications). On 10/17/17 at approximately 3:50 PM, a medication observation was conducted with LPN (A). LPN (A) entered the room without knocking. After giving the medication via the gastrostomy tube, LPN (A) washed her hands at the sink for	F 441	1. LPN A was educated by the DON on 10/17/17 for proper handwashing technique and the procedure for completing a glucometer test utilizing appropriate infection control techniques. 2. All residents are at risk for failure to ensure an effective prevention infection control program. 3. All department staff will be educated on proper handwashing technique by Clinical Educator by 11/22/17. Licensed nursing staff will be educated by Clinical Educator on procedure for utilizing glucometer to include infection control standards by 11/22/17. 4. The DON or designee will audit 3 staff weekly times 4 weeks and then 2 staff weekly times 4 weeks to ensure proper handwashing. The DON or designee will audit 3 Licensed nurses weekly times 4 weeks and then 2 licensed nurses weekly times 4 weeks and that glucometer procedure is utilized including infection control practices. The results of the audits will be reported at the QAPI meeting by the DON/Designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis. 5. All corrective actions will be completed by 11/22/17.	

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F 441	Continued From page 43 approximately 12 seconds, then turned off the faucet with her bare hands. On 10/17/17 at 4:05 PM, LPN (A) entered Resident #11's room without knocking. LPN (A) had placed the glucometer on a foil barrier, which she placed on the resident's bedside table. After completing the medication pass, LPN (A) removed the glucometer with the foil barrier and placed the foil and glucometer back on the medication cart. Review of the facility's policy on handwashing (revised 7/4/17) revealed: "Hands must be washed for a minimum of 15 seconds...the faucet should be turned off with a paper towel." On 10/19/17 at 8:20 AM, a review of the infection control program was conducted with RN (registered nurse) B. The facility does have a hand hygiene report using multiple observations of handwashing. The DON (director of nursing) stated that by using bare hands to turn off the faucet, she touched a "dirty surface." On 10/18/17 at the end of the day exit, the Administrator and DON (director of nursing) were notified of above findings.	F 441		
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-	F 514		11/22/17

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F 514	Continued From page 44 (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (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, the facility staff failed to ensure a complete and accurate clinical record for 4 residents (Resident #4, 5, 1, 7) of 15 residents in the survey sample. 1. Resident #4's pharmacy recommendation and the physician's response was not kept with the clinical record. 2. Resident #5's pharmacy recommendation and the physician's response was not kept with the	F 514	1. To ensure complete medical records, the pharmacy recommendations with the physician□s response were placed on the medical record for resident #4, #5, #1 and #7 on 10/30/17 by the DON. 2. Pharmacy recommendations with the physician response will be placed in all current resident records and monthly upon completion by DON or designee.	

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F 514	Continued From page 45 clinical record. 3. Resident #1's pharmacy recommendation and the physician's response was not kept with the clinical record. 4. Resident #7's pharmacy recommendation and the physician's response was not kept with the clinical record. The findings included: 1. Resident #4's pharmacy recommendation and the physician's response was not kept with the clinical record. Resident #4, a 60 year old, was admitted to the facility on 2/10/00. Diagnoses included cerebral palsy, hypertension, depression, intellectual disability and mood disorder. The most recent Minimum Data Set assessment was a comprehensive assessment with an assessment reference date of 7/18/17. Resident #4 was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment. He required extensive assistance with activities of daily living. Review of the clinical record revealed monthly medication reviews. However, pharmacy recommendations and physician response to the recommendations were not available on the record. The Corporate Nurse provided six recommendations (4/4/17, 8/2/17 (2), 9/6/17 (2), 10/4/17) that were kept in a location other than the clinical record. On 10/18/17 at 1:45 p.m., the Corporate Nurse stated that the facility does not keep the pharmacy recommendations on the chart.	F 514	3. Facility nursing and pharmacy leadership will be provided additional education by QA support team regarding pharmacy recommendation process with the physician response and placement in the medical record to ensure complete medical records by 11/22/17. 4. The DON or designee will review 5 records monthly for 3 months to ensure pharmacy recommendations have a physician response and are placed on the medical record. The results of the audits will be reported at the QAPI meeting by the DON/Designee for evaluation of compliance and ongoing monitoring for continuous improvement analysis. 5. All corrective actions will be completed by 11/22/17.	

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2. Resident #5's pharmacy recommendation and the physician's response was not kept with the clinical record.

Resident #5, a 72 year old, was admitted to the facility on 2/4/16. Her diagnoses included colon cancer, diabetes, hypertension, dementia, and lupus. The most recent Minimum Data Set assessment was a comprehensive assessment with an assessment reference date of 9/15/17. She has a Brief Interview of Mental Status score of 15 indicating no cognitive impairment and required assistance with activities of daily living.

Review of the clinical record revealed monthly medication reviews. However, pharmacy recommendations and physician response to the recommendations were not available on the record. The Corporate Nurse provided eight recommendations (10/4/16, 11/2/16, 1/5/17, 2/2/17, 5/4/17, 6/7/17, 8/2/17, 9/6/17) that were kept in a location other than the clinical record.

3. Resident #1's pharmacy recommendation and the physician's response was not kept with the clinical record.

Resident #1, a female, was admitted to the facility 8/22/16. Her diagnoses included high blood pressure, Alzheimer's dementia, low vision both eyes and hearing loss bilaterally.

Resident #1's most recent MDS (minimum data set) with an ARD (assessment reference date) of 7/28/17 was coded as a quarterly assessment. Resident #1 was coded as having a BIMS (brief interview of mental status) of "15" out of 15, or no cognitive loss. She was coded as requiring

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extensive to total assistance of one to two staff members to perform her activities of daily living. She was coded as being continent of bowel and occasional urinary incontinence.

Review of the clinical record revealed monthly medication reviews. However, pharmacy recommendations and physician response to the recommendations were not available and had to be asked for. Resident #1 had three recommendations, dated 2/6/17, 4/8/17 and 5/8/17, which had to be requested.

4. Resident #7's pharmacy recommendation and the physician's response was not kept with the clinical record.

Resident #7, was admitted to the facility 5/4/16. Diagnoses included high blood pressure, dementia with psychotic disorder, and diabetes.

Resident #7's most recent MDS (minimum data set) with an ARD (assessment reference date) of 9/14/17 was coded as a quarterly assessment. Resident #7 was coded as having a BIMS (brief interview of mental status) of "3" out of 15, or severe cognitive loss. He was coded as requiring extensive to total assistance of one to two staff members to perform activities of daily living, such as walking and locomotion. He was coded as having two falls without injury and one fall with minor injury.

Review of the clinical record revealed monthly medication reviews. However, pharmacy recommendations and physician response to the recommendations were not available and had to be asked for. Resident #7 had two recommendations, dated 8/3/17 and 10/8/17,

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F 514	Continued From page 48 which had to be requested. On 10/19/17 at approximately 12:00 PM, the facility Administrator and DON (director of nursing) were notified of above findings.	F 514		