STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 03/29/2018

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BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 3-20-18 through 3-29-18. Corrections are required with 42 CFR Part 483.73, (emergency preparedness) Requirement for Long-Term Care Facilities.	E 000	This plan of correction is prepared and executed because it is required by the provisions of state and federal law and not because Battlefield Park HealthCare Center admits or denies the validity of the allegations and citations listed on the pages of this Statement of Deficiencies. CommuniCare, Battlefield Park HealthCare Center maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit our capability to render adequate care. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction: **Date of Compliance: May 10th, 2018**	
E 007 SS=E	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on Staff interview and facility record review, the facility staff failed to fully document a facility wide assessment to determine what resources are necessary to care for it's residents competently, during both day-to-day operations, and during emergencies. The facility failed to fully answer area 3 of the document including the staff competencies necessary to provide the level and types of care needed for the resident population, and further failed to actively involve the facility administration	E 007	E 007 – 1.) The Facility Wide Assessment has been reviewed and revised by Administrator and or designee to ensure the individual care needs of the resident population are met. 2.) The Facility Wide Assessment has been reviewed with the RDO, RDCO, and or designee to ensure resident's needs within the population were met.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 4/20/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 007	Continued From page 1 in the facility assessment. The findings included; On 3-29-18 at 2:00 p.m., The emergency preparedness program was reviewed with the Administrator. A copy of the "Facility - Wide - Assessment" was requested and supplied. The Administrator was asked if she was involved in the assessment process, and she stated "no." "She stated she received the initial document from their corporate office in October of 2017, and reviewed it with the maintenance director and QAPI in December 2017. She stated this was the only assessment the facility had. Upon review of the document it was noted that in multiple areas of the assessment, the answers to questions were not answered or were insufficient to reflect the individual care needs of the resident population in this facility. In the following areas, the problems with that document is explained; In area #3.2 the staffing plan was not complete. "Licensed nurses providing care", and "Nurse aids" was not included. The box for "total number needed or average or range" stated "see above table", and "see additional staff in above table" was written in. There was no table, only a statement documenting "We review residents needs and abilities to ensure adequate staffing, not just a population based ppd". In area 3.3 (individual staff assignment) of the document, a question asks that a description be given to "describe how individual staff assignments are reviewed for coordination and continuity of care within, and across staff assignments". The process by which	E 007	3.) RDO and or designee will educate Administrator and IDT on how to properly assess facility needs and ensuring those needs are written in section 3 of the facility wide assessment. 4.) The facility will review the Facility Wide Assessment annually within QAPI to ensure compliance.	

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E 007	Continued From page 2 assignments are made was not answered in this document. The below was documented; "Staff and residents are welcome to provide input on preferences. PPD (unknown acronym) is monitored daily and residents are assessed personally for ADL involvement to ensure needs are being met." In area 3.4 (staff training, education, and competencies) a question asks, "Describe staff training/education and competencies that are necessary to provide the level and types of support and care needed for your resident population." "Include staff certification requirements, ...include hiring, education, training, competency instruction, and testing policies." The answer is insufficient and does not describe education necessary to care for the resident population. The below was documented; "Resident rights, transfers, infection control, fire/disaster drills, applicable CNA/Nursing license." In the facility assessment document, specific questions were asked requiring descriptive answers. The responses the facility gave did not answer the questions. The below was documented by the facility; Question (1.) area 3.5, How are policies developed and updated. Answer (1) Policies are reviewed annually and as needed by QA committee. Question (2.) area 3.6, Describe how the facility recruits, and retains medical practitioners, and ensures they are adequately trained and	E 007		

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E 007	Continued From page 3 understand professional standards, and the facility population. Answer (2) Facility contracts with qualified professional physicians to ensure the needs of the residents are met. physician meets with DON, ADON, or ED on a weekly basis at risk meeting along with QA meeting to ensure all residents needs are being met. Question (3.) area 3.7, How do management and staff familiarize themselves with professional standards and know what expect from healthcare professionals standards, protocols and terms of care delivery processes developed by the medical director. Answer (3) Practitioners attend weekly at risk meetings and monthly at QA meetings to ensure strong communication and an IDT approach. Medical Director also works very closely and in a timely manner with the nursing team. Question (4.) area 3.9, List contracts memoranda of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies. Answer (4) Refer to local vendor list in emergency preparedness binder. Question (5.) area 3.10, Describe how the facility will share information with other organizations and securely transfer health information to providers during emergencies, and ensuring access to residents and their families. Answer (5) Point Click care is our EMR system. Requests for health information is routed through our EMR department. Upon completed request, all requests are completed in a timely fashion. Power outage policy details systems for	E 007		

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E 007	Continued From page 4 managing resident records in an emergency. Question (6.) area 3.11, describe how you evaluate your infection prevention and control program including effective systems 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 agreement, that follow accepted national standards. Answer (6) Infection control is reviewed during our weekly at risk meeting. Additionally it is reviewed at QA. Any additional review is done on an as needed basis. On 3-29-18 the facility staff was notified and made aware that the facility assessment contained errors. No further information was presented by the facility.	E 007		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 03/20/2018 through 03/29/2018. An extended survey was conducted 03/20/2018 through 03/29/2018. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two complaints were investigated during the survey. Immediate Jeopardy (IJ) was identified in the area of Quality of Care on 03/20/2018 at 6:13 p.m. The facility removed the immediacy on 03/20/2018 at 9:09 p.m. After removal of the immediacy the Scope and Severity was lowered to a Level III, isolated.	F 000		

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F 000	Continued From page 5 Substandard Quality of Care (SQC) was identified in the area of Quality of Care, Level III, Pattern on 03/20/2018 at 6:13 p.m.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity 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. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550	**F550** 1.) Resident #364's ADL care and incontinent care was completed as indicated. Resident # 32 urinary drainage was lifted off the floor and was provided a cover for privacy and dignity. 2.) Current residents were evaluated for ADL and incontinent needs and addressed as indicated. Current residents with urinary catheters were reviewed for drainage bag covers and that the drainage bag is secured off of floor. 3.) The Assistant Director of Nursing/designee educated Nursing staff on the policies and procedures for ADL care, incontinent care, storage and privacy for indwelling catheter and drainage bag. Charge Nurse/designee will complete every shift observations of current residents to ensure ADL and incontinent care are provided per plan of care and that indwelling catheter bag is secured off floor and covered for privacy and dignity.	

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F 550	Continued From page 6 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation review, the facility failed to ensure 2 residents (Resident #364 and #32) in a survey sample of 38 residents were treated with dignity and respect. 1. For Resident #364, the facility staff failed to provide incontinent and ADL care. 2. For Resident #32, the facility staff failed to ensure the urinary catheter bag and tubing were not touching the floor and failed to provide a privacy cover for the urinary bag. During the initial tour of the facility, Resident # 32 was observed to be lying in bed with his urinary drainage bag and tubing touching the floor and with no privacy urinary bag cover. The findings included: 1. For Resident #364, the facility staff failed to provide incontinent and ADL care. Resident #364 was admitted to the facility on 3/15/18 with diagnoses to include but not limited to Bronchitis related to trachea, traumatic brain injury due to Motor Vehicle Accident Hydrocephalus, sacral pressure ulcer stage II and Peg tube.	F 550	4.) Assistant Director of Nursing/Designee will completed observational validations of 10 residents per week for 12 weeks to ensure ADLS and incontinent care are completed as per plan of care. Results of Audits will brought to QAPI. Central Supply will complete an audit weekly for 12 weeks of current residents with a urinary drainage bag to ensure drainage bag is off floor and covered with results brought to QAPI.	

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F 550	Continued From page 7 Resident # 364's had not been at the facility long enough for MDS to be completed. The Admission Resident Evaluation dated 03/15/2018 coded Resident # 364 as Unresponsive to physical and verbal stimuli. It was documented that Resident #364 required Total assist of 2+ persons of for turning and positioning as well as Activities of Daily living. On 3/20/2018 several observations were made on Resident #364. At 12:05 p.m. Resident #364 was observed positioned on his back, dressed in hospital gown. The top sheet was not covering the right side of resident, draw sheet was folded under resident from hips to mid-thigh and the bottom sheet was visibly stained with a yellow stain, appearing dried. The stain extended beyond the level of the draw sheet, the odor of urine in room. The following observations were made on that same day (3/20/18) at 1:20 p.m. in same condition dressed in hospital gown and soiled sheets beneath him positioned on his back. Observed resident again at 1:55 PM and found CNA C performing incontinent care. During the end of day debriefing on 3/23/2015 at 4:45 PM, the Administrator (Admin A), Director of Nursing (Admin B), Regional Nurse (Admin C) were informed of the findings. No further information was provided.	F 550		

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F 550	Continued From page 8 2. For Resident # 32, the facility staff failed to ensure the urinary catheter bag and tubing were not touching the floor and failed to provide a privacy cover for the urinary bag. During the initial tour of the facility, Resident # 32 was observed to be lying in bed with his urinary drainage bag and tubing touching the floor and with no privacy urinary bag cover. Resident # 32 was a 75 year old male admitted to the facility on 6/21/2012 and readmitted on 3/9/2018 with the diagnoses of, but not limited to, Peripheral Vascular Disease, Neuromuscular Dysfunction of the bladder, Gastroesophageal Reflux Disease, Chronic Kidney Disease, Dysphagia, Atherosclerosis of native arteries of extremities with Gangrene Bilateral Legs, Amputation of toes, Hypothyroidism, Glaucoma, Chronic Viral Hepatitis, Paraplegia, BPH (Benign Prostatic Hypertrophy) and Dementia Resident #32's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 1/30/2018. The MDS coded Resident # 32 with a Brief Interview for Mental Status (BIMS) score of 6 out of 15 indicating severe cognitive impairment. Resident # 32 required extensive assistance of one to two staff members with activities of daily living except required total assistance of one staff person for bathing and always incontinent of bowel and Resident # 32 was coded to have an indwelling urinary catheter. During the initial tour of the facility on 3/20/2018 at 11:30 AM, Resident # 32 was observed lying on his back in bed with an uncovered urinary catheter bag which was visible from the doorway. The bag and tubing were observed to be touching	F 550		

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F 550	Continued From page 9 the floor. On 3/20/2018 at 1:25 PM, observed Resident # 32 was observed lying in bed. The urinary drainage bag and tubing were no longer touching on the floor and was covered with a privacy bag. On 3/20/2018 at 3:20 PM, an interview was conducted with Employee A who stated he placed a cover over the catheter bag for Resident # 32. Employee A stated he lifted the bag off the floor. Employee A stated he saw the bag on the floor and corrected the problem. Employee A stated the bag on the floor was "an Infection Control problem" and the lack of a cover for the urinary bag was a "Privacy" problem. Employee A stated he worked in Central Supply but helped out whenever he could. Review of the clinical record was conducted 3/21/2018 at 3:30 PM. Review of the Physician's Orders revealed orders written on 2/8/2018 included orders for a "Foley catheter for BPH (Benign Prostatic Hypertrophy)" Review of the Care Plan date initiated 11/13/2017 revealed a Focus of "Has indwelling catheter": Skin Breakdown. Goal: Will be/remain free from catheter-related trauma through review date. Revision 3/12/2018/ target date: 5/16/2018 A copy of the facility policy on Catheters was requested. During the end of day debriefing on 3/23/2018 at 1:15 PM, the administrator, Director of Nursing and Corporate Consultant (Admin C) were informed of the findings. The DON and Corporate	F 550		

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F 550	Continued From page 10 Consultant (Admin C) agreed that the urinary bag and tubing should not touch the floor and the urinary catheter bag should be covered. The Director of Nursing stated the facility used Lippincott for Professional Nursing Guidance. No further information was provided.	F 550		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(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 §483.10(g)(17)(i)(A) and (B) of this section. §483.10(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 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	F 582	**F 582** 1.) Resident #165 is not a current resident. No noted negative outcomes related to absence of Notice of Medicare Non-Coverage 2.) Assistant Business Office Manager/designee completed an audit of residents discharged within the last 30 days to ensure no additional residents were effected, any identified areas of concern were addressed as indicated. 3.) The Regional Business Office Manager provided education regarding Notice of Medicare Non-Coverage to the Executive Director, Director of Nursing, Business Office, Social Services and Interdisciplinary team.	

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F 582	Continued From page 11 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 Staff interview and facility documentation review, facility staff failed to complete an Advanced Beneficiary Notice (ABN) or Notice of Medicare Non-coverage (NOMNC) for one resident, Resident #165, in a sample of 38 residents. Resident #165 was not provided a NOMNC prior to discharge from skilled services. The findings included: Resident #165's most recent Minimum Data Set assessment (MDS) was a Discharge assessment with an assessment reference date (ARD) of	F 582	4.) The Assistant Business Office Manager/designee will audit discharges weekly to ensure Notice of Medicare Non-Coverage were issued per requirements x12 weeks with results brought to QAPI to ensure compliance.	

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F 582	Continued From page 12 11/27/2018. Resident #165's Brief Interview for Mental Status (BIMS) assessed a score of 15, indicating no cognitive impairment. Resident #165's diagnoses included: Ataxia, dysphagia, hemiplegia, hemiparesis, cerebral infarct, gastrostomy, dysarthria, hypertension, inguinal hernia, hyperlipidemia, and gastro-esophageal reflux disease. On 3/22/2018, a review of the facility's ABN/NOMNCs was conducted. Three discharged residents were chosen for review. Of the 3 chosen, one resident, Resident #165, did not have a NOMNC immediately available. The Facility Administrator was asked to review the facility records and locate Resident #165's NOMNC. On 3/22/2018, at the end of day meeting, the Facility Administrator informed surveyors that a NOMNC for Resident #165 could not be located. The Facility Administrator provided a document signed by her stating that Resident #165's NOMNC could not be located.	F 582		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the	F 583	**F 583** 1.) Resident #112 and resident #364's records were both placed into appropriate charts 2.) Electronic Health Records Coordinator completed an audit of current residents' charts to ensure each resident had only their information in their record, any identified concerns were addressed as indicated.	

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F 583	Continued From page 13 residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on clinical record review and facility documentation the facility failed to ensure privacy and confidentiality of resident records for 2 residents (Resident #112 and Resident #364) in a sample size of 38 residents. 1. For Resident # 112 facility filed this residents records in another residents chart. 2. For Resident # 364 facility placed other resident's records in this residents chart. Findings include: 1. For Resident # 112 facility filed this residents records in another residents chart.	F 583	3.) The ADON/ designee educated facility staff on confidentiality and privacy of residents' records 4.) The Administrator and or designees will audit 100% of resident's charts weekly for x12 weeks with results brought to QAPI to ensure compliance.	

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F 583	Continued From page 14 1. Resident # 112 is a 62 yr. old male that was admitted to the facility on 03/01/2018 with diagnoses of but not limited to Cancer of Larynx, Chronic Pancreatitis, Hepatitis C, failure to thrive. On 3/23/18 resident #112's face sheet with picture and all identifying information including diagnosis, Medicaid number, Social Security number and emergency contact information, also his physician's orders and medical appointment and transportation information for an upcoming appointment were found in Resident # 364's chart. 2. For Resident # 364 facility placed other resident's records in this residents chart. Resident #364 was admitted to the facility on 3/15/18 with diagnoses to include but not limited to Bronchitis related to trachea, traumatic brain injury due to Motor Vehicle Accident Hydrocephalus, sacral pressure ulcer stage II and Peg tube. Resident # 364's admission was too recent for a Minimum Data Set (MDS) assessment (an assessment tool.) The Admission Resident Evaluation dated 03/15/2018 coded Resident # 364 as Unresponsive to physical and verbal stimuli It was documented that Resident #364 required Total assist of 2+ persons of for turning and positioning as well as Activities of Daily living. While reviewing chart of Resident #364 information for Resident #112 including face	F 583		

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F 583	Continued From page 15 sheet, diagnosis, Medicaid #, Social Security #, physician orders, and transportation information for resident to attend doctor appointment outside of facility was found in Resident 364's chart . During the end of day debriefing on 3/23/2015 at 4:45 PM, the Administrator (Admin A), Director of Nursing (Admin B), Regional Nurse (Admin C) were informed of the findings. No further information was provided. No further information was provided.	F 583		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, clinical record review, facility documentation review, and in the course of a complaint investigation the facility staff failed to ensure 3 residents (Resident #90, 99, and 111) of 38 residents in the survey sample were free from	F 600	**F600** 1.) Resident #90's allegation was reinvestigated and resident has been moved to a new room, with no further issues noted. Resident #99's allegations have also been reviewed, resident was moved to new room on 11/29/17 per patient request patient has no additional issues noted, and resident #111's incident was reviewed DON and Administrator moved resident to new location where resident has had no additional incidents. Resident #85 has been seen by facility psych physician and is to remain on 1:1.	

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F 600	Continued From page 16 abuse. 1. Resident #85 physically and verbally attacked Resident #90, Resident #99, and Resident #111 over a period of four months. No interventions were put into place to ensure all residents were safe from Resident #85 until after the survey began. The findings included: 1. Resident #85 physically and verbally attacked Resident #90, Resident #99, and Resident #111 over a period of four months. No interventions were put into place to ensure all residents were safe from Resident #85 until after the survey began. Resident #90, a 72 year old, was admitted to the facility on 7/14/17. Diagnoses included End Stage Renal Disease, spinal stenosis, hyperlipidemia, and reflux. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 1/17/18. Resident #90 was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment and required limited assistance with activities of daily living. The following nursing notes were documented in Resident #90's clinical record: 12/18/17, 8:54 a.m. "Resident was attacked by another resident. He states resident came in his room striking him in the head and neck multiply (sic) times. Also, attempting to take walker from him. Resident does not have any bruises or other	F 600	2.) The ADON, Unit managers, and wound care nurse have completed a skin sweep of all residents with a BIMS under 9 with no additional issues noted. The social services director completed an abuse questionnaire with residents with a BIMS 9 and over with no additional issues noted. Facility reported incidents were reviewed from March 2018 to ensure all incidents had appropriate interventions in place for residents effected. 3.) The ADON and or designee completed education with all staff on the Abuse policy and appropriately intervening. 4.) The Administrator/DON or designees will interview if able or conduct a skin assessment on 100% of the residents 1x weekly for 4 weeks, 50% of residents 1x weekly for 4 weeks, and 25% 1x weekly for 4 weeks, with results brought to QAPI x 3 months.	

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marks noted on him. He verbalize that he was okay, just shaken up a bit. Resident is his own RP (responsible party). On call provider called and left a message. Awaiting call back."

1/9/18, 7:00 a.m. "11-7: At around 0300, resident was involved in an altercation with another resident; per resident he was lying in bed and awoke to other resident hitting/slapping him in his face; he was heard yelling and staff responded immediately; removed other resident from his room and (Resident #90) was able to transfer himself out of bed into his wheelchair; he then went propelled himself into the hallway highly upset and trying to tell staff of what had occurred; while he was yet speaking with writer, other resident walked back down to where (Resident #90) sat in his wheelchair all the while yelling and cursing and (unreceptive to redirection) then hocked and spat in (Resident #90) face, writer got in between the two residents to prevent any further altercation, and was able to redirect with hands on (one hand placed at his right forearm and the other hand placed at his back) back to his room. (Resident #90) was cleaned up and encouraged to verbalize his feelings/ emotional hurt from this incident. Resident remained in his room the remainder of shift."

On 3/21/18 in the afternoon, the Administrator was asked to identify the resident that hurt Resident #90. She returned later in the afternoon and stated that it was Resident #85. When asked if she had investigated and reported both instances of resident to resident abuse to the state office, the Administrator stated no.

On 3/21/18 at 4:30 p.m., an interview was conducted with Resident #90. When asked if

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anyone at the facility had hit him or hurt him, Resident #90 stated no. He stated that there are guys around that talk smart to him and a female nurse that talks smart to him, but no one had hurt him. He could not provide the names of anyone. When asked if he was scared of any other residents, Resident #90 stated no. The Administrator and Director of Nursing were notified that Resident #90 stated staff talked smart to him.

Resident #85, a 56 year old, was admitted to the facility on 7/19/17. Diagnoses included major depression, attention-deficit hyperactivity disorder, stroke, traumatic brain injury, hyperlipidemia, reflux, pain, and convulsions.

The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 11/1/17. Resident #85 was coded with a Brief Interview of Mental Status score of 9 indicating moderate cognitive impairment and required limited assistance with activities of daily living.

On 3/21/18 at 4:40 p.m., Resident #85 was sitting on his bed looking out the window. When asked how he was doing, Resident #85 stated he was ok.

On 3/20/18 during the initial tour of the facility, Resident #85 was observed to live in the room next to Resident #90. They shared an adjoining bathroom. Resident #85 was roommates with Resident #111.

On 3/22/18 in the morning, Resident #85 was observed in his room. He had a 1:1 sitter with him. He wore a wander guard to the right ankle.

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F 600	Continued From page 19 He had a roommate (Resident #111). On 3/22/18 at 2:30 p.m., the Administrator and Director of Nursing (DON) were interviewed. When asked if the resident to resident abuse involving Resident #90 and Resident #85 was investigated, the Administrator stated no. When asked if the resident to resident abuse was reported, the Administrator stated no. When asked if she considered the altercations caused by Resident #85 as abuse, the Administrator stated yes. When asked if Resident #90 hurt any other residents, the Administrator stated no. She stated that Resident #85 usually stayed in his own room or at the nursing station. She stated that he hollers out while in his own room. The Administrator was the Abuse Coordinator for the facility. The Abuse Coordinator interview was conducted on 3/23/18 at 11:30 a.m. When asked what she considered abuse, the Administrator named resident to resident abuse, neglect, misappropriation, verbal abuse, mental abuse, physical abuse, corporal punishment, seclusion and sexual abuse. When asked when she was supposed to report abuse to the state office, the Administrator stated abuse was to be reported within 2 hours if harm occurred and within 24 hours for other allegations. When asked if resident burns should be reported, the Administrator stated yes because they are unusual occurrences. Resident #85's clinical record was reviewed. The following notes documented the occasions on which Resident #85 had physical and verbal altercations with other residents: 1. 11/21/17 "resident upset, yelling, and knocking	F 600		

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F 600	Continued From page 20 roommate's tv down in room. RN (registered nurse) administered his medications and he calmed down apologetic and remained in bed for the duration of shift" 2. 11/23/17 "Resident remains on behavior monitoring. Redirected for arguing with roommate. Resident could not clearly specify why he was upset and arguing with roommate but went into garbage can and pulled out and empty plate and shoved it at the roommate stating 'here thank you and yelling incoherently'. Resident asked if he was hungry or wanted a snack. He responded yes. Given HS (evening) snack then resident laid down. No further issues noted. Resident currently in bed with call bell in reach." 3. 11/29/17 "On Wing 1 hallway outside of room, (nurse name) and this nurse observed resident extremely upset, hitting roommate on top of head with his shoe. Yelling 'f**k you!' repeatedly. Separated two residents immediately. Resident continued to curse out inside of room and pace from bathroom to bed and back. Spilled food was also noted on Resident's side of room by his window. Resident was advised to sit and relax to calm down and told that everything will be ok. Resident stated 'Ok, Thank you.' Then took a seat. Stayed in room. Wetness noted to roommates hair, no pain noted but was very upset. Stated 'He spit on me first. I was telling him that he can't put that in the toilet. I got to get out of this room.' Supervisor notified. Resident's mother notified and will be on her way to facility shortly." 4. 12/5/17 "Resident remains on behavior monitoring. Resident came running out of room yelling get him, get him. Staff went to residents	F 600		

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room and he was in there pointing at his roommate speaking incoherently and cursing. Resident was not easily redirected. He started grabbing his roommates bed linens and yanking the privacy curtain back. He refused to calm down after asked repeatedly. Staff attempted to explain to resident that he has a new roommate. Resident finally came out of room but had grabbed some of the roommates Christmas decorations of the table and sat with them at the nurse station. Resident given PRN (as needed) Lorazepam for agitation. medication was effective. Resident accepted HS (evening) snack and then returned to room. Currently in bed resting with call bell in reach."

5. 12/17/17 "Resident showed signs of aggression towards assigned CNA (certified nursing assistant), while caring for his roommate. Resident was difficult to redirect, but, wasn't combative. CNA was instructed to stay away from resident during his throws of aggression to prevent him fro (sic) becoming combative. Resident calmed down & sat on his bed quietly. Continued to monitor resident throughout the day. During lunch, parents were @ bedside & resident was cooperative & pleasant. Assigned CNA was able to give assistance where needed. No further acting out from resident during the remainder of the shift.

6. 12/18/17 "Resident was in another resident's room striking him when the CNA broke up the altercation. Resident was unable to re-direct. He was still trying to get in other resident room to attack him again. Resident snatched roommates pictures off the wall. Resident was redirected to nurses station to calm down. Attempted to call resident mom. Unable to get her the first few

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times. Resident sitting at nursing station calming down. Called residents RP (responsible party) and was able to get her. RP talked to resident for a while and then he handed the phone to the nurse and walked to his room. Resident in room laying on the bed quietly. No further behaviors noted."

7. 12/25/17 "Resident Approached roommate (number) shouting that resident stinks and then (number) went back to his bed trying to take his bed apart. This writer redirected resident to sit down and that maintenance man will fix his bed. Resident (number) then told this writer that he was afraid of roommate and that (number) was balling his fist up at him. This writer then removed resident (number) from room and moved resident to wing 2 (room number). DON (director of nursing) called and informed of above. (Doctor) called x 2 no answer. Nurse practitioner called x 1 no answer. Resident (number) is calm and laying back in his bed."

8. 1/9/18 "11-7: At around 0300 resident to resident altercation occurred with this resident being aggressor. Resident got out of bed, went into another resident's room via the bathroom door; went over to the resident in the "B" bed/ (next to window) and was reportedly slapping the other resident in the face as the other resident lay in bed asleep; other resident awakened to being slapped in his face. When other resident began to yell for help, staff immediately intervened and this resident was escorted/ redirected out of the other resident's room into the hallway. When staff and this resident began to ambulate back to this resident's room, the resident heard the accosted resident up in the hall way; this resident stopped and turned back towards the accosted

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resident and began to curse and yell at him ambulating towards the other resident in the meantime threatening to hurt him; resident was resistant to redirection; pulling away from staff/ supervisor and walked up very close to other resident, hocked and spat in other resident's face and yelled, "I hate you. I'll kill you, F--k you!" Writer was able to step in front of accosted resident and with hands on (one hand placed at his right forearm and the other hand placed at his back), redirected (resident) back up to his room; resident was talked to until he calmed down; received PRN (as needed) and no further behavior(s) remainder of shift."

9. 2/8/18 "Resident noted in room banging on the wall and on the bathroom door. He started hitting and pushing the night stand by the door into the wall. Staff tried to ask resident what was wrong but he was speaking incoherently and turned toward staff saying something with his fist clenched. He then entered into the bathroom and went into the adjacent room and began pointing his finger and yelling incoherently at the resident. (Resident #85) started cursing and saying 'I'm gone f**k you up' repeatedly to the resident. Staff got in between the residents and tried to redirect (Resident #85) back to his room. He continued to curse yell and push staff while attempting to move toward the resident aggressively. MD (doctor) notified of situation."

10. 2/11//18 "Resident witnessed by staff was standing on roommate side of room, squeezing his hand and foot. The roommate denied any pain and no visible injuries noted on him. Resident also attempting to move furniture out of the room. MD (doctor) and RP (responsible party) called and notified. This writer spoke with

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F 600	Continued From page 24 resident and he was calm and verbalized that he understood that he can not touch other residents." 11. 2/13/18 "At 6:00 p.m. a new resident (number) was admitted to room (number). At 7:15 pm, undersigned nurse and co-workers noted new resident yelling 'somebody come in here and get this man.' Resident states that his room mate was 'spitting, yelling attempting to hit him, balling his fist up (shaking fist at him), pulled call light cords out of the wall, pulled residents cell phone charger out of the wall, ate his chips and cursed him out.' Resident (number) then noted by staff members walking to wing 2 and sitting in the chairs beside the vending machine. MD (doctor called), related to incident; awaiting return call. RP (responsible party) called and aware of all above information. Director of Nursing made aware. At 8:00 pm, resident (number) states, 'I am not worrying about it because I have called the police.' At 8:15 am, (Police Department) in facility. Director of Nursing called and made aware. Resident (number) moved to room (number)." 12. 3/17/18 "Resident became agitated about roommate repeatedly yelling, resident was immediately redirected and given a snack for comfort, resident remained at nursing station in good spirits, will continue to monitor." 13. 3/18/18 "CNA (certified nursing assistant) reported resident yelling at roommate, resident was redirected to nursing station stating 'im sorry', resident was encouraged to sit down for comfort and given snack, resident was also given a prn (as needed) anxiety medication Lorazepam, resident remains at nursing station, will continue	F 600		

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F 600	Continued From page 25 to monitor." The Administrator and DON were given a list of the above incidents and asked to provide the names of the residents harmed by Resident #85. The following information was provided by the DON: 12/18/17 and 1/9/18= Resident #90 11/21/17, 11/23/17 and 11/29/17= Resident #99 12/5/17 and 12/25/17= discharged resident 2/8/18, 2/9/18, 2/11/18, 2/13/18, 3/17/18, 3/18/17= Resident #111 Resident #99, a 67 year old, was admitted to the facility on 3/2/17. Diagnoses included stroke, depression, hemiplegia, dementia, reflux, anemia, and hypertension. The most recent Minimum Data Set assessment was an annual assessment with an assessment reference date of 3/4/18. Resident #99 was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment and required extensive assistance with activities of daily living. On 3/29/18 an interview was attempted with Resident #99. He was not available for interview. Resident #111, a 65 year old, was admitted to the facility on 2/9/18 and readmitted on 2/16/18. Diagnoses included dysphagia, cognitive communication deficit, stroke, anemia,encephalopathy, and acute kidney failure. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 3/9/18. Resident #111 was coded with moderate cognitive impairment and required extensive assistance with activities of	F 600		

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F 600	Continued From page 26 daily living. Resident #111 lived in the room with Resident #85 from admission on 2/9/18-2/13/18 and upon re-admission on 2/16/18. They were living together on 3/20/18 during the initial tour of the facility. On 3/23/18, Resident #111 was observed in Room 201 B. According to the census list, he was moved out of the room he shared with Resident #85 and into the new room on 3/21/18. While the facility staff indicated that the incident on 2/13/18 involved Resident #111, it is questionable because the nursing note read that the resident involved changed rooms. Resident #111 was discharged on this date. On 3/26/18 at 11:25 a.m., Resident #85 was observed in his room He had a 1:1 sitter with him and he did not have a roommate. On 3/26/18 at 11:30 a.m. the Administrator was interviewed. When asked if Resident #85 was put on 1:1 after the survey team brought forth the issue of Resident #85's abusive behavior, the Administrator stated yes. She stated that the corporate staff thought it would be a good idea. On 3/29/18 at 11:55 a.m. the Administrator was asked if she reported or investigated any of the incidents between Resident #85 and the other residents. The Administrator stated no. When asked if she was aware that all of the other incidents had occurred, she stated that she was not aware of all of the incidents. She stated that she became fully aware after she read the incidents once the survey team requested the names of the residents that were involved. She stated that the incidents were not reported to her	F 600		

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with the severity that they were documented. She stated that staff reported things such as Resident #85 was his "same old self" yesterday, but the staff did not report the details of Resident #85's actions.

On 3/27/18 at 8:46 a.m., Licensed Practical Nurse E (LPN E) was sitting in Resident #85's room. When asked if she was the 1:1 sitter, LPN E stated yes. When asked if she knew why the resident needed a 1:1 sitter, LPN E stated it was for behaviors.

Resident #85's care plan was reviewed. A Focus initiated on 11/12/17 read "(Resident #85) uses psychotropic medications Abilify, Haloperidol and Seroquel r/t (related to) Behavior management yelling, aggressiveness toward staff and other residents. The Interventions included Administer medications as ordered. Monitor/ document for side effects and effectiveness (initiated 11/12/17), Consult with pharmacy, doctor to consider dosage reduction when clinically appropriate (initiated 11/12/17), and Resident is on 1:1 for safety and aggression (initiated 3/22/18).

Resident #85's Physician Progress Notes were reviewed:

12/7/17 note did not address behavior

1/10/18 note read "Pt (patient) family concerned about his behavior was on Haldol before." Haldol 5 milligram twice a day was ordered.
1/25/18 psychiatric note read "seen today for evaluation of status and review of medication. Today he is seen in his room, good eye contact, interaction appropriate but aphasia is evident during the interview. He denies any difficulty

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eating or sleeping, denies any significant symptoms of depression but acknowledges some frustration/ anxiety due to his difficulty in speaking and denies suicidality. No noted or reported side effects of medications. He is more alert today and much more calm. Will recommend BuSpar to help with agitation/ anxiety and follow next visit to evaluate status and efficacy of medication recommendation."

1/29/18 note did not address behavior

2/9/18 note read "Pt (patient) had agitated behavior yesterday, very aggressive Given Ativan which help" Ativan 1 milligram twice a day as needed was ordered.

3/22/18 note read "see pt (patient) behaviors, keep 1:1"

3/22/18 psychiatric note read "No evidence of responding to internal stimuli/ psychosis but impaired cognition is evident and his (sic) he has limited insight and judgement. He is able to respond that he will not hurt anyone and does not appear to be in eminent danger of hurting another individual. However with his TBI (traumatic brain injury) this is subject to change. Discussed with staff the importance of redirection and support given in the method of redirecting him, taking him to the nursing area and providing a snack."

3/23/18 noted read "see pt (patient) behaviors, keep 1:1"

Employee training was reviewed. Abuse training was completed.

The facility policy "Abuse, Neglect and

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Exploitation" dated 1/19/17 was reviewed. The "Policy" section read "It is the intent of this facility to prevent the abuse, mistreatment, or neglect of residents or the misappropriation of their property, corporal punishment and/ or involuntary seclusion and to provide guidance to direct staff to manage any concerns or allegations of abuse, neglect or misappropriation of their property." "Employees will receive abuse prevention training as required as part of their orientation, as needed/ indicated and annually thereafter." "Accurate and timely reporting of incidents, both alleged and substantiated, will be sent to officials in accordance with the state law.

The policy section titled "Identification of incidents and allegations" read "1. The accurate and timely identification of any event which would place our residents at risk is a primary concern of the facility." "a. Each occurrence of resident incident, bruise, abrasion, or injury of unknown source; or report of alleged abuse, neglect or misappropriation of funds will be identified and reported to the supervisor and investigated timely. b. The supervisor or designee will notify the Director of Nursing and Executive Director of the incident or allegation immediately and no later than twenty four hours after being notified of incident or allegation and direct required notification of agencies, physician, family and resident representative c. The Executive Director will direct the investigation."

The section titled "Investigation of Incidents" read "1. In the event a situation is identified as abuse, neglect or misappropriation, an investigation by the executive leadership will immediately follow."

The section titled "Reporting of Incidents and

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F 600	Continued From page 30 Facility Response" read "1. Alleged violations are reported immediately to the Executive Director of the facility. a. The ED/ designee will report appropriate incidents to the Adult Protective Services and the Division of Licensing and Regulation as required by state law." Over a period of four months, there were thirteen documented occurrences of abusive behavior committed by Resident #85. Resident #85 was allowed to repeatedly abuse the same residents. Two of the residents who had been abused by Resident #85 were not offered the opportunity to change rooms. Resident #90 continued to live next to and share a bathroom with Resident #85. Resident #111 continued to live in the same room with Resident #85. The Administrator was unaware that the incidents had occurred. None of the incidents were reported or investigated. With each act of abuse, no interventions were put into place to ensure all facility residents were free from Resident #85's continued abusive behavior.	F 600		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced	F 607	**F 607** 1.) Resident #90's allegation was reinvestigated and resident has been moved to a new room, with no further issues noted. Resident #99's allegations have also been reviewed, resident was moved to new room on 11/29/17 per patient request patient has no additional issues noted, resident #72's allegation was investigated on 3/29/2018 and reported to the state, resident #72 is happy with current situation at nursing home no adverse side effected noted from alleged abuse in October, and resident #111's investigation was reviewed DON and	

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F 607	Continued From page 31 by: Based on observation, staff interview, resident interview, clinical record review, facility documentation review, and in the course of a complaint investigation the facility staff failed to implement the abuse policy for 4 residents (Resident #90, 99, 111, and 72) of 38 residents in the survey sample. 1. Resident #85 physically and verbally attacked Resident #90, Resident #99, and Resident # 111 over a period of four months. The Administrator was unaware of the incidents. The incidents were not investigated or reported. 2. For Resident # 72, the facility staff failed to implement the abuse policies. The findings included: 1. Resident #85 physically and verbally attacked Resident #90, Resident #99, and Resident # 111 over a period of four months. The Administrator was unaware of the incidents. The incidents were not investigated or reported. Resident #90, a 72 year old, was admitted to the facility on 7/14/17. Diagnoses included End Stage Renal Disease, spinal stenosis, hyperlipidemia, and reflux. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 1/17/18. Resident #90 was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment and required limited assistance with activities of daily living.	F 607	Administrator moved resident to new location where resident has had no additional incidents. Resident #85 has been seen by facility psych physician and is to remain on 1:1. 2.) Facility reported incidents were review from March 2018 to ensure timely completion, thorough investigations, and timely reporting to reporting agencies occurred by DON/Administrator and or designee. 3.) Facility staff will be educated on the need to immediately report incidents and suspicions of abuse by ADON and or designee. 4.) Facility reported incidents will be reviewed timely and reported as per abuse policy. Results from audits will be brought to QAPI committee to ensure compliance and further monitoring for 3 months.	

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F 607	Continued From page 32 The following nursing notes were documented in Resident #90's clinical record: 12/18/17, 8:54 a.m. "Resident was attacked by another resident. He states resident came in his room striking him in the head and neck multiply (sic) times. Also, attempting to take walker from him. Resident does not have any bruises or other marks noted on him. He verbalize that he was okay, just shaken up a bit. Resident is his own RP (responsible party). On call provider called and left a message. Awaiting call back." 1/9/18, 7:00 a.m. "11-7: At around 0300, resident was involved in an altercation with another resident; per resident he was lying in bed and awoke to other resident hitting/slapping him in his face; he was heard yelling and staff responded immediately; removed other resident from his room and (Resident #90) was able to transfer himself out of bed into his wheelchair; he then went propelled himself into the hallway highly upset and trying to tell staff of what had occurred; while he was yet speaking with writer, other resident walked back down to where (Resident #90) sat in his wheelchair all the while yelling and cursing and (unreceptive to redirection) then hocked and spat in (Resident #90) face, writer got in between the two residents to prevent any further altercation, and was able to redirect with hands on (one hand placed at his right forearm and the other hand placed at his back) back to his room. (Resident #90) was cleaned up and encouraged to verbalize his feelings/ emotional hurt from this incident. Resident remained in his room the remainder of shift." On 3/21/18 in the afternoon, the Administrator was asked to identify the resident that hurt	F 607		

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Resident #90. She returned later in the afternoon and stated that it was Resident #85. When asked if she had investigated and reported both instances of resident to resident abuse to the state office, the Administrator stated no.

On 3/21/18 at 4:30 p.m., an interview was conducted with Resident #90. When asked if anyone at the facility had hit him or hurt him, Resident #90 stated no. He stated that there are guys around that talk smart to him and a female nurse that talks smart to him, but no one had hurt him. He could not provide the names of anyone. When asked if he was scared of any other residents, Resident #90 stated no. The Administrator and Director of Nursing were notified that Resident #90 stated staff talked smart to him.

Resident #85, a 56 year old, was admitted to the facility on 7/19/17. Diagnoses included major depression, attention-deficit hyperactivity disorder, stroke, traumatic brain injury, hyperlipidemia, reflux, pain, and convulsions.

The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 11/1/17. Resident #85 was coded with a Brief Interview of Mental Status score of 9 indicating moderate cognitive impairment and required limited assistance with activities of daily living.

On 3/21/18 at 4:40 p.m., Resident #85 was sitting on his bed looking out the window. When asked how he was doing, Resident #85 stated he was ok.

On 3/20/18 during the initial tour of the facility,

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Resident #85 was observed to live in the room next to Resident #90. They shared an adjoining bathroom. Resident #85 was roommates with Resident #111.

On 3/22/18 in the morning, Resident #85 was observed in his room. He had a 1:1 sitter with him. He wore a wander guard to the right ankle. He had a roommate (Resident #111).

On 3/22/18 at 2:30 p.m., the Administrator and Director of Nursing (DON) were interviewed. When asked if the resident to resident abuse involving Resident #90 and Resident #85 was investigated, the Administrator stated no. When asked if the resident to resident abuse was reported, the Administrator stated no. When asked if she considered the altercations caused by Resident #85 as abuse, the Administrator stated yes. When asked if Resident #90 hurt any other residents, the Administrator stated no. She stated that Resident #85 usually stayed in his own room or at the nursing station. She stated that he hollers out while in his own room.

The Administrator was the Abuse Coordinator for the facility. The Abuse Coordinator interview was conducted on 3/23/18 at 11:30 a.m. When asked what she considered abuse, the Administrator named resident to resident abuse, neglect, misappropriation, verbal abuse, mental abuse, physical abuse, corporal punishment, seclusion and sexual abuse. When asked when she was supposed to report abuse to the state office, the Administrator stated abuse was to be reported within 2 hours if harm occurred and within 24 hours for other allegations. When asked if resident burns should be reported, the Administrator stated yes because they are

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F 607	Continued From page 35 unusual occurrences. Resident #85's clinical record was reviewed. The following notes documented the occasions on which Resident #85 had physical and verbal altercations with other residents: 1. 11/21/17 "resident upset, yelling, and knocking roommate's tv down in room. RN (registered nurse) administered his medications and he calmed down apologetic and remained in bed for the duration of shift" 2. 11/23/17 "Resident remains on behavior monitoring. Redirected for arguing with roommate. Resident could not clearly specify why he was upset and arguing with roommate but went into garbage can and pulled out and empty plate and shoved it at the roommate stating 'here thank you and yelling incoherently'. Resident asked if he was hungry or wanted a snack. He responded yes. Given HS (evening) snack then resident laid down. No further issues noted. Resident currently in bed with call bell in reach." 3. 11/29/17 "On Wing 1 hallway outside of room, (nurse name) and this nurse observed resident extremely upset, hitting roommate on top of head with his shoe. Yelling 'f[**]k you!' repeatedly. Separated two residents immediately. Resident continued to curse out inside of room and pace from bathroom to bed and back. Spilled food was also noted on Resident's side of room by his window. Resident was advised to sit and relax to calm down and told that everything will be ok. Resident stated 'Ok, Thank you.' Then took a seat. Stayed in room. Wetness noted to roommates hair, no pain noted but was very upset. Stated 'He spit on me first. I was telling	F 607		

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F 607	Continued From page 36 him that he can't put that in the toilet. I got to get out of this room.' Supervisor notified. Resident's mother notified and will be on her way to facility shortly." 4. 12/5/17 "Resident remains on behavior monitoring. Resident came running out of room yelling get him, get him. Staff went to residents room and he was in there pointing at his roommate speaking incoherently and cursing. Resident was not easily redirected. He started grabbing his roommates bed linens and yanking the privacy curtain back. He refused to calm down after asked repeatedly. Staff attempted to explain to resident that he has a new roommate. Resident finally came out of room but had grabbed some of the roommates Christmas decorations of the table and sat with them at the nurse station. Resident given PRN (as needed) Lorazepam for agitation. medication was effective. Resident accepted HS (evening) snack and then returned to room. Currently in bed resting with call bell in reach." 5. 12/17/17 "Resident showed signs of aggression towards assigned CNA (certified nursing assistant), while caring for his roommate. Resident was difficult to redirect, but, wasn't combative. CNA was instructed to stay away from resident during his throws of aggression to prevent him fro (sic) becoming combative. Resident calmed down & sat on his bed quietly. Continued to monitor resident throughout the day. During lunch, parents were @ bedside & resident was cooperative & pleasant. Assigned CNA was able to give assistance where needed. No further acting out from resident during the remainder of the shift.	F 607		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 607	Continued From page 37 6. 12/18/17 "Resident was in another resident's room striking him when the CNA broke up the altercation. Resident was unable to re-direct. He was still trying to get in other resident room to attack him again. Resident snatched roommates pictures off the wall. Resident was redirected to nurses station to calm down. Attempted to call resident mom. Unable to get her the first few times. Resident sitting at nursing station calming down. Called residents RP (responsible party) and was able to get her. RP talked to resident for a while and then he handed the phone to the nurse and walked to his room. Resident in room laying on the bed quietly. No further behaviors noted." 7. 12/25/17 "Resident Approached roommate (number) shouting that resident stinks and then (number) went back to his bed trying to take his bed apart. This writer redirected resident to sit down and that maintenance man will fix his bed. Resident (number) then told this writer that he was afraid of roommate and that (number) was balling his fist up at him. This writer then removed resident (number) from room and moved resident to wing 2 (room number). DON (director of nursing) called and informed of above. (Doctor) called x 2 no answer. Nurse practitioner called x 1 no answer. Resident (number) is calm and laying back in his bed." 8. 1/9/18 "11-7: At around 0300 resident to resident altercation occurred with this resident being aggressor. Resident got out of bed, went into another resident's room via the bathroom door; went over to the resident in the "B" bed/ (next to window) and was reportedly slapping the other resident in the face as the other resident lay in bed asleep; other resident awakened to being	F 607		

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F 607	Continued From page 38 slapped in his face. When other resident began to yell for help, staff immediately intervened and this resident was escorted/ redirected out of the other resident's room into the hallway. When staff and this resident began to ambulate back to this resident's room, the resident heard the accosted resident up in the hall way; this resident stopped and turned back towards the accosted resident and began to curse and yell at him ambulating towards the other resident in the meantime threatening to hurt him; resident was resistant to redirection; pulling away from staff/ supervisor and walked up very close to other resident, hocked and spat in other resident's face and yelled, "I hate you. I'll kill you, F--k you!" Writer was able to step in front of accosted resident and with hands on (one hand placed at his right forearm and the other hand placed at his back), redirected (resident) back up to his room; resident was talked to until he calmed down; received PRN (as needed) and no further behavior(s) remainder of shift." 9. 2/8/18 "Resident noted in room banging on the wall and on the bathroom door. He started hitting and pushing the night stand by the door into the wall. Staff tried to ask resident what was wrong but he was speaking incoherently and turned toward staff saying something with his fist clenched. He then entered into the bathroom and went into the adjacent room and began pointing his finger and yelling incoherently at the resident. (Resident #85) started cursing and saying 'I'm gone f[**]k you up' repeatedly to the resident. Staff got in between the residents and tried to redirect (Resident #85) back to his room. He continued to curse yell and push staff while attempting to move toward the resident aggressively. MD (doctor) notified of situation."	F 607		

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F 607	Continued From page 39 10. 2/11//18 "Resident witnessed by staff was standing on roommate side of room, squeezing his hand and foot. The roommate denied any pain and no visible injuries noted on him. Resident also attempting to move furniture out of the room. MD (doctor) and RP (responsible party) called and notified. This writer spoke with resident and he was calm and verbalized that he understood that he can not touch other residents." 11. 2/13/18 "At 6:00 p.m. a new resident (number) was admitted to room (number). At 7:15 pm, undersigned nurse and co-workers noted new resident yelling 'somebody come in here and get this man.' Resident states that his room mate was 'spitting, yelling attempting to hit him, balling his fist up (shaking fist at him), pulled call light cords out of the wall, pulled residents cell phone charger out of the wall, ate his chips and cursed him out.' Resident (number) then noted by staff members walking to wing 2 and sitting in the chairs beside the vending machine. MD (doctor called), related to incident; awaiting return call. RP (responsible party) called and aware of all above information. Director of Nursing made aware. At 8:00 pm, resident (number) states, 'I am not worrying about it because I have called the police.' At 8:15 am, (Police Department) in facility. Director of Nursing called and made aware. Resident (number) moved to room (number)." 12. 3/17/18 "Resident became agitated about roommate repeatedly yelling, resident was immediately redirected and given a snack for comfort, resident remained at nursing station in good spirits, will continue to monitor."	F 607		

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F 607	Continued From page 40 13. 3/18/18 "CNA (certified nursing assistant) reported resident yelling at roommate, resident was redirected to nursing station stating 'im sorry', resident was encouraged to sit down for comfort and given snack, resident was also given a prn (as needed) anxiety medication Lorazepam, resident remains at nursing station, will continue to monitor." The Administrator and DON were given a list of the above incidents and asked to provide the names of the residents harmed by Resident #85. The following information was provided by the DON: 12/18/17 and 1/9/18= Resident #90 11/21//17, 11/23/17 and 11/29/17= Resident #99 12/5/17 and 12/25/17= discharged resident 2/8/18, 2/9/18, 2/11/18, 2/13/18, 3/17/18, 3/18/17= Resident #111 Resident #99, a 67 year old, was admitted to the facility on 3/2/17. Diagnoses included stroke, depression, hemiplegia, dementia, reflux, anemia, and hypertension. The most recent Minimum Data Set assessment was an annual assessment with an assessment reference date of 3/4/18. Resident #99 was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment and required extensive assistance with activities of daily living. On 3/29/18 an interview was attempted with Resident #99. He was not available for interview. Resident #111, a 65 year old, was admitted to the facility on 2/9/18 and readmitted on 2/16/18.	F 607		

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F 607	Continued From page 41 Diagnoses included dysphagia, cognitive communication deficit, stroke, anemia,encephalopathy, and acute kidney failure. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 3/9/18. Resident #111 was coded with moderate cognitive impairment and required extensive assistance with activities of daily living. Resident #111 lived in the room with Resident #85 from admission on 2/9/18-2/13/18 and upon re-admission on 2/16/18. They were living together on 3/20/18 during the initial tour of the facility. On 3/23/18, Resident #111 was observed in Room 201 B. According to the census list, he was moved out of the room he shared with Resident #85 and into the new room on 3/21/18. While the facility staff indicated that the incident on 2/13/18 involved Resident #111, it is questionable because the nursing note read that the resident involved changed rooms. Resident #111 was discharged on this date. On 3/26/18 at 11:25 a.m., Resident #85 was observed in his room He had a 1:1 sitter with him and he did not have a roommate. On 3/26/18 at 11:30 a.m. the Administrator was interviewed. When asked if Resident #85 was put on 1:1 after the survey team brought forth the issue of Resident #85's abusive behavior, the Administrator stated yes. She stated that the corporate staff thought it would be a good idea. On 3/29/18 at 11:55 a.m. the Administrator was asked if she reported or investigated any of the	F 607		

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F 607	Continued From page 42 incidents between Resident #85 and the other residents. The Administrator stated no. When asked if she was aware that all of the other incidents that had occurred, she stated that she was not aware of all of the incidents. She stated that she became fully aware after she read the incidents once the survey team requested the names of the residents that were involved. She stated that the incidents were not reported to her with the severity that they were documented. She stated that staff reported things such as Resident #85 was his "same old self" yesterday, but the staff did not report the details of Resident #85's actions. On 3/27/18 at 8:46 a.m., Licensed Practical Nurse E (LPN E) was sitting in Resident #85's room. When asked if she was the 1:1 sitter, LPN E stated yes. When asked if she knew why the resident needed a 1:1 sitter, LPN E stated it was for behaviors. Resident #85's care plan was reviewed. A Focus initiated on 11/12/17 read "(Resident #85) uses psychotropic medications Abilify, Haloperidol and Seroquel r/t (related to) Behavior management yelling, aggressiveness toward staff and other residents. The Interventions included Administer medications as ordered. Monitor/ document for side effects and effectiveness (initiated 11/12/17), Consult with pharmacy, doctor to consider dosage reduction when clinically appropriate (initiated 11/12/17), and Resident is on 1:1 for safety and aggression (initiated 3/22/18). Resident #85's Physician Progress Notes were reviewed: 12/7/17 note did not address behavior	F 607		

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F 607	Continued From page 43 1/10/18 note read "Pt (patient) family concerned about his behavior was on Haldol before." Haldol 5 milligram twice a day was ordered. 1/25/18 psychiatric note read "seen today for evaluation of status and review of medication. Today he is seen in his room, good eye contact, interaction appropriate but aphasia is evident during the interview. He denies any difficulty eating or sleeping, denies any significant symptoms of depression but acknowledges some frustration/ anxiety due to his difficulty in speaking and denies suicidality. No noted or reported side effects of medications. He is more alert today and much more calm. Will recommend BuSpar to help with agitation/ anxiety and follow next visit to evaluate status and efficacy of medication recommendation." 1/29/18 note did not address behavior 2/9/18 note read "Pt (patient) had agitated behavior yesterday, very aggressive Given Ativan which help" Ativan 1 milligram twice a day as needed was ordered. 3/22/18 note read "see pt (patient) behaviors, keep 1:1" 3/22/18 psychiatric note read "No evidence of responding to internal stimuli/ psychosis but impaired cognition is evident and his (sic) he has limited insight and judgement. He is able to respond that he will not hurt anyone and does not appear to be in eminent danger of hurting another individual. However with his TBI (traumatic brain injury) this is subject to change. Discussed with staff the importance of redirection and support	F 607		

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F 607	Continued From page 44 given in the method of redirecting him, taking him to the nursing area and providing a snack." 3/23/18 noted read "see pt (patient) behaviors, keep 1:1" Employee training was reviewed. Abuse training was completed. The facility policy "Abuse, Neglect and Exploitation" dated 1/19/17 was reviewed. The "Policy" section read "It is the intent of this facility to prevent the abuse, mistreatment, or neglect of residents or the misappropriation of their property, corporal punishment and/ or involuntary seclusion and to provide guidance to direct staff to manage any concerns or allegations of abuse, neglect or misappropriation of their property." "Employees will receive abuse prevention training as required as part of their orientation, as needed/ indicated and annually thereafter." "Accurate and timely reporting of incidents, both alleged and substantiated, will be sent to officials in accordance with the state law. The policy section titled "Identification of incidents and allegations" read "1. The accurate and timely identification of any event which would place our residents at risk is a primary concern of the facility." "a. Each occurrence of resident incident, bruise, abrasion, or injury of unknown source; or report of alleged abuse, neglect or misappropriation of funds will be identified and reported to the supervisor and investigated timely. b. The supervisor or designee will notify the Director of Nursing and Executive Director of the incident or allegation immediately and no later than twenty four hours after being notified of incident or allegation and direct required	F 607		

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F 607	Continued From page 45 notification of agencies, physician, family and resident representative c. The Executive Director will direct the investigation." The section titled "Investigation of Incidents" read "1. In the event a situation is identified as abuse, neglect or misappropriation, an investigation by the executive leadership will immediately follow." The section titled "Reporting of Incidents and Facility Response" read "1. Alleged violations are reported immediately to the Executive Director of the facility. a. The ED/ designee will report appropriate incidents to the Adult Protective Services and the Division of Licensing and Regulation as required by state law." Over a period of four months, there were thirteen documented occurrences of abusive behavior committed by Resident #85. Resident #85 was allowed to repeatedly abuse the same residents. Two of the residents who had been abused by Resident #85 were not offered the opportunity to change rooms. Resident #90 continued to live next to and share a bathroom with Resident #85. Resident #111 continued to live in the same room with Resident #85. The Administrator was unaware that the incidents had occurred. None of the incidents were reported or investigated. With each act of abuse, no interventions were put into place to ensure all facility residents were free from Resident #85's continued abusive behavior. 2. For Resident # 72, the facility staff failed to implement the abuse policies. Resident # 72, a female, was admitted to the	F 607		

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F 607	Continued From page 46 facility 11/2/12015. Her diagnoses included but were not limited to Diverticulitis of both small and large intestines with perforation and abscess, insomnia, neuropathy, Gastroparesis, Anxiety Disorder, Major Depressive Disorder, Multiple Sclerosis, Hypertension and weakness. Resident # 72's most recent MDS with an ARD of 2/21/2018 was coded as a quarterly assessment. Resident # 72's cognitive status (her ability to make every day life decisions and memory ability) was not coded. Dashes were entered in the areas of Section C 100 "Should Brief Interview for Mental Status" through C 1000" Cognitive Skill for Daily Decision Making." Resident # 72 was coded as needing supervision assistance of one staff member to perform her activities of daily living. Resident # 72 was coded as being able to hear, speak, understand, and be understood. On 3/28/2018 at 1:40 PM, Resident # 72 asked to speak to the surveyors. At 1:50 PM, Resident # 72 came to the conference room with the surveyors. Resident # 72 stated she thought the facility was getting much better but slowly. Resident # 72 stated the facility staff were often busy doing other things like running behind residents who wander into other residents' rooms. Resident # 72 stated the facility used to admit residents to the facility that could not be managed by the facility staff. She stated one resident was very violent and hit other residents. Resident # 72 stated that particular resident hit her in her chest one day. Resident # 72 stated while she was standing at the end of the hall talking to a nurse who was passing medications, that resident knocked things off of the medication cart and then punched Resident # 72 in her chest.	F 607		

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F 607	Continued From page 47 Resident # 72 stated she could not remember the resident's name. Resident # 72 stated the Administrator and Director of Nursing worked hard to get that resident discharged from the facility because she had become violent with many people. Review of the clinical record was conducted on 3/28/2018 at 2:25 PM. There was no documentation of an incident report or a FRI (Facility Reported Incident) submitted to the State Agency. The facility policy "Abuse, Neglect and Exploitation" dated 1/19/17 was reviewed. The "Policy" section read "It is the intent of this facility to prevent the abuse, mistreatment, or neglect of residents or the misappropriation of their property, corporal punishment and/ or involuntary seclusion and to provide guidance to direct staff to manage any concerns or allegations of abuse, neglect or misappropriation of their property." "Employees will receive abuse prevention training as required as part of their orientation, as needed/ indicated and annually thereafter." "Accurate and timely reporting of incidents, both alleged and substantiated, will be sent to officials in accordance with the state law. The policy section titled "Identification of incidents and allegations" read "1. The accurate and timely identification of any event which would place our residents at risk is a primary concern of the facility." "a. Each occurrence of resident incident, bruise, abrasion, or injury of unknown source; or report of alleged abuse, neglect or misappropriation of funds will be identified and reported to the supervisor and investigated timely.	F 607		

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F 607	Continued From page 48 b. The supervisor or designee will notify the Director of Nursing and Executive Director of the incident or allegation immediately and no later than twenty four hours after being notified of incident or allegation and direct required notification of agencies, physician, family and resident representative c. The Executive Director will direct the investigation." The section titled "Investigation of Incidents" read "1. In the event a situation is identified as abuse, neglect or misappropriation, an investigation by the executive leadership will immediately follow." The section titled "Reporting of Incidents and Facility Response" read "1. Alleged violations are reported immediately to the Executive Director of the facility. a. The ED/ designee will report appropriate incidents to the Adult Protective Services and the Division of Licensing and Regulation as required by state law." On 3/28/2018 at 2:45 PM, the Director of Nursing and Administrator were asked to present any incident reports involving Resident # 72. Both stated there had been no incidents involving Resident # 72 of which they were aware. On 3/29/2018 at 9:00 AM, the Director of Nursing stated she was unaware of any incidents of resident to resident altercations involving Resident # 72. During the end of day debriefing on 3/29/2018, the facility administrator and Director of Nursing were informed of the findings. No further information was provided.	F 607		

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F 609	Continued From page 49	F 609	**F 609**	
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, clinical record review, facility documentation review, and in the course of a complaint investigation the facility staff failed to report allegations of abuse and burns to the state agency for 4 residents (Resident #90, 99, 111,	F 609	1.) Resident #90's allegation was reinvestigated and resident has been moved to a new room, with no further issues noted. Resident #99's allegations have also been reviewed, resident was moved to new room on 11/29/17 per patient request patient has no additional issues noted, resident #72's allegation was investigated on 3/29/2018 and reported to the state, resident #72 is happy with current situation at nursing home no adverse side effected noted from alleged abuse in October, and resident #111's investigation was reviewed DON and Administrator moved resident to new location where resident has had no additional incidents. Resident #85 has been seen by facility psych physician and is to remain on 1:1. 2.) The ADON, Unit managers, and wound care nurse and or designees have completed a skin sweep of all residents with a BIMS under 9 with no additional issues noted. The social services director and or designees have completed an abuse questionnaire with residents with a BIMS 9 and over with no additional issues noted. 3.) Facility staff will be educated on the need to immediately report incidents and suspicions of abuse by ADON and or designee. 4.) Facility reported incidents will be reviewed timely and reported as per abuse policy. Results from audits will be brought to QAPI committee to ensure compliance and further monitoring for 3 months.	

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BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

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F 609	Continued From page 50 and 72) of 38 residents in the survey sample. 1. Resident #85 physically and verbally attacked Resident #90, Resident #99, and Resident #111 over a period of four months. The incidents were not reported by the facility staff to the Administrator or by the Administrator to the state agency. 2. For Resident # 72, the facility staff failed to report an allegation of resident to resident altercation. The findings included: 1. Resident #85 physically and verbally attacked Resident #90, Resident #99, and Resident #111 over a period of four months. The incidents were not reported by the facility staff to the Administrator or by the Administrator to the state agency. Resident #90, a 72 year old, was admitted to the facility on 7/14/17. Diagnoses included End Stage Renal Disease, spinal stenosis, hyperlipidemia, and reflux. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 1/17/18. Resident #90 was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment and required limited assistance with activities of daily living. The following nursing notes were documented in Resident #90's clinical record: 12/18/17, 8:54 a.m. "Resident was attacked by	F 609		

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F 609	Continued From page 51	F 609		

another resident. He states resident came in his room striking him in the head and neck multiply (sic) times. Also, attempting to take walker from him. Resident does not have any bruises or other marks noted on him. He verbalize that he was okay, just shaken up a bit. Resident is his own RP (responsible party). On call provider called and left a message. Awaiting call back."

1/9/18, 7:00 a.m. "11-7: At around 0300, resident was involved in an altercation with another resident; per resident he was lying in bed and awoke to other resident hitting/slapping him in his face; he was heard yelling and staff responded immediately; removed other resident from his room and (Resident #90) was able to transfer himself out of bed into his wheelchair; he then went propelled himself into the hallway highly upset and trying to tell staff of what had occurred; while he was yet speaking with writer, other resident walked back down to where (Resident #90) sat in his wheelchair all the while yelling and cursing and (unreceptive to redirection) then hocked and spat in (Resident #90) face, writer got in between the two residents to prevent any further altercation, and was able to redirect with hands on (one hand placed at his right forearm and the other hand placed at his back) back to his room. (Resident #90) was cleaned up and encouraged to verbalize his feelings/ emotional hurt from this incident. Resident remained in his room the remainder of shift."

On 3/21/18 in the afternoon, the Administrator was asked to identify the resident that hurt Resident #90. She returned later in the afternoon and stated that it was Resident #85. When asked if she had investigated and reported both instances of resident to resident abuse to the

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F 609	Continued From page 52 state office, the Administrator stated no. On 3/21/18 at 4:30 p.m., an interview was conducted with Resident #90. When asked if anyone at the facility had hit him or hurt him, Resident #90 stated no. He stated that there are guys around that talk smart to him and a female nurse that talks smart to him, but no one had hurt him. He could not provide the names of anyone. When asked if he was scared of any other residents, Resident #90 stated no. The Administrator and Director of Nursing were notified that Resident #90 stated staff talked smart to him. Resident #85, a 56 year old, was admitted to the facility on 7/19/17. Diagnoses included major depression, attention-deficit hyperactivity disorder, stroke, traumatic brain injury, hyperlipidemia, reflux, pain, and convulsions. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 11/1/17. Resident #85 was coded with a Brief Interview of Mental Status score of 9 indicating moderate cognitive impairment and required limited assistance with activities of daily living. On 3/21/18 at 4:40 p.m., Resident #85 was sitting on his bed looking out the window. When asked how he was doing, Resident #85 stated he was ok. On 3/20/18 during the initial tour of the facility, Resident #85 was observed to live in the room next to Resident #90. They shared an adjoining bathroom. Resident #85 was roommates with Resident #111.	F 609		

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F 609	Continued From page 53 On 3/22/18 in the morning, Resident #85 was observed in his room. He had a 1:1 sitter with him. He wore a wander guard to the right ankle. He had a roommate (Resident #111). On 3/22/18 at 2:30 p.m., the Administrator and Director of Nursing (DON) were interviewed. When asked if the resident to resident abuse involving Resident #90 and Resident #85 was investigated, the Administrator stated no. When asked if the resident to resident abuse was reported, the Administrator stated no. When asked if she considered the altercations caused by Resident #85 as abuse, the Administrator stated yes. When asked if Resident #90 hurt any other residents, the Administrator stated no. She stated that Resident #85 usually stayed in his own room or at the nursing station. She stated that he hollers out while in his own room. The Administrator was the Abuse Coordinator for the facility. The Abuse Coordinator interview was conducted on 3/23/18 at 11:30 a.m. When asked what she considered abuse, the Administrator named resident to resident abuse, neglect, misappropriation, verbal abuse, mental abuse, physical abuse, corporal punishment, seclusion and sexual abuse. When asked when she was supposed to report abuse to the state office, the Administrator stated abuse was to be reported within 2 hours if harm occurred and within 24 hours for other allegations. When asked if resident burns should be reported, the Administrator stated yes because they are unusual occurrences. Resident #85's clinical record was reviewed. The following notes documented the occasions on	F 609		

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F 609	Continued From page 54 which Resident #85 had physical and verbal altercations with other residents: 1. 11/21/17 "resident upset, yelling, and knocking roommate's tv down in room. RN (registered nurse) administered his medications and he calmed down apologetic and remained in bed for the duration of shift" 2. 11/23/17 "Resident remains on behavior monitoring. Redirected for arguing with roommate. Resident could not clearly specify why he was upset and arguing with roommate but went into garbage can and pulled out and empty plate and shoved it at the roommate stating 'here thank you and yelling incoherently'. Resident asked if he was hungry or wanted a snack. He responded yes. Given HS (evening) snack then resident laid down. No further issues noted. Resident currently in bed with call bell in reach." 3. 11/29/17 "On Wing 1 hallway outside of room, (nurse name) and this nurse observed resident extremely upset, hitting roommate on top of head with his shoe. Yelling 'f**k you!' repeatedly. Separated two residents immediately. Resident continued to curse out inside of room and pace from bathroom to bed and back. Spilled food was also noted on Resident's side of room by his window. Resident was advised to sit and relax to calm down and told that everything will be ok. Resident stated 'Ok, Thank you.' Then took a seat. Stayed in room. Wetness noted to roommates hair, no pain noted but was very upset. Stated 'He spit on me first. I was telling him that he can't put that in the toilet. I got to get out of this room.' Supervisor notified. Resident's mother notified and will be on her way to facility shortly."	F 609		

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F 609	Continued From page 55 4. 12/5/17 "Resident remains on behavior monitoring. Resident came running out of room yelling get him, get him. Staff went to residents room and he was in there pointing at his roommate speaking incoherently and cursing. Resident was not easily redirected. He started grabbing his roommates bed linens and yanking the privacy curtain back. He refused to calm down after asked repeatedly. Staff attempted to explain to resident that he has a new roommate. Resident finally came out of room but had grabbed some of the roommates Christmas decorations of the table and sat with them at the nurse station. Resident given PRN (as needed) Lorazepam for agitation. medication was effective. Resident accepted HS (evening) snack and then returned to room. Currently in bed resting with call bell in reach." 5. 12/17/17 "Resident showed signs of aggression towards assigned CNA (certified nursing assistant), while caring for his roommate. Resident was difficult to redirect, but, wasn't combative. CNA was instructed to stay away from resident during his throws of aggression to prevent him fro (sic) becoming combative. Resident calmed down & sat on his bed quietly. Continued to monitor resident throughout the day. During lunch, parents were @ bedside & resident was cooperative & pleasant. Assigned CNA was able to give assistance where needed. No further acting out from resident during the remainder of the shift. 6. 12/18/17 "Resident was in another resident's room striking him when the CNA broke up the altercation. Resident was unable to re-direct. He was still trying to get in other resident room to	F 609		

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attack him again. Resident snatched roommates pictures off the wall. Resident was redirected to nurses station to calm down. Attempted to call resident mom. Unable to get her the first few times. Resident sitting at nursing station calming down. Called residents RP (responsible party) and was able to get her. RP talked to resident for a while and then he handed the phone to the nurse and walked to his room. Resident in room laying on the bed quietly. No further behaviors noted."

7. 12/25/17 "Resident Approached roommate (number) shouting that resident stinks and then (number) went back to his bed trying to take his bed apart. This writer redirected resident to sit down and that maintenance man will fix his bed. Resident (number) then told this writer that he was afraid of roommate and that (number) was balling his fist up at him. This writer then removed resident (number) from room and moved resident to wing 2 (room number). DON (director of nursing) called and informed of above. (Doctor) called x 2 no answer. Nurse practitioner called x 1 no answer. Resident (number) is calm and laying back in his bed."

8. 1/9/18 "11-7: At around 0300 resident to resident altercation occurred with this resident being aggressor. Resident got out of bed, went into another resident's room via the bathroom door; went over to the resident in the "B" bed/ (next to window) and was reportedly slapping the other resident in the face as the other resident lay in bed asleep; other resident awakened to being slapped in his face. When other resident began to yell for help, staff immediately intervened and this resident was escorted/ redirected out of the other resident's room into the hallway. When

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F 609	Continued From page 57 staff and this resident began to ambulate back to this resident's room, the resident heard the accosted resident up in the hall way; this resident stopped and turned back towards the accosted resident and began to curse and yell at him ambulating towards the other resident in the meantime threatening to hurt him; resident was resistant to redirection; pulling away from staff/ supervisor and walked up very close to other resident, hocked and spat in other resident's face and yelled, "I hate you. I'll kill you, F--k you!" Writer was able to step in front of accosted resident and with hands on (one hand placed at his right forearm and the other hand placed at his back), redirected (resident) back up to his room; resident was talked to until he calmed down; received PRN (as needed) and no further behavior(s) remainder of shift." 9. 2/8/18 "Resident noted in room banging on the wall and on the bathroom door. He started hitting and pushing the night stand by the door into the wall. Staff tried to ask resident what was wrong but he was speaking incoherently and turned toward staff saying something with his fist clenched. He then entered into the bathroom and went into the adjacent room and began pointing his finger and yelling incoherently at the resident. (Resident #85) started cursing and saying 'I'm gone f**k you up' repeatedly to the resident. Staff got in between the residents and tried to redirect (Resident #85) back to his room. He continued to curse yell and push staff while attempting to move toward the resident aggressively. MD (doctor) notified of situation." 10. 2/11//18 "Resident witnessed by staff was standing on roommate side of room, squeezing his hand and foot. The roommate denied any	F 609		

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F 609	Continued From page 58 pain and no visible injuries noted on him. Resident also attempting to move furniture out of the room. MD (doctor) and RP (responsible party) called and notified. This writer spoke with resident and he was calm and verbalized that he understood that he can not touch other residents." 11. 2/13/18 "At 6:00 p.m. a new resident (number) was admitted to room (number). At 7:15 pm, undersigned nurse and co-workers noted new resident yelling 'somebody come in here and get this man.' Resident states that his room mate was 'spitting, yelling attempting to hit him, balling his fist up (shaking fist at him), pulled call light cords out of the wall, pulled residents cell phone charger out of the wall, ate his chips and cursed him out.' Resident (number) then noted by staff members walking to wing 2 and sitting in the chairs beside the vending machine. MD (doctor called), related to incident; awaiting return call. RP (responsible party) called and aware of all above information. Director of Nursing made aware. At 8:00 pm, resident (number) states, 'I am not worrying about it because I have called the police.' At 8:15 am, (Police Department) in facility. Director of Nursing called and made aware. Resident (number) moved to room (number)." 12. 3/17/18 "Resident became agitated about roommate repeatedly yelling, resident was immediately redirected and given a snack for comfort, resident remained at nursing station in good spirits, will continue to monitor." 13. 3/18/18 "CNA (certified nursing assistant) reported resident yelling at roommate, resident was redirected to nursing station stating 'im	F 609		

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F 609	Continued From page 59 sorry', resident was encouraged to sit down for comfort and given snack, resident was also given a prn (as needed) anxiety medication Lorazepam, resident remains at nursing station, will continue to monitor." The Administrator and DON were given a list of the above incidents and asked to provide the names of the residents harmed by Resident #85. The following information was provided by the DON: 12/18/17 and 1/9/18= Resident #90 11/21//17, 11/23/17 and 11/29/17= Resident #99 12/5/17 and 12/25/17= discharged resident 2/8/18, 2/9/18, 2/11/18, 2/13/18, 3/17/18, 3/18/17= Resident #111 Resident #99, a 67 year old, was admitted to the facility on 3/2/17. Diagnoses included stroke, depression, hemiplegia, dementia, reflux, anemia, and hypertension. The most recent Minimum Data Set assessment was an annual assessment with an assessment reference date of 3/4/18. Resident #99 was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment and required extensive assistance with activities of daily living. On 3/29/18 an interview was attempted with Resident #99. He was not available for interview. Resident #111, a 65 year old, was admitted to the facility on 2/9/18 and readmitted on 2/16/18. Diagnoses included dysphagia, cognitive communication deficit, stroke, anemia,encephalopathy, and acute kidney failure.	F 609		

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The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 3/9/18. Resident #111 was coded with moderate cognitive impairment and required extensive assistance with activities of daily living.

Resident #111 lived in the room with Resident #85 from admission on 2/9/18-2/13/18 and upon re-admission on 2/16/18. They were living together on 3/20/18 during the initial tour of the facility. On 3/23/18, Resident #111 was observed in Room 201 B. According to the census list, he was moved out of the room he shared with Resident #85 and into the new room on 3/21/18.

While the facility staff indicated that the incident on 2/13/18 involved Resident #111, it is questionable because the nursing note read that the resident involved changed rooms. Resident #111 was discharged on this date.

On 3/26/18 at 11:25 a.m., Resident #85 was observed in his room He had a 1:1 sitter with him and he did not have a roommate.

On 3/26/18 at 11:30 a.m. the Administrator was interviewed. When asked if Resident #85 was put on 1:1 after the survey team brought forth the issue of Resident #85's abusive behavior, the Administrator stated yes. She stated that the corporate staff thought it would be a good idea.

On 3/29/18 at 11:55 a.m. the Administrator was asked if she reported or investigated any of the incidents between Resident #85 and the other residents. The Administrator stated no. When asked if she was aware that all of the other incidents that had occurred, she stated that she

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was not aware of all of the incidents. She stated that she became fully aware after she read the incidents once the survey team requested the names of the residents that were involved. She stated that the incidents were not reported to her with the severity that they were documented. She stated that staff reported things such as Resident #85 was his "same old self" yesterday, but the staff did not report the details of Resident #85's actions.

On 3/27/18 at 8:46 a.m., Licensed Practical Nurse E (LPN E) was sitting in Resident #85's room. When asked if she was the 1:1 sitter, LPN E stated yes. When asked if she knew why the resident needed a 1:1 sitter, LPN E stated it was for behaviors.

Resident #85's care plan was reviewed. A Focus initiated on 11/12/17 read "(Resident #85) uses psychotropic medications Abilify, Haloperidol and Seroquel r/t (related to) Behavior management yelling, aggressiveness toward staff and other residents. The Interventions included Administer medications as ordered. Monitor/ document for side effects and effectiveness (initiated 11/12/17), Consult with pharmacy, doctor to consider dosage reduction when clinically appropriate (initiated 11/12/17), and Resident is on 1:1 for safety and aggression (initiated 3/22/18).

Resident #85's Physician Progress Notes were reviewed:

12/7/17 note did not address behavior

1/10/18 note read "Pt (patient) family concerned about his behavior was on Haldol before." Haldol 5 milligram twice a day was ordered.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

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F 609	Continued From page 62 1/25/18 psychiatric note read "seen today for evaluation of status and review of medication. Today he is seen in his room, good eye contact, interaction appropriate but aphasia is evident during the interview. He denies any difficulty eating or sleeping, denies any significant symptoms of depression but acknowledges some frustration/ anxiety due to his difficulty in speaking and denies suicidality. No noted or reported side effects of medications. He is more alert today and much more calm. Will recommend BuSpar to help with agitation/ anxiety and follow next visit to evaluate status and efficacy of medication recommendation." 1/29/18 note did not address behavior 2/9/18 note read "Pt (patient) had agitated behavior yesterday, very aggressive Given Ativan which help" Ativan 1 milligram twice a day as needed was ordered. 3/22/18 note read "see pt (patient) behaviors, keep 1:1" 3/22/18 psychiatric note read "No evidence of responding to internal stimuli/ psychosis but impaired cognition is evident and his (sic) he has limited insight and judgement. He is able to respond that he will not hurt anyone and does not appear to be in eminent danger of hurting another individual. However with his TBI (traumatic brain injury) this is subject to change. Discussed with staff the importance of redirection and support given in the method of redirecting him, taking him to the nursing area and providing a snack." 3/23/18 noted read "see pt (patient) behaviors,	F 609		

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F 609	Continued From page 63 keep 1:1" Employee training was reviewed. Abuse training was completed. The facility policy "Abuse, Neglect and Exploitation" dated 1/19/17 was reviewed. The "Policy" section read "It is the intent of this facility to prevent the abuse, mistreatment, or neglect of residents or the misappropriation of their property, corporal punishment and/ or involuntary seclusion and to provide guidance to direct staff to manage any concerns or allegations of abuse, neglect or misappropriation of their property." "Employees will receive abuse prevention training as required as part of their orientation, as needed/ indicated and annually thereafter." "Accurate and timely reporting of incidents, both alleged and substantiated, will be sent to officials in accordance with the state law. The policy section titled "Identification of incidents and allegations" read "1. The accurate and timely identification of any event which would place our residents at risk is a primary concern of the facility." "a. Each occurrence of resident incident, bruise, abrasion, or injury of unknown source; or report of alleged abuse, neglect or misappropriation of funds will be identified and reported to the supervisor and investigated timely. b. The supervisor or designee will notify the Director of Nursing and Executive Director of the incident or allegation immediately and no later than twenty four hours after being notified of incident or allegation and direct required notification of agencies, physician, family and resident representative c. The Executive Director will direct the investigation."	F 609		

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F 609	Continued From page 64 The section titled "Investigation of Incidents" read "1. In the event a situation is identified as abuse, neglect or misappropriation, an investigation by the executive leadership will immediately follow." The section titled "Reporting of Incidents and Facility Response" read "1. Alleged violations are reported immediately to the Executive Director of the facility. a. The ED/ designee will report appropriate incidents to the Adult Protective Services and the Division of Licensing and Regulation as required by state law." Over a period of four months, there were thirteen documented occurrences of abusive behavior committed by Resident #85. Resident #85 was allowed to repeatedly abuse the same residents. Two of the residents who had been abused by Resident #85 were not offered the opportunity to change rooms. Resident #90 continued to live next to and share a bathroom with Resident #85. Resident #111 continued to live in the same room with Resident #85. The Administrator was unaware that the incidents had occurred. None of the incidents were reported or investigated. With each act of abuse, no interventions were put into place to ensure all facility residents were free from Resident #85's continued abusive behavior. 2. For Resident # 72, the facility staff failed to report an allegation of resident to resident altercation. Resident # 72, a female, was admitted to the facility 11/2/12015. Her diagnoses included but were not limited to Diverticulitis of both small and large intestines with perforation and abscess, insomnia, neuropathy, Gastroparesis, Anxiety	F 609		

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F 609	Continued From page 65 Disorder, Major Depressive Disorder, Multiple Sclerosis, Hypertension and weakness. Resident # 72's most recent MDS with an ARD of 2/21/2018 was coded as a quarterly assessment. Resident # 72's cognitive status (her ability to make every day life decisions and memory ability) was not coded. Dashes were entered in the areas of Section C 100 "Should Brief Interview for Mental Status" through C 1000" Cognitive Skill for Daily Decision Making." Resident # 72 was coded as needing supervision assistance of one staff member to perform her activities of daily living. Resident # 72 was coded as being able to hear, speak, understand, and be understood. On 3/28/2018 at 1:40 PM, Resident # 72 asked to speak to the surveyors. At 1:50 PM, Resident # 72 came to the conference room with the surveyors. Resident # 72 stated she thought the facility was getting much better but slowly. Resident # 72 stated the facility staff were often busy doing other things like running behind residents who wander into other residents' rooms. Resident # 72 stated the facility used to admit residents to the facility that could not be managed by the facility staff. She stated one resident was very violent and hit other residents. Resident # 72 stated that particular resident hit her in her chest one day. Resident # 72 stated while she was standing at the end of the hall talking to a nurse who was passing medications, that resident knocked things off of the medication cart and then punched Resident # 72 in her chest. Resident # 72 stated she could not remember the resident's name. Resident # 72 stated the Administrator and Director of Nursing worked hard to get that resident discharged from the	F 609		

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F 609	Continued From page 66 facility because she had become violent with many people. Review of the clinical record was conducted on 3/28/2018 at 2:30 PM. Review of the Progress notes revealed no documentation of any resident to resident altercations. On 3/28/2018 at 2:45 PM, the Director of Nursing and Administrator were asked to present any incident reports involving Resident # 72. Both stated there had been no incidents involving Resident # 72 of which they were aware. On 3/29/2018 at 9:00 AM, the Director of Nursing stated she was unaware of any incidents of resident to resident altercations involving Resident # 72. The facility policy "Abuse, Neglect and Exploitation" dated 1/19/17 was reviewed. The "Policy" section read "It is the intent of this facility to prevent the abuse, mistreatment, or neglect of residents or the misappropriation of their property, corporal punishment and/ or involuntary seclusion and to provide guidance to direct staff to manage any concerns or allegations of abuse, neglect or misappropriation of their property." "Employees will receive abuse prevention training as required as part of their orientation, as needed/ indicated and annually thereafter." "Accurate and timely reporting of incidents, both alleged and substantiated, will be sent to officials in accordance with the state law. The policy section titled "Identification of incidents and allegations" read "1. The accurate and timely	F 609		

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F 609	Continued From page 67 identification of any event which would place our residents at risk is a primary concern of the facility." "a. Each occurrence of resident incident, bruise, abrasion, or injury of unknown source; or report of alleged abuse, neglect or misappropriation of funds will be identified and reported to the supervisor and investigated timely. b. The supervisor or designee will notify the Director of Nursing and Executive Director of the incident or allegation immediately and no later than twenty four hours after being notified of incident or allegation and direct required notification of agencies, physician, family and resident representative c. The Executive Director will direct the investigation." The section titled "Investigation of Incidents" read "1. In the event a situation is identified as abuse, neglect or misappropriation, an investigation by the executive leadership will immediately follow." The section titled "Reporting of Incidents and Facility Response" read "1. Alleged violations are reported immediately to the Executive Director of the facility. a. The ED/ designee will report appropriate incidents to the Adult Protective Services and the Division of Licensing and Regulation as required by state law." On 3/29/2018 at 12:05 during the end of day debriefing, the Administrator and Director of Nursing stated Resident # 72 was very vocal and had not told them of an incident with another resident striking her in the chest. The Administrator stated she wanted to talk with Resident # 72 to find out more details. On 3/29/2018 at 1:45 PM when the surveyors returned to the conference room, the	F 609		

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F 609	Continued From page 68 Administrator presented a handwritten note from Resident # 72 which stated: "I am making this statement of my own accord. I did not report my incident with being struck by _____ a patient, was not that serious. I was not harmed to the point of making a big issue of it. I do feel safe and secure at Battlefield. " The Administrator stated she did not ask Resident # 72 to write that statement but that Resident # 72 wanted to write it. The Administrator stated she created an incident report and would start an investigation. On 3/29/2018 at 2:00 PM, an interview was conducted with Resident # 72 who stated she did not want to make a big deal about the resident hitting her in her chest. Resident # 72 stated "it was no big deal. I was not afraid. She is gone now anyway." On 3/29/2018 at 3:05 PM, an interview was conducted with LPN (Licensed Practical Nurse) E who stated she remembered an incident involving another resident who knocked things off of her cart. LPN E stated she did observe that resident reach and touch Resident # 72 in the chest. LPN E stated it was not a punch in the chest or anything like a fight. LPN E stated she did not view the incident as one to report as physical abuse because" it was like a tap" and the resident was immediately redirected. LPN E stated she knew to report any incident of resident to resident abuse but did not view that incident as abuse. LPN E stated Resident # 72 was not injured and expressed no fear of that other resident to her. LPN E stated Resident # 72 had no other interactions with that resident. LPN E stated the incident happened months ago. LPN E stated in	F 609		

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F 609	Continued From page 69 the future, she would report any incidents to the Director of Nursing or Administrator. No further information was provided.	F 609		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, clinical record review, facility documentation review, and in the course of a complaint investigation the facility staff failed to investigate allegations of abuse for 4 residents (Resident #90, 99, 111, 72) of 38 residents in the survey sample. 1. Resident #85 physically and verbally attacked Resident #90, Resident #99, and Resident #111 over a period of four months. The incidents were	F 610	**F 610** 1.) Resident #90's allegation was reinvestigated and resident has been moved to a new room, with no further issues noted. Resident #99's allegations have also been reviewed, resident was moved to new room on 11/29/17 per patient request patient has no additional issues noted, resident #72's allegation was investigated on 3/29/2018 and reported to the state, resident #72 is happy with current situation at nursing home no adverse side effected noted from alleged abuse in October, and resident #111's investigation was reviewed DON and Administrator moved resident to new location where resident has had no additional incidents. Resident #85 has been seen by facility psych physician and is to remain on 1:1. 2.) The ADON, Unit managers, and wound care nurse and or designees have completed a skin sweep of all residents with a BIMS under 9 with no additional issues noted. The social services director completed an abuse questionnaire with residents with a BIMS 9 and over with no additional issues noted.	

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F 610	Continued From page 70 not investigated. 2. For Resident # 72, the facility staff failed to investigate an allegation of resident to resident altercation. The findings included: 1. Resident #85 physically and verbally attacked Resident #90, Resident #99, and Resident #111 over a period of four months. The incidents were not investigated. Resident #90, a 72 year old, was admitted to the facility on 7/14/17. Diagnoses included End Stage Renal Disease, spinal stenosis, hyperlipidemia, and reflux. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 1/17/18. Resident #90 was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment and required limited assistance with activities of daily living. The following nursing notes were documented in Resident #90's clinical record: 12/18/17, 8:54 a.m. "Resident was attacked by another resident. He states resident came in his room striking him in the head and neck multiply (sic) times. Also, attempting to take walker from him. Resident does not have any bruises or other marks noted on him. He verbalize that he was okay, just shaken up a bit. Resident is his own RP (responsible party). On call provider called and left a message. Awaiting call back."	F 610	3.) The ADON and or designee completed education with all staff on the Abuse policy and appropriately investigating and reporting. 4.) Facility reported incidents will be reviewed timely and reported as per abuse policy. Results from audits will be brought to QAPI committee to ensure compliance and further monitoring for 3 months.	

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F 610	Continued From page 71 1/9/18, 7:00 a.m. "11-7: At around 0300, resident was involved in an altercation with another resident; per resident he was lying in bed and awoke to other resident hitting/slapping him in his face; he was heard yelling and staff responded immediately; removed other resident from his room and (Resident #90) was able to transfer himself out of bed into his wheelchair; he then went propelled himself into the hallway highly upset and trying to tell staff of what had occurred; while he was yet speaking with writer, other resident walked back down to where (Resident #90) sat in his wheelchair all the while yelling and cursing and (unreceptive to redirection) then hocked and spat in (Resident #90) face, writer got in between the two residents to prevent any further altercation, and was able to redirect with hands on (one hand placed at his right forearm and the other hand placed at his back) back to his room. (Resident #90) was cleaned up and encouraged to verbalize his feelings/ emotional hurt from this incident. Resident remained in his room the remainder of shift." On 3/21/18 in the afternoon, the Administrator was asked to identify the resident that hurt Resident #90. She returned later in the afternoon and stated that it was Resident #85. When asked if she had investigated and reported both instances of resident to resident abuse to the state office, the Administrator stated no. On 3/21/18 at 4:30 p.m., an interview was conducted with Resident #90. When asked if anyone at the facility had hit him or hurt him, Resident #90 stated no. He stated that there are guys around that talk smart to him and a female nurse that talks smart to him, but no one had hurt him. He could not provide the names of anyone.	F 610		

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F 610	Continued From page 72	F 610		

When asked if he was scared of any other residents, Resident #90 stated no. The Administrator and Director of Nursing were notified that Resident #90 stated staff talked smart to him.

Resident #85, a 56 year old, was admitted to the facility on 7/19/17. Diagnoses included major depression, attention-deficit hyperactivity disorder, stroke, traumatic brain injury, hyperlipidemia, reflux, pain, and convulsions.

The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 11/1/17. Resident #85 was coded with a Brief Interview of Mental Status score of 9 indicating moderate cognitive impairment and required limited assistance with activities of daily living.

On 3/21/18 at 4:40 p.m., Resident #85 was sitting on his bed looking out the window. When asked how he was doing, Resident #85 stated he was ok.

On 3/20/18 during the initial tour of the facility, Resident #85 was observed to live in the room next to Resident #90. They shared an adjoining bathroom. Resident #85 was roommates with Resident #111.

On 3/22/18 in the morning, Resident #85 was observed in his room. He had a 1:1 sitter with him. He wore a wander guard to the right ankle. He had a roommate (Resident #111).

On 3/22/18 at 2:30 p.m., the Administrator and Director of Nursing (DON) were interviewed. When asked if the resident to resident abuse

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F 610	Continued From page 73	F 610		

involving Resident #90 and Resident #85 was investigated, the Administrator stated no. When asked if the resident to resident abuse was reported, the Administrator stated no. When asked if she considered the altercations caused by Resident #85 as abuse, the Administrator stated yes. When asked if Resident #90 hurt any other residents, the Administrator stated no. She stated that Resident #85 usually stayed in his own room or at the nursing station. She stated that he hollers out while in his own room.

The Administrator was the Abuse Coordinator for the facility. The Abuse Coordinator interview was conducted on 3/23/18 at 11:30 a.m. When asked what she considered abuse, the Administrator named resident to resident abuse, neglect, misappropriation, verbal abuse, mental abuse, physical abuse, corporal punishment, seclusion and sexual abuse. When asked when she was supposed to report abuse to the state office, the Administrator stated abuse was to be reported within 2 hours if harm occurred and within 24 hours for other allegations. When asked if resident burns should be reported, the Administrator stated yes because they are unusual occurrences.

Resident #85's clinical record was reviewed. The following notes documented the occasions on which Resident #85 had physical and verbal altercations with other residents:

1. 11/21/17 "resident upset, yelling, and knocking roommate's tv down in room. RN (registered nurse) administered his medications and he calmed down apologetic and remained in bed for the duration of shift"

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F 610	Continued From page 74 2. 11/23/17 "Resident remains on behavior monitoring. Redirected for arguing with roommate. Resident could not clearly specify why he was upset and arguing with roommate but went into garbage can and pulled out and empty plate and shoved it at the roommate stating 'here thank you and yelling incoherently'. Resident asked if he was hungry or wanted a snack. He responded yes. Given HS (evening) snack then resident laid down. No further issues noted. Resident currently in bed with call bell in reach." 3. 11/29/17 "On Wing 1 hallway outside of room, (nurse name) and this nurse observed resident extremely upset, hitting roommate on top of head with his shoe. Yelling 'f**k you!' repeatedly. Separated two residents immediately. Resident continued to curse out inside of room and pace from bathroom to bed and back. Spilled food was also noted on Resident's side of room by his window. Resident was advised to sit and relax to calm down and told that everything will be ok. Resident stated 'Ok, Thank you.' Then took a seat. Stayed in room. Wetness noted to roommates hair, no pain noted but was very upset. Stated 'He spit on me first. I was telling him that he can't put that in the toilet. I got to get out of this room.' Supervisor notified. Resident's mother notified and will be on her way to facility shortly." 4. 12/5/17 "Resident remains on behavior monitoring. Resident came running out of room yelling get him, get him. Staff went to residents room and he was in there pointing at his roommate speaking incoherently and cursing. Resident was not easily redirected. He started grabbing his roommates bed linens and yanking the privacy curtain back. He refused to calm	F 610		

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down after asked repeatedly. Staff attempted to explain to resident that he has a new roommate. Resident finally came out of room but had grabbed some of the roommates Christmas decorations of the table and sat with them at the nurse station. Resident given PRN (as needed) Lorazepam for agitation. medication was effective. Resident accepted HS (evening) snack and then returned to room. Currently in bed resting with call bell in reach."

5. 12/17/17 "Resident showed signs of aggression towards assigned CNA (certified nursing assistant), while caring for his roommate. Resident was difficult to redirect, but, wasn't combative. CNA was instructed to stay away from resident during his throws of aggression to prevent him fro (sic) becoming combative. Resident calmed down & sat on his bed quietly. Continued to monitor resident throughout the day. During lunch, parents were @ bedside & resident was cooperative & pleasant. Assigned CNA was able to give assistance where needed. No further acting out from resident during the remainder of the shift.

6. 12/18/17 "Resident was in another resident's room striking him when the CNA broke up the altercation. Resident was unable to re-direct. He was still trying to get in other resident room to attack him again. Resident snatched roommates pictures off the wall. Resident was redirected to nurses station to calm down. Attempted to call resident mom. Unable to get her the first few times. Resident sitting at nursing station calming down. Called residents RP (responsible party) and was able to get her. RP talked to resident for a while and then he handed the phone to the nurse and walked to his room. Resident in room

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F 610	Continued From page 76 laying on the bed quietly. No further behaviors noted." 7. 12/25/17 "Resident Approached roommate (number) shouting that resident stinks and then (number) went back to his bed trying to take his bed apart. This writer redirected resident to sit down and that maintenance man will fix his bed. Resident (number) then told this writer that he was afraid of roommate and that (number) was balling his fist up at him. This writer then removed resident (number) from room and moved resident to wing 2 (room number). DON (director of nursing) called and informed of above. (Doctor) called x 2 no answer. Nurse practitioner called x 1 no answer. Resident (number) is calm and laying back in his bed." 8. 1/9/18 "11-7: At around 0300 resident to resident altercation occurred with this resident being aggressor. Resident got out of bed, went into another resident's room via the bathroom door; went over to the resident in the "B" bed/ (next to window) and was reportedly slapping the other resident in the face as the other resident lay in bed asleep; other resident awakened to being slapped in his face. When other resident began to yell for help, staff immediately intervened and this resident was escorted/ redirected out of the other resident's room into the hallway. When staff and this resident began to ambulate back to this resident's room, the resident heard the accosted resident up in the hall way; this resident stopped and turned back towards the accosted resident and began to curse and yell at him ambulating towards the other resident in the meantime threatening to hurt him; resident was resistant to redirection; pulling away from staff/ supervisor and walked up very close to other	F 610		

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resident, hocked and spat in other resident's face and yelled, "I hate you. I'll kill you, F--k you!" Writer was able to step in front of accosted resident and with hands on (one hand placed at his right forearm and the other hand placed at his back), redirected (resident) back up to his room; resident was talked to until he calmed down; received PRN (as needed) and no further behavior(s) remainder of shift."

9. 2/8/18 "Resident noted in room banging on the wall and on the bathroom door. He started hitting and pushing the night stand by the door into the wall. Staff tried to ask resident what was wrong but he was speaking incoherently and turned toward staff saying something with his fist clenched. He then entered into the bathroom and went into the adjacent room and began pointing his finger and yelling incoherently at the resident. (Resident #85) started cursing and saying 'I'm gone f**k you up' repeatedly to the resident. Staff got in between the residents and tried to redirect (Resident #85) back to his room. He continued to curse yell and push staff while attempting to move toward the resident aggressively. MD (doctor) notified of situation."

10. 2/11//18 "Resident witnessed by staff was standing on roommate side of room, squeezing his hand and foot. The roommate denied any pain and no visible injuries noted on him. Resident also attempting to move furniture out of the room. MD (doctor) and RP (responsible party) called and notified. This writer spoke with resident and he was calm and verbalized that he understood that he can not touch other residents."

11. 2/13/18 "At 6:00 p.m. a new resident

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(number) was admitted to room (number). At 7:15 pm, undersigned nurse and co-workers noted new resident yelling 'somebody come in here and get this man.' Resident states that his room mate was 'spitting, yelling attempting to hit him, balling his fist up (shaking fist at him), pulled call light cords out of the wall, pulled residents cell phone charger out of the wall, ate his chips and cursed him out.' Resident (number) then noted by staff members walking to wing 2 and sitting in the chairs beside the vending machine. MD (doctor called), related to incident; awaiting return call. RP (responsible party) called and aware of all above information. Director of Nursing made aware. At 8:00 pm, resident (number) states, 'I am not worrying about it because I have called the police.' At 8:15 am, (Police Department) in facility. Director of Nursing called and made aware. Resident (number) moved to room (number)."

12. 3/17/18 "Resident became agitated about roommate repeatedly yelling, resident was immediately redirected and given a snack for comfort, resident remained at nursing station in good spirits, will continue to monitor."

13. 3/18/18 "CNA (certified nursing assistant) reported resident yelling at roommate, resident was redirected to nursing station stating 'im sorry', resident was encouraged to sit down for comfort and given snack, resident was also given a prn (as needed) anxiety medication Lorazepam, resident remains at nursing station, will continue to monitor."

The Administrator and DON were given a list of the above incidents and asked to provide the names of the residents harmed by Resident #85.

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F 610	Continued From page 79 The following information was provided by the DON: 12/18/17 and 1/9/18= Resident #90 11/21//17, 11/23/17 and 11/29/17= Resident #99 12/5/17 and 12/25/17= discharged resident 2/8/18, 2/9/18, 2/11/18, 2/13/18, 3/17/18, 3/18/17= Resident #111 Resident #99, a 67 year old, was admitted to the facility on 3/2/17. Diagnoses included stroke, depression, hemiplegia, dementia, reflux, anemia, and hypertension. The most recent Minimum Data Set assessment was an annual assessment with an assessment reference date of 3/4/18. Resident #99 was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment and required extensive assistance with activities of daily living. On 3/29/18 an interview was attempted with Resident #99. He was not available for interview. Resident #111, a 65 year old, was admitted to the facility on 2/9/18 and readmitted on 2/16/18. Diagnoses included dysphagia, cognitive communication deficit, stroke, anemia,encephalopathy, and acute kidney failure. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 3/9/18. Resident #111 was coded with moderate cognitive impairment and required extensive assistance with activities of daily living. Resident #111 lived in the room with Resident #85 from admission on 2/9/18-2/13/18 and upon re-admission on 2/16/18. They were living together on 3/20/18 during the initial tour of the	F 610		

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F 610	Continued From page 80 facility. On 3/23/18, Resident #111 was observed in Room 201 B. According to the census list, he was moved out of the room he shared with Resident #85 and into the new room on 3/21/18. While the facility staff indicated that the incident on 2/13/18 involved Resident #111, it is questionable because the nursing note read that the resident involved changed rooms. Resident #111 was discharged on this date. On 3/26/18 at 11:25 a.m., Resident #85 was observed in his room He had a 1:1 sitter with him and he did not have a roommate. On 3/26/18 at 11:30 a.m. the Administrator was interviewed. When asked if Resident #85 was put on 1:1 after the survey team brought forth the issue of Resident #85's abusive behavior, the Administrator stated yes. She stated that the corporate staff thought it would be a good idea. On 3/29/18 at 11:55 a.m. the Administrator was asked if she reported or investigated any of the incidents between Resident #85 and the other residents. The Administrator stated no. When asked if she was aware that all of the other incidents that had occurred, she stated that she was not aware of all of the incidents. She stated that she became fully aware after she read the incidents once the survey team requested the names of the residents that were involved. She stated that the incidents were not reported to her with the severity that they were documented. She stated that staff reported things such as Resident #85 was his "same old self" yesterday, but the staff did not report the details of Resident #85's actions.	F 610		

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F 610	Continued From page 81 On 3/27/18 at 8:46 a.m., Licensed Practical Nurse E (LPN E) was sitting in Resident #85's room. When asked if she was the 1:1 sitter, LPN E stated yes. When asked if she knew why the resident needed a 1:1 sitter, LPN E stated it was for behaviors. Resident #85's care plan was reviewed. A Focus initiated on 11/12/17 read "(Resident #85) uses psychotropic medications Abilify, Haloperidol and Seroquel r/t (related to) Behavior management yelling, aggressiveness toward staff and other residents. The Interventions included Administer medications as ordered. Monitor/ document for side effects and effectiveness (initiated 11/12/17), Consult with pharmacy, doctor to consider dosage reduction when clinically appropriate (initiated 11/12/17), and Resident is on 1:1 for safety and aggression (initiated 3/22/18). Resident #85's Physician Progress Notes were reviewed: 12/7/17 note did not address behavior 1/10/18 note read "Pt (patient) family concerned about his behavior was on Haldol before." Haldol 5 milligram twice a day was ordered. 1/25/18 psychiatric note read "seen today for evaluation of status and review of medication. Today he is seen in his room, good eye contact, interaction appropriate but aphasia is evident during the interview. He denies any difficulty eating or sleeping, denies any significant symptoms of depression but acknowledges some frustration/ anxiety due to his difficulty in speaking and denies suicidality. No noted or reported side effects of medications. He is more alert today and much more calm. Will recommend BuSpar to help with agitation/ anxiety and follow next visit to evaluate status and efficacy of medication	F 610		

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F 610	Continued From page 82 recommendation." 1/29/18 note did not address behavior 2/9/18 note read "Pt (patient) had agitated behavior yesterday, very aggressive Given Ativan which help" Ativan 1 milligram twice a day as needed was ordered. 3/22/18 note read "see pt (patient) behaviors, keep 1:1" 3/22/18 psychiatric note read "No evidence of responding to internal stimuli/ psychosis but impaired cognition is evident and his (sic) he has limited insight and judgement. He is able to respond that he will not hurt anyone and does not appear to be in eminent danger of hurting another individual. However with his TBI (traumatic brain injury) this is subject to change. Discussed with staff the importance of redirection and support given in the method of redirecting him, taking him to the nursing area and providing a snack." 3/23/18 noted read "see pt (patient) behaviors, keep 1:1" Employee training was reviewed. Abuse training was completed. The facility policy "Abuse, Neglect and Exploitation" dated 1/19/17 was reviewed. The "Policy" section read "It is the intent of this facility to prevent the abuse, mistreatment, or neglect of residents or the misappropriation of their property, corporal punishment and/ or involuntary seclusion and to provide guidance to direct staff to manage any concerns or allegations of abuse, neglect or misappropriation of their property." "Employees will receive abuse prevention training as required as part of their orientation, as needed/ indicated and annually thereafter." "Accurate and timely reporting of incidents, both alleged and substantiated, will be sent to officials	F 610		

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in accordance with the state law.

The policy section titled "Identification of incidents and allegations" read "1. The accurate and timely identification of any event which would place our residents at risk is a primary concern of the facility." "a. Each occurrence of resident incident, bruise, abrasion, or injury of unknown source; or report of alleged abuse, neglect or misappropriation of funds will be identified and reported to the supervisor and investigated timely. b. The supervisor or designee will notify the Director of Nursing and Executive Director of the incident or allegation immediately and no later than twenty four hours after being notified of incident or allegation and direct required notification of agencies, physician, family and resident representative c. The Executive Director will direct the investigation."

The section titled "Investigation of Incidents" read "1. In the event a situation is identified as abuse, neglect or misappropriation, an investigation by the executive leadership will immediately follow."

The section titled "Reporting of Incidents and Facility Response" read "1. Alleged violations are reported immediately to the Executive Director of the facility. a. The ED/ designee will report appropriate incidents to the Adult Protective Services and the Division of Licensing and Regulation as required by state law."

Over a period of four months, there were thirteen documented occurrences of abusive behavior committed by Resident #85. Resident #85 was allowed to repeatedly abuse the same residents. Two of the residents who had been abused by Resident #85 were not offered the opportunity to

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change rooms. Resident #90 continued to live next to and share a bathroom with Resident #85. Resident #111 continued to live in the same room with Resident #85. The Administrator was unaware that the incidents had occurred. None of the incidents were reported or investigated. With each act of abuse, no interventions were put into place to ensure all facility residents were free from Resident #85's continued abusive behavior.

2. For Resident # 72, the facility staff failed to investigate an allegation of resident to resident altercation.

Resident # 72, a female, was admitted to the facility 11/2/2015. Her diagnoses included but were not limited to Diverticulitis of both small and large intestines with perforation and abscess, insomnia, neuropathy, Gastroparesis, Anxiety Disorder, Major Depressive Disorder, Multiple Sclerosis, Hypertension and weakness.

Resident # 72's most recent MDS with an ARD of 2/21/2018 was coded as a quarterly assessment. Resident # 72's cognitive status (her ability to make every day life decisions and memory ability) was not coded. Dashes were entered in the areas of Section C 100 "Should Brief Interview for Mental Status" through C 1000" Cognitive Skill for Daily Decision Making." Resident # 72 was coded as needing supervision assistance of one staff member to perform her activities of daily living. Resident # 72 was coded as being able to hear, speak, understand, and be understood.

On 3/28/2018 at 1:40 PM, Resident # 72 asked to speak to the surveyors. At 1:50 PM, Resident # 72 came to the conference room with the surveyors. Resident # 72 stated she thought the

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facility was getting much better but slowly. Resident # 72 stated the facility staff were often busy doing other things like running behind residents who wander into other residents' rooms.

Resident # 72 stated the facility used to admit residents to the facility that could not be managed by the facility staff. She stated one resident was very violent and hit other residents. Resident # 72 stated that particular resident hit her in her chest one day. Resident # 72 stated while she was standing at the end of the hall talking to a nurse who was passing medications, that resident knocked things off of the medication cart and then punched Resident # 72 in her chest. Resident # 72 stated she could not remember the resident's name. Resident # 72 stated the Administrator and Director of Nursing worked hard to get that resident discharged from the facility because she had become violent with many people.

Review of the clinical record was conducted on 3/28/2018 at 2:25 PM.

On 3/28/2018 at 2:45 PM, the Director of Nursing and Administrator were asked to present any incident reports involving Resident # 72. Both stated there had been no incidents involving Resident # 72 of which they were aware.

On 3/29/2018 at 9:00 AM, the Director of Nursing stated she was unaware of any incidents of resident to resident altercations involving Resident # 72.

On 3/29/2018 at 12:05 during the end of day debriefing, the Administrator and Director of Nursing stated Resident # 72 was very vocal and

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had not told them of an incident with another resident striking her in the chest. The Administrator stated she wanted to talk with Resident # 72 to find out more details.

On 3/29/2018 at 1:45 PM when the surveyors returned to the conference room, the Administrator presented a handwritten note from Resident # 72 which stated: "I am making this statement of my own accord. I did not report my incident with being struck by _____ a patient, was not that serious. I was not harmed to the point of making a big issue of it. I do feel safe and secure at Battlefield. "

The Administrator stated she did not ask Resident # 72 to write that statement but that Resident # 72 wanted to write it. The Administrator stated she created an incident report and would start an investigation.

However, on 3/29/2018 at 3:05 PM, an interview was conducted with LPN (Licensed Practical Nurse) E who stated she remembered an incident involving another resident who knocked things off of her cart. LPN E stated she did observe that resident reach and touch Resident # 72 in the chest. LPN E stated it was not a punch in the chest or anything like a fight. LPN E stated she did not view the incident as one to report as physical abuse because" it was like a tap" and the resident was immediately redirected. LPN E stated she knew to report any incident of resident to resident abuse but did not view that incident as abuse. LPN E stated Resident # 72 was not injured and expressed no fear of that other resident to her. LPN E stated Resident # 72 had no other interactions with that resident. LPN E stated the incident happened months ago. LPN E

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stated in the future, she would report any incidents to the Director of Nursing or Administrator.

The facility policy "Abuse, Neglect and Exploitation" dated 1/19/17 was reviewed. The "Policy" section read "It is the intent of this facility to prevent the abuse, mistreatment, or neglect of residents or the misappropriation of their property, corporal punishment and/ or involuntary seclusion and to provide guidance to direct staff to manage any concerns or allegations of abuse, neglect or misappropriation of their property." "Employees will receive abuse prevention training as required as part of their orientation, as needed/ indicated and annually thereafter." "Accurate and timely reporting of incidents, both alleged and substantiated, will be sent to officials in accordance with the state law.

The policy section titled "Identification of incidents and allegations" read "1. The accurate and timely identification of any event which would place our residents at risk is a primary concern of the facility." "a. Each occurrence of resident incident, bruise, abrasion, or injury of unknown source; or report of alleged abuse, neglect or misappropriation of funds will be identified and reported to the supervisor and investigated timely. b. The supervisor or designee will notify the Director of Nursing and Executive Director of the incident or allegation immediately and no later than twenty four hours after being notified of incident or allegation and direct required notification of agencies, physician, family and resident representative c. The Executive Director will direct the investigation."

The section titled "Investigation of Incidents" read

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F 610	Continued From page 88 "1. In the event a situation is identified as abuse, neglect or misappropriation, an investigation by the executive leadership will immediately follow." The section titled "Reporting of Incidents and Facility Response" read "1. Alleged violations are reported immediately to the Executive Director of the facility. a. The ED/ designee will report appropriate incidents to the Adult Protective Services and the Division of Licensing and Regulation as required by state law." On 3/29/2018 at 2:00 PM, an interview was conducted with Resident # 72 who stated she did not want to make a big deal about the resident hitting her in her chest. Resident # 72 stated "it was no big deal. I was not afraid. She is gone now anyway." The Administrator stated the policy was for all incidents to be reported immediately and investigated within 5 days. During the end of day debriefing on 3/29/2018, the facility administrator and Director of Nursing were informed of the findings. No further information was provided.	F 610		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The	F 623	**F 623** 1.) Resident #165 is not a current resident. No noted negative outcomes related to absence of Discharge Notification.	

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F 623	Continued From page 89 facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge;	F 623	2.) Assistant Business Office Manager/ designee did an audit of residents discharged in the last 30 days to ensure policies and procedures were followed for Notice Requirements before Transfer/Discharge, any identified concerns will be addressed as indicated. 3.) Regional Director of Clinical Operations will Educate Interdisciplinary Team on the process for Notice Requirements before Transfer/Discharge. 4.) The EHR Coordinator and or designee will audit the discharges weekly to ensure proper notifications are completed for transfers/discharges and in a timely manner x12 weeks with results brought to QAPI to ensure compliance.	

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F 623	Continued From page 90 (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is	F 623		

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F 623	Continued From page 91 the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, facility staff failed to provide a discharge notification for one resident, Resident #165, in a sample of 38 residents. For Resident #165, a discharged resident, a discharge notification was not provided. The findings included: Resident #165's most recent Minimum Data Set assessment (MDS) was a Discharge assessment with an assessment reference date (ARD) of 11/27/2018. Resident #165's Brief Interview for Mental Status (BIMS) assessed a score of 15, indicating no cognitive impairment. Resident #165's diagnoses included: Ataxia, dysphagia, hemiplegia, hemiparesis, cerebral infarct, gastrostomy, dysarthria, hypertension, inguinal hernia, hyperlipidemia, and gastro-esophageal reflux disease. On 3/23/2018, a review of Resident #165's closed record was conducted. It was noted that no discharge notification could be found in the record provided by the facility. At the end of day on 3/23/2018, the DON was informed of the missing discharge notification, and was asked to assist with locating it. The DON stated "it should be	F 623		

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F 623	Continued From page 92 there, it is a green document", but stated she would see what she could do. On 3/27/2018, the DON was asked if the discharge notification for Resident #165 had been located. The DON stated "no", and that she did not know where it could be. No further documents were provided.	F 623		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's	F 640	**F 640** 1.) Resident #17 had a discharge assessment completed and submitted 2.) Current residents with a discharge assessment with an ARD 5-1-17 to 4-4-18 were audited to ensure transmission of discharge assessments were submitted by the MDS Coordinator and or designee 3.) MDS coordinator will be educated by Regional MDS and or designee on timely transmission of discharge assessments. 4.) A weekly audit of transmitted discharge assessments completed that week will be conducted to ensure assessment is transmitted within 14 days of completion of encoding x 12 weeks by MDS Coordinator and or designee. Results from audits will be brought to QAPI to ensure compliance and need for further monitoring.	

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F 640	Continued From page 93	F 640		

assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and facility documentation review, the facility staff failed to transmit a completed encoded discharge assessment timely to CMS (Centers for Medicare & Medicaid services) for 1 Residents (Residents #17) of 38 residents in the survey sample.

For Resident #17, the facility staff failed to transmit the discharge assessment within 14 days of completion of encoding on 12-12-17.

The findings included:

Resident #17 was originally admitted to the facility on 8-1-17. Diagnoses included; End stage renal disease, weakness, altered mental status, and

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F 640	Continued From page 94 cataract extraction. Resident #17's most recent quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 11-8-17. The Resident was coded with a Brief interview for mental status (BIMS) score of 8 points scored in a possible 15 points, indicating moderate cognitive impairment. The Resident was coded as requiring supervision to limited assistance of staff for dressing, toileting, and hygiene. Resident #17's most recent Minimum Data Set (MDS) assessment was a "discharge return not anticipated" assessment with an Assessment Reference Date (ARD) of 12-1-17. The Discharge assessment was signed as completed on 12-12-17, and at the time of survey (3-28-18) the assessment had still not been submitted to CMS. On 3-28-18 the MDS coordinator (Admin E) was interviewed at 10:00 a.m. She stated that this particular MDS was completed by a previous MDS nurse who was no longer employed with the company, and that the MDS submission not being transmitted, was an error. Admin E then stated she would submit the document immediately. On 3-28-18 at 11:30 a.m. Admin E returned to the conference room and submitted a document showing the omitted assessment had now been submitted as a late submission. On 3-28-18 at the end of the day debrief, the Administrator and DON (director of nursing) were notified of findings. No further documentation was available to be presented.	F 640		

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F 641 F 641 SS=D	Continued From page 95 Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure an accurate MDS/RAI assessment was completed for two residents (Residents #72 and # 16) in a survey sample of 38 residents. 1. For Resident # 72, the facility staff failed to complete Section C: Cognitive Patterns in an Quarterly assessment dated 2/21/2018. 2. For Resident # 16, the facility staff failed to complete Section C: Cognitive Patterns in an Quarterly assessment dated 2/15/2018. Findings included: 1. For Resident # 72, the facility staff failed to complete Section C: Cognitive Patterns in an Quarterly assessment dated 2/21/2018. Resident # 72, a female, was admitted to the facility 11/2/2015. Her diagnoses included but were not limited to Diverticulitis of both small and large intestines with perforation and abscess, insomnia, neuropathy, Gastroparesis, Anxiety Disorder, Major Depressive Disorder, Multiple Sclerosis, Hypertension and weakness. Resident # 72's most recent MDS with an ARD of 2/21/2018 was coded as a quarterly assessment.	F 641 F 641	1.) Resident #72 and #16 cognitive patterns were evaluated and any identified changes were evaluated and plan of care reviewed and revised accordingly. 2.) MDS Coordinator/Designee reviewed current resident assessments for the last 30 days, if any resident assessments were identified with dashes in Section C, resident's cognitive patterns were evaluated and any identified changes were addressed as indicated. 3.) Regional MDS Coordinator/designee will provide education to the interdisciplinary team on the timing requirement for the completion of Section C of the MDS in accordance with the RAI guidelines. MDS interviews for section C that are not completed on or before the Assessment Reference Date will be coded with dash indicating that the interview was not completed during the lookback period in accordance with RAI guidelines. The Quarterly assessment requirement will be fulfilled by completing interview during the 14 day	

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F 641	Continued From page 96 Resident # 72's cognitive status (her ability to make every day life decisions and memory ability) was not coded. Dashes were entered in the areas of Section C 100 "Should Brief Interview for Mental Status" through C 1000" Cognitive Skill for Daily Decision Making." Resident # 72 was coded as needing supervision assistance of one staff member to perform her activities of daily living. Resident # 72 was coded as being able to hear, speak, understand, and be understood. Review of the clinical record was conducted on 3/28/2018 at 2:30 PM. Review of the MDS revealed blanks in the Cognitive Section. On 3/28/2018 at 3:15 PM, an interview was conducted with LPN (Licensed Practical Nurse) B who stated Resident # 72 was alert and had no cognitive impairment. On 3/28/2018 at 4:00 PM, the Director of Nursing was asked if she knew what Resident # 72's BIMS score was. The Director of Nursing stated Resident # 72 probably would have a BIMS score of 15 because she had no cognitive impairment. On 3/29/2018 at 9:20 AM, an interview was conducted with Registered Nurse Assessment Coordinator (Admin E) who stated that dashes on the MDS (Minimum Data Set) meant the staff did not complete the interview. Admin E stated she was told that certain sections must be filled out by the Social Worker before the ARD. Admin E stated the Social Worker usually conducted the interviews in that section and the facility had no social worker "for a period of time, since January 2018." Admin E stated "we are not allowed to do	F 641	completion period and documenting resident responses in the PointClickCare User Defined Assessment. 4.) MDS Coordinator/designee will review completed resident assessments Section C for 30 days and then 10/week for 60 days and results will be brought to QAPI.	

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F 641	Continued From page 97 interviews after the ARD." Admin E stated the other facility staff worked as a team to get everything completed. The Corporate Mobile MDS Coordinator (Admin K) was in the room while Admin E was being interviewed. Admin K stated "the RAI manual instructed us to not conduct any interviews after the ARD." Admin K stated they were told to use dashes in several situations. Admin E and Admin K stated they would research the manual and present any additional information obtained. Guidance was provided in "Long Term Care Facility Resident Assessment User's Manual Version 3.0 May 2013, p. C-3 "Steps for Assessment 1. Determine if the resident is rarely/never understood verbally or in writing. If rarely/never understood, skip to C0700 - C1000, Staff Assessment of Mental Status. 2. Review Language item (A1100), to determine if the resident needs or wants an interpreter. · If the resident needs or wants an interpreter, complete the interview with an interpreter. Coding Instructions Record whether the cognitive interview should be attempted with the resident. Code 0, no: if the interview should not be attempted because the resident is rarely/never understood, cannot respond verbally or in writing, or an interpreter is needed but not available. Skip to C0700, Staff Assessment of Mental Status. · Code 1, yes: if the interview should be attempted because the resident is at least sometimes understood verbally or in writing, and	F 641		

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F 641	Continued From page 98 if an interpreter is needed, one is available. Proceed to C0200, Repetition of Three Words. CMS ' s RAI Version 3.0 Manual CH 3: MDS Items [C] May 2013 Page C-2 C0100: Should Brief Interview for Mental Status Be Conducted? (cont.) Coding Tips · If the resident needs an interpreter, every effort should be made to have an interpreter present for the BIMS. If it is not possible for a needed interpreter to participate on the day of the interview, code C0100 = 0 to indicate interview not attempted and complete C0700-C1000, Staff Assessment of Mental Status, instead of C0200-C0500, Brief Interview for Mental Status. · Includes residents who use American Sign Language (ASL). C0200-C0500: Brief Interview for Mental Status (BIMS)" Also, same reference p. 3-4: "Almost all MDS 3.0 items allow a dash (-) value to be entered and submitted to the MDS QIES ASAP system. - A dash value indicates that an item was not assessed. This most often occurs when a resident is discharged before the item could be assessed. - Dash values allow a partial assessment to be submitted when an assessment is required for payment purposes. - There are four date items (A2400C, O0400A6, O0400B6, and O0400C6) that use a dash-filled value to indicate that the event has not yet occurred. For example, if there is an ongoing	F 641		

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F 641	Continued From page 99 Medicare stay, then the end date for that Medicare stay (A2400C) has not occurred, therefore, this item would be dash-filled. - The few items that do not allow dash values include identification items in Section A [e.g., Legal Name of Resident (Item A0500), Assessment Reference Date (Item A2300), Type of Assessment (Item A0310), and Gender (Item A0800)] and ICD-9 diagnosis codes (Item I8000). All items for which a dash is not an acceptable value can be found on the CMS MDS 3.0 Technical Information web page at the following link: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html" On 3/29/2018 at 3:00 PM, Admin E stated she was sorry but misunderstood about the interviews. Admin E stated the MDS should be complete with interviews done prior to the ARD and timely. Admin E stated that the interviews must be done and dashes should not be used in the Cognitive section. The Administrator, DON (director of nursing), and corporate consultants were informed of the failure of the staff to complete Section C100-C1000 accurately for a quarterly MDS with the ARD of 2/18/2018 during the end of day debriefing on 3/29/2018. No further information was provided. 2. For Resident # 16, the facility staff failed to complete Section C: Cognitive Patterns in an Quarterly assessment dated 2/15/2018.	F 641		

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F 641	Continued From page 100	F 641		

Resident # 16, a female, was admitted to the facility 3/9/2015. Her diagnoses included but were not limited to Pneumonia, Urinary Tract Infection, Hyperlipidemia, Cerebrovascular Accident, Dementia and Seizure Disorder.

Resident # 16's most recent MDS with an ARD of 2/15/2018 was coded as a quarterly assessment. Resident # 16's cognitive status (her ability to make every day life decisions and memory ability) was not coded. Dashes were entered in the areas of Section C 100 "Should Brief Interview for Mental Status" through C 1000" Cognitive Skill for Daily Decision Making." Resident # 16 was coded as needing supervision assistance of one staff member to perform her activities of daily living. Resident # 16 was coded as being able to hear, speak, understand, and be understood.

Review of the clinical record was conducted on 3/20/2018 at 2:30 PM.

Review of the MDS revealed dashes in Section C for Cognitive Patterns.

Guidance was provided in "Long Term Care Facility Resident Assessment User's Manual Version 3.0 May 2013, p. C-3

"Steps for Assessment
1. Determine if the resident is rarely/never understood verbally or in writing. If rarely/never understood, skip to C0700 - C1000, Staff Assessment of Mental Status.
2. Review Language item (A1100), to determine if the resident needs or wants an interpreter.
· If the resident needs or wants an interpreter, complete the interview with an interpreter.

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F 641	Continued From page 101 Coding Instructions Record whether the cognitive interview should be attempted with the resident. Code 0, no: if the interview should not be attempted because the resident is rarely/never understood, cannot respond verbally or in writing, or an interpreter is needed but not available. Skip to C0700, Staff Assessment of Mental Status. · Code 1, yes: if the interview should be attempted because the resident is at least sometimes understood verbally or in writing, and if an interpreter is needed, one is available. Proceed to C0200, Repetition of Three Words. CMS ' s RAI Version 3.0 Manual CH 3: MDS Items [C] May 2013 Page C-2 C0100: Should Brief Interview for Mental Status Be Conducted? (cont.) Coding Tips · If the resident needs an interpreter, every effort should be made to have an interpreter present for the BIMS. If it is not possible for a needed interpreter to participate on the day of the interview, code C0100 = 0 to indicate interview not attempted and complete C0700-C1000, Staff Assessment of Mental Status, instead of C0200-C0500, Brief Interview for Mental Status. · Includes residents who use American Sign Language (ASL). C0200-C0500: Brief Interview for Mental Status (BIMS)" Also, same reference p. 3-4: "Almost all MDS 3.0 items allow a dash (-) value	F 641		

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F 641	Continued From page 102 to be entered and submitted to the MDS QIES ASAP system. - A dash value indicates that an item was not assessed. This most often occurs when a resident is discharged before the item could be assessed. - Dash values allow a partial assessment to be submitted when an assessment is required for payment purposes. - There are four date items (A2400C, O0400A6, O0400B6, and O0400C6) that use a dash-filled value to indicate that the event has not yet occurred. For example, if there is an ongoing Medicare stay, then the end date for that Medicare stay (A2400C) has not occurred, therefore, this item would be dash-filled. - The few items that do not allow dash values include identification items in Section A [e.g., Legal Name of Resident (Item A0500), Assessment Reference Date (Item A2300), Type of Assessment (Item A0310), and Gender (Item A0800)] and ICD-9 diagnosis codes (Item I8000). All items for which a dash is not an acceptable value can be found on the CMS MDS 3.0 Technical Information web page at the following link: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html" On 3/29/2018 at 3:00 PM, Admin E stated she was sorry but misunderstood about the interviews. Admin E stated the MDS should be complete with interviews done prior to the ARD and timely. Admin E stated that the interviews must be done and dashes should not be used in the Cognitive section.	F 641		

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F 641	Continued From page 103 The Administrator, DON (director of nursing), and corporate consultants were informed of the failure of the staff to complete Section C100-C1000 accurately for a quarterly MDS during the end of day debriefing on 3/29/2018. No further information was provided.	F 641		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657	F 657 1.) Resident #9s care plan was reviewed and revised to reflect methods to prevent future hot liquid burns on 3/20/2018 and 3/21/2018. Resident #42s care plan was reviewed and revised to prevent further hoarding of medications. Resident #92s care plan was reviewed and revised to include interventions for depression and past suicidal ideations. Resident #101 care plan was reviewed and revised to reflect anticoagulant status. 2. DON/Designee will review Incident/Accidents, Progress Notes, and Behavior Notes for the past 30 days to ensure care plan reviews and revisions were completed as indicated. Current Residents receiving Anticoagulants will be audited to ensure care plan review and revisions have been completed as indicated. 3.) Regional Clinical Director will educate Interdisciplinary Team and Licensed Nurses on the requirements for review and revisions of the care plan.	

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F 657	Continued From page 104 by: Based on observation, resident interview, staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed, for 4 residents (Resident #9, Resident #42, Resident #92, Resident #101) of the survey sample of 32 residents to review and revise the care plan. 1. For Resident #9, the facility staff failed to revise the care plan to include burn injury prevention, after a burn injury from hot liquid. 2. For Resident #42, the facility staff failed to revise the care plan to prevent further hoarding of medications after multiple medications were found in her room. 3. Resident #92's care plan was not updated to include suicidal ideation and depression. 4. For Resident #101, facility Staff failed to develop a comprehensive person-centered care plan that addressed the resident's anticoagulation status. The Findings included: 1. Resident #9 was a 79 year old who was admitted to the facility on 11/19/10. Resident #9's diagnoses included Bilateral Leg Amputations above the Knee, Major Depressive Disorder, Hemiplegia and Hemiparesis following Unspecified Cerebrovascular Disease Affecting Left Non-Dominant Side, Hyperlipidemia, Hypertension, Chronic Obstructive Pulmonary Disease, Arteriosclerotic Heart Disease, Old Myocardial Infarction, Heart Failure Unspecified,	F 657	DON/Designee will review Progress notes, Order Recap, Occurrence Reports, and New Admissions daily to ensure care plan review and revisions are completed as indicated. 4.) ADON/Designee will complete Weekly audits x 12 weeks of 10 resident care plan to ensure compliance with review and revision of care plans. Results of Audits will be brought to QAPI	

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F 657	Continued From page 105 Generalized Muscle Weakness, and Cerebral Infarction Due to Unspecified Occlusion or Stenosis of Unspecified Cerebral Artery. Resident #9 was cognitively intact with a Brief Interview of Mental Status score of 15, indicating no cognitive impairment, Mobility Impairment, Range of Motion Limitations, History of Cardiovascular Accident with left Hemiplegia, Chronic Obstructive Pulmonary Disease, multiple cardiac problems deficit related to Generalized Weakness, Poor Endurance, Impaired Balance and Motor Control secondary to Above the Knee Amputation. On 3/20/18, a review was conducted of Resident #9's clinical record. On 3/7/18, Resident #9 was given a cup of hot coffee in his room without a lid on it. He put cream into the coffee, then accidentally hit the cup with his elbow, spilling it onto his abdomen and sustaining a burn on his abdomen. Resident #9's care plan read, "Increased risk for nutrition/hydration imbalance related to history of Mental Illness, diuretic use, Hypertension, Chronic Heart Failure, Major Depressive Disorder, and Chronic Obstructive Pulmonary Disorder. Provide assistance as meals as needed." On 3/20/18 at 1:00 P.M. an interview was conducted with Resident #9. When asked how he received the burn injury, he stated, "I was drinking coffee. I put the cream in the coffee. I was getting ready to put the sugar in the coffee. I hit the cup..." Resident #9's clinical record contained the	F 657		

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following Skin Assessment, "3/2/18. new non-pressure area. first observed 3/2/18. Site Abdomen 4 cm L x 1.5 cm open area. Burn. Color open area. Exudate type: none. Odor: no. Infection: no. Current treatment orders: clean area with normal Saline and apply nonstick drsg (dressing) with Alocane and border drsg.. every shift until healed. Pain Assessment: Pain associated with non pressure wound - yes."

Resident #9's clinical record contained an Initial Evaluation Wound Treatment. It read, "3/13/18 Burn wound on abdomen Size 0.8 x 1.1 x Not Measurable MC. Surface area 0.88 CM. Dried Fibrinous exudate. Additional information: mostly heated burn. Treatment: Skin prep apply 1 x daily for 30 days. Foam apply 1x daily x 30 days."

Resident #9's signed Physician's Orders read, "3/2/18. Alocane Emergency Burn Max Str. Gel 4%. Apply to abdomen topically three times a day for burn. Clean area with normal saline then apply Alocane Emergency Burn Gel with non stick drsg with cling until area healed. 3/8/18. Daily wound assessment burns to stomach. Document abnormalities in progress notes. Document level of pain at wound site." According to the Medication Administration record, the treatment was administered from 3/2/18 at 5:00 P.M. until 3/8/18 at 8:00 A.M.

After Resident #9 sustained a burn injury on 3/2/18, his care plan had not been updated to include interventions to prevent further burns. Prior to the survey, there was no Hot Liquid Assessment done either before or after the burn. There was no intervention put in place to prevent another burn injury.

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F 657	Continued From page 107 As of the last day of the survey on 3/29/18, the care plan had not been revised to include burn injury prevention even after IJ was called on 3/20/18 and the plan of correction submitted for the IJ, stated that care plans would be revised as stated below: 1. Identified residents have been evaluated by Nurse Manager for ability to safely handle hot liquids. The plan of care will be revised as indicated. Residents have current treatment plans in place. 2. Current residents will be evaluated by nursing to ensure safety and ability to handle hot liquids. Plan of care will be reviewed and revised as indicated. Residents identified at risk for handling hot liquids will be evaluated to determine need for alternative interventions. The facility has removed potential hot liquid accessibility. Nursing will complete skin assessments on all residents within facility to ensure no other burns noted. Social Service Department will interview interviewable residents to ensure they have had no issues with hot liquids. 3. Facility nursing will evaluate ability to handle hot liquids upon admission, quarterly, and with change of condition. All facility staff will be educated prior to working on the process for evaluating resident's safety and ability to handle hot liquids, and the proper temperature to serve hot liquids. Dietary will continue to monitor hot liquid temperatures before each meal to ensure the hot liquids are not served above 135 degrees at point of service with log sign off. 4. Director of Nursing or designee will audit 10 residents per week to ensure hot liquid safety assessments have been completed x 4 weeks, and 5 residents per week x 3 weeks, with results found brought to QAPI (Quality Committee).	F 657		

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Administrator or designee will audit hot liquid temperature logs once daily x 4 weeks and will bring results found to QAPI.
5. Corrective Action will be completed by 11:59 pm on March 20, 2018."

On March 20, 2018 the facility Administrator (Administration A) and Director of Nursing (Administration B) were notified of the findings. The facility subsequently submitted a Hot Liquid Assessment of Resident #9, which indicated that he was At Risk for handling hot liquids due to his "Contractures - Fingers, hand wrist , elbow, shoulder of non-dominant side, Strength - Weakness, paresis, paralysis of upper extremity. Intervention: resident to drink hot liquids with lid on cup, resident to be evaluated by therapy, resident to be educated by staff preparing coffee for him." In addition, Hot Liquid Assessments were submitted for all other residents. The facility staff received inservice training that covered the following: "No resident can have any hot liquid until properly assessed by a nurse. If they are a new admission they are not given hot liquids until assessment is completed. All hot liquids must be under 135 degrees with log signed off and covered with a lid."

2. For Resident #42, the facility staff failed to revise the care plan to prevent further hoarding of medications after multiple medications were found in her room.

Resident #42 was an 81 year old who was admitted to the facility on 8/31/17. Resident #42's diagnoses included Encephalopathy, Peripheral Vascular Disease, Non-Alzheimer's Dementia, Altered Mental Status, Dysphasia Oropharyngeal

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Phase, Cognitive Communication Deficit, Repeated Falls, Gastro-Esophageal Reflux Disease, Hypertension, Pain in Unspecified Joint, Vitamin B 12 Deficiency Anemia, and Muscle Weakness - Generalized.

The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 3/2/17, coded Resident #42 as being able to understand and be understood by others.

On 3/26/18 a review was conducted on Resident#42's clinical record, revealing the following Nursing Progress Note, "3/9/18. Resident noted hoarding her medications, complains of taking too many pills. Excess pills removed from residents possession, she became combative with staff, unable to redirect. Nurse Practitioner called...No new orders. Message left for residents (RP) representative."

Resident #42's care plan was reviewed. It was not updated to include prevention of hoarding medications.

On 3/26/18 a review was conducted of facility documentation, revealing a Medication Administration Policy. It read, "Revised 12/14/17. Remain with resident until the medication is swallowed. Do not leave medication at bedside."

On 3/26/18 at 1:45 P.M. the surveyor found a small white oval tablet inside of a medication cup on top of Resident #42's nightstand table. The Regional Nurse (Administration C) was present outside of the resident's room. When asked to identify the pill, she looked at the physician's orders along with the nurse (LPN B). They both identified the pill as Losartan 25 MG. LPN B

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F 657	Continued From page 110 stated, "I have given her medication during the past few days. She always takes the cup and pours the pills into her hand either 1, 2 or 3 at a time. She then puts them into her mouth and drinks water." On 03/26/18 at 3:25 P.M., an interview was conducted with the Regional Nurse. When asked to describe the Losartan 25 MG. pill found in the resident's room, she stated, " It's dry, the number 113 is on one side and the number 25 is on the other. It's white, oval and the numbers are easily read. It does not appear to be touched by liquid. It doesn't look like it has any coating on it." When asked to describe the process that should be followed when a resident is found to be hoarding pills, the Regional Nurse stated, "We should identify the pills. Figure out what occurred. Determine what narcotics if any were involved. In this case, the resident did not have any physician ordered narcotics. Also, find out why the pills are there. You interview staff, etc. We need to determine within 24 hours what happened. We need to notify the MD. Change plan of care. When administering the pills, the nurse maybe should confirm that they swallowed the pills." On 3/26/18 at approximately 4:00 P.M. the facility Administrator (Administration A), and Director of Nursing (Administration B) were notified of the findings. The DON stated that the nurses should administer Resident #42's medications on a "slower schedule". The further stated that the facility did not provide inservice training for nurses regarding the hoarding of medications. 3. Resident #92's care plan was not updated to include suicidal ideation and depression.	F 657		

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F 657	Continued From page 111 Resident #92, a 67 year old, was admitted to the facility on 10/12/17. Diagnoses included stroke, hemiplegia, major depression disorder, hyperlipidemia, reflux, pain, skin cancer, and convulsions. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 1/18/18. Resident #92 was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment and requiring assistance with activities of daily living. An interview was conducted with Resident #92 on 3/20/18 at 12:00 p.m. During the interview, Resident #92 was tearful. He stated that he never used to be a person who cried. He stated that he no longer wanted to be around due to his health conditions. He was asked if he had ever talked with the social worker about his feelings. He stated no. When asked if he was interested in talking with the social worker, Resident #92 stated yes. Resident #92's clinical record was reviewed. The following notes were documented: 10/19/17, 5:00 a.m., Behavior Note. "Resident lying in a fetal position in bed, w/ eyes opened. NAD, no c/o pain or discomfort voiced. Alert, confused & verbal. Upon assessment, resident voiced he had taken a certain amount of pills that would set him on fire, but, when he woke up he feels angry that he's still alive. Writer questioned resident about the fire, resident stated that he wanted to kill himself because his sister won't take him home. Resident doesn't have any items	F 657		

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F 657	Continued From page 112 within reach that could harm him & frequent monitoring was accessed." 10/28/17, 8:56 a.m., eMAR note. "While in residents room to administer meds, resident stated, Don't tell no body but I'm threw I don't wanna live anymore. Resident refused meds at first. With redirection took medication." At the end of day meeting on 3/26/18, the Director of Nursing (DON) and Administrator were notified that it did not appear the facility staff were providing for Resident #92's behavioral health needs. It was reviewed that it did not appear that Resident #92's depression and hopelessness were care planned. 4. For Resident #101, facility Staff failed to develop a comprehensive person-centered care plan that addressed the resident's anticoagulation status. Resident #101's most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an Assessment Reference Date (ARD) of 2/4/2018. The Brief Interview for Mental Status (BIMS) gave a score of 15, indicating no mental impairment. Resident #101's diagnoses included: Quadriplegia, contracture, HIV, major depressive disorder, Non-ST-Elevated Myocardial Infarction, insomnia, hyperlipidemia, gastro-esophageal reflux disease, hepatitis-c, hypertension, and opioid dependence. Resident #101 required extensive assistance of one staff member with activities of daily living of hygiene, dressing and for transfer; required total assistance of one staff person for bathing, required limited assistance of one staff member	F 657		

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F 657	Continued From page 113 for eating, and extensive assistance of two staff members for bed mobility. Resident #101 was coded as frequently incontinent of bowel and bladder. On 3/27/2018, a review of Resident #101's record was started. In the course of the record review, it was noted that Resident #101 had been hospitalized for a Non-ST Elevated Myocardial infarction, a type of heart attack, and had artery stents placed. Resident #101's hospital discharge orders included two medications to reduce clotting: Plavix, a tablet to be taken daily, and Lovenox, an injection to be given every 12 hours. A copy of Resident #101's Care Plan was reviewed on 3/27/2018. No goals or interventions addressing the resident's increased risk for bleeding or other anticoagulation related needs were found. The findings were discussed with the Administrator and DON at the end of day meeting on 3/27/2018. The DON stated that the resident's anticoagulation status should have been addressed, and that the resident's care plan would be immediately revised. On 3/29/2018 the DON informed surveyors that Resident #101's care plan had been updated to address the anticoagulation treatment.	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 658	1.) Resident #32, #72 Physician was notified of missed medications. No negative outcomes noted for these residents. Resident #72's and Resident #164 identified medications were clarified by MD and processed accordingly. No negative outcomes noted for these residents. Resident #364 PICC Line was inserted and ABT administered. No negative outcomes noted for this resident.	

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F 658	Continued From page 114 Based on observation, staff interview, clinical record review and facility documentation review the facility staff failed to follow professional standards of quality for 4 residents (Resident #32, 72, 164, and 364) in a survey sample of 38 residents. 1. For Resident # 32, the facility staff failed to administer medications as ordered by the physician. 2. For Resident # 72, the facility staff failed to ensure medications were available for administration as ordered by the physician, failed to consult physician for an alternative medication to be given when prescribed medication was unavailable and failed to clarify orders for medications that were questioned by the resident. 3. For Resident #164, facility staff failed to clarify an order for Trazodone. 4. For Resident #364 a PICC line and ABT were not started until 14 hours after being ordered. Facility failed to provide Peripherally Inserted Central Catheter Line (PICC line) and for 14 hrs. Findings included: 1. For Resident # 32, the facility staff failed to administer medications as ordered by the physician. Resident # 32 was a 75 year old male admitted to the facility on 6/21/2012 and readmitted on 3/9/2018 with the diagnoses of, but not limited to, Peripheral Vascular Disease, Neuromuscular Dysfunction of the bladder, Gastroesophageal Reflux Disease, Chronic Kidney Disease,	F 658	**2.)** Current residents' orders will be reviewed and any clarifications that need addressed will be referred to MD for correction. EMAR notes for the last 14 days will be reviewed, any identified concerns related to medication availability and obtaining alternative medication will be addressed as indicated. Current residents' new orders for the last 14 days will be reviewed for Antibiotic and IV orders to ensure timely processing and implementation, identified concerns will be addressed as indicated. **3.)** Licensed Nurses will be educated on Medication Administration Guidelines, Pharmacy (medication) ordering, Medication Management, and Daily Order Recap Review. Licensed Nurses will be educated on the policies and procedures for processing new orders and the process for obtaining IV access timely. Unit Manager/Designee will review EMAR notes and Order Recap Summary daily to ensure medication orders are clarified as indicated, medications are available as ordered. Charge Nurse/Designee will validate that new orders from Physician/NP are reviewed and addressed timely. Licensed Nurses will complete daily chart checks.	

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F 658	Continued From page 115 Dysphagia, Atherosclerosis of native arteries of extremities with Gangrene Bilateral Legs, Amputation of toes, Hypothyroidism, Glaucoma, Chronic Viral Hepatitis, Paraplegia, and Dementia Resident #32's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 1/30/2018. The MDS coded Resident # 32 with a Brief Interview for Mental Status (BIMS) score of 6 out of 15 indicating severe cognitive impairment. Resident # 32 required extensive assistance of one to two staff members with activities of daily living except required total assistance of one staff person for bathing and always incontinent of bowel and Resident # 32 was coded to have an indwelling urinary catheter. Review of the clinical record was conducted on 3/21/2018 at 2:30 PM. Review of the Progress Notes revealed documentation of an eMar (electronic Medication Administration Note) on 3/10/2018 at 3:25 PM which stated Metoprolol Tartrate tablet 25 milligrams give 2 tablet by mouth every 12 hours related to Essential Hypertension (110) hold for HR <60 (heart rate less than 60) "Awaiting arrival from pharmacy." Further review of the Progress Notes revealed other documentation of medications not available from the pharmacy. On 11/4/2017 at 4:27 PM eMar (electronic Medication Administration Note) Dulera Aerosol 200-5 micrograms per activation 2 puffs inhale orally two times a day for Bronchitis. "Med not available."	F 658	4.) DON/Designee will review order recap and EMAR notes daily 5 x week to ensure Medication orders are clarified as needed, and medications are delivered and given as ordered and timely or an alternative medication is obtained if needed. DON/Designee will validate daily with order recap that IV and Antibiotic orders have been processed timely. Audit results will be reported to QAPI.	

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F 658	Continued From page 116 On 11/4/2017 at 4:30 PM eMar (electronic Medication Administration Note) Dorzolamide HCL (Hydrochloride) Solution 2 % instill one drop in both eyes two times a day related to other specified Glaucoma: "Med not available" On 11/4/2017 at 4:30 PM eMar (electronic Medication Administration Note) Timoptic Solution 0.5 % Instill one drop in right eye one time a day related to other specified Glaucoma. "Med not available." On 11/4/2017 at 10:10 PM eMar (electronic Medication Administration Note) Zosyn Solution Reconstituted 3.375 grams Use 3.375 milligrams intravenously every 12 hours for MRSA (Methicillin Resistant Staphylococcus Aureus)in wound for 14 days. "Med has not been delivered" On 11/5/2017 at 7:45 AM eMar (electronic Medication Administration Note) LevoFloxacin in D5W Solution 500 milligrams intravenously every 24 hours for MRSA in wound for 14 days "awaiting on pharm" On 3/22/2018 at 9 AM, an interview was conducted with LPN (Licensed Practical Nurse) B who stated the staff should notify the Pharmacy when medications are not available. On 3/22/2018 at 2 PM, an interview was conducted with the Director of Nursing who stated the Pharmacy should have medications available for administration as per Physicians Orders. The Director of Nursing also stated the facility staff should check the "First Dose" medications to see if the missing medication is available in that supply.	F 658		

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F 658	Continued From page 117 Review of the STAT box "First Dose" contents list revealed the Medication, Lopressor (Generic Name-Metoprolol Tartrate) 25 milligrams was available to the staff. During the end of day debriefing on 3/23/2018, the Facility Administrator, Director of Nursing and Corporate Nurse were informed of the findings. The Director of Nursing stated the Pharmacy should ensure medications were available for administration as ordered by the physician and should have administered medications available in the STAT First Dose Box. No further information was provided. 2. For Resident # 72, the facility staff failed to ensure medications were available for administration as ordered by the physician, failed to consult physician for an alternative medication to be given when prescribed medication was unavailable and failed to clarify orders for medications that were questioned by the resident. Resident # 72, a female, was admitted to the facility 11/2/2015. Her diagnoses included but were not limited to Diverticulitis of both small and large intestines with perforation and abscess, insomnia, neuropathy, Gastroparesis, Anxiety Disorder, Major Depressive Disorder, Multiple Sclerosis, Hypertension and weakness. Resident # 72's most recent MDS with an ARD of 2/21/2018 was coded as a quarterly assessment. Resident # 72's cognitive status (her ability to make every day life decisions and memory ability) was not coded. Dashes were entered in the	F 658		

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F 658	Continued From page 118 areas of Section C 100 "Should Brief Interview for Mental Status" through C 1000" Cognitive Skill for Daily Decision Making." Resident # 72 was coded as needing supervision assistance of one staff member to perform her activities of daily living. Resident # 72 was coded as being able to hear, speak, understand, and be understood. Review of the clinical record was conducted on 3/28/2018 at 2:25 PM. Review of the Progress Notes revealed documentation that several medications were not available from the Pharmacy during November 2017 to March 2018. On 2/12/2018 at 3:42 PM- Mirabegron ER (Extended Release) 24 hour 25 milligrams tablet "Medication not available. Pharmacist stated medication will be sent out tonight 2/12/2018. Awaiting arrival." On 2/11/2018 at 1:20 PM: Mirabegron ER tablet Extended Release 24 hour 25 milligrams give one tablet by mouth one time a day for Bladder spasms. Med not available On 2/10/2018 at 9:03 AM: Mirabegron ER tablet Extended Release 24 hour 25 milligrams give one tablet by mouth one time a day for Bladder Spasms. Med not available On 1/8/2018 at 3:46 PM: Ergocalciferol Capsule 50000 Unit give one capsule by mouth one time a day every Monday related to Multiple Sclerosis. Awaiting arrival from Pharmacy" On 1/8/2018 at 3:49 PM: Naloxegol Oxalate tablet 25 milligrams give one tablet by mouth one	F 658		

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F 658	Continued From page 119 time a day for Constipation "Awaiting arrival from pharmacy." On 1/5/2018 at 8:34 AM: Naloxegol Oxalate tablet 25 milligrams give one tablet by mouth one time a day for Constipation "Pharm notified to send." On 12/3/2017 at 10:18 AM: Fenofibrate Capsule give 134 milligrams by mouth one time a day related to Multiple Sclerosis "Not available." On 12/2/2017 at 11:53 AM: Fenofibrate Capsule give 134 milligrams by mouth one time a day related to Multiple Sclerosis "Not available." On 11/23/2017 at 7:00 AM: Oxycodone HCL tablet 30 milligrams give one tablet by mouth every 6 hours for Pain "Med unavailable." On 11/16/2017 at 12:40 AM: Oxycodone HCL tablet 30 milligrams give one tablet by mouth every 6 hours for Pain "Med unavailable." On 11/15/2017 at 1:08 PM: Oxycodone HCL tablet 30 milligrams give one tablet by mouth every 6 hours for Pain "Med unavailable." On 11/12/2017 at 6:44 PM: Clonazepam tablet 0.5 milligrams give one tablet by mouth two times a day related to Anxiety Disorder "Not available." On 11/12/2017 at 8:57 AM: Clonazepam tablet 0.5 milligrams give one tablet by mouth two times a day related to Anxiety Disorder "Not available." On 11/1/2017 at 12:40 PM: Metformin HCL tablet	F 658		

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F 658	Continued From page 120 1000 milligrams give one tablet by mouth two times a day for Elevated Glucose "Med not available." Review of the Stat Box "First Dose" contents list from the current Pharmacy revealed Metformin 500 milligrams in the supply available for administration. Further review of the Progress Notes revealed documentation of problems with medication orders and administration. On 2/12/2018 at 12:44 eMAR (electronic Medication Administration Note): Metformin 1000 milligrams give one tablet by mouth two times a day for elevated glucose "resident refused." On 2/13/2018 at 4:59 PM electronic Medication Administration Note: Metformin 1000 milligrams give one tablet by mouth two times a day for elevated glucose "Resident states she does not take this medication anymore." On 2/14/2018 at 12:25 AM Nurses Note: "Resident returned from the dentist around 1645 (4:45 PM). She had a new order for Zithromax 250 milligrams by mouth but resident is allergic to medication. Attempted to contact MD/NP (Medical Doctor/Nurse Practitioner) but phone went to voice mail....." On 2/14/2018 at 12:39 AM- doctor "notified residents allergy to Azithromycin. New order from Amoxicillin 500 milligrams" by mouth three times a day for 7 days per Dr_____. On 2/14/2018 at 8:03 AM orders were received from the doctor "for antibiotics to be changed	F 658		

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F 658	Continued From page 121 from amoxicillin to clindamycin d/t (due to) allergy to penicillin. On 2/14/2018 at 12:34 electronic Medication Administration Note: Metformin 1000 milligrams give one tablet by mouth two times a day for elevated glucose "resident refused." Review of the Allergies listed on the Orders Summary Report included several antibiotics: Azithromycin, Erythromycin, Penicillin, Keflex and Bactrim. Other allergies included: Belladonna, Fish Oil, Ibuprofen, Iodine, Lansoprazole, Morphine, Pantoprazole, Phenobarbital, Reglan, Fentanyl and Related, Peanut, ammoniated mercury, Latex. Review of Physicians Orders Summary Sheet with order status: active, completed, discontinued revealed no documentation of Metformin. Review of the March 2018 Medication Administration Record revealed Resident # 72 refused Metformin 1000 milligrams by mouth 18 times during the month. The medication was scheduled to be administered at 9 AM and 5 PM each day. The medication was documented as administered by facility staff 36 times during the month. There was no documentation of Metformin 1000 milligrams by mouth two times a day being discontinued. There was no noted documentation of the facility staff notifying the doctor that Resident # 72 was refusing to take Metformin until 3/9/2018. The Nurses Note dated 3/9/2018 at 18:59 (6:59 PM) stated "Dr._____ in facility Informed him of Residents refusal to take medication Metformin.	F 658		

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F 658	Continued From page 122 NO (New Order) received. Resident is her own RP (Responsible Party) made aware of NO (new order). " The new order was not written in the Nurses Note. Further review of the Nurses Notes revealed Resident # 72 refused to take Metformin 11 times at 9 AM and two times at 5 PM after 3/9/2018. Documentation revealed Metformin was administered 7 times at 9 AM and 16 times at 5 PM after 3/9/2018. On 3/17/2018 at 5 PM, the documentation on the MAR listed a code of "9" instructing to see the Nurses Note. The Nurses Note dated 3/17/2018 at 5:19 PM stated Metformin 1000 milligrams by mouth two times a day for elevated glucose "Medication has been discontinued." The MAR did not reflect that the Metformin had been discontinued. Resident # 72 continued to refuse the Metformin at times but was administered the medication at other times throughout the rest of the month. Review of the Facility policy on Medication Administration effective 8/3/2010 and Revised 12/14/2017 on Page 1 of 7 stated "Administer Medications only as prescribed by the provider" On page 2 of 7 was written: " f. Observe the "five rights of" in giving each medication: i. the right resident ii. the right time iii. the right medicine iv. the right dose v. the right route..... j. Full attention should be given during preparation of medications. i. Avoiding distractions is important for infection prevention	F 658		

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F 658	Continued From page 123 and reducing errors." There was no noted documentation of the facility staff notifying the doctor that Resident # 72 was refusing to take Metformin because she was felt she was no longer on that medication. There was no documentation the facility staff notified the doctor that scheduled doses of Oxycodone were unavailable and to request an alternative medication. There was no documentation that the doctor was notified that Mirabegron used for bladder spasms was not available for three consecutive days and to request an alternative. The facility cited Lippincott as the resource used for professional nursing standards. Guidance was given from Lippincott, Fundamentals of Nursing, which reads: "To prevent medication errors, follow the six rights of medication administration consistently every time you administer medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to these rights: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation" On 3/29/2018 at 8:40 AM, an interview was conducted with the Director of Nursing who stated medications should be administered as ordered by the physician and clarified if there were questions. The Director of Nursing stated the nurses should follow the five rights of medication administration at all times and verify the correct medication is being given.	F 658		

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F 658	Continued From page 124 No further information was provided. 3. For Resident #164, facility staff failed to clarify an order for Trazodone. Resident #164's most recent Minimum Data Set (MDS) Assessment was an Admission/Medicare 5 Day assessment with an Assessment Reference Date (ARD) of 3/23/2018. Resident #164's Brief Interview for Mental Status (BIMS) and Activity of Daily Living (ADL) assessments were not performed on this assessment. Resident #164's diagnoses included: Major Depressive Disorder, Diabetes Mellitus Type-II, Schizoaffective Disorder, Undifferentiated Schizophrenia, and Hypertension. A review of Resident #164's clinical documentation was conducted beginning on 3/22/2018. At that time, the resident's Medication Administration Record was noted to contain the following order: "Trazodone HCL tablet 50 MG give 50 tablet by mouth every 24 hours as needed for sleep related to MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED, (F32.9) at bedtime." A copy of Resident #164's Physician Orders dated Mar. 22 2018 was requested and obtained. Upon review, the Physician Orders contained text identical to the MAR. Resident #164's orders and MAR were reviewed with the Director of Nursing (DON) at the end of day meeting on 3/23/2018. The DON stated "that isn't written correctly" and stated that facility staff should have clarified the order with the Physician. The DON stated that Lippincott is used as the facility's nursing reference. According to Lippincott's "Nursing" journal, Volume 33 Number	F 658		

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F 658	Continued From page 125 5 article "Clarifying a medication order", it is the Nurse's responsibility to clarify unclear orders in order to protect both the patient and themselves. No further documents were provided. 4. For Resident #364 a PICC line and ABT were not started until 14 hours after being ordered. Facility failed to provide Peripherally Inserted Central Catheter Line (PICC line) for 14 hrs. Resident #364 was admitted to the facility on 3/15/18 with diagnoses to include but not limited to Bronchitis related to trachea, traumatic brain injury due to Motor Vehicle Accident Hydrocephalus, sacral pressure ulcer stage II and Peg tube. Resident # 364's admission was too recent for a Minimum Data Set (MDS) assessment (an assessment tool.) The Admission Resident Evaluation dated 03/15/2018 coded Resident # 364 as Unresponsive to physical and verbal stimuli Resident required Total Dependence assist of 2+ persons of for turning and positioning as well as activities of daily living. On 3/26/18 at 9:40 a.m. the physician ordered Zosyn (antibiotic) to be administered through a PICC line to treat Pneumonia. Resident was ordered by the physician to be administered an Intravenous (IV) antibiotic for pneumonia through a Peripherally Inserted Central Catheter Line (PICC line) By 4:00 p.m. that same day, the antibiotic had not	F 658		

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been administered and the PICC line had not been inserted.

During an interview with the unit 2 nursing managers (RN A) at 4:00 p.m., she stated the orders received that morning had not yet been taken off, meaning that the nursing staff had not acted on the order.

When RN A was asked if the doctor was aware that the order had not been acted upon, RN A responded "no".

RN A stated she was busy passing medications, doing treatments, and helping the CNA's (certified nursing assistants) give care to the Residents, and that they had no extra staff to take off orders, and there just wasn't enough staff to take care of everything.

RN A went on to say she had to call a company which inserts PICC lines so that the medication could be administered, because the facility could not insert the line.

RN A stated she would take care of the order at 4:00 p.m. RN A admitted that the doctor should have been notified, and that the orders should have been instituted immediately.

Per facility documentation company that inserts PICC lines - Insertion Record states, PICC line was not inserted until 8:00 pm on 3/26/18, and according to facility MAR the first dose of antibiotic was not given until Midnight 3/27/18.

The facility administration was notified of the issue on 3/26/18 at 4:00 pm.

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F 661	Continued From page 127	F 661		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, facility staff failed to document a physician discharge summary for one resident, Resident #165, in a sample of 38 residents. For Resident #165, a discharged resident, a	F 661	**F661** 1.) Resident #165 is not a current resident. No noted negative outcomes related to absence of discharge summary. 2.) EHR Coordinator/designee completed an audit of residents who discharged in the last 30 days for completion of discharge summary, any identified concerns were addressed as indicated. 3.) Electronic Health Record Coordinator will educate Interdisciplinary Team and Attending Physicians regarding policies and procedures for resident discharge summaries. 4.) The Electronic Health Records Coordinator/ designee will audit the discharges weekly x12 with results brought to QAPI to ensure compliance.	

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F 661	Continued From page 128 physician discharge summary was not completed. The findings included: Resident #165's most recent Minimum Data Set assessment (MDS) was a Discharge assessment with an assessment reference date (ARD) of 11/27/2018. Resident #165's Brief Interview for Mental Status (BIMS) assessed a score of 15, indicating no cognitive impairment. Resident #165's diagnoses included: Ataxia, dysphagia, hemiplegia, hemiparesis, cerebral infarct, gastrostomy, dysarthria, hypertension, inguinal hernia, hyperlipidemia, and gastro-esophageal reflux disease. On 3/23/2018, a review of Resident #165's closed record was conducted. It was noted that no physician discharge summary could be found in the record provided by the facility. At the end of day on 3/23/2018, the DON was informed of the missing discharge summary, and was asked to assist with locating it. The DON stated that it should be in the closed record, but stated she would see what she could do. On 3/27/2018, the DON was asked if the discharge summary for Resident #165 had been located. The DON stated "no", and that she did not know where it could be. No further documents were provided.	F 661		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 684	F684 1. Resident #72 was evaluated by social services and no current psychosocial distress noted. Medication review completed by Physician and new orders received and noted.	

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F 684	Continued From page 129 facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, and in the course of a complaint, the facility staff failed, for residents 3 residents (Resident #72, Resident #87, Resident #32) of the survey sample of 32 residents, to ensure the highest practicable well-being resulting in psychosocial harm for Resident # 72. 1. For Resident # 72, the facility staff failed to ensure care and services were received according to physicians orders resulting in psychosocial harm related to anxiety about medications being given by distracted nurses. The resident stated she was "afraid." 2. For Resident # 87, the Facility staff failed to administer intravenous antibiotics as ordered by the physician. 3. For Resident # 32, the facility staff failed to provide medications as ordered by the physician. The medications which included antibiotics, aerosol for Bronchitis and eye drops for Glaucoma were listed as medication unavailable. The resident was on Hospice. The findings include: 1. For Resident # 72, the facility staff failed to	F 684	Physician and DON met with resident and reviewed current medications, plan of care for medication administration, and resident's personal preferences related to medication administration. Identified concerns were addressed as indicated and plan of care reviewed and revised as indicated. Plan of care reviewed and revised as indicated. Resident #87's Physician notified of missed doses of IV antibiotics and no noted adverse outcomes noted. Resident #32's Physician was notified of missed medications. No noted negative outcomes. 2. Current residents will be audited to ensure Physician ordered medications are available. Current residents with a BIMs of Greater than 9 will be interviewed regarding Licensed Nurses Medication Administration practices.	

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F 684	Continued From page 130 ensure care and services were received according to physicians orders resulting in psychosocial harm related to anxiety about medications being given by distracted nurses. The resident stated she was "afraid." Resident # 72, a female, was admitted to the facility 11/2/2015. Her diagnoses included but were not limited to Diverticulitis of both small and large intestines with perforation and abscess, insomnia, neuropathy, Gastroparesis, Anxiety Disorder, Major Depressive Disorder, Multiple Sclerosis, Hypertension and weakness. Resident # 72's most recent MDS with an ARD of 2/21/2018 was coded as a quarterly assessment. Resident # 72's cognitive status (her ability to make every day life decisions and memory ability) was not coded. Dashes were entered in the areas of Section C 100 "Should Brief Interview for Mental Status" through C 1000" Cognitive Skill for Daily Decision Making." Resident # 72 was coded as needing supervision assistance of one staff member to perform her activities of daily living. Resident # 72 was coded as being able to hear, speak, understand, and be understood. On 3/28/2018 at 1:47 PM, Resident # 72 requested to talk with the surveyors about some things she had "experienced living at the facility for the past 3 years." On 3/28/2018 at 1:50 PM, Resident # 72 came to the conference room with all of the surveyors. Resident # 72 stated she had deemed herself as the advocate for others. Resident # 72 stated she was happy to see things beginning to improve at the facility since new management was in place over the past few months. However, she was	F 684	Medication Administration Competencies will be completed with Licensed Nurses Current residents' new orders and EMAR notes will be reviewed for the last 14 days for order accuracy, medication availability, antibiotics, PICC line orders, potential allergies, and timely processing and implementation of new orders. Any identified concerns will be addressed as indicated. 3. ADON/Designee will educate Licensed Nurses on Medication Administration Guidelines, Pharmacy Ordering, Medication Management, and Daily order management. Licensed Nurses will complete Medication Administration Competencies Unit Manager/Designee will review EMAR notes and new orders daily to ensure medication orders are clarified as indicated, medications are available as ordered, and new orders for ATB and PICC lines are processed and implemented timely.	

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F 684	Continued From page 131 concerned that the nurses passing medications often had to be interrupted to take care of residents who wander or need other assistance. Resident # 72 stated she was "afraid" to take her medicine several times because the nurses were interrupted so often. Resident # 72 stated she often inquired about the medications presented to her because she was unsure if what was being given by the nurses was correct. Resident # 72 also stated she often had to wait for pain medication because the nurses were busy doing paperwork. She stated the nurses should be able to focus on their jobs and the residents. She stated the nurses often have too much to do that could be assigned to someone else. She stated that" Unit Secretaries should do more paperwork which would allow the nurses to give pain medications when requested by residents and do other things for the residents." Resident # 72 stated a big problem at the facility was the high turnover of CNAs (Certified Nursing Assistants). Resident # 72 stated new CNAs come in, get overworked and quit and means more work for the nurses. She stated she also was upset that she had missed six appointments with doctors because of no transportation was available. Resident # 72 stated her appointments with specialists often take almost a year to schedule and it was upsetting to have to cancel appointments due to transportation. Resident # 72 stated she thought the current Administrator and Director of Nursing were making positive changes in the facility and things would get better with time. On 3/28/2018 at 2:25 PM, Review of the clinical record was conducted.	F 684	Charge Nurse/Designee will validate that new orders from Physician/NP are reviewed and addressed timely. Licensed Nurses will complete 24 hour chart checks and order recap review. 4. DON/Designee will review order recap and EMAR notes daily 5 x week to ensure Medication orders are clarified as needed, and medications are delivered and given as ordered or an alternative medication is obtained if needed. DON/Designee will validate daily with order recap that IV and Antibiotic orders have been processed timely. Audit results will be reported to QAPI.	

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F 684	Continued From page 132 Review of the Progress Notes revealed documentation of problems with medication orders and administration. On 2/12/2018 at 12:44 eMAR (electronic Medication Administration Note): Metformin 1000 milligrams give one tablet by mouth two times a day for elevated glucose "resident refused." On 2/13/2018 at 4:59 PM electronic Medication Administration Note: Metformin 1000 milligrams give one tablet by mouth two times a day for elevated glucose "Resident states she does not take this medication anymore." On 2/14/2018 at 12:25 AM Nurses Note: "Resident returned from the dentist around 1645 (4:45 PM). She had a new order for Zithromax 250 milligrams by mouth but resident is allergic to medication. Attempted to contact MD/NP (Medical Doctor/Nurse Practitioner) but phone went to voice mail....." On 2/14/2018 at 12:39 AM- doctor "notified residents allergy to Azithromycin. New order from Amoxicillin 500 milligrams" by mouth three times a day for 7 days per Dr_____. On 2/14/2018 at 8:03 AM orders were received from the doctor "for antibiotics to be changed from amoxicillin to clindamycin d/t (due to) allergy to penicillin. On 2/14/2018 at 12:34 electronic Medication Administration Note: Metformin 1000 milligrams give one tablet by mouth two times a day for elevated glucose "resident refused." Review of the Allergies listed on the Orders	F 684		

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F 684	Continued From page 133 Summary Report included several antibiotics: Azithromycin, Erythromycin, Penicillin, Keflex and Bactrim. Other allergies included: Belladonna, Fish Oil, Ibuprofen, Iodine, Lansoprazole, Morphine, Pantoprazole, Phenobarbital,, Fentanyl and Related, Peanut, ammoniated mercury, Latex. Review of Physicians Orders Summary Sheet with order status: active, completed, discontinued revealed no documentation of Metformin orders. Review of the March 2018 Medication Administration Record revealed Resident # 72 refused Metformin 1000 milligrams by mouth 18 times during the month. The medication was scheduled to be administered at 9 AM and 5 PM each day. The medication was documented as administered by facility staff 36 times during the month. There was no documentation of Metformin 1000 milligrams by mouth two times a day being discontinued. There was no noted documentation of the facility staff notifying the doctor that Resident # 72 was refusing to take Metformin until 3/9.2018. The Nurses Note dated 3/9/2018 at 18:59 (6:59 PM) stated "Dr._____ in facility Informed him of Residents refusal to take medication Metformin. NO (New Order) received. Resident is her own RP (Responsible Party) made aware of NO (new order)." The new order was not written in the Nurses Note. Further review of the Nurses Notes revealed Resident # 72 refused to take Metformin 11 times at 9 AM and two times at 5 PM after 3/9/2018. Documentation revealed Metformin was administered 7 times at 9 AM and 16 times at 5	F 684		

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F 684	Continued From page 134 PM after 3/9/2018. On 3/17/2018 at 5 PM, the documentation on the MAR listed a code of "9" instructing to see the Nurses Note. The Nurses Note dated 3/17/2018 at 5:19 PM stated Metformin 1000 milligrams by mouth two times a day for elevated glucose "Medication has been discontinued." The MAR did not reflect that the Metformin had been discontinued. Resident # 72 continued to refuse the Metformin at times but was administered the medication at other times throughout the rest of the month. Review of the Order Summary Report Printed on 3/29/2018 at 9:19 AM for "Order Status: Active, Completed, Discontinued Order date range 9/28/2017-3/28/2018" revealed no documentation of any orders for Metformin listed in the list of medications. Review of the Facility policy on Medication Administration effective 8/3/2010 and Revised 12/14/2017 on Page 1 of 7 stated "Administer Medications only as prescribed by the provider" On page 2 of 7 was written: " f. Observe the "five rights of" in giving each medication: i. the right resident ii. the right time iii. the right medicine iv. the right dose v. the right route..... j. Full attention should be given during preparation of medications. i. Avoiding distractions is important for infection prevention and reducing errors." The facility cited Lippincott as the resource used	F 684		

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F 684	Continued From page 135 for professional nursing standards. Guidance was given from Lippincott, Fundamentals of Nursing, which reads: "To prevent medication errors, follow the six rights of medication administration consistently every time you administer medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to these rights: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation" On 3/29/2018 at 8:40 AM, an interview was conducted with the Director of Nursing who stated medications should be administered as ordered by the physician and clarified if there were questions. The Director of Nursing stated the nurses should follow the five rights of medication administration at all times and verify the correct medication is being given. The Director of Nursing stated the nurses should not be interrupted repeatedly while giving medications so they can focus. The Director of Nursing stated the residents should feel confident that they are receiving the correct medications and should not miss appointments due to lack of transportation. No further information was provided. 2. For Resident # 87, the Facility staff failed to administer intravenous antibiotics as ordered by the physician. Resident # 87 was admitted to the facility on 12/132017 and readmitted on 2/16/2018 with	F 684		

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F 684	Continued From page 136 diagnoses of but not limited to: Hypertension, convulsions, Major Depressive Disorder, Congestive Heart Failure (CHF), Dysphagia, Gastrostomy, Metabolic Encephalopathy, muscle weakness, Chronic Obstructive Pulmonary Disease (COPD), Cutaneous Abscess of Buttock, Hidradenitis Suppurativa. Resident # 87's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 1/30/2018. The MDS coded Resident # 87 with a Brief Interview for Mental Status (BIMS) score not assessed. Resident # 87 required extensive assistance of one to two staff members with activities of daily living and always incontinent of bowel and bladder. Resident was admitted to the hospital on 2/14/2018 and discharged on 2/16/2018. Review of the Hospital Discharge Summary revealed final diagnosis of infected decubitus ulcer, Urinary tract infection, hypertension, COPD, CHF, history of seizures, depression and history of Hidradenitis around the pelvis area sacral ulcer." ON Page 3 of 4 under Hospital Course was documented "...patient have some pus drainage and blood drainage from these decubitus ulcers seen by the surgeon and plan to do the debridement but patient refused. Patient discharged back to nursing home on IV antibiotic. discuss with the patient and patient daughter this morning and if in case ulcer worse she will come back to the hospital for debridement. Also discussed about patient and going to sepsis with worsening sacral wound." Review of the March 2018 Medication Administration Record (MAR) revealed	F 684		

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F 684	Continued From page 137 documentation eight missing doses of intravenous antibiotics. Missing doses were 3/2/2018 at 2 PM and 10 PM, 3/3/2018 at 6 AM and 2 PM, 3/5/2018 at 10 PM, 3/9/2018 at 10 PM, 3/10/2018 at 6 AM and 2 PM. Review of the Nurses Notes revealed documentation: 3/2/2018 at 5:43 PM of medication Piperacillin-Tazobactam in Dex Solution 3-0.375 grams per 50 milliliters give 3.375 grams intravenously every 8 hours for ABSCESS for 6 weeks. Notified Pharmacy. Stated they will send ABT (Antibiotic) to facility on next run. Notified MD (medical doctor). Stated to hold until arrival of medication. 3/3/2018 at 2:28 PM nurses note stated the IV (intravenous) antibiotics remain on hold. 3/5/2018 5:10 PM-Awaiting Pharmacy to send resident's IV ABT Tx. Notified provider stated to hold medication until arrive from pharmacy. 3/5/2018 at 5:16 PM eMAR (electronic medication administration record) Medication Administration Note: "Piperacillin-Tazobactam in Dex Solution 3-0.375 grams per 50 milliliters give 3.375 grams intravenously every 8 hours for ABSCESS for 6 weeks. Awaiting arrival from pharmacy. See nurse note." 3/5/2018 7:28 PM IV Antibiotic on hold per doctor... 3/9/2018 10:07 PM eMAR (electronic medication administration record) Medication Administration Note: "Piperacillin-Tazobactam in Dex Solution 3-0.375 grams per 50 milliliters give 3.375 grams	F 684		

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F 684	Continued From page 138	F 684		

intravenously every 8 hours for ABSCESS for 6 weeks. Awaiting refill from pharmacy. Coming on run"
3/9/2018 10:16 PM Nurse Note:
Doctor_____ aware of 2200 (10 PM) dose of ABT not available.

3/10/2018 7:01 AM eMAR (electronic medication administration record) Medication Administration Note: "Piperacillin-Tazobactam in Dex Solution 3-0.375 grams per 50 milliliters give 3.375 grams intravenously every 8 hours for ABSCESS for 6 weeks. Awaiting on order from pharmacy."

3/10/2018 3:04 PM eMAR (electronic medication administration record) Medication Administration Note: "Piperacillin-Tazobactam in Dex Solution 3-0.375 grams per 50 milliliters give 3.375 grams intravenously every 8 hours for ABSCESS for 6 weeks. Awaiting arrival from pharmacy."

3/10/2018 4:05 PM "Resident remains on IV ABT r/t (related to)abscess to buttocks. Resident currently out of ABT Tx (treatment). Awaiting arrival from pharmacy. MD aware. Will resume ABT when they arrive from pharmacy."

3/10/2018 10:43 PM Nurses Note: Call was placed to Pharmacy to check status of delivery of IV ABT Zosyn. Pharmacy tech stated that Zosyn was delivered by Pharmacy to the wrong Facility and that it should be arriving shortly. Zosyn has not arrived as of 1045 (8:45 PM). MD is aware.."

Further review of the Nurses Notes revealed Resident # 87 was medicated daily with Tramadol 50 milligrams by mouth for sacral pain and/or pain to buttocks. The pain was rated between 6-7 out of ten on a pain scale of 10 being the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 139 worst pain and with the follow up pain scale being rated between 0 and 2 on each day except 3/12/2018. On 3/12/2018 at 10:39 AM, Resident # 87 was administered Tramadol 50 milligrams for pain of 9 out of 10. On 3/12/2018 at 11:57 AM, the pain was rated a 7 out of 10. On 3/23/2018 at 2:40 PM, an interview was conducted with the Director of Nursing (DON) who stated the facility had experienced difficulty with a previous Pharmacy and had recently changed to a different Pharmacy. The DON stated the new pharmacy was located in Maryland and made three regular runs to the facility each day. The DON stated the expectation was that medications should be available for administration as ordered by the physician. The DON stated the course of antibiotics should be administered without interruption. No further information was provided. 3. For Resident # 32, the facility staff failed to provide medications as ordered by the physician. The medications which included antibiotics, aerosol for Bronchitis and eye drops for Glaucoma were listed as medication unavailable. The resident was on Hospice. Resident # 32 was a 75 year old male admitted to the facility on 6/21/2012 and readmitted on 11/3/2017 and 3/9/2018 with the diagnoses of, but not limited to,Peripheral Vascular Disease, Neuromuscular Dysfunction of the bladder, Gastroesophageal Reflux Disease, Chronic	F 684		

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F 684	Continued From page 140 Kidney Disease, Dysphagia, Atherosclerosis of native arteries of extremities with Gangrene Bilateral Legs, Amputation of toes, Hypothyroidism, Glaucoma, Chronic Viral Hepatitis, Paraplegia, and Dementia Resident #32's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 1/30/2018. The MDS coded Resident # 32 with a Brief Interview for Mental Status (BIMS) score of 6 out of 15 indicating severe cognitive impairment. Resident # 32 required extensive assistance of one to two staff members with activities of daily living except required total assistance of one staff person for bathing and always incontinent of bowel and Resident # 32 was coded to have an indwelling urinary catheter. Resident currently on Hospice. Review of the clinical record was conducted on 3/21/2018 at 2:30 PM. Review of the Progress Notes revealed documentation of an eMar (electronic Medication Administration Note) on 3/10/2018 at 3:25 PM which stated Metoprolol Tartrate tablet 25 milligrams give 2 tablet by mouth every 12 hours related to Essential Hypertension (110) hold for HR <60 (heart rate less than 60) "Awaiting arrival from pharmacy." Further review of the Progress Notes revealed other documentation of medications not available from the pharmacy. On 11/4/2017 at 4:27 PM eMar (electronic Medication Administration Note) Dulera Aerosol 200-5 micrograms per activation 2 puffs inhale	F 684		

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F 684	Continued From page 141 orally two times a day for Bronchitis. "Med not available." On 11/4/2017 at 4:30 PM eMar (electronic Medication Administration Note) Dorzolamide HCL (Hydrochloride) Solution 2 % instill one drop in both eyes two times a day related to other specified Glaucoma:" Med not available" On 11/4/2017 at 4:30 PM eMar (electronic Medication Administration Note) Timoptic Solution 0.5 % Instill one drop in right eye one time a day related to other specified Glaucoma. "Med not available." On 11/4/2017 at 10:10 PM eMar (electronic Medication Administration Note) Zosyn Solution Reconstituted 3.375 grams Use 3.375 milligrams intravenously every 12 hours for MRSA (Methicillin Resistant Staphylococcus Aureus) in wound for 14 days. "Med has not been delivered" On 11/5/2017 at 7:45 AM eMar (electronic Medication Administration Note) LevoFloxacin in D5W Solution 500 milligrams intravenously every 24 hours for MRSA in wound for 14 days "awaiting on pharm" On 3/22/2018 at 9 AM, an interview was conducted with LPN (Licensed Practical Nurse) B who stated the staff should notify the Pharmacy when medications are not available. On 3/22/2018 at 2 PM, an interview was conducted with the Director of Nursing who stated the Pharmacy should have medications available for administration as per Physicians Orders. The Director of Nursing also stated the facility staff should check the "First Dose" medications to see	F 684		

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F 684	Continued From page 142 if the missing medication is available in that supply. Review of the STAT box "First Dose" contents list revealed the Medication, Lopressor (Generic Name-Metoprolol Tartrate) 25 milligrams was available to the staff. During the end of day debriefing on 3/23/2018, the Facility Administrator, Director of Nursing and Corporate Nurse were informed of the findings. The Director of Nursing stated the Pharmacy should ensure medications were available for administration as ordered by the physician. No further information was provided.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the	F 686	**F 686** 1.) Resident #68 has had skin sweep conducted with no additional issues noted and interventions in place, resident #70 has had skin sweep conducted with no additional issues noted and interventions in place. Resident # 68 Wounds to Left distal medial calf and Right Medial Knee are resolved. Resident # 70 Sacral Wound is resolved. 2.) Nursing Management has conducted a skin assessment of current residents within facility, any newly identified skin alterations will be addressed as indicated. Current Residents with wounds will be reviewed to ensure skin/wound management orders and care plans are in place per plan of care.	

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F 686	Continued From page 143 facility staff failed, for 2 residents (Resident #68, Resident #70) of the survey sample of 38 residents, to prevent and identify pressure ulcers, resulting in harm. 1. For Resident #68, the facility staff failed to prevent the development of two stage three pressure ulcers, resulting in harm. 2. For Resident #70, the facility staff failed to prevent the development of an unstageable sacral pressure ulcers, resulting in harm. The Findings included: 1. For Resident #68, the facility staff failed to prevent the development of two stage three pressure ulcers, resulting in harm. Resident #68 was an 85 year old who was admitted to the facility on 2/15/17. Resident #68's diagnoses included, Left Distal Medial Calf Pressure Ulcer Stage 3, Right Medial Knee Pressure Ulcer Stage 3, Hypertension, Contracture-Unspecified Joint, Dysphasia -Oral Phase, Sacral Pressure Ulcer (Upon Admission), Gastronomy Status, Gastro-Esophageal Reflux Disease without Esophagitis, Conversion Disorder with Seizures, Expressive Language Disorder, Muscle Weakness, Generalized, Alzheimer's Disease-Unspecified. The Minimum Data Set, which was an Admission Assessment with an Assessment Reference Date of 2/27/18, coded Resident #68 as Rarely/never being to understand or be understood by others. In addition, she was coded as requiring the extensive physical assistance of at least 2	F 686	3.) The ADON/designee will educate Nursing staff on the Skin/wound management program including identification and reporting of changes in skin condition, prevention interventions, following plan of care and physician's orders for skin/wound prevention and management. ADON/Designee will educate Nursing Staff on policy and procedures for completing skin checks with daily care and weekly skin checks. Nursing staff will complete skin evaluation competency. 4.) The Unit Manager/Designee will visually validate 5 weekly skin assessments per week x 4 weeks to ensure early detection of wounds and accuracy of skin evaluation. Nursing management team and or designees will conduct 100% skin sweep 1x weekly for 4 weeks. 50% of residents 1x weekly for 4 weeks, and 25% skin sweep 1 x weekly for 4 weeks with all results brought to QAPI.	

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F 686	Continued From page 144 persons for bed mobility and transfers. On 3/21/18 a review was conducted of Resident #68's clinical record, revealing the following nurse's Skin Assessments, and Physician Wound Consultation: "Facility acquired pressure ulcer Date area First observed 3/11/18. House Acq. 1. Skin Grid Pressure . Left distal mid calf. Pressure. Length 1.2 Width 1.2 Depth 0.1 Stage 3 Distinct, outlined clearly visible, attached, even with wound base. Granulation tissue present. Pink wound bed. Exudate amount Moderate. Peri-wound appearance pink or normal for ethnic type. No tunneling present. No associated pain." "2. 3/11/18 House Acquired. Right Medial Knee. Pressure. length 1.3 Width 1.2 Depth 0.1 Stage 3. Distinct, outlined clearly visible, attached, even with wound base. Appearance Granulation present. Color of wound bed Pink. Exudate amount Moderate. Peri-wound appearance Pink of normal for ethnic type. No tunneling present. No pain associated." Wound Physician consultation "3/13/18. Wound Care Evaluation. Patient has a wound on her calf. She presents with a stage 3 pressure wound of the left , distal, medial calf of at least 1 days duration. There is moderate sero - sanguineous exudate." On 03/21/18 at 4:54 P.M., an observation was made of Resident #68 in her bed. Resident #68 did not have a pillow between her legs. Also, the Certified Nursing Assistant (CNA D) was present. She stated that she had worked with this resident for 6 months, and that the pillow that goes	F 686		

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F 686	Continued From page 145	F 686		

between the residents legs was missing. She stated that the only pillow she found was the small wedge pillow that goes on the resident's back on her right side. She described the missing pillow as being blue with 2 white straps that wrap around from the back of her legs to the front. She stated that the therapy department trained her on how to use the pillow that is missing. She stated that she had also been in the resident's room at about 3:30 P.M., and that the pillow was not in use by the resident, and not in her room.

On 03/22/18 at 9:11 A.M., an observation was made of Resident #68 in bed. Resident #68 did not have a pillow between her legs. She had a wedge pillow on her upper left side above her waist. The Charge Nurse (LPN F) was present. She stated that there was no pillow between Resident #68's legs. "The pillow goes between her legs to prevent skin breakdown because she's contracted and has limited mobility. The pillow keeps her bony prominences from rubbing together. I supervise the CNA's. When asked what the physician's order read, " she stated, "The physicians order says float pillow between legs and knees at all times."

Resident #68's signed Physician Orders read, "6/2/17 MA65 Mattress -Pressure reduction mattress check for placement and functionality
9/15/17 Turn and reposition Q 2 hours for pressure relief
3/16/18 float pillow between legs and knees at all times
3/23/18 float heels qs."

On 3/31/18 a review was conducted of facility documentation, revealing a Pressure Ulcers/Wounds Acquired Log. It read, " 2 new

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F 686	Continued From page 146 facility acquired pressure ulcers. 3/11/18 right medial knee stage 3 3/11/18 left distal calf stage 3. Resident #68's bathing record was reviewed, indicating that prior to the discovery of both stage 3 pressure ulcers, on 3/11/18, she hadn't been bathed since 3/9/18. Resident #60's care plan was reviewed. It read, "Impaired skin integrity related to impaired mobility, incontinence of bowel and bladder. Receives tube feedings. Dependent upon staff for all aspects of mobility and toileting as evidence by right hip and left buttock wounds. Actual wounds to left medial leg and right medial knee...Nutritional and hydration support, place pillow between legs and knees at all times. Provide pressure reducing wheelchair cushion. Provide thorough skin care after incontinent episodes and apply barrier cream. Specialty mattress. Treatments as ordered." 03/26/18 02:11 PM Interview with the Director of Nursing (Administration B) The DON was asked to state her expectation regarding when the development of a pressure ulcer should be discovered by staff. She stated, "As soon as redness is noted before it becomes a stage 1." On 3/22/18 at approximately 4:00 P.M. the facility Administrator (Administration A) and Director of Nursing (Administration B) were notified of the findings. No further information was received. 2. For Resident #70, the facility staff failed to prevent the development of an unstageable sacral pressure ulcers, resulting in harm.	F 686		

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F 686	Continued From page 148 as of 3/27/18. On 3/26/18 at 5:06 P.M., an Interview was conducted with the Regional Nurse (Administration C), and the wound nurse (LPN G). The Regional Nurse stated, "I feel like they have been identifying the wounds. We consider the co morbidity. When a new wound is reported I look at it, also we let the wound doctor know about it so that she checks the next Tuesday". She stated that they do skin assessment upon admission and that the wound report contains all of the identified wounds. She further stated that LPN G does assessments every other weekend, and that LPN F works Monday thru Friday. The Regional Nurse was unable to state why Resident #70's sacral pressure ulcer was first identified after it had become unstageable. On 3/27/18 a review was conducted of Resident #70's clinical record, revealing a Skin Grid dated 1/4/18 which identified a new unstageable pressure ulcer on his sacrum. Measurements: 1.9 x 0.9 x 0.2 cm. Wound bed- Necrotic. The Wound Report documented a Diabetic wound on Resident #70" Right Dorsal Foot on 1/4/18, and a Deep Tissue Injury on his Right Heel on 2/6/18. Resident #70 care plan was reviewed. The care plan did not address Resident #70's need for assistance with turning and repositioning while in bed. He was also coded on the MDS as requiring the extensive physical assistance of at least two people for bed mobility. The care plan read, "2/8/18. Actual impairment to skin integrity related to Diabetes Mellitus, impaired mobility. Actual	F 686		

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F 686	Continued From page 149 wound to top of R foot, left heel and sacral. Interventions: Bilateral heels are to be floated at all times while in bed. Placed a pillow folded in half under the calf of each leg. Elevate legs while in wheelchair, Multi podus boots (initiated on 3/9/18) applied at all times for pressure relief." Prior to the development of the pressure ulcers, Resident #70 had the following interventions in place: wheelchair cushion, regular mattress. In addition, prior Resident #70 had not received a Braden Risk Assessment prior to the development of his Sacral Pressure Ulcer, Deep Tissue Injury, or Diabetic Wound. On 3/22/18 at approximately 4:00 P.M. the facility Administrator (Administration A) and Director of Nursing (Administration B) were notified of the findings. No further information was received.	F 686		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed, for 3 residents (Resident #9, Resident #59 and Resident #13) of the survey sample of 38	F 689	F689 1.) Resident #9s care plan has been updated to prevent resident from having further incidents with hot liquids. Resident #59s care plan has been reviewed to ensure resident is receiving proper ADL care. Resident #13s care plan has been updated to prevent resident from having further incidents with hot liquids. No identified residents effected by med cart being unlocked.	

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F 689	Continued From page 150 residents, to provide adequate supervision to prevent accidents. On 3/20/18 at 6:13 P.M. Immediate Jeopardy was called due to residents being burned by hot coffee. Prior to the survey, there was no Hot Liquid Assessments done for residents. There were no interventions put in place to prevent burn injury from hot liquids. 1. For Resident #9, the facility staff failed to provide adequate supervision to prevent a burn injury from hot liquid, resulting in harm. 2. For Resident #59, the facility staff failed to ensure that 2 persons provided extensive physical assistance during a transfer, resulting in a spiral fracture of her lower leg, resulting in harm. 3. Resident #13 sustained multiple large fluid filled blisters on his thigh after spilling hot coffee on himself, resulting in harm. 4. The facility staff failed to ensure that an unattended medication cart was locked. The Findings included: 1. For Resident #9, the facility staff failed to provide adequate supervision to prevent a burn injury from hot liquid. Resident #9 was a 79 year old who was admitted to the facility on 11/19/10. Resident #9's diagnoses included Bilateral Leg Amputations above the Knee, Major Depressive Disorder, Hemiplegia and Hemiparesis following Unspecified Cerebrovascular Disease Affecting Left Non-Dominant Side, Hyperlipidemia, Hypertension, Chronic Obstructive Pulmonary	F 689	2.) Nurse management has conducted an assessment on all current residents to assess ability to handle hot liquids with interventions noted on care plan, the dietary department is also monitoring the temperature coffee is being served to ensure it is served at 135 degrees and below and coffee has been removed from the nurses stations. DON/Designee completed facility medication storage review, and identified concerns were addressed as indicated. 3.) The ADON/designees have educated all staff on the proper temperature for coffee to be served along with ensuring when coffee is served the residents interventions from the Kardex are in place. The ADON and designees also educated clinical staff on properly transferring residents with returned competencies, and how to properly read the Kardex.	

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F 689	Continued From page 151 Disease, Arteriosclerotic Heart Disease, Old Myocardial Infarction, Heart Failure Unspecified, Generalized Muscle Weakness, and Cerebral Infarction Due to Unspecified Occlusion or Stenosis of Unspecified Cerebral Artery. Resident #9 was cognitively intact with a Brief Interview of Mental Status score of 15, indicating no cognitive impairment, Mobility Impairment, Range of Motion Limitations, History of Cardiovascular Accident with left Hemiplegia, Chronic Obstructive Pulmonary Disease, multiple cardiac problems deficit related to Generalized Weakness, Poor Endurance, Impaired Balance and Motor Control secondary to Above the Knee Amputation. On 3/20/18, a review was conducted of Resident #9's clinical record. On 3/7/18, Resident #9 was given a cup of hot coffee in his room without a lid on it. He put cream into the coffee, then accidentally hit the cup with his elbow, spilling it onto his abdomen and sustaining a burn on his abdomen. Resident #9's care plan read, "Increased risk for nutrition/hydration imbalance related to history of Mental Illness, diuretic use, Hypertension, Chronic Heart Failure, Major Depressive Disorder, and Chronic Obstructive Pulmonary Disorder. Provide assistance as meals as needed." Resident #9's clinical record contained the following Skin Assessment, "3/2/18. new non-pressure area. first observed 3/2/18. Site Abdomen 4 cm L x 1.5 cm open area. Burn. Color open area. Exudate type: none. Odor: no. Infection: no. Current treatment orders: clean	F 689	The ADON/Designee has educated all the nurses on the documentation of the Hot Liquid Assessments upon admission and upon any resident ADL capabilities changes. ADON/Designee educated Licensed Nurses on the policies and procedures for medication storage. 4.) The Administrator and or designee will audit the coffee temperature logs weekly x 12 to ensure it is being served at the proper temperature with results brought to QAPI. The DON and or designee will audit 10 residents Kardex weekly x 12 weeks to ensure interventions are in place for handling hot liquids with results brought to QAPI. The UMS and or designees will assess 10 CNAs per week transferring residents to ensure residents are being transferred according to Kardex x12 weeks with results brought to QAPI to ensure compliance. ADON/Designee will complete medication storage daily x 4 weeks and then weekly x 8 weeks and results will be reported to QAPI.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 152 area with normal Saline and apply nonstick drsg (dressing) with Alocane and border drsg.. every shift until healed. Pain Assessment: Pain associated with non pressure wound - yes." Resident #9's clinical record contained an Initial Evaluation Wound Treatment. It read, "3/13/18 Burn wound on abdomen Size 0.8 x 1.1 x Not Measurable MC. Surface area 0.88 CM. Dried Fibrinous exudate (scab). Additional information: mostly heated burn. Treatment: Skin prep apply 1 x daily for 30 days. Foam apply 1x daily x 30 days." Resident #9's signed Physician's Orders read, "3/2/18. Alocane Emergency Burn Max Str. Gel 4%. Apply to abdomen topically three times a day for burn. Clean area with normal saline then apply Alocane Emergency Burn Gel with non stick drsg with cling until area healed. 3/8/18. Daily wound assessment burns to stomach. Document abnormalities in progress notes. Document level of pain at wound site." According to the Medication Administration record, the treatment was administered from 3/2/18 at 5:00 P.M. until 3/8/18 at 8:00 A.M. After Resident #9 sustained a burn injury on 3/2/18, his care plan had not been updated to include interventions to prevent further burns. After the IJ was called, "The Hot Liquids Evaluation" recommended using lids on hot coffee as of 3/20/17. As of the last day of the survey on 3/29/18, the care plan had not been revised to include burn injury prevention. Prior to the survey, there was no Hot Liquid Assessment done either before or after the burn. There was no intervention put in place to prevent	F 689		

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F 689	Continued From page 153 another burn injury. On 3/20/18 at 1:15 P.M.., a coffee carafe was observed on a tray at both units. Cups and lids were available on the tray. On 3/20/18 at 4:58 P.M., a coffee carafe was observed on a tray at both units. Cups and lids were available on the tray. Licensed Practical Nurse D on Unit 2 stated that the dinner carafe had been delivered. She stated that the other carafe at the nursing station was the lunch carafe and needed to be picked up. On 3/20/18, at 5:15 P.M. an observation was made of the dinner meal. A Resident, who was put into the sample and identified as Resident #24 was holding a cup coffee in his hand. There was no top on the cup and steam was observed rising from the cup. He gave permission to have the Dietary Manager take the temperature, which was 141.6 degrees. Resident #24 was a 90 year old who was admitted to the facility on 5/31/12. Resident #24's diagnoses included Dementia, Dysphasia Oral Phase, Urinary Tract Infection, Weakness Difficulty Walking, Pain in Unspecified Joint and Unspecified Abnormalities of Gait and Mobility. On 3/26/18 at 10:40 A.M. Resident # 24 was observed ambulating in the hallway in his wheelchair. Resident stated, "I have nothing to do. They took away my coffee." DON stated the he used to go to get his own coffee. 3/26/18 4:40 P.M. Interviewed Regional Nurse. She stated, "He is used to get his own coffee at the Nurse's station." Now, the Activities person gives out the coffee."	F 689		

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F 689	Continued From page 154 On 3/20/18 at 12:30 P.M., an interview was conducted with the dietary Manager. She described the coffee service process. "Coffee is sent in an Curtis Airpot, it holds the temperature for 8 hours. We put it on a tray along with empty cups and a stack of lids. Whoever serves the coffee should put lids on the cups, if the resident needs one." The Dietary Manager was unable to state which residents needed lids as a safety measure. On 3/20/18 a review was conducted of facility documentation. According to the monthly menus submitted by the Dietary Manager, Hot Coffee and Hot Tea were served at every meal, including breakfast, lunch, and dinner. The Dietary Manager submitted a copy of the Manufacturer's Instructions for the Wilbur Curtis D500 Generation 3 Airpot Brewer. According to the manufacturer's instructions for the brew temperature was factory pre-set to 200 degrees. The coffee is brewed directly into the Airpot, which are delivered to the dining room and nurse's stations, and are accessible by staff and residents. On 3/20/18 at 5:53 P.M. on Unit 1, and Unit 2, there were large carafes of hot coffee on top of both nurses' stations. The coffee was accessible to any resident who walked by, or who wanted to drink coffee. Upon request by the surveyor, the Dietary Manager obtained a measurement of the temperature of the coffee on Unit 1. At 5:53 P.M., the temperature was 161.6 degrees. In addition, the Dietary Manager measured the temperature in the carafe on Unit 2. The temperature was 151.0 degrees at 5:54 P.M.	F 689		

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F 689	Continued From page 155 On 3/20/18 at 6:05 P.M., an interview was conducted with the Regional Nurse. She stated that the facility did not have a Hot Liquid Assessment tool. She stated that if a resident had a decline in their ability to feed themselves they could be assessed by therapy. The Director of Nursing stated that the facility had not done any Hot Liquid Assessments on any of the residents. On 3/20/18 at 6:13 P.M. Immediate Jeopardy was called. The facility Administrator (Administration A), and Director of Nursing (Administration B) were informed immediately. The Immediate Jeopardy was abated on 3/20/18 at 9:09 P.M. The facility submitted the following Abatement Plan: "Battlefield Park Plan of Correction Findings: Facility did not prevent recurrence of hot liquid injury. 1. Identified residents have been evaluated by Nurse Manager for ability to safely handle hot liquids. The plan of care will be revised as indicated. Residents have current treatment plans in place. 2. Current residents will be evaluated by nursing to ensure safety and ability to handle hot liquids. Plan of care will be reviewed and revised as indicated. Residents identified at risk for handling hot liquids will be evaluated to determine need for alternative interventions. The facility has removed potential hot liquid accessibility. Nursing will complete skin assessments on all residents within facility to ensure no other burns noted. Social Service Department will interview interviewable residents to ensure they have had	F 689		

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F 689	Continued From page 156 no issues with hot liquids. 3. Facility nursing will evaluate ability to handle hot liquids upon admission, quarterly, and with change of condition. All facility staff will be educated prior to working on the process for evaluating resident's safety and ability to handle hot liquids, and the proper temperature to serve hot liquids. Dietary will continue to monitor hot liquid temperatures before each meal to ensure the hot liquids are not served above 135 degrees at point of service with log sign off. 4. Director of Nursing or designee will audit 10 residents per week to ensure hot liquid safety assessments have been completed x 4 weeks, and 5 residents per week x 3 weeks, with results found brought to QAPI (Quality Committee). Administrator or designee will audit hot liquid temperature logs once daily x 4 weeks and will bring results found to QAPI. 5. Corrective Action will be completed by 11:59 pm on March 20, 2018." On March 20, 2018 the facility Administrator (Administration A) and Director of Nursing (Administration B) were notified of the findings. The facility subsequently submitted a Hot Liquid Assessment of Resident #9, which indicated that he was At Risk for handling hot liquids due to his "Contractures - Fingers, hand wrist , elbow, shoulder of non-dominant side, Strength - Weakness, paresis, paralysis of upper extremity. Intervention: resident to drink hot liquids with lid on cup, resident to be evaluated by therapy, resident to be educated by staff preparing coffee for him."	F 689		

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In addition, Hot Liquid Assessments were submitted for all other residents. The facility staff received inservice training that covered the following: "No resident can have any hot liquid until properly assessed by a nurse. If they are a new admission they are not given hot liquids until assessment is completed. All hot liquids must be under 135 degrees with log signed off and covered with a lid."

On 3/23/18 at 9:25 A.M., an interview was conducted with Licensed Practical Nurse E. When asked if she had received training regarding hot liquids, she stated, "Yes. The residents need to be assessed upon admission, annually, quarterly, and after a change in condition. The temperature of any hot liquids should not exceed 135 degrees."

On 3/23/18 at 9:20 A.M., an interview was conducted with Certified Nursing Assistant I. When asked if she had received training regarding hot liquids, she stated, "Yes. Everybody has been assessed. Everybody has to have a lid on their cups. Coffee is served not hotter than 135 degrees."

On 3/23/18 at 9:30 A.M., Certified Nursing Assistant C (CNA C) was interviewed. When asked if she had received training regarding the service of hot liquids, CNA C stated yes. When asked what she was instructed to do, she stated that coffee could not be served over 135 degrees and coffee cups needed to have lids on them.

On 3/23/18 at 9:31 A.M. Licensed Practical Nurse F (LPN F) was interviewed. When asked if she had received training about hot liquids, LPN F stated yes. She said that residents were

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F 689	Continued From page 158 assessed to see if they were safe to handle hot liquids. She stated that the white lids were to be used when serving hot liquids and hot liquids needed to be below 135 degrees. 2. For Resident #59, the facility staff failed to provide adequate supervision to prevent an improper transfer, resulting in a spiral fracture of the lower left leg and resulting in harm. Resident #59 was a 75 year old who was admitted to the facility on 7/10/17. Resident #59's diagnoses included Fracture of Lower End Of Left Tibia, Generalized Muscle Weakness, Dysphasia Following Cerebral Infarction, Aphasia Following Cerebral Infarction, Cerebral Infarction Due to Unspecified Occlusion or Stenosis of Unspecified Cerebral Artery, Difficulty Walking, End Stage Renal Disease, Breast Cancer, Type 2 Diabetes Without Complications, Unspecified Lack of Coordination, Age-Related Physical Debility, Epilepsy, Anxiety Disorder, Convulsions, Hypertension, Glaucoma, Arteriosclerosis, and Hyperlipidemia. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 11/3/17, coded Resident # 59 as having a Brief Interview of Mental Status Score of 15, indicating no cognitive impairment, and as requiring the extensive physical assistance of at least 2 persons for transfers. On 3/21/18 a review was conducted of Resident #59's clinical record, revealing a care plan initiated on 7/11/17. The care plan did not address the residents' requirement per MDS Assessment on 11/3/17 for the extensive physical	F 689		

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assistance of at least two persons for transfers, until 1/21/18, which was the month following her spiral fracture injury. It read, "1/21/18. Risk for falls r/t (related to) gait/balance problems. Tibial Plateau Fracture of LLE (left lower extremity) and fracture of right ankle. Requires assistance with mobility and transfers, medication side effects, pain control. Interventions. Resident transfers with hoyer lift 2 person assist."

On 3/21/18 at 4:45 P.M. an observation was conducted of Resident #59. The head of her bed was elevated, and she was watching television, while wearing headphones. She stated that she was "ok", and denied having any concerns. She was wearing a nightgown.

On 3/22/18 at 10:15 A.M. another observation was made of Resident #59. Licensed Practical Nurse C (LPN C) was present, and stated, "She is supposed to have a pillow under her left leg and assistive rails on both sides." Resident #57's heels were not floated. Both heels were directly on her bed. LPN C was asked to state what the physician's order was. LPN C returned to the computer and read the order. She then stated, "The order says to float both heels. It is to relieve pressure and edema to avoid pressure sores from her heels. She has a pressure sore on the underside of her left calf." LPN C did not ensure that Resident #59's heels were floated after reading the physician's order to float them.

On 3/22/18 at 10:25 A.M., the Regional Nurse (Administration C) was asked to accompany the surveyor into Resident #59's room. The Regional Nurse stated, "Her heels are not floated. It's important for pressure wound prevention."

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On 3/21/18 a review was conducted of facility documentation. The facility sent the resident for a left leg fracture which was discovered by x-ray. The facility reported to the hospital that resident had been complaining of pain; there was no indication that resident had fallen or the fracture was a result of an injury.

The x-ray performed at the hospital indicated the resident had a spiral fracture of the distal tibia and a chest x-ray. The reporter indicated that a spiral fracture would mean that there was some force used and not the result of a fall."

On 3/21/18 a review was conducted of Resident #59's clinical record, revealing that on her original admission date of 7/10/17, she had a diagnosis of Unspecified Fracture of Upper End of Left Tibia. That injury occurred at her home prior to her admission to the facility.

The clinical record also contained two Radiology Reports. 1.) "12/12/17. Results: There is an acute appearing non-displaced oblique fracture of the distal shaft of the tibia. A small plantar spur is present. No other fracture. Conclusion: Acute appearing non-displaced fracture of the distal tibia."

2) "12/28/17. Results: There is a hairline nondisplaced obliquely oriented distal tibial shaft fracture best visualized on the lateral examination. The fracture appears recent. In addition, there is a healing/healed fracture of the proximal tibia and the fibula neck. No dislocation. There is bone demineralization. Vascular calcifications identified. Conclusion: Headline nondisplaced fracture of the distal tibial shaft best visualized on the lateral examination. ANKLE AP

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F 689	Continued From page 161 and LAT 2V, Left." The hospital Assessment/Plan read: "Admission date 12/29/17. (Resident #59) is a 74 year -old female with: 1. End-stage renal disease on hemodialysis 2. Acute ischemia of the right frontal lobe, small focus right occipital lobe in right Middle cerebral artery territory. Expressive aphasia. 3. Hypertension with hypertensive heart disease 4. Chronic Atrial fibrillation 5. Left eye blindness 6. Diabetes mellitus 7. Spiral fracture of the distal left tibial Diaphysis 8. Functional quadriplegia 9. CVA (Cardio Vascular Accident) 10. History of breast cancer Lower leg pain-swelling. Pneumonia, Unspecified organism. Medications: Vancomycin (antibiotic)Per Pharmacy Protocol 1 EA, Q (duration) 30 Days, Hydrocodone-acetaminophen (pain medication) 5 mg-325 mg Tab 1 tab, oral q 4h-int (every 4 hours), Aspirin 235 mg Tab 1 tab oral daily." Resident #59's clinical record contained a re-admission progress note signed by her physician at the facility. It read, "1/19/18. Pt. (patient) Readmitted from Hospital. Patient admitted/discharge diagnoses. Acute ischemic left frontal lobe small form related to history of small vessel ischemic disease. Hx. (history) Hypertension, A-Fib (Atrial fibrillation) L eye Blindness, diabetes mellitus, spiral fracture of the tibial diaphysis, End Stage Renal Disease on Hemodialysis, MRSA (Methicillin-resistant Staphylococcus aureus) Infection, History of Breast CA (Cancer), Patient is legally Blind.	F 689		

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F 689	Continued From page 162 Patient discharged in stable condition on MRSA, or Vancomycin, Zosyn. Patient was seen by infectious disease. Patient doing well. No chest pain no shortness of breath, eating and drinking well, vital signs are stable, heart irregular, lungs good air entry, abdomen soft non tender, extremities no edema. Assessment - Continue current medication. Medication reviewed and hospital record reviewed." A review of facility documentation revealed a Corrective Action Report dated 1/5/18. It read, "(Certified Nursing Assistant - CNA G) Current counseling step: Written. Violation of Safety Standards. Description of incident: CNA G performed an improper transfer on a resident (Resident #59) resulting in an injury by not using a gait belt." The facility Administrator submitted the following written Investigation timeline: "12/11/17 evening shift - Resident requested to return to bed from wheelchair. CNA G transferred resident. CNA interview and re-enactment of transfer does not reveal that anything unusual occurred during the transfer. CNA G transferred the resident by herself. Patient complained of discomfort when CNA G was positioning her feet on pillows. CNA G reported this discomfort to the nurse. 12/12/17 at 0456 A.M. resident reported to nurse supervisor that earlier on 12/11/17 while being lifted from her wheelchair to the bed, she felt as though her left foot was twisted behind her and she felt a pop. After assessing her foot, it was noted that her foot was swollen and warm to the touch with positive pedal pulse bilaterally.	F 689		

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F 689	Continued From page 163 Resident was unable to lift or move her left foot. MD was notified and a new order was received for a 2 view x-ray of the left foot, and to delay dialysis until x-ray is completed. On 12/12/17 at 1017 LPN (incorrectly reported) reported that the x-ray report revealed no fracture or dislocation to the left lower extremity, this information was called to the MD and report was noted and filed in the chart. 12/12/17 at 1020 AM Resident c/o (complained of) pain in left lower extremity 5/10 Tylenol 325 given and was effective. 12/12/17 at 1020 AM Resident c/o pain in left lower extremity 5/10, Tramadol 50 mg was given and shown to be effective 12/13/17 - 12/28/17 No other c/o pain were noted and no pain medications were administered until 12/28/17. 12/28/17 While pharmacy and the facility Assistant Director of Nursing (Administration I) were looking at resident lab information it was noted that there was an x-ray report from 12/12/17 at 0849 that resident had an oblique fracture non-displaced to the distal end of the tibia shaft on lower left extremity. MD was notified..New order was received to send resident to (hospital) for evaluation and treat. 12/2917 Resident was admitted to the hospital with a diagnoses of fracture and pneumonia." On 3/22/18 at approximately 4:00 P.M. the facility Administrator (Administration A) and Director of Nursing (Administration B) were notified of the	F 689		

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F 689	Continued From page 164 findings. No further information was received. 3. Resident #13 sustained multiple large fluid filled blisters on his thigh after spilling hot coffee on himself, resulting in harm. Resident #13, a 60 year old, was admitted to the facility on 11/29/16. Diagnoses included major depression disorder, hyperlipidemia, hypertension, convulsions, peripheral vascular disease, diabetes, glaucoma, and reflux. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 12/28/17. Resident #13 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 and was coded as 2/2 (limited assistance/ 1 person assist) for eating. Resident #13 was identified by the survey team to have sustained burns from hot coffee. The investigation report was requested. The burn occurred on 12/31/17. The "Incident Description" read "Resident alert & oriented was OOB (out of bed), sitting in his w/c (wheel chair). Stated that he spilled a cup of hot coffee on himself while eating his breakfast & now feeling a burring sensation. 2/person assist transferred resident back to bed, upon assessment observed multiple large fluid filled intact blisters on his right upper thigh distal to groin. Supervisor on duty DON (director of nursing), wound nurse, wound doctor per wound nurse & (doctor) were notified of the incident. New order for Silvadene, to apply to affected area. No further c/o (complaint of) discomfort voiced, will continue to monitor, call	F 689		

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bell within reach. Stated that he spilled a cup of hot coffee on himself while eating his breakfast & now feeling burring sensation."

A "Skin Grid Non-Pressure" was initiated on 12/31/17. The wound is described as a burn to the front of the right thigh with large fluid filled blisters with periodic pain.

Another form 'Skin Grid Pressure" was initiated on 12/31/17. Impaired mobility and seizures were documented as "risk factors." The wound was documented as a burn to the groin with pain present.

Resident #13 was assessed by the wound care doctor on 1/9/18. The burn on the upper thigh measured 4 x 15 x 0.1 centimeters, with heavy serous drainage, 50% necrotic tissue and 50% granulation tissue. The wound was described as "Large 2nd degree burn with blister roof ruptured but intact. This was removed sharply."

The most current wound measurements were documented on 3/14/18. The wound measured 2.1 x 3.7 x 0.1 with moderate serosanguineous drainage.

Resident #13 was interviewed on 3/28/18. When asked if was burned by hot coffee, he stated yes. When asked what happened, Resident #13 stated that he meant to pull the overbed table but instead pulled on the meal tray. He stated that tray tipped over and the coffee spilled onto his lap.

An interview was conducted with the Administrator and Director of Nursing (DON) on 3/23/18 at 11:15 a.m. The Administrator was

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asked if a hot liquid assessment had been completed for Resident #13 prior to the burn, the Administrator stated no. She did provide a copy of the Hot Liquid Evaluation that was completed for Resident #13 as a result of the survey findings. The assessment dated 3/20/18 concluded Resident #13 was "unsafe- unable to manage."

When asked what the facility changed with regard to the service of hot beverages after Resident #13 was burned, the Administrator stated that she instructed the dietary and nursing staff to use lids for the coffee cups.

On 3/23/18 at 9:10 a.m., the Dietary Manager (DM) was interviewed. When asked if she was aware that a resident was burned by hot coffee on 12/31/17, the DM stated that she was not aware. When asked if she was aware that a second person (Resident #9) was burned by hot coffee, the DM stated that she was aware of the second person. When asked if she was instructed to change anything regarding the service of hot coffee, the DM stated that she was asked to send lids to the units on the tray with the coffee pot. The DM stated that she had already been sending lids prior to the burn to the second resident.

When asked what the usual temperature of the coffee served from the kitchen measured, the DM stated that she tried to keep it in the range of 145-150 degrees Fahrenheit. She stated that if it was higher than that range, she would put ice in the coffee pots.

It was reviewed with the DM that on 3/20/18 the survey team had a concern that the coffee was

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F 689	Continued From page 167 served too hot and residents were burned as a result. The DM was asked if anything had changed with the coffee temperatures since 3/20/18. The DM stated that coffee now needs to be 135 degrees or below before it is sent out to the units for service. At the end of day meeting on 3/22/18, the Administrator and DON were notified of the concerns regarding Resident #13's burn. No further information was provided. 4. A medication cart was observed unlocked and unattended during medication pass. On 3/22/18 at 8:40 a.m., Licensed Practical Nurse C (LPN C) was working one of the medication carts. She was in a resident room administering medications to a resident in the bed near the door. The medication cart was pulled in front of the door frame with the drawer side facing the room. The cart was unlocked. A medication pour and pass observation was conducted with LPN C. She prepared and administered medications for two residents. She locked her cart on both occasions before entering the room. On 3/22/18 at 11:00 a.m., this surveyor stood in the hall waiting to ask LPN C a question. LPN C was in a resident room. The curtain was pulled and she was behind the curtain with the resident in the window bed. The cart was not within her vision. The cart was pulled close to the door frame with drawers facing the room. The cart was unlocked.	F 689		

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F 689	Continued From page 168 At this time, there were two residents in wheelchairs within arms reach of the cart. There was a visitor standing next to the cart waiting to speak with LPN C. In addition, the housekeeping staff pulled one end of the cart about two feet from the door frame towards the hallway so that she could go in and out of the room. At the end of day meeting on 3/23/18, the Administrator and Director of Nursing were notified that the medication cart had been unlocked on two occasions. The facility policy titled "Medication Administration" was reviewed. The Procedure section read "K. Do not leave medication cart unlocked."	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one	F 690	F690 1.) Resident #32 had his urinary drainage bag lifted off the floor and was given a cover to ensure privacy. 2.) The central supply manager completed an audit of residents with indwelling catheters to ensure drainage bags were covered and that drainage bag was lifted off the floor. 3.) The ADON/designee educated Nursing staff on how to properly store urinary catheter bags to prevent infection and keeping the urinary drainage bag covered for privacy and dignity. 4.) Unit Manager/designee will complete an audit daily x 12 weeks of residents with a urinary drainage bag to ensure bag is off floor and covered x 12 weeks with results brought to QAPI to ensure compliance.	

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F 690	Continued From page 169 is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed to ensure that a urinary catheter drainage bag and tubing were maintained in a manner to prevent the spread of infection for one resident (Resident # 32) in a survey sample of 38 residents. 1. For Resident # 32, the facility staff failed to ensure the urinary catheter bag and tubing were not touching the floor and failed to provide a privacy cover for the urinary bag. During the initial tour of the facility, Resident # 32 was observed to be lying in bed with his urinary drainage bag and tubing touching the floor and with no privacy urinary bag cover. Findings included: Resident # 32 was a 75 year old male admitted to the facility on 6/21/2012 and readmitted on	F 690		

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F 690	Continued From page 170 3/9/2018 with the diagnoses of, but not limited to,Peripheral Vascular Disease, Neuromuscular Dysfunction of the bladder, Gastroesophageal Reflux Disease, Chronic Kidney Disease, Dysphagia, Atherosclerosis of native arteries of extremities with Gangrene Bilateral Legs, Amputation of toes, Hypothyroidism, Glaucoma, Chronic Viral Hepatitis, Paraplegia, BPH (Benign Prostatic Hypertrophy) and Dementia Resident #32's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 1/30/2018. The MDS coded Resident # 32 with a Brief Interview for Mental Status (BIMS) score of 6 out of 15 indicating severe cognitive impairment. Resident # 32 required extensive assistance of one to two staff members with activities of daily living except required total assistance of one staff person for bathing and always incontinent of bowel and Resident # 32 was coded to have an indwelling urinary catheter. During the initial tour of the facility on 3/20/2018 at 11:30 AM, Resident # 32 was observed lying on his back in bed with an uncovered urinary catheter bag which was visible from the doorway. The bag and tubing were observed to be touching the floor. On 3/20/2018 at 1:25 PM, Resident # 32 was observed still lying in bed. The urinary drainage bag and tubing were no longer touching on the floor and was covered with a privacy bag. On 3/20/2018 at 3:20 PM, an interview was conducted with Employee A who stated he placed a cover over the catheter bag for Resident # 32. Employee A stated he lifted the bag off the floor.	F 690		

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F 690	Continued From page 171 Employee A stated he saw the bag on the floor and corrected the problem. Employee A stated the bag on the floor was "an Infection Control problem" and the lack of a cover for the urinary bag was a "Privacy" problem. Employee A stated he worked in Central Supply but helped out whenever he could. Review of the clinical record was conducted 3/21/2018 at 3:30 PM. Review of the Physician's Orders revealed orders written on 2/8/2018 included orders for a "Foley catheter for BPH (Benign Prostatic Hypertrophy)" Review of the Care Plan date initiated 11/13/2017 revealed a Focus of "Has indwelling catheter": Skin Breakdown. Goal: Will be/remain free from catheter-related trauma through review date. Revision 3/12/2018/ target date: 5/16/2018 A copy of the facility policy on Catheters was requested. During the end of day debriefing on 3/23/2018 at 1:15 PM, the administrator, Director of Nursing and Corporate Consultant (Admin C) were informed of the findings. The DON and Corporate Consultant (Admin C) agreed that the urinary bag and tubing should not touch the floor and the urinary catheter bag should be covered. The Director of Nursing stated the facility used Lippincott for Professional Nursing Guidance. No further information was provided.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		

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F 692	Continued From page 172 §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review the facility staff failed for 1 resident (Resident #52) of 38 residents in the survey sample to maintain nutrition status. Resident #52 experienced a weight loss of 5% in 1 month, a severe weight loss of 12.4% in 3 months, and a severe weight loss of 14.1% in 6 months. No dietary interventions were put into place to slow or stop the weight loss. The findings included: Resident # 52, a 76 year old, was admitted to the facility on 3/2/15. Diagnoses included	F 692	F692 1.) A nutritional assessment was completed for resident #52 on April 17, 2018, with recommendations. 2.) A review of weights of current residents in the facility was conducted to ensure significant weight changes have been addressed and dietary specific recommendations implemented. 3.) The facility RD will be educated by the Regional Dietician/ designee on review of residents with significant weight changes, including appropriate recommendations and documentation in the medical record. 4.) Regional Dietician or designee will review 3 charts weekly for a period x12 weeks to ensure that significant weight changes have been addressed, with appropriate recommendations implemented. RD recommendations will be reviewed weekly by DON or designee to ensure compliance x 8 weeks with results brought to QAPI.	

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F 692	Continued From page 173 hypertension, dementia, reflux, anxiety, depression, irritable bowel syndrome, insomnia, and peripheral vascular disease. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 2/15/18. Resident #52 was coded with a Brief Interview of Mental Status score of 14 indicating no cognitive impairment. She required extensive assistance with activities of daily living, to include set up and supervision for eating. Resident #52's weights (in pounds) were documented as follows: 8/19/17- 157 9/6/17- 149 9/11/17- 143 10/4/17- 142.2 11/14/17- 137.4 12/8/17- 135 12/12/17- 137.9 1/3/18- 138.1 1/10/18- 136.8 1/16/18- 134 1/23/18- 133.2 1/29/18- 134.2 1/31/18- 134.4 2/5/18- 134.8 2/14/18- 136.6 3/5/18- 135.8 The weight loss of 5% in 1 month occurred between 8/10/17 (157#[pounds]) and 9/6/17 (149#) The severe weight loss of 12.4% in 3 months occurred between 8/10/17 (157#) and 11/14/17 (137.4#) The severe weight loss of 14.1% in 6 months occurred between 8/10/17 (157#) and 2/5/18	F 692		

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F 692	Continued From page 174 (134.8#)	F 692		

Resident #52's "Nutritional Review" forms were reviewed. The form completed on 8/14/17 documented Resident #52's weight as 157.0 and Usual Body Weight (UBW) as 140-145 pounds. The "weight 6 months ago" was documented as 144 pounds. The "% change" box read "+8", meaning an 8% weight gain had occurred. The "Comments" box read "Remeron was discontinued in May to prevent further wt (weight) gain".

The next "Nutritional Review" was completed on 11/16/17. Weight was documented as 137.4 pounds. Usual Body Weight (UBW) was documented as 125-135 pounds. The "weight 3 months ago" was documented as 157 pounds. The "% change" box read "-13", meaning an 13% weight loss had occurred. The Comments and Care Plan Decision" section read "(Resident #52) is tolerating her diet well and has no dietary concerns/ requests at this time. Wt (weight) is now back down near her usual body wt (weight) since Remeron d/c (discontinue). Will continue current POC (plan of care).

The 13% weight loss that occurred in 3 months is considered a severe weight loss. According to the Nutrition Review, no interventions were put into place to slow or stop the weight loss.

On 2/15/18, a "Nutritional Review" was completed. Weight was documented as 136.6 pounds. Usual Body Weight (UBW) was documented as 125-135 pounds. The Comments and Care Plan Decision" section read "Resident tolerating current mechanical soft diet well. PO (by mouth) intake of meals mostly

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F 692	Continued From page 175 50-75%. Able to feed self w/(with) supervision if needed. Significant wt (weight) loss x 6 months, however wt (weight) currently stable. Remeron restarted d/t (due to) gradual wt (weight) loss. Skin intact. Will continue current POC (plan of care)." According to the Nutrition Review, no dietary interventions were put into place to slow or stop the weight loss. Remeron is an antipsychotic medication used to treat major depression. A side effect of the medication is weight gain. Resident #52 had orders for Remeron (antidepressant) in the amount of 7.5 milligrams as follows: 9/20/15- 10/21/15 10/1/16- 5/12/17 1/24/18- 2/8/18 2/8/18- current The most current order dated 2/8/18 read "Give 7.5 mg (milligram) by mouth at bedtime for Depression with decreased appetite". Resident #52's diet order was reviewed with Employee B, Dietary Manager, on 3/23/18 at 1:45 p.m. Resident #52 was on a Regular-Mechanical Soft diet. She did not have any dietary interventions in place, such as supplements, snacks between meals or fortified foods, that would be implemented for someone with weight loss or weight maintenance. Resident #52 was observed eating in her room on two occasions. The first observation took place on 3/27/18 at 8:27 a.m. This surveyor stood in	F 692		

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F 692	Continued From page 176 the hall outside Resident #52's room waiting for the breakfast tray to be delivered. While waiting, Resident #52 was asked if she was hungry. She stated she was a little hungry and she was ready to eat. Staff delivered the tray. Staff adjusted the bed so Resident #52 was in an upright position and arranged the overbed table over the bed within Resident #52's reach. Resident #52 fed herself. On 3/28/18 at 1:15 p.m., Resident #52 was observed in her room. The bed was almost flat, at an approximately 10 degree angle. The overbed table was in place over the bed. The lunch tray was open. Resident #52 was lying flat feeding herself with her hands. She could not see into the bowls or plate. At this time, a Corporate Registered Nurse (Employee D) was on the hall clearing lunch trays. Employee D was asked to observe the position of Resident #52 in bed while eating. Employee D was asked if it was ok that resident #52 was lying almost flat in the bed while eating. Employee D stated that she needed to ask the resident if she wanted to be positioned as such. When asked, Resident #52 stated yes. Employee D stated that it was the resident's choice to lay flat and eat. It was reviewed with Employee D that Resident #52 had dementia and weight loss issues and was positioned improperly to eat. Employee D stated that she didn't know the resident. On 3/28/18 at 1:20 p.m. Licensed Practical Nurse D (LPN D) was on the hall. LPN D was asked to observe the resident. When asked if it was ok that Resident #52 was reclined almost flat while eating, LPN D stated no- she should be placed upright so she can eat.	F 692		

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F 692	Continued From page 177 Resident #52's care plan was reviewed. The Focus "(Resident) has a self care deficit r/t (related to) Parkinsonism, Gout, COPD (chronic obstructive pulmonary disease) and require assistance with Bathing, dressing, grooming and hygiene deficit related to decreased balance, strength and endurance." "Eating assistance if needed" is listed as an intervention. Another Focus revised on 2/8/18 read "(Resident) has the potential for nutrition/hydration imbalance r/t (related to) dementia, HTN (hypertension), MDD (major depression disorder), hx (history) IBS (irritable bowel syndrome) w/ (with) diarrhea, cardiomyopathy, COPD (chronic obstructive pulmonary disease), and a mechanically altered texture diet." The interventions included hot beverages will be served with lids, Monitor/record/report to MD (doctor) PRN (as needed) s/sx (signs and symptoms) of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss: 3 lbs(pounds) in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months, Provide, serve diet as ordered. Monitor intake and record q (every) meal, RD (registered dietitian) to evaluate and make diet change recommendations PRN (as needed), Weights per facility protocol. The Academy of Nutrition and Dietetics (AND) document "Unintended Weight Loss (UWL) in Older Adults Guideline (2009)" was accessed at https://www.andeal.org/topic.cfm?cat=3652 on 4/3/18 at 10:28 a.m. The following information pertains to the use of appetite stimulants in the elderly: "When medical nutrition therapy (MNT) interventions for older adults have not resulted in improved nutrient intake and/or stabilization of weight, the Registered Dietitian (RD) should collaborate with other healthcare professionals to	F 692		

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BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 692	Continued From page 178 consider appetite stimulants. There is no research on the effectiveness of appetite stimulants for older adults that meets the American Dietetic Association criteria for evidence analysis." The Registered Dietitian (RD) was interviewed on 3/27/18 at 9:20 a.m. The RD stated that she had only worked at the facility about 2 months. The RD was asked why no dietary interventions such as supplements, snacks or fortified foods had been provided to Resident #52 to help slow or stop the weight loss. It was reviewed that only Remeron, an antipsychotic medication being used for the purposes of an appetite stimulant, was ordered. The RD stated that she was new at the time when the doctor ordered the Remeron. The RD stated that the medication had worked in the past. It was reviewed with the RD that when the Remeron was used in the past, Resident #52 gained in excess of 20 pounds above her Usual Body Weight and as a result, the facility allowed Resident #52 to lose weight at a rate in which the loss was considered severe. To correct the loss, the facility has now put the resident back on the Remeron. At no time were dietary interventions put into place before the decision was made to put Resident #52 back on Remeron to be used as an appetite stimulant. The RD provided a copy of her "Medical Nutritional Therapy Assessment Recommendations" form. There was an entry for Resident #52. The recommendations read "No RD recommendation. Remeron restarted 1/24 per MD (doctor)." At the end of day meeting on 3/29/18, Resident #52's weight loss, lack of dietary intervention and	F 692		

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F 692	Continued From page 179 use of Remeron as an appetite stimulant was reviewed with the Administrator and Director of Nursing. No further information was provided.	F 692		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure Enteral feedings were administered per physician order for 3 residents (Residents #364, #74 and #32) in a survey sample of 38 residents. 1. For Resident # 364, the facility staff failed to	F 693	F693 1.) Resident #364s tube feeding were clarified and corrected to correct rate. Resident #74s recommendation from the Dietician were clarified and put into place. Resident #32s tube feeding was changed out with new and dated for the correct date. 2.) The Unit Manager/designee completed an order clarification of tube feeding rates to ensure residents receiving tube feeding were receiving the correct amount. The ADON/ designees reviewed tube feeding recommendations from last 60 days to ensure dietician recommendations were put into place for those residents receiving tube feeding. The Unit Mangers/ designees evaluated current resident receiving tube feeding to ensure labeling was within correct date range. 3.) The ADON/designee educated licensed nurses on properly administering tube feeding to include the right rate and the correct dating of the tube feeding. The Regional Director of Clinical operation educated the DON, ADON, and Unit Managers on the system for processing Dietary Recommendation.	

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F 693	Continued From page 180 administer correct tube feeding. 2. For Resident #74, tube feeding recommendations made by the dietitian were not implemented for a month. 3. For Resident # 32, the tube feeding bottle was dated 2/21/2018, a month prior to survey. Findings included: 1. For Resident # 364, the facility staff failed to administer correct tube feeding. Resident #364 was admitted to the facility on 3/15/18 with diagnoses to include but not limited to Bronchitis related to trachea, traumatic brain injury due to Motor Vehicle Accident Hydrocephalus, sacral pressure ulcer stage II and Peg tube. Resident # 364's admission was too recent for a Minimum Data Set (MDS) assessment (an assessment tool.) The Admission Resident Evaluation dated 03/15/2018 coded Resident # 364 as Unresponsive to physical and verbal stimuli It was documented that Resident #364 required Total assist of 2+ persons of for turning and positioning as well as Activities of Daily living. On 3/20/18 at 12:05 pm on initial tour observed resident #364 had Jevity 1.5 (tube feeding formula) infusing @ 75/milliliters per hour (ml/hr.) via enteral pump with no water flush bag hanging. Discharge order from hospital dated 3/15/18 read Tube Feeding Jevity 1.5 @ 55 ml/hr.	F 693	4.) The Unit Managers/designee will conduct weekly audits x 12 weeks on all residents who receive tube feeding to ensure accurate rates and dating of tube feeding with all results brought to QAPI to ensure compliance. The DON/designees will conduct weekly audits x 12 weeks of all RD recommendations to ensure recommendations have been acted upon with results brought to QAPI	

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F 693	Continued From page 181 Handwritten document titled Medical Nutritional Therapy Assessment Recommendations was provided by the RD. An entry dated 3/14/18 read New TF order Jevity 1.5 @ 65 ml/hr. X 20 hrs. (On at 12 PM) to provide 1300 ml tube feeding and 1950 Kcal per day. New flush order 200 ml of water every 4 hours. " March's Medication administration record shows resident receiving 65 ml/hr. beginning 3/15/18 until 3/21/18. On Nutritional Assessment the box is checked for continuous tube feed instead of Intermittent or Cyclic, however under comments it read Jevity 1.5 @ 65 ml/hr. X 20 hrs. Flush with 200 ml water every 4 hrs. No further information was provided 2. For Resident #74, tube feeding recommendations made by the dietitian were not implemented for a month. Resident #74, an 82 year old, was admitted to the facility on 11/19/15. Diagnoses included stroke, major depression, hypertension, glaucoma, dysphagia, diabetes, and peripheral vascular disease. The most recent Minimum Data Set assessment was an annual assessment with an assessment reference date of 1/3/18. Resident #74 was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment. She required extensive assistance with activities of daily living.	F 693		

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F 693	Continued From page 182 Resident #74 was observed in bed on 3/20/18 at 12:15 p.m. A tube feeding pole was by the bed. There was no feeding hung at the time. A lunch tray with soup was brought in by staff. According to the March 2018 Medication Administration Record (MAR), as of 3/20/18, Resident #74 had been receiving the following tube feeding order: "Enteral Feed Order every shift for tube feeding Jevity 1.2 continuous @ 55 ML (milliliters)/ HR (hour) x 18 hours (on 2 pm, off 8 am) to provide 990 ml (milliliter) total TF (tube feed)/ 1188 kcal per 24 hrs." A 2/22/18 Dietary Progress note read "Notified by unit manager that resident is refusing her continuous EN (enteral nutrition) night feedings of Jevity 1.2 @ 55 ml (milliliter)/hr (hour) x 18 hrs and flush 225 ml water Q (every) 4 hr (hour). She also receives a regular diet for pleasure feedings prn (as needed). CBW (current body weight) is 131# (2/6); BMI 24. Wt (weight) has been stable over the past 4 months. CBW (current body weight) is WNL (within normal limits). Would recommend changing to bolus feeds for possible improved acceptance of nutrition. Would recommend bolus 250 ml (milliliters) Jevity 1.2 QID (four times per day) and flush 200 ml (milliliter) water QID (four times per day) to provide 1000 ml TF (tube feed), 1200 kcal, 56 g pro (protein), and 1607 ml free water to meet estimated nutritional needs. Will monitor TF (tube feed) tolerance and f/u (follow up) per protocol." A 3/1/18 Dietary Progress Note read "Update: Will change new TF (tube feed) order to: bolus 237 ml (milliliter) Jevity 1.5 QID (four times per day) and flush 200 ml (milliliter) water QID (four times per	F 693		

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F 693	Continued From page 183 day) to provide 948 ml (milliliter) total TF (tube feed), 1422 kcal, 60 g (gram) pro (protein), and 1520 ml (milliliter) free water daily. EN (enteral nutrition) plus PO (by mouth) pleasure feedings to meet estimated nutritional needs." On 3/21/18 at 5:09 p.m., the tube feeding recommendation made on 3/1/18 was ordered and implemented. On 3/26/18 at 8:55 a.m., the administration of Resident #74's bolus feed was observed. Licensed Practical Nurse D (LPN D) administered one can of Jevity 1.5 via bolus feed. LPN D was asked if Resident #74 had always been on bolus feeds. LPN D stated that the feedings had been continuous until recently. The Registered Dietitian (RD) was interviewed on 3/27/18 at 9:20 a.m. She was asked to explain how the dietary recommendations she made become orders. The RD stated that she keeps a recommendation sheet that she gives to the Dietary Manager, Administrator, Director of Nursing, Assistant Director of Nursing and Unit Managers on the days that she is at the facility. She stated that she is at the facility Tuesdays and Wednesday afternoons. The RD stated that she notes on the recommendation sheet the date that her recommendation is implemented by a physician order. A copy of the recommendation sheet was requested. It was reviewed with the RD that she made tube feeding recommendations for Resident #74 on 2/22/18 and 3/1/18 and the 3/1/18 recommendation was not implemented until 3/21/18. The RD was aware that the tube feeding had not been implemented. She stated that	F 693		

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F 693	Continued From page 184 around the end of February she began to have issues with getting her recommendations implemented. A copy of the dietary recommendation sheet was provided. There were no tube feeding recommendations for Resident #74 on the sheet. On 3/28/18 at the end of day meeting, the Administrator and DON were notified that Resident #74's tube feeding changes had not been implemented after recommendations for changes were made twice by the RD. No further information was provided. 3. For Resident # 32, the facility staff administered tube feeding that was dated as opened 2/21/2018, a month prior to survey. Resident # 32 was a 75 year old male admitted to the facility on 6/21/2012 and readmitted on 11/3/2017 and 3/9/2018 with the diagnoses of, but not limited to,Peripheral Vascular Disease, Neuromuscular Dysfunction of the bladder, Gastroesophageal Reflux Disease, Chronic Kidney Disease, Dysphagia, Atherosclerosis of native arteries of extremities with Gangrene Bilateral Legs, Amputation of toes, Hypothyroidism, Glaucoma, Chronic Viral Hepatitis, Paraplegia, BPH (Benign Prostatic Hypertrophy) and Dementia Resident #32's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 1/30/2018. The MDS coded Resident # 32 with a Brief Interview for Mental Status (BIMS) score of 6 out of 15 indicating severe cognitive impairment. Resident # 32 required extensive assistance of	F 693		

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F 693	Continued From page 185 one to two staff members with activities of daily living except required total assistance of one staff person for bathing and always incontinent of bowel and Resident # 32 was coded to have an indwelling urinary catheter and currently on Hospice. Review of the clinical record was conducted on 3/21/2018 at 2:30 PM. Review of the Physicians Orders revealed an order written 3/21/2018 for Enteral Feed Order every shift Jevity 1.5 Cal at 75 milliliters per hour for 20 hours on at 12 PM to infuse 1500 milliliters of tube feeding and provide 2250 kilocalories per day. On 3/23/2018 at 9:05 AM, observed the tube feeding was hanging on a pump stand on the left side of Resident # 32's bed. The date on the bottle was 2/21/2018 and the tubing was dated 3/23/18. Resident # 32 was lying in bed. The tube feeding was not infusing at the time of observation. The Director of Nursing (DON) immediately came to the room and observed the bottle and tubing. The DON stated the bottle was dated in February and the tubing for that current day 3/23/2018. The DON stated she did not understand why the date on the bottle was a month old and that the entire feeding set up needed to be discarded. The DON stated the expectation was that tube feedings should be dated the day it was opened, administered immediately and discarded after 24 hours. She also stated the bottle and tubing should be dated the same date. During the end of day debriefing on 3/23/2018,	F 693		

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F 693	Continued From page 186 the Facility Administrator, Director of Nursing and Corporate Regional Consultant were informed of the findings. The DON again stated that tube feedings should be dated and administered immediately upon opening and discarded after 24 hours. No further information was provided.	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed to ensure the safe storage of an empty oxygen cylinder for two residents (Residents # 16 and # 14) and failed to ensure the oxygen tubing was dated for one resident (Resident # 364) in as survey sample of 38 residents. 1. For Residents # 16 and # 14, the facility staff failed to safely store an empty oxygen canister. An oxygen canister was found leaning against a wall in the room which Residents # 16 and # 14 shared. There was a used nasal cannula attached.	F 695	F695 1.) The empty oxygen tank in Resident #16 and resident #14's room was removed immediately and put into proper storage place. Resident #364s oxygen tubing was immediately replaced with new tubing that was dated accurately. 2.) The Unit Manager/designee completed a facility audit to ensure there were no additional oxygen tanks out of place and that oxygen tubing was labeled and dated accurately. . 3.) The ADON/designee educated staff on how to properly store oxygen tanks. The ADON/designee educated Nursing staff on the process for labeling and dating of oxygen tubing. 4.) The maintenance director/designee will conduct audits 5 x per week for 12 week to ensure all oxygen tanks are stored properly with results brought to QAPI.	

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F 695	Continued From page 187 2. For Resident #364 the facility staff failed to date the oxygen tubing and failed to clarify physicians order for oxygen. Findings included: 1. For Residents # 16 and # 14, the facility staff failed to safely store an empty oxygen canister. An oxygen canister was found leaning against a wall in the room which Residents # 16 and # 14 shared. There was a used nasal cannula attached. Resident # 16, a female, was admitted to the facility 3/9/2015. Her diagnoses included but were not limited to Pneumonia, Urinary Tract Infection, Hyperlipidemia, Cerebrovascular Accident, Dementia and Seizure Disorder. Resident # 16's most recent MDS with an ARD of 2/15/2018 was coded as a quarterly assessment. Resident # 16's cognitive status (her ability to make every day life decisions and memory ability) was not coded. Dashes were entered in the areas of Section C 100 "Should Brief Interview for Mental Status" through C 1000" Cognitive Skill for Daily Decision Making." Resident # 16 was coded as needing supervision assistance of one staff member to perform her activities of daily living. Resident # 16 was coded as being able to hear, speak, understand, and be understood. During the initial tour of the facility on 3/20/2018 at 12:45 PM, an oxygen canister was observed leaning against a wall between the sink and the first wardrobe closet. It was situated to the right of the sink and to the left of the closet. There was a used nasal cannula attached to the oxygen canister. There was no date on the tubing. There	F 695	The Unit Managers/designee will complete weekly audit x 12 weeks of all residents on oxygen to ensure residents tubing is properly dated.	

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F 695	Continued From page 188 was no Oxygen sign posed on the door. On 3/20/2018 at 12:55 PM, the nurse working near that room LPN (Licensed Practical Nurse) B was interviewed. LPN B stated neither resident in that room had an order for oxygen. LPN B stated she did not know who put the oxygen canister in that room. LPN B also stated she did not know how long the oxygen canister had been in that room. On 3/20/2018 at 1:05 PM, LPN B determined that the oxygen canister was empty. LPN B stated oxygen should be stored properly because of safety. LPN B also stated oxygen canisters should not be taken into other resident's room once discontinued due to infection control concerns. On 3/20/2018 at 1:25 PM, a copy of the "Oxygen sign in/out sheet was requested from the Central Supply Coordinator. Review of the Oxygen Sign in/Out form revealed no documentation of oxygen being signed out to either resident in that room from December 15, 2017 - March 20, 2018. Review of the clinical record was conducted on 3/20/2018 at 2:30 PM. Review of the clinical records of both Residents (Residents # 16 and # 14) revealed no documentation of Physicians orders for oxygen. On 3/20/2018 at 3:00 PM, the Director of Nursing (DON) was informed of the oxygen canister being found in the room that Residents # 16 and # 14 shared. The DON stated she did not think either resident had used oxygen. The DON stated it was a safety concern for oxygen to be not stored	F 695		

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F 695	Continued From page 189 securely and an infection control issue for used oxygen equipment to be transported to another resident's room. No further information was provided. 2. For Resident #364 the facility staff failed to date the oxygen tubing and failed to clarify physicians order for oxygen. Resident #364 was admitted to the facility on 3/15/18 with diagnoses to include but not limited to Bronchitis related to trachea, traumatic brain injury due to Motor Vehicle Accident Hydrocephalus, sacral pressure ulcer stage II and Peg tube. Resident # 364's admission was too recent for a Minimum Data Set (MDS) assessment (an assessment tool.) The Admission Resident Evaluation dated 03/15/2018 coded Resident as Unresponsive to physical and verbal stimuli. Resident required Total Dependence assist of 2+ persons of for turning and positioning as well as Activities of Daily living. On 3/20/18 at 12:05 tubing was observed not dated and concentrator was set at 6 L/m (liters per minute) The Unit manager (RN A) was notified of the issue with the tubing she immediately left the room and came back and placed a date sticker on the existing tubing. She did not change the tubing first. The Unit manager stated that oxygen tubing is	F 695		

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F 695	Continued From page 190 changed weekly on Tues 11-7 shift. She also stated that concentrator should be on 10 L/m. She then changed the setting to 10 L/m. Physician order dated read Oxygen at 28% humidity. It did not give a quantity of L/M. Upon review of resident record the following was documented; Nurse note dated 3/22/18 read O2 @ 97% on 5 L/M of O2 with 28% humidification. Nurse's note dated 3/25/18 and 3/26/18 nurse's notes read O2 @ 10 L/m via trach. The Director of Nursing was made aware of the oxygen order and nurses documentation she stated the Concentrator should be at 5-6 L/M. Regional nurse (administrator C) was also present and agreed the setting should be 5-6 L/m. No further information provided.	F 695		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental	F 740	F 740 1.) Resident #92 was assessed by the SSD with a note to have the facility psych physician evaluate. residents Kardex was also updated to match emotional needs. 2.) The UMS and or designees have reviewed progress notes/behavior notes on current residents for past 14 days to ensure all mental health needs have been assessed or interventions put into place.	

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	495252	A. BUILDING _____ B. WING _____	C 03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 740	Continued From page 191 and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review the facility staff failed for 1 resident (Resident #92) of 38 residents in the survey sample to provide behavioral health services. Resident 92's clinical record documented that suicidal ideations were verbalized. A continued assessment of Resident #92 behavioral health needs was not performed by facility staff. The findings included: Resident #92, a 67 year old, was admitted to the facility on 10/12/17. Diagnoses included stroke, hemiplegia, major depression disorder, hyperlipidemia, reflux, pain, skin cancer, and convulsions. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 1/18/18. Resident #92 was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment and requiring assistance with activities of daily living. An interview was conducted with Resident #92 on 3/20/18 at 12:00 p.m. During the interview, Resident #92 was tearful. He stated that he never used to be a person who cried. He stated that he no longer wanted to be around due to his health conditions. He was asked if he had ever talked with the social worker about his feelings. He stated no. When asked if he was interested in talking with the social worker, Resident #92	F 740	3.) The ADON and or designees have educated facility staff to notify nursing when a resident shows signs or depression or suicidal ideations to ensure patient can be assessed for potential interventions. 4.) The DON/designees will review residents progress/behavior notes weekly x 12 weeks to ensure all residents with mental health needs are being addressed appropriately with results brought to QAPI.	

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F 740	Continued From page 192 stated yes. Resident #92's clinical record was reviewed. The following notes were documented: 10/19/17, 5:00 a.m., Behavior Note. "Resident lying in a fetal position in bed, w/ eyes opened. NAD, no c/o pain or discomfort voiced. Alert, confused & verbal. Upon assessment, resident voiced he had taken a certain amount of pills that would set him on fire, but, when he woke up he feels angry that he's still alive. Writer questioned resident about the fire, resident stated that he wanted to kill himself because his sister won't take him home. Resident doesn't have any items within reach that could harm him & frequent monitoring was accessed." 10/19/17, 11:42 a.m., Nurses Note. "Today resident denies wanting to hurt himself. States, I had a bad dream, I did not mean that' Talked to resident, letting him know we have to take it serious when you say that, states 'I know, I did not mean it. Will continue to monitor resident for safety." 10/19/17, 11:46 a.m., Nurses Note. "Spoke with (name) the psychiatrist concerning resident. She will follow up with resident on next visit." 10/19/17, 5:11 p.m. Social Services Note. "Completed 5 day/ADMS assessment with resident today 10-19-17 to reflect ARD (assessment reference date) 10-19-17 to include sections A-1500, C, D, E, and Q of MDS (minimum data set). Resident was able to repeat the three words sock, blue, and bed and was able to recall all three without cueing after a five minute period. Resident was able to state the	F 740		

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F 740	Continued From page 193 correct year, month, and day of the week. Resident does not feel down or depressed and eats and sleeps good daily. Resident did state that he feels tired some days. Per Rehab Manager resident has been refusing to participate in therapy sessions. Resident will continue to be encouraged. Sister is very supportive and visits often. Stay will continue to remain long term at this time. Social Services to remain available as needed." 10/19/17, 6:22 p.m., Nurses Note. "Resident is alert and responsive. No statements made about self harm." 10/28/17, 8:56 a.m., eMAR note. "While in residents room to administer meds, resident stated, Don't tell no body but I'm threw I don't wanna live anymore. Resident refused meds at first. With redirection took medication." At the end of day meeting on 3/26/18, the Director of Nursing (DON) and Administrator were notified that it did not appear the facility staff were providing for Resident #92's behavioral health needs. It was reviewed that it did not appear that Resident #92's depression and hopelessness were care planned. The administrative staff were directed to review the Behavior Note written on 10/19/17. They were asked to provide all social services notes. They were also asked to provide the dates for which the facility did not have a social services staff in place. It is unclear if the psychiatrist evaluated Resident #92 as documented on 10/19/17. If the visit was completed, the progress note was not provided. The social services note written 10/19/17 did not	F 740		

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F 740	Continued From page 194 specifically address if the suicidal thoughts were addressed during the assessment. According to the social services notes provided by the facility, the social worker did not document any further follow up or assessment regarding Resident #92's behavioral health status after the note written on 10/19/17. According to the Administrator, the social services staff left her position on 1/22/18. The social services position was vacant for two months. The new social services staff started the week of 3/19/18. A Social Services Note dated 3/26/18, 6:46 p.m. was provided. Then note was completed by the new social services staff. The note read "During hourly rounds (name) completed a welfare check on (Resident #92). HE expressed that things are fair and he is having a difficult time sleeping. After his sister and cousin visited him he expressed that he felt down and depressed because he is unable to be around his family as they grow up. He stated 'I am trying to find a way out just waiting for a miracle to happen and I can walk again'. He then appeared to cry and during the interview and stated I just want to be around my family. (name) continued to engage in conversation with (Resident #92) and asked if he felt safe or had any plans to harm himself. He then replied 'I would hurt someone else before I hurt myself not to say I want to hurt anybody'. He then stated 'I just want to be at home with my family and he became very emotional again and stated 'I just want freedom I once had because I have lost interest in talking on the phone and watching tv after I had my stroke' He then expressed that he just wants to feel important and that he is treated fair."	F 740		

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F 740	Continued From page 195 The physician assessed Resident #92 on 3/26/18. The note read "Pt (patient) seen for evaluation for depression, s/w (spoke with) pt in detail, pt says I feel depressed, not sleeping well, no SI (suicidal ideation), or homicidal, does not want to hurt any one, little frustrated due to he as so active before coming here now stay in room all the time. No crying spell, some time anger episode. A/P 1)Depression Add Trazodone 50 mg (milligram) Q (every) HS (evening)" The Administrator and DON were notified of the concern regarding Resident #92 at the end of day meeting on 3/28/17. No further information was provided.	F 740		
F 741 SS=E	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the	F 741	F 741 1.) On 3/29/18 the facility Social Services Director conducted a psychosocial assessment on Resident #92 which showed signs of depression but no suicidal ideations. Resident #92 was then seen by physician who prescribed the patient Trazodone for depression. Resident #92 was referred to facility psych physician for assessment. 2.) Executive Director has coordinated Qualified Social Services for the facility. The UMS/designee designees have reviewed progress notes/behavior notes on all current residents from past 14 days to ensure all mental health and psychosocial needs have been evaluated and interventions put into place as indicated.	

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F 741	Continued From page 196 facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]. §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review the facility staff failed for 1 resident (Resident #92) of 38 residents in the survey sample to ensure sufficient staff were available to provide behavioral health services. Resident 92's behavioral health needs were not assessed by the social services staff from 10/19/17 until 3/26/18. There was no social services staff employed at the facility from 1/22/17 until 3/19/18. The findings included: Resident #92, a 67 year old, was admitted to the facility on 10/12/17. Diagnoses included stroke, hemiplegia, major depression disorder, hyperlipidemia, reflux, pain, skin cancer, and convulsions. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 1/18/18. Resident #92 was coded with a Brief Interview of Mental Status score of 15 indicating no cognitive impairment and requiring assistance with activities of daily living.	F 741	3.) Regional Director of Clinical operations will educate Executive Director, Director of Nursing, and the Interdisciplinary Team on the requirements for providing services to residents with behavioral and psychosocial health needs and the development of an appropriate plan of care. Facility staff will be educated on identifying, reports, and caring for residents with behaviors, mental health needs, and psychosocial needs. Social Services/designee will review each reported changes in behavior, mental health, and psychosocial health to ensure appropriate intervention and plan of care has been implemented. New hires will be educated on providing care and services to residents with behavioral, mental health, and psychosocial health needs. DON/Designee will review progress notes daily and identified behavior, mental health, and psychosocial changes will be referred to social services for follow-up.	

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F 741	Continued From page 197 An interview was conducted with Resident #92 on 3/20/18 at 12:00 p.m. During the interview, Resident #92 was tearful. He stated that he never used to be a person who cried. He stated that he no longer wanted to be around due to his health conditions. He was asked if he had ever talked with the social worker about his feelings. He stated no. When asked if he was interested in talking with the social worker, Resident #92 stated yes. Resident #92's clinical record was reviewed. The following notes were documented: 10/19/17, 5:00 a.m., Behavior Note. "Resident lying in a fetal position in bed, w/ eyes opened. NAD, no c/o pain or discomfort voiced. Alert, confused & verbal. Upon assessment, resident voiced he had taken a certain amount of pills that would set him on fire, but, when he woke up he feels angry that he's still alive. Writer questioned resident about the fire, resident stated that he wanted to kill himself because his sister won't take him home. Resident doesn't have any items within reach that could harm him & frequent monitoring was accessed." 10/19/17, 11:42 a.m., Nurses Note. "Today resident denies wanting to hurt himself. States, I had a bad dream, I did not mean that' Talked to resident, letting him know we have to take it serious when you say that, states 'I know, I did not mean it. Will continue to monitor resident for safety." 10/19/17, 11:46 a.m., Nurses Note. "Spoke with (name) the psychiatrist concerning resident. She will follow up with resident on next visit."	F 741	4.) DON/Designee will complete a weekly review of residents with psychosocial, mental health, and behavior changes to ensure all appropriate reviews, referrals, and interventions have been completed. Results will be reported to QAPI X 3 months	

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F 741	Continued From page 198 10/19/17, 5:11 p.m. Social Services Note. "Completed 5 day/ADMS assessment with resident today 10-19-17 to reflect ARD (assessment reference date) 10-19-17 to include sections A-1500, C, D, E, and Q of MDS (minimum data set). Resident was able to repeat the three words sock, blue, and bed and was able to recall all three without cueing after a five minute period. Resident was able to state the correct year, month, and day of the week. Resident does not feel down or depressed and eats and sleeps good daily. Resident did state that he feels tired some days. Per Rehab Manager resident has been refusing to participate in therapy sessions. Resident will continue to be encouraged. Sister is very supportive and visits often. Stay will continue to remain long term at this time. Social Services to remain available as needed." 10/19/17, 6:22 p.m., Nurses Note. "Resident is alert and responsive. No statements made about self harm." 10/28/17, 8:56 a.m., eMAR note. "While in residents room to administer meds, resident stated, Don't tell no body but I'm threw I don't wanna live anymore. Resident refused meds at first. With redirection took medication." At the end of day meeting on 3/26/18, the Director of Nursing (DON) and Administrator were notified that it did not appear the facility staff were providing for Resident #92's behavioral health needs. It was reviewed that it did not appear that Resident #92's depression and hopelessness were care planned. The administrative staff were directed to review the Behavior Note written on	F 741		

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F 741	Continued From page 199 10/19/17. They were asked to provide all social services notes. They were also asked to provide the dates for which the facility did not have a social services staff in place. It is unclear if the psychiatrist evaluated Resident #92 as documented on 10/19/17. If the visit was completed, the progress note was not provided. The social services note written 10/19/17 did not specifically address if the suicidal thoughts were addressed during the assessment. According to the social services notes provided by the facility, the social worker did not document any further follow up or assessment regarding Resident #92's behavioral health status after the note written on 10/19/17. According to the Administrator, the social services staff left her position on 1/22/18. The social services position was vacant for two months. The new social services staff started the week of 3/19/18. A Social Services Note dated 3/26/18, 6:46 p.m. was provided. Then note was completed by the new social services staff. The note read "During hourly rounds (name) completed a welfare check on (Resident #92). HE expressed that things are fair and he is having a difficult time sleeping. After his sister and cousin visited him he expressed that he felt down and depressed because he is unable to be around his family as they grow up. He stated 'I am trying to find a way out just waiting for a miracle to happen and I can walk again'. He then appeared to cry and during the interview and stated I just want to be around my family. (name) continued to engage in conversation with (Resident #92) and asked if he	F 741		

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F 741	Continued From page 200 felt safe or had any plans to harm himself. He then replied 'I would hurt someone else before I hurt myself not to say I want to hurt anybody'. He then stated 'I just want to be at home with my family and he became very emotional again and stated 'I just want freedom I once had because I have lost interest in talking on the phone and watching tv after I had my stroke' He then expressed that he just wants to feel important and that he is treated fair." The physician assessed Resident #92 on 3/26/18. The note read "Pt (patient) seen for evaluation for depression, s/w (spoke with) pt in detail, pt says I feel depressed, not sleeping well, no SI (suicidal ideation), or homicidal, does not want to hurt any one, little frustrated due to he as so active before coming here now stay in room all the time. No crying spell, some time anger episode. A/P 1)Depression Add Trazodone 50 mg (milligram) Q (every) HS (evening)" The Administrator and DON were notified of the concern regarding Resident #92 at the end of day meeting on 3/28/17. No further information was provided.	F 741		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755	F 755 1.) Resident #72, #32, and #87's physician was notified of medications not given as ordered. 2.) Current residents will be reviewed to ensure Physician ordered medications are available, any identified concerns will be addressed as indicated.	

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F 755	Continued From page 201 §483.45(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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, facility documentation review and clinical record review, the facility staff failed to ensure multiple medications on multiple days were dispensed timely for three residents (Residents # 32, 87, and 72) in a survey sample of 38 residents. Facility staff did not administer antibiotics 1. For Resident # 32, the facility staff failed to provide medications as ordered by the physician. The medications were listed as medication unavailable. 2. For Resident # 87, the Facility staff failed to	F 755	3.) Licensed nurses will be educated on Medication Administration Guidelines, Medication Ordering Processes, and Orders Management. Unit Manager/Designee will review EMAR notes and Order recap summary daily to ensure medications are available as ordered 4.) DON/Designee will review 5 residents each unit per week x 12 weeks to ensure that Medications are available as prescribed with results brought to QAPI to ensure compliance.	

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F 755	Continued From page 202	F 755		

ensure medications were available for administration as ordered by the physician. Antibiotics were unavailable on several occasions.

3. For Resident # 72, the facility staff failed to ensure medications were available for administration as ordered by the physician.

Findings included:

1. For Resident # 32, the facility staff failed to provide medications as ordered by the physician. The medications were listed as medication unavailable.

Resident # 32 was a 75 year old male admitted to the facility on 6/21/2012 and readmitted on 11/3/2017 and 3/9/2018 with the diagnoses of, but not limited to, Peripheral Vascular Disease, Neuromuscular Dysfunction of the bladder, Gastroesophageal Reflux Disease, Chronic Kidney Disease, Dysphagia, Atherosclerosis of native arteries of extremities with Gangrene Bilateral Legs, Amputation of toes, Hypothyroidism, Glaucoma, Chronic Viral Hepatitis, Paraplegia, BPH (Benign Prostatic Hypertrophy) and Dementia.

Resident #32's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 1/30/2018. The MDS coded Resident # 32 with a Brief Interview for Mental Status (BIMS) score of 6 out of 15 indicating severe cognitive impairment. Resident # 32 required extensive assistance of one to two staff members with activities of daily living except required total assistance of one staff person for bathing and always incontinent of

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F 755	Continued From page 203 bowel and Resident # 32 was coded to have an indwelling urinary catheter and currently on Hospice. Review of the clinical record was conducted on 3/21/2018 at 2:30 PM. Review of the Progress Notes revealed documentation of an eMar (electronic Medication Administration Note) on 3/10/2018 at 3:25 PM which stated Metoprolol Tartrate tablet 25 milligrams give 2 tablet by mouth every 12 hours related to Essential Hypertension (110) hold for HR <60 (heart rate less than 60) "Awaiting arrival from pharmacy." Further review of the Progress Notes revealed other documentation of medications not available from the pharmacy. On 11/4/2017 at 4:27 PM eMar (electronic Medication Administration Note) Dulera Aerosol 200-5 micrograms per activation 2 puffs inhale orally two times a day for Bronchitis. "Med not available." On 11/4/2017 at 4:30 PM eMar (electronic Medication Administration Note) Dorzolamide HCL (Hydrochloride) Solution 2 % instill one drop in both eyes two times a day related to other specified Glaucoma:" Med not available" On 11/4/2017 at 4:30 PM eMar (electronic Medication Administration Note) Timoptic Solution 0.5 % Instill one drop in right eye one time a day related to other specified Glaucoma. "Med not available." On 11/4/2017 at 10:10 PM eMar (electronic	F 755		

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F 755	Continued From page 204 Medication Administration Note) Zosyn Solution Reconstituted 3.375 grams Use 3.375 milligrams intravenously every 12 hours for MRSA (Methicillin Resistant Staphylococcus Aureus) in wound for 14 days. "Med has not been delivered" On 11/5/2017 at 7:45 AM eMar (electronic Medication Administration Note) LevoFloxacin in D5W Solution 500 milligrams intravenously every 24 hours for MRSA in wound for 14 days "awaiting on pharm" On 3/22/2018 at 9 AM, an interview was conducted with LPN (Licensed Practical Nurse) B who stated the staff should notify the Pharmacy when medications are not available. On 3/22/2018 at 2 PM, an interview was conducted with the Director of Nursing who stated the Pharmacy should have medications available for administration as per Physicians Orders. The Director of Nursing also stated the facility staff should check the "First Dose" medications to see if the missing medication is available in that supply. Review of the STAT box "First Dose" contents list revealed the Medication, Lopressor (Generic Name-Metoprolol Tartrate) 25 milligrams was available to the staff. During the end of day debriefing on 3/23/2018, the Facility Administrator, Director of Nursing and Corporate Nurse were informed of the findings. The Director of Nursing stated the Pharmacy should ensure medications were available for administration as ordered by the physician. No further information was provided.	F 755		

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F 755	Continued From page 205	F 755		

2. For Resident # 87, the Facility staff failed to ensure medications were available for administration as ordered by the physician. Antibiotics were unavailable on several occasions.

Resident # 87 was admitted to the facility on 12/132017 and readmitted on 2/16/2018 with diagnoses of but not limited to: Hypertension, convulsions, Major Depressive Disorder, Congestive Heart Failure (CHF), Dysphagia, Gastrostomy, Metabolic Encephalopathy, muscle weakness, Chronic Obstructive Pulmonary Disease (COPD), Cutaneous Abscess of Buttock, Hidradenitis Suppurativa.

Resident # 87's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 1/30/2018. The MDS coded Resident # 87 with a Brief Interview for Mental Status (BIMS) score not assessed. Resident # 87 required extensive assistance of one to two staff members with activities of daily living and always incontinent of bowel and bladder.

Resident was admitted to the hospital on 2/14/2018 and discharged on 2/16/2018. Review of the Hospital Discharge Summary revealed final diagnosis of infected decubitus ulcer, Urinary tract infection, hypertension, COPD, CHF, history of seizures, depression and history of Hidradenitis around the pelvis area sacral ulcer." On Page 3 of 4 under Hospital Course was documented "...patient have some pus drainage and blood drainage from these decubitus ulcers seen by the surgeon and plan to do the

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debridement but patient refused. Patient discharged back to nursing home on IV antibiotic. discuss with the patient and patient daughter this morning and if in case ulcer worse she will come back to the hospital for debridement. Also discussed about patient and going to sepsis with worsening sacral wound."

Review of the March 2018 Medication Administration Record (MAR) revealed documentation eight missing doses of intravenous antibiotics. Missing doses were 3/2/2018 at 2 PM and 10 PM, 3/3/2018 at 6 AM and 2 PM, 3/5/2018 at 10 PM, 3/9/2018 at 10 PM, 3/10/2018 at 6 AM and 2 PM.

Review of the nurses notes revealed documentation:
3/2/2018 at 5:43 PM of medication Piperacillin-Tazobactam in Dex Solution 3-0.375 grams per 50 milliliters give 3.375 grams intravenously every 8 hours for ABSCESS for 6 weeks. Notified Pharmacy. Stated they will send ABT (Antibiotic) to facility on next run. Notified MD (medical doctor). Stated to hold until arrival of medication.

3/3/2018 at 2:28 PM nurses note stated the IV (intravenous) antibiotics remain on hold.

3/5/2018 5:10 PM-Awaiting Pharmacy to send resident's IV ABT Tx. Notified provider stated to hold medication until arrive from pharmacy.

3/5/2018 at 5:16 PM eMAR (electronic medication administration record) Medication Administration Note: "Piperacillin-Tazobactam in Dex Solution 3-0.375 grams per 50 milliliters give 3.375 grams intravenously every 8 hours for ABSCESS for 6

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F 755	Continued From page 207 weeks. Awaiting arrival from pharmacy. See nurse note." 3/5/2018 7:28 PM IV Antibiotic on hold per doctor... 3/9/2018 10:07 PM eMAR (electronic medication administration record) Medication Administration Note: "Piperacillin-Tazobactam in Dex Solution 3-0.375 grams per 50 milliliters give 3.375 grams intravenously every 8 hours for ABSCESS for 6 weeks. Awaiting refill from pharmacy. Coming on run" 3/9/2018 10:16 PM Nurse Note: Doctor_____ aware of 2200 (10 PM) dose of ABT not available. 3/10/2018 7:01 AM eMAR (electronic medication administration record) Medication Administration Note: "Piperacillin-Tazobactam in Dex Solution 3-0.375 grams per 50 milliliters give 3.375 grams intravenously every 8 hours for ABSCESS for 6 weeks. Awaiting on order from pharmacy." 3/10/2018 3:04 PM eMAR (electronic medication administration record) Medication Administration Note: "Piperacillin-Tazobactam in Dex Solution 3-0.375 grams per 50 milliliters give 3.375 grams intravenously every 8 hours for ABSCESS for 6 weeks. Awaiting arrival from pharmacy." 3/10/2018 4:05 PM Resident remains on IV ABT r/t (related to)abscess to buttocks. Resident currently out of ABT Tx (treatment). Awaiting arrival from pharmacy. MD aware. Will resume ABT when they arrive from pharmacy. 3/10/2018 10:43 PM Nurses Note: Call was placed to Pharmacy to check status of delivery of	F 755		

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F 755	Continued From page 208 IV ABT Zosyn. Pharmacy tech stated that Zosyn was delivered by Pharmacy to the wrong Facility and that it should be arriving shortly. Zosyn has not arrived as of 1045 (8:45 PM). MD is aware.." On 3/23/2018 at 2:40 PM, an interview was conducted with the Director of Nursing (DON) who stated the facility had experienced difficulty with a previous Pharmacy and had recently changed to a different Pharmacy. The DON stated the new pharmacy was located in Maryland and made three regular runs to the facility each day. The DON stated the expectation was that medications should be available for administration as ordered by the physician. The DON stated the course of antibiotics should be administered without interruption. Review of the Facility policy on Medication Administration effective 8/3/2010 and Revised 12/14/2017 on Page 1 of 7 stated "Administer Medications only as prescribed by the provider" Interview with the Pharmacist who stated their pharmacy started with the facility on 3/1/2018. The Pharmacist stated the process for antibiotics was to dispense antibiotics for a short duration all at one time. However, if the antibiotic was cost prohibitive or any potential problem with payment or if the course of therapy might be expected to change, the Pharmacy would refill the antibiotic every 3 days. The Pharmacist stated the process for intravenous medications was handled a little differently. Intravenous medications needed to be dispensed more often because once the medication was reconstituted, it would need to be administered within a shorter period of time. The Pharmacist stated for Intravenous medications	F 755		

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F 755	Continued From page 209 with a longer course of therapy, reorder sheets were utilized and would be automatically refilled based on the number of doses needed and as long as the order was current. 3. For Resident # 72, the facility staff failed to ensure medications were available for administration as ordered by the physician. Resident # 72, a female, was admitted to the facility 11/2/2015. Her diagnoses included but were not limited to Diverticulitis of both small and large intestines with perforation and abscess, insomnia, neuropathy, Gastroparesis, Anxiety Disorder, Major Depressive Disorder, Multiple Sclerosis, Hypertension and weakness. Resident # 72's most recent MDS with an ARD of 2/21/2018 was coded as a quarterly assessment. Resident # 72's cognitive status (her ability to make every day life decisions and memory ability) was not coded. Dashes were entered in the areas of Section C 100 "Should Brief Interview for Mental Status" through C 1000" Cognitive Skill for Daily Decision Making." Resident # 72 was coded as needing supervision assistance of one staff member to perform her activities of daily living. Resident # 72 was coded as being able to hear, speak, understand, and be understood. Review of the Progress Notes revealed documentation that several medications were not available from the Pharmacy during November 2017 to March 2018. On 2/12/2018 at 3:42 PM- Mirabegron ER (Extended Release) 24 hour 25 milligrams tablet "Medication not available. Pharmacist stated	F 755		

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F 755	Continued From page 210 medication will be sent out tonight 2/12/2018. Awaiting arrival." On 2/11/2018 at 1:20 PM: Mirabegron ER tablet Extended Release 24 hour 25 milligrams give one tablet by mouth one time a day for Bladder spasms. Med not available On 2/10/2018 at 9:03 AM: Mirabegron ER tablet Extended Release 24 hour 25 milligrams give one tablet by mouth one time a day for Bladder Spasms. Med not available On 1/8/2018 at 3:46 PM: Ergocalciferol Capsule 50000 Unit give one capsule by mouth one time a day every Monday related to Multiple Sclerosis. Awaiting arrival from Pharmacy" On 1/8/2018 at 3:49 PM: Naloxegol Oxalate tablet 25 milligrams give one tablet by mouth one time a day for Constipation "Awaiting arrival from pharmacy." On 1/5/2018 at 8:34 AM: Naloxegol Oxalate tablet 25 milligrams give one tablet by mouth one time a day for Constipation "Pharm notified to send." On 12/3/2017 at 10:18 AM: Fenofibrate Capsule give 134 milligrams by mouth one time a day related to Multiple Sclerosis "Not available." On 12/2/2017 at 11:53 AM: Fenofibrate Capsule give 134 milligrams by mouth one time a day related to Multiple Sclerosis "Not available." On 11/23/2017 at 7:00 AM: Oxycodone HCL tablet 30 milligrams give one tablet by mouth every 6 hours for Pain "Med unavailable."	F 755		

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F 755	Continued From page 211 On 11/16/2017 at 12:40 AM: Oxycodone HCL tablet 30 milligrams give one tablet by mouth every 6 hours for Pain "Med unavailable." On 11/15/2017 at 1:08 PM: Oxycodone HCL tablet 30 milligrams give one tablet by mouth every 6 hours for Pain "Med unavailable." On 11/12/2017 at 6:44 PM: Clonazepam tablet 0.5 milligrams give one tablet by mouth two times a day related to Anxiety Disorder "Not available." On 11/12/2017 at 8:57 AM: Clonazepam tablet 0.5 milligrams give one tablet by mouth two times a day related to Anxiety Disorder "Not available." On 11/1/2017 at 12:40 PM: Metformin HCL tablet 1000 milligrams give one tablet by mouth two times a day for Elevated Glucose "Med not available." Review of the Stat Box "First Dose" contents list from the current Pharmacy revealed Metformin 500 milligrams in the supply available for administration. During the end of day debriefing on 3/29/2018, the Facility Administrator, Director of Nursing and Corporate Nurse were informed of the findings. The Director of Nursing stated the Pharmacy should ensure medications are available for administration as ordered by the physician. No further information was provided.	F 755		
F 757	Drug Regimen is Free from Unnecessary Drugs	F 757		

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F 757 SS=E	Continued From page 212 CFR(s): 483.45(d)(1)-(6) §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- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility documentation review and clinical record review, the facility staff failed to ensure one resident (Resident # 72) in a survey sample of 38 residents did not receive unnecessary medications. 1. For Resident # 72, the facility staff failed to ensure care and services were received according to physicians orders. Metformin was administered multiple times on multiple days after the physician discontinued the medication.	F 757	F 757 1. Resident #72 Physician reviewed medications and new orders were received and noted. 2. Current residents orders will be reviewed for the last 14 days to ensure orders have been noted and processed appropriately. 3. ADON/Designees will educate staff on policies and procedures related to orders management, including discontinued medications. Facility will implement a 24 hour Chart Check system to ensure all orders have been processed and entered in to PCC properly. 4. The Unit Manager/designee will conduct a weekly audit of 10 residents/week each unit for 12 weeks utilizing order recap and chart check process to ensure discontinued medications are processed appropriately and result of audits will be brought to QAPI.	

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F 757	Continued From page 213 Findings included: Resident # 72, a female, was admitted to the facility 11/2/2015. Her diagnoses included but were not limited to Diverticulitis of both small and large intestines with perforation and abscess, insomnia, neuropathy, Gastroparesis, Anxiety Disorder, Major Depressive Disorder, Multiple Sclerosis, Hypertension and weakness. Resident # 72's most recent MDS with an ARD of 2/21/2018 was coded as a quarterly assessment. Resident # 72's cognitive status (her ability to make every day life decisions and memory ability) was not coded. Dashes were entered in the areas of Section C 100 "Should Brief Interview for Mental Status" through C 1000" Cognitive Skill for Daily Decision Making." Resident # 72 was coded as needing supervision assistance of one staff member to perform her activities of daily living. Resident # 72 was coded as being able to hear, speak, understand, and be understood. On 3/28/2018 at 1:47 PM, Resident # 72 requested to talk with the surveyors about some things she had "experienced living at the facility for the past 3 years." On 3/28/2018 at 1:50 PM, Resident # 72 came to the conference room with all of the surveyors. Resident # 72 stated she had deemed herself as the advocate for others. Resident # 72 stated she was happy to see things beginning to improve at the facility since new management was in place over the past few months. However, she was concerned that the nurses passing medications often had to be interrupted to take care of residents who wander or need other assistance. Resident # 72 stated she was "afraid" to take her	F 757		

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F 757	Continued From page 214 medicine several times because the nurses were interrupted so often. Resident # 72 stated she often inquired about the medications presented to her because she was unsure if what was being given by the nurses was correct. Resident # 72 also stated she often had to wait for pain medication because the nurses were busy doing paperwork. She stated the nurses should be able to focus on their jobs and the residents. She stated the nurses often have too much to do that could be assigned to someone else. She stated that" Unit Secretaries should do more paperwork which would allow the nurses to give pain medications when requested by residents and do other things for the residents." On 3/28/2018 at 2:25 PM, Review of the clinical record was conducted. Review of the Progress Notes revealed documentation of problems with medication orders and administration. On 2/12/2018 at 12:44 eMAR (electronic Medication Administration Note): Metformin 1000 milligrams give one tablet by mouth two times a day for elevated glucose "resident refused." On 2/13/2018 at 4:59 PM electronic Medication Administration Note: Metformin 1000 milligrams give one tablet by mouth two times a day for elevated glucose "Resident states she does not take this medication anymore." On 2/14/2018 at 12:34 electronic Medication Administration Note: Metformin 1000 milligrams give one tablet by mouth two times a day for elevated glucose "resident refused."	F 757		

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F 757	Continued From page 215 Review of Physicians Orders Summary Sheet with order status: active, completed, discontinued revealed no documentation of Metformin orders. Review of the March 2018 Medication Administration Record revealed Resident # 72 refused Metformin 1000 milligrams by mouth 18 times during the month. The medication was scheduled to be administered at 9 AM and 5 PM each day. The medication was documented as administered by facility staff 36 times during the month. There was no documentation of Metformin 1000 milligrams by mouth two times a day being discontinued. There was no noted documentation of the facility staff notifying the doctor that Resident # 72 was refusing to take Metformin until 3/9.2018. The Nurses Note dated 3/9/2018 at 18:59 (6:59 PM) stated "Dr._____ in facility Informed him of Residents refusal to take medication Metformin. NO (New Order) received. Resident is her own RP (Responsible Party) made aware of NO (new order). The new order was not written in the Nurses Note. Further review of the Nurses Notes revealed Resident # 72 refused to take Metformin 11 times at 9 AM and two times at 5 PM after 3/9/2018. Documentation revealed Metformin was administered 7 times at 9 AM and 16 times at 5 PM after 3/9/2018. On 3/17/2018 at 5 PM, the documentation on the MAR listed a code of "9" instructing to see the Nurses Note. The Nurses Note dated 3/17/2018 at 5:19 PM stated Metformin 1000 milligrams by mouth two times a day for elevated glucose "Medication has been discontinued." The MAR	F 757		

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F 757	Continued From page 216 did not reflect that the Metformin had been discontinued. Resident # 72 continued to refuse the Metformin at times but was administered the medication at other times throughout the rest of the month. Review of the Order Summary Report Printed on 3/29/2018 at 9:19 AM for "Order Status: Active, Completed, Discontinued Order date range 9/28/2017-3/28/2018" revealed no documentation of any orders for Metformin listed in the list of medications. Review of the Facility policy on Medication Administration effective 8/3/2010 and Revised 12/14/2017 on Page 1 of 7 stated "Administer Medications only as prescribed by the provider" On page 2 of 7 was written: " f. Observe the "five rights of" in giving each medication: i. the right resident ii. the right time iii. the right medicine iv. the right dose v. the right route..... j. Full attention should be given during preparation of medications. i. Avoiding distractions is important for infection prevention and reducing errors." The facility cited Lippincott as the resource used for professional nursing standards. Guidance was given from Lippincott, Fundamentals of Nursing, which reads: "To prevent medication errors, follow the six rights of medication administration consistently every time you administer medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to these rights:	F 757		

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F 757	Continued From page 217 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation" On 3/29/2018 at 8:40 AM, an interview was conducted with the Director of Nursing who stated medications should be administered as ordered by the physician and clarified if there were questions. The Director of Nursing stated the nurses should follow the five rights of medication administration at all times and verify the correct medication is being given. The Director of Nursing stated the nurses should not be interrupted repeatedly while giving medications so they can focus. The Director of Nursing stated the residents should feel confident that they are receiving the correct medications. No further information was provided.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758	F 758 1. Resident #85's Physician's ordered Ativan was reviewed and new orders were received and noted. 2.) Current residents with PRN Psychotropic Medications will be reviewed and referred to the MD as indicated per requirements. 3. Regional Director of Clinical Operations will educate DON, Licensed Nurses, Attending Physician, and Psych Nurse Practitioner on the requirements related to PRN psychotropic medications.	

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F 758	Continued From page 218 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review the facility staff failed to ensure 1 resident (Resident #85) of 38 residents in the survey sample were free from unnecessary psychotropic medications.	F 758	The DON/designee will review residents on PRN psychotropic drugs weekly and refer to MD as indicated. Residents will be presented at P&T for discussion of GRD and/or discontinuation of medications. 4.) The Pharmacy Consultant will review prn psychotropic medications monthly x 12 weeks and results will be brought to QAPI.	

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F 758	Continued From page 219 Resident #85 had an order dated 2/9/18 for Ativan PRN (as needed). This PRN medication is a psychotropic medication and requires a new order every 14 days. The findings included: Resident #85, a 56 year old, was admitted to the facility on 7/19/17. Diagnoses included major depression, attention-deficit hyperactivity disorder, stroke, traumatic brain injury, hyperlipidemia, reflux, pain, and convulsions. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 11/1/17. Resident #85 was coded with a Brief Interview of Mental Status score of 9 indicating moderate cognitive impairment and required limited assistance with activities of daily living. Resident #85's physician orders were requested. Included was the order Ativan 1 milligram (mg) tablet, Give 1 mg by mouth every 8 hours as needed for agitation twice a day. Regulation stipulates that psychotropic mediations prescribed on a PRN (as needed) basis must be re-ordered every 14 days after the physician evaluates the resident.	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced	F 760	F760 1.) Resident #87, and #32's Physician was notified of medications not given as ordered. Resident #37's Physician was notified that Keppra was crushed and administered inappropriately. New orders were received for Liquid form of medication.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 760	Continued From page 220 by: Based on staff interview, facility documentation review, clinical record review, the facility staff failed to ensure 3 residents (Resident #87, #32 and #37) in a survey sample of 38 residents were free of significant medication errors. 1. For Resident # 87, the Facility staff failed to ensure medications were available for administration as ordered by the physician. Antibiotics were unavailable on several occasions. 2. For Resident # 32, the facility staff failed to provide medications as ordered by the physician. The medications which included antibiotics, aerosol for Bronchitis and eye drops for Glaucoma were listed as medication unavailable. 3. For Resident #37, the facility staff crushed Keppra, a medication that should not be crushed. Findings included: 1. For Resident # 87, the Facility staff failed to ensure medications were available for administration as ordered by the physician. Antibiotics were unavailable on several occasions. Resident # 87 was admitted to the facility on 12/132017 and readmitted on 2/16/2018 with diagnoses of but not limited to: Hypertension, convulsions, Major Depressive Disorder, Congestive Heart Failure (CHF), Dysphagia, Gastrostomy, Metabolic Encephalopathy, muscle weakness, Chronic Obstructive Pulmonary Disease (COPD), Cutaneous Abscess of Buttock, Hidradenitis Suppurativa.	F 760	2.) EMAR notes will be reviewed for the last 14 days any identified concerns related to Medication Availability will be addressed as indicated. Current residents receiving Keppra will be reviewed to ensure medication is being administered proper form. Any identified concerns will be addressed as indicated. 3.) Licensed nurses will be educated on the medication administration guidelines, pharmacy ordering, and identification of no crush medications. Licensed Nurses will complete Medication Administration Competencies. Unit Manager/Designee will review EMAR notes and Order recap summary daily to ensure medications are available as ordered and are ordered in proper form.	

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F 760	Continued From page 221 Resident # 87's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 1/30/2018. The MDS coded Resident # 87 with a Brief Interview for Mental Status (BIMS) score not assessed. Resident # 87 required extensive assistance of one to two staff members with activities of daily living and always incontinent of bowel and bladder. Resident was admitted to the hospital on 2/14/2018 and discharged on 2/16/2018. Review of the Hospital Discharge Summary revealed final diagnosis of infected decubitus ulcer, Urinary tract infection, hypertension, COPD, CHF, history of seizures, depression and history of Hidradenitis around the pelvis area sacral ulcer." On Page 3 of 4 under Hospital Course was documented "...patient have some pus drainage and blood drainage from these decubitus ulcers seen by the surgeon and plan to do the debridement but patient refused. Patient discharged back to nursing home on IV antibiotic. discuss with the patient and patient daughter this morning and if in case ulcer worse she will come back to the hospital for debridement. Also discussed about patient and going to sepsis with worsening sacral wound." Review of the March 2018 Medication Administration Record (MAR) revealed documentation eight missing doses of intravenous antibiotics. Missing doses were 3/2/2018 at 2 PM and 10 PM, 3/3/2018 at 6 AM and 2 PM, 3/5/2018 at 10 PM, 3/9/2018 at 10 PM, 3/10/2018 at 6 AM and 2 PM. Review of the nurses notes revealed	F 760	4.) DON/Designee will review 5 residents each unit per week x 12 weeks to ensure that Medications are available as prescribed. ADON/Designee will complete 3 medication administration observations for 3 Nurses per week for 12 weeks to ensure medication administration practices are compliant. Results will be brought to QAPI.	

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F 760	Continued From page 222 documentation: 3/2/2018 at 5:43 PM of medication Piperacillin-Tazobactam in Dex Solution 3-0.375 grams per 50 milliliters give 3.375 grams intravenously every 8 hours for ABSCESS for 6 weeks. Notified Pharmacy. Stated they will send ABT (Antibiotic) to facility on next run. Notified MD (medical doctor). Stated to hold until arrival of medication. 3/3/2018 at 2:28 PM nurses note stated the IV (intravenous) antibiotics remain on hold. 3/5/2018 5:10 PM-Awaiting Pharmacy to send resident's IV ABT Tx. Notified provider stated to hold medication until arrive from pharmacy. 3/5/2018 at 5:16 PM eMAR (electronic medication administration record) Medication Administration Note: "Piperacillin-Tazobactam in Dex Solution 3-0.375 grams per 50 milliliters give 3.375 grams intravenously every 8 hours for ABSCESS for 6 weeks. Awaiting arrival from pharmacy. See nurse note." 3/5/2018 7:28 PM IV Antibiotic on hold per doctor... 3/9/2018 10:07 PM eMAR (electronic medication administration record) Medication Administration Note: "Piperacillin-Tazobactam in Dex Solution 3-0.375 grams per 50 milliliters give 3.375 grams intravenously every 8 hours for ABSCESS for 6 weeks. Awaiting refill from pharmacy. Coming on run" 3/9/2018 10:16 PM Nurse Note: Doctor_____ aware of 2200 (10 PM) dose of ABT not available.	F 760		

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F 760	Continued From page 223 3/10/2018 7:01 AM eMAR (electronic medication administration record) Medication Administration Note: "Piperacillin-Tazobactam in Dex Solution 3-0.375 grams per 50 milliliters give 3.375 grams intravenously every 8 hours for ABSCESS for 6 weeks. Awaiting on order from pharmacy." 3/10/2018 3:04 PM eMAR (electronic medication administration record) Medication Administration Note: "Piperacillin-Tazobactam in Dex Solution 3-0.375 grams per 50 milliliters give 3.375 grams intravenously every 8 hours for ABSCESS for 6 weeks. Awaiting arrival from pharmacy." 3/10/2018 4:05 PM Resident remains on IV ABT r/t (related to)abscess to buttocks. Resident currently out of ABT Tx (treatment). Awaiting arrival from pharmacy. MD aware. Will resume ABT when they arrive from pharmacy. 3/10/2018 10:43 PM Nurses Note: Call was placed to Pharmacy to check status of delivery of IV ABT Zosyn. Pharmacy tech stated that Zosyn was delivered by Pharmacy to the wrong Facility and that it should be arriving shortly. Zosyn has not arrived as of 1045 (8:45 PM). MD is aware.." On 3/23/2018 at 2:40 PM, an interview was conducted with the Director of Nursing (DON) who stated the facility had experienced difficulty with a previous Pharmacy and had recently changed to a different Pharmacy. The DON stated the new pharmacy was located in Maryland and made three regular runs to the facility each day. The DON stated the expectation was that medications should be available for administration as ordered by the physician. The DON stated the course of antibiotics should be administered without	F 760		

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F 760	Continued From page 224 interruption. Review of the Facility policy on Medication Administration effective 8/3/2010 and Revised 12/14/2017 on Page 1 of 7 stated "Administer Medications only as prescribed by the provider" Interview with the Pharmacist who stated their pharmacy started with the facility on 3/1/2018. The Pharmacist stated the process for antibiotics was to dispense antibiotics for a short duration all at one time. However, if the antibiotic was cost prohibitive or any potential problem with payment or if the course of therapy might be expected to change, the Pharmacy would refill the antibiotic every 3 days. The Pharmacist stated the process for intravenous medications was handled a little differently. Intravenous medications needed to be dispensed more often because once the medication was reconstituted, it would need to be administered within a shorter period of time. The Pharmacist stated for Intravenous medications with a longer course of therapy, reorder sheets were utilized and would be automatically refilled based on the number of doses needed and as long as the order was current. No further information was provided. 2. For Resident # 32, the facility staff failed to provide medications as ordered by the physician. The medications which included antibiotics, aerosol for Bronchitis and eye drops for Glaucoma were listed as medication unavailable. Resident # 32 was a 75 year old male admitted to the facility on 6/21/2012 and readmitted on 11/3/2017 and 3/9/2018 with the diagnoses of, but not limited to,Peripheral Vascular Disease,	F 760		

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F 760	Continued From page 225 Neuromuscular Dysfunction of the bladder, Gastroesophageal Reflux Disease, Chronic Kidney Disease, Dysphagia, Atherosclerosis of native arteries of extremities with Gangrene Bilateral Legs, Amputation of toes, Hypothyroidism, Glaucoma, Chronic Viral Hepatitis, Paraplegia, BPH (Benign Prostatic Hypertrophy) and Dementia Resident #32's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 1/30/2018. The MDS coded Resident # 32 with a Brief Interview for Mental Status (BIMS) score of 6 out of 15 indicating severe cognitive impairment. Resident # 32 required extensive assistance of one to two staff members with activities of daily living except required total assistance of one staff person for bathing and always incontinent of bowel and Resident # 32 was coded to have an indwelling urinary catheter. Resident currently on Hospice. Review of the clinical record was conducted on 3/21/2018 at 2:30 PM. Review of the Progress Notes revealed documentation of an eMar (electronic Medication Administration Note) on 3/10/2018 at 3:25 PM which stated Metoprolol Tartrate tablet 25 milligrams give 2 tablet by mouth every 12 hours related to Essential Hypertension (110) hold for HR <60 (heart rate less than 60) "Awaiting arrival from pharmacy." Further review of the Progress Notes revealed other documentation of medications not available from the pharmacy.	F 760		

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F 760	Continued From page 226 On 11/4/2017 at 4:27 PM eMar (electronic Medication Administration Note) Dulera Aerosol 200-5 micrograms per activation 2 puffs inhale orally two times a day for Bronchitis. "Med not available." On 11/4/2017 at 4:30 PM eMar (electronic Medication Administration Note) Dorzolamide HCL (Hydrochloride) Solution 2 % instill one drop in both eyes two times a day related to other specified Glaucoma:" Med not available" On 11/4/2017 at 4:30 PM eMar (electronic Medication Administration Note) Timoptic Solution 0.5 % Instill one drop in right eye one time a day related to other specified Glaucoma. "Med not available." On 11/4/2017 at 10:10 PM eMar (electronic Medication Administration Note) Zosyn Solution Reconstituted 3.375 grams Use 3.375 milligrams intravenously every 12 hours for MRSA (Methicillin Resistant Staphylococcus Aureus) in wound for 14 days. "Med has not been delivered" On 11/5/2017 at 7:45 AM eMar (electronic Medication Administration Note) LevoFloxacin in D5W Solution 500 milligrams intravenously every 24 hours for MRSA in wound for 14 days "awaiting on pharm" On 3/22/2018 at 9 AM, an interview was conducted with LPN (Licensed Practical Nurse) B who stated the staff should notify the Pharmacy when medications are not available. On 3/22/2018 at 2 PM, an interview was conducted with the Director of Nursing who stated the Pharmacy should have medications available	F 760		

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F 760	Continued From page 227 for administration as per Physicians Orders. The Director of Nursing also stated the facility staff should check the "First Dose" medications to see if the missing medication is available in that supply. Review of the STAT box "First Dose" contents list revealed the Medication, Lopressor (Generic Name-Metoprolol Tartrate) 25 milligrams was available to the staff. During the end of day debriefing on 3/23/2018, the Facility Administrator, Director of Nursing and Corporate Nurse were informed of the findings. The Director of Nursing stated the Pharmacy should ensure medications were available for administration as ordered by the physician. No further information was provided. 3. For Resident #37, the facility staff crushed Keppra, a medication that should not be crushed. Resident #37, a 79 year old, was admitted to the facility on 7/14/15. Diagnoses included hyperlipidemia, hypertension, cerebrovascular disease, hemiplegia and convulsions. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 1/18/18. Resident #37 was coded with a Brief Interview of Mental status score of 6 indicating severe cognitive impairment. He required extensive assistance with activities of daily living. A medication pour and pass observation was conducted on 3/22/18 at 8:45 a.m. with Licensed Practical Nurse C (LPN C). LPN C prepared	F 760		

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F 760	Continued From page 228 seven pills total. Included was a Keppra 500 milligram tablet. LPN C crushed all seven pills and administered them to Resident #37 in applesauce. On 3/22/18 at 11:00 a.m., LPN C was asked if she had a medication reference book on the medication cart. She stated that she had access to medication information on the computer through the pharmacy link. She stated that she was too busy to access the link at the time. At the end of day meeting on 3/22/18, the facility administration was asked to provide the medication information for Keppra that was available to the nurses through the pharmacy link. Documentation was provided. The section titled "Oral Solid Formulations" read "Swallow whole, do not chew or crush." Resident #37 had an order dated 3/1/18 for Keppra 500 milligram tablet, give 1 tablet by mouth two times a day for convulsions. On 3/23/18 at the end of day meeting, the Administrator and Director of Nursing were notified that Resident #37's Keppra had been crushed resulting in a significant medication error.	F 760		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812	F 812 1. No residents were identified for this concern. 2.) The air flow gap on the ice machine was fixed immediately by Maintenance Director cutting a 2 inch space on the pipe. The dietary staff was immediately educated on properly filling out the temperature logs for each meal by Regional Director of HCSG.	

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F 812	Continued From page 229 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff Interview and facility documentation review, the facility staff failed to prepare and serve food in a safe and sanitary manner. The facility staff failed to measure food temperatures. And; The facility staff failed to ensure the ice machine plumbing had an air gap to prevent the backflow of contaminated water. The Findings included: On 3/20/18 at approximately 11:50 A.M., a tour of kitchen was conducted. The temperature logs were reviewed. No temperatures had been taken of the breakfast meal. An interview with the Dietary Manager (Employee B) was conducted. When asked why the temperatures had not been obtained, she stated, "The breakfast temps are supposed to be on the same sheet as the one for the lunch and dinner meal. The breakfast temperatures are not	F 812	3.) The District Director of HCSG / Designee has educated all staff on properly documenting temperatures of food for each meal. The Regional Director of Operations educated the Maintenance Director, Administrator, and Dietary Manager on the standards of having the air gap for sanitation purposes. 4.) Dietary Director /Designee to monitor food temperature logs for completion 2x per day 7 days per week for 6 weeks with results brought to QAPI to ensure compliance. The maintenance Director will conduct a weekly audit for 12 weeks to ensure air gap is properly working with results brought to QAPI x 3 months.	

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F 812	Continued From page 230	F 812		

documented. We want to make sure food is at the appropriate temperature. The staff didn't do it. You want to make sure that food doesn't grow bacteria on it because bacteria can cause you to catch illness that makes the resident sick. This morning we served eggs, bacon, grits, biscuits, oatmeal, cold cereal, apple juice, coffee , milk."

On 03/20/18 at 12:30 P.M., a second observation of the kitchen was conducted. The lunch temperatures had been taken.

On 3/20/18 a review was conducted of facility documentation. According to the Food Temperature Logs, both breakfast and lunch temperatures were missing for the following Dates:

December 2017
12/3, 12/18, 12/20, 12/22, 12/23, 12/25, 12/26, 12/30

January 2018
1/2, 1/3, 1/6, 1/8, 1/11, 1/13, 1/14, 1/16, 1/19, 1/20, 1/22, 1/24, 1/28, 1/29

February 2018
2/1, 2/7, 2/8, 2/10, 2/14, 2/16, 2/21, 2/23, 2/24, 2/25

March 2018
3/4, 3/8, 3/10, 3/14, 3/15, 3/16, 3/17, 3/19

On 03/23/18 at 9:44 A.M., an observation of the facility ice machine was conducted. The ice machine drain pipe did not have an air gap. The pipe had a plastic cover on it. When the cover was removed the pipe was extended 3 inches down into the drain in the floor.

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F 812	Continued From page 231 On 3/23/18 at 10:00 A.M., an interview was conducted with the Manager of Maintenance (Employee E). When asked why the pipe did not have an air gap, he stated, "Cups were falling into the hole. I had to unblock the hole a lot. I put on a plastic trap cover. The purpose of an air gap is to free flow. All I can do is cut the pipe and give it a 2 inch space between the pipe and the drain hole." On 3/23/18 at approximately 4:00 P.M., the facility Administrator (Administration A) was informed of the findings. She stated that the pipe had been shortened to allow for a 2 inch air gap.	F 812		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, facility documentation review, and clinical record review, the facility staff failed to ensure it's resources were used effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility failed to effectively use it's budget, staff, supplies, and other services necessary, to provide for the needs of the residents.	F 835	F 835 1. Adverse Events for identified residents #13, #9, #72, #364 have been reviewed and facility has implemented interventions to prevent re-occurrence. 2. QAPI committee will meet 4/18/2018 to review current facility quality and safety problems and will set action priorities, define goals, and develop plans.	

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F 835	Continued From page 232 The findings included; On 12-31-17 Resident #13 was burned with hot liquids. On 3-7-18, Resident #9 had been burned with hot liquids as well. Resident #9's care plan had not been updated to include interventions to prevent further burns. The hot liquid evaluation, conducted before survey, recommended using lids on hot liquids. This intervention had not been completed, nor had the care plan for Resident #9 been updated with the new interventions to prevent burns. This omissions lead to immediate jeopardy identification in the facility, with two residents receiving burns. Since the facility staff themselves knew of the burn hazard, and conducted the hot liquids evaluation, they were aware of the hazard, and did nothing to prevent reoccurrence for this Resident or others. After two Residents were burned in the facility, the facility continued to fail to have a plan of correction instituted, and failed to discuss the hazard in risk or QAPI meetings, as of the time of survey on 3-20-18, resulting in Immediate Jeopardy. On 3-26-18, 3-27-18, and 3-28-18, the facility Administrator, Director of nursing (DON) and Corporate Regional Registered Nurses were told of issues concerning resident protected health information (PHI). Clinical records were commingled and in other resident charts. These PHI records remained in the wrong charts for the entire survey, and were never correctly filed in the correct charts. The facility was made aware of the deficient practice for days, and they did not correct the issue.	F 835	3. Regional Director of Clinical Operations will educate Medical Director Executive Director, Director of Nursing and IDT on the policy, procedures, and regulatory requirements related to QAPI, including identifications of quality and safety concerns, tracking, investigation, root cause analysis, monitoring adverse events, and referral to corporate risk management as indicated. 4. Regional Director of Clinical Operations will review QAPI report each month x3 months to ensure compliance with QAPI policies and procedures.	

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F 835	Continued From page 233 The Administrator and DON were interviewed by surveyors in the conference room about staff education and competencies. The Administrator and DON stated that the education was being conducted by them during the 30 minute time frame at shift change when each 8 hour shift overlapped. The overlap occurred when one group came in to work, while another prepared to leave. During this shift change, the oncoming staff was receiving report on important resident information, that occurred on the previous shift, from the outgoing staff. Staff was also getting the next medication pour and pass prepared, and other responsibilities were being prepared. The Administrator and DON stated that the education appeared to not have been retained, and stated "we are going to have to change that, because I see it is not working." They were asked when general staff are educated about QAPI plans, and she responded that "general staff education is completed at our daily huddles, during shift change, but staff still have to answer call bells and assist residents if needed at that time, and so they are really interrupted." An interview was conducted on 3/28/2018 at 1:50 PM with Resident # 72. The Resident was cognitively intact and came to the conference room with all of the surveyors. Resident # 72 stated she was happy to see things beginning to improve at the facility since new management was in place over the past few months. However, she was concerned that the nurses passing medications often had to be interrupted to take care of residents who wander or need other assistance. Resident # 72 stated she was "afraid" to take her medicine several times because the	F 835		

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F 835	Continued From page 234 nurses were interrupted so often. Resident # 72 stated she often inquired about the medications presented to her because she was unsure if what was being given by the nurses was correct. Resident # 72 also stated she often had to wait for pain medication because the nurses were busy doing paperwork. She stated the nurses should be able to focus on their jobs and the residents. She stated the nurses often have too much to do that could be assigned to someone else. She stated that" Unit Secretaries should do more paperwork which would allow the nurses to give pain medications when requested by residents and do other things for the residents." The Resident was asked why she was not in the group council meeting with surveyors, and she stated that the staff never told her one was being conducted, and when she found out that she was not invited, that is when she sought out surveyors for help. Delayed medication administration for an infection involving Resident (#364), was observed by surveyors where staff failure to be able to provide needed care and services was known by staff. Resident #364, was ordered by the physician to be administered an Intravenous (IV) antibiotic for pneumonia through a PICC (peripherally inserted Central Line Catheter) at 09:40 a.m., on 3-26-18. At 4:00 p.m. that same day, the antibiotic had not been administered, and the PICC line had not been inserted. During observation, and interview with the unit 2 nursing manager (RN A) at 4:00 p.m., it was discovered that the orders received that morning for Resident #364 had not yet been "Taken off". This describes the act of applying the order to the MAR (Medication Administration Record)	F 835		

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F 835	Continued From page 235 document where nurses are instructed to administer the medication, and further the medication is ordered from the pharmacy for administration. When RN A was asked if the doctor was aware that the order had not been acted upon, RN A responded "no". RN A stated she was busy passing medications, doing treatments, and helping the CNA's (certified nursing assistants) give care to the Residents, and that they had no extra staff to take off orders, and there just wasn't enough staff to take care of everything. RN A went on to say she had to call a company which inserts PICC lines so that the medication could be administered, because the facility could not insert the line. This revealed that the PICC line may not be inserted for another day, and would further impede the antibiotic administration. RN A stated she would take care of the order at 4:00 p.m. Per facility documentation (Vascular Wellness Insertion Record) PICC line was not inserted for Resident #364 until 8:00 pm on 3-27-18, 36 hours after the order was received, and according to facility MAR (medication administration record), the first dose of antibiotic was not given until 4 hours after the IV access was obtained at Midnight on 3-27-18. During the second week of survey, 3-26-18 through 3-29-18, lists from the Administration were requested 3 times by surveyors to indicate all residents with wounds, and then all residents with pressure sores. The result was the same each time. Resident #364 was omitted from the lists. When this was reported to the DON and	F 835		

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F 835	Continued From page 236 Admin they asked "does he have a pressure sore?" Indicating they were unaware that one of the Residents in their facility (who was admitted with no wounds), had developed one in the facility, in less than 10 days from admission. Since this is a quality measure standard for the facility's QAPI program, the administration should have been aware of all pressure wounds and their treatments in the facility. The QAPI program, and responsibilities of the medical director were reviewed with administration on 3-29-18 at 10:00 a.m.. The Administration stated facility corporate offices manage the QAPI program for all of it's facilities. This revealed that QAPI topics and goals are decided at the corporate level by reviewing quality measure reports from the MDS (minimum data set) data bank at CMS (Centers for Medicare and Medicaid Services). The facility then receives the goals and collects data in the facility to send to the corporate office for root cause analysis, and performance improvement plan. This pattern removes the facility from the actual quality improvement in their own facility, and leaves it to a corporate office who is not involved on a daily basis with this resident population. Examples continue below how lack of involvement contributed to the deficient practice. The Corporate office gives topics on which to base QAPI improvements, which is not decided at the facility level. The corporate office did the facility-wide assessment, and delivered it to the facility. None of the Administration there during survey was involved in the development of the assessment as stated by the Administrator, "We are all newly hired since October 2017", and the Administrator received it in October 2017, and	F 835		

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F 835	Continued From page 237 reviewed it within the monthly QAPI meeting held in the facility on December 2017. Quarterly QAPI meetings are held at a regional corporate level according to policy. The facility assessment revealed 24 individuals from October 2016 to Sept 2017 had physical behaviors directed at others. This area should have been actively planned as a hazard in the QAPI program, however, it was not, and an individual was found during survey to have continued to assault other residents without administration intervention. The facility assessment documented under the heading "Resident behavior risked injury to others" answer "No" which was found to be incorrect during survey, however, the corporate office did not know that, and the facility was not involved in the assessment. The facility - wide assessment numbers came from the MDS and quality indicators sent into CMS, which was also found during survey to be incorrect, as individual Resident MDS information was found during survey to be inaccurate. The corporate body would not have known the MDS information was incorrect, as they are not involved in the daily operations of the facility and do not know the resident population. The facility assessment list of competencies required for staff, lists the competencies required to provide competent care and services revealing that the facility staff should have known what types of care and services the Resident population required, however, did not receive, as was evidenced in the deficient practices involving prevention of abuse and neglect, Identifying pressure sores, and identifying hazards and risks	F 835		

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F 835	Continued From page 238 for Residents. Part 3 of the facility assessment describes staffing as; based on the resident populations needs for care and support, and residents receive the minimum direct care staff to meet the needs of the residents at any given time. The document does not state numbers of nursing or direct care staff, stating residents needs and abilities are reviewed to ensure adequate staffing, no qualitative or quantifiable information is given. In the facility- wide- assessment, at area #3, and it's subset areas, the information was vague and not measurable in goal setting. Area 3.6 "Medical practitioners" states; The medical staff meets with the facility staff on a weekly basis at "Risk Meeting" and "QA" (quality assessment) meeting monthly to ensure all residents needs are met." The Administrator and DON were asked for any plans of corrections that had been previously written for the areas identified during survey involving harm and immediate Jeopardy to the Resident population. They stated there were none. A "QAPI plan" policy, and a "Medical Director" policy, were reviewed. The two policies revealed they were not followed. In regard to the "QAPI plan" policy, see below, the following letters (a.), through (h.); 1. (a.) "QAPI Plan" with an initial "effective" date of 10-1-17. The document stated that QAPI data is used to identify quality and safety problems, and to identify opportunities for improvement, while setting priorities for action.	F 835		

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F 835	Continued From page 239 (b.) QAPI identifies needs, identifies root causes, and sets goals to change and eliminate problems. The program uses evidence to define and measure goals and develop plans. (c.) The QAPI committee will identify QA and performance improvement needs at; daily and weekly interdisciplinary meetings, and at the QAPI monthly meeting at the facility. (d.) A quarterly QAPI meeting will be held at the regional corporate level. All staff will receive training upon hire and annually on how to bring a concern to QAPI. (e.) The facility will track, investigate, and monitor adverse events that must be investigated every time they occur and action plans will be implemented to prevent a recurrence. (f.) The facility leadership will respond to identified quality and safety concerns by using a performance improvement plan document, developed by the QAPI committee. (g.) "Development of a performance improvement plan; before starting a plan, the solution cannot be arrived at unless the problem has been thoroughly explored. Many identified problems are systematic and involve multiple departments and processes." First perform a root cause analysis, after identifying the problem, plan for how improvement will be measured, carry out the plan, study what you have learned and then decide what to do next. (h.) "Charter teams (at the corporate level) analyze the root cause, identify priorities, identify if resources exist or are available for the plan,	F 835		

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F 835	Continued From page 240 develop the plan, and deliver it to the facility for initiation, they then conduct ongoing review of progress and maintenance after compliance is achieved." Quality and safety concerns were not identified, investigated, nor tracked. No root cause analysis nor action plan was developed, or sent to the corporate level for "Charter team" review. No interventions were implemented in the facility to prevent reoccurrence of; Development of harm level pressure sores, burn hazards, or Resident abuse. In regard to the "Medical Director" policy see below; 2. The second policy was for the Medical Director job description, and "Roles/Responsibilities" which had no effective date, no review date, and no revision date. The document listed 12 policies that the medical director had oversight, and direction for. The document revealed; Under the heading "Procedure": I. "Duties of the Medical Director in the facility" Active member of the QAPI committee, and attend meetings at least quarterly, assist the QAPI committee in reviewing and updating existing resident care policies, and the development and implementation of new resident care policies. The Medical Director shall work with the facility to coordinate safe and effective care that may at times, include facility staff." II. "Oversight and direction for facility policies will	F 835		

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F 835	Continued From page 241 include, but are not limited to: 1. Admission, transfers, and discharges 2. Infection control, and infection prevention 3. Physical and chemical restraint usage 4. Physician privileges and practices 5. Responsibilities of non-physician health care workers 6. Accidents and incidents 7. Ancillary services 8. Medication use 9. Use and release of clinical information 10. Overall quality of care 11. Ensure appropriate resident care provision through direct oversight and supervision of physician services, and the medical care provided to each resident. 12. The medical Director shall provide peer-to-peer counseling for other physician's/providers within the facility when conflict arises. The Medical director also was required by policy to review monthly reports, which would contain data based on facility experiences of resident need, involving each of the 9 topics below. These topics included those cited as deficient on this survey at immediate Jeopardy, and harm levels. These areas which should have been captured and included in QAPI meetings, planning, tracking, investigation, and correction, were not, as evidenced above in citing deficient practice. III. Oversight and review: a. The Medical Director shall review the following reports on a monthly basis;	F 835		

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F 835	Continued From page 242 1. Quality Measure Indicator report (QMI) 2. pharmacy reviews 3. infection control 4. safety committee minutes 5. Behavior management 6. Restraint reduction 7. Address wounds concerns 8. Weight/nutrition 9. And other as requested by the QAPI committee or facility leadership. The QAPI documents were reviewed, and revealed discussions on the following topics for each of the 3 months prior to survey.; December 2017 the problem topics discussed for QAPI were - gait belts, shower schedule, unavailable medications, lab and x-ray tracking, CNA (certified nursing assistant) Kardex understanding, abuse neglect training, and CNA's reporting changes in condition leading to re-hospitalization. January 2018 the problem topics discussed for QAPI were - falls and updating interventions, identifying signs of depression, adding more restorative programs and aids, and ADL decline and referral to therapy. February 2018 the problem topics discussed for QAPI were - pain with facial scale, weights current and completed with same device, new orders and signing the MAR/TAR (medication administration record/treatment administration record) and taking off orders, peri care. and hand washing. The administrator was asked during the interview on 3-29-18 at 10:00 a.m. when general staff are	F 835		

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F 835	Continued From page 243 educated about QAPI plans, and she responded that "general staff education is completed at our daily huddles, during shift change, but staff still have to answer call bells and assist residents if needed at that time, and so they are really interrupted." On 3-29-18 at the end of day debrief, the Administrator, DON, and Corporate RN were made aware of the failure of administration to effectively use it's budget, staff, supplies, and other services necessary, to provide for the needs of the residents. No further information was presented by the facility.	F 835		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential	F 842	F 842 1. Resident #314 is not a current resident. Facility unable to acquire requested records from previous ownership Resident #32 record was reviewed and comingling was corrected and labeling was completed as indicated. Resident #315 comingled physician's orders were filed in to the chart as required was reviewed and comingling was corrected. 2.) Electronic Health Records Coordinator completed an audit of current residents' charts to ensure each resident had only their information in their record and each forms was labeled appropriately.	

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F 842	Continued From page 244 all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;	F 842	3.) The ADON/ designee educated facility staff on confidentiality and privacy of residents' records and requirements for labeling of each page in the record. 4.) The Administrator and or designees will audit 100% of resident's charts weekly for x12 weeks with results brought to QAPI to ensure compliance.	

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F 842	Continued From page 245 (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 observation, staff interview, clinical record review and in the course of a complaint investigation the facility staff failed for 3 residents (Resident #314, 32, 315) of 38 residents in the survey sample to ensure a complete and accurate clinical record. 1. For Resident #314, the clinical record did not include all wound related documentation or restorative nursing documentation. 2. For Resident # 32, the facility staff failed to ensure a complete and accurate clinical record. 3. For Resident # 315, the facility staff failed to ensure a complete and accurate clinical record. The findings included: 1. For Resident #314, the clinical record did not include all wound related documentation or restorative nursing documentation. Resident #314 was discharged from the facility on 3/31/17. In May 2017, the facility was bought by a new owner. During the time of the survey, the facility had to request Resident #314's closed medical record from the old owner. The clinical record that was provided to the survey team was incomplete. Resident #314, a 74 year old, was admitted to the facility on 1/16/17. Diagnoses included	F 842		

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F 842	Continued From page 246	F 842		

hypothyroidism, insomnia, dementia, and osteoporosis. Resident #314 was admitted to the facility for rehabilitation after a left femur fracture.

The most recent Minimum Data Set (MDS) assessment was a 14 day assessment with an assessment reference date of 2/21/17. Resident #314 was coded to have moderately impaired cognitive ability and required extensive assistance with activities of daily living. Two wounds were coded as "Unstageable-Deep Tissue Injury" in section M300 G, with one of the wounds coded as present upon admission.

Wounds:
While it was documented that the coccyx had an open area, there was no documentation that the area was staged. A "Weekly Skin Review" sheet completed 2/23/17 documented an open area that was pre-existing. The location of the wound is not documented. A description of the wound was not documented.

There was no documentation in the clinical record that described the measurements or staging of Resident #314's wounds. There was a nursing note dated 3/9/17 that documented the wound care specialist evaluated the left heel and sacral wounds. The wound care specialist's notes were not provided as part of the clinical record.

Restorative Nursing Care:
Resident #314 participated in Speech Therapy from 2/10/17-3/2/17, Occupational Therapy from 2/8/17-2/21/17, and Physical Therapy from 2/8/17- 3/2/17.

A Physician Progress Note dated 3/8/17 read "New orders written today to keep patient at

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F 842	Continued From page 247 current facility for long term restorative status that was effective 3/3/17." An order written on the "Physician's Telephone Order Log" read "change patient to long term status with restorative effective 3/3/17." There was no documentation in the clinical record that Resident #314 was provided restorative services. On 3/28/18, the Administrator was notified that the survey team was looking for restorative nursing notes in Resident #314's clinical record and were unable to locate any restorative nursing documentation. The Administrator was asked to contact the previous owner to see if they had any additional documentation. On 3/29/18, the Administrator stated there was no further restorative nursing documentation available. The Administrator and Director of Nursing were notified of the incomplete clinical record at the end of day meeting on 3/29/18. COMPLAINT DEFICIENCY 2. For Resident # 32, the facility staff failed to ensure a complete and accurate clinical record. Resident # 32 was a 75 year old male admitted to the facility on 6/21/2012 and readmitted on 11/3/2017 and 3/9/2018 with the diagnoses of, but not limited to,Peripheral Vascular Disease, Neuromuscular Dysfunction of the bladder, Gastroesophageal Reflux Disease, Chronic Kidney Disease, Dysphagia, Atherosclerosis of native arteries of extremities with Gangrene Bilateral Legs, Amputation of toes, Hypothyroidism, Glaucoma, Chronic Viral Hepatitis, Paraplegia, and Dementia	F 842		

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F 842	Continued From page 248 Resident #32's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 1/30/2018. The MDS coded Resident # 32 with a Brief Interview for Mental Status (BIMS) score of 6 out of 15 indicating severe cognitive impairment. Resident # 32 required extensive assistance of one to two staff members with activities of daily living except required total assistance of one staff person for bathing and always incontinent of bowel and Resident # 32 was coded to have an indwelling urinary catheter. Resident currently on Hospice. Review of the clinical record was conducted on 3/21/2018 at 2:30 PM. Review of Physicians Progress notes revealed four sheets of progress notes. None of the notes were labeled with the name of a resident. Further review of the clinical record revealed documents from other residents filed in Resident # 32's record. Review of the Physicians orders revealed 4 original Physicians telephone orders for another resident (Resident # 315) The orders were not signed by a physician. The other resident was placed in the survey sample as Resident # 315. Review of the electronic medical record revealed Resident # 345 was discharged from the facility on 3/9/2018. The telephone orders for Resident # 315 that were placed in the wrong chart were:	F 842		

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F 842	Continued From page 249 10/23/17 downgrade to honey thick liquids. 11/21/17 ST (Speech Therapy) recertification: Continue skilled ST services 5 x/ week x 3 days to aid in tolerance /safety of least restrictive diet. No date listed when ordered but signed on 10/11/17: Diet Modification: D/C (Discontinue) mechanical soft diet and thin liquids. Change diet to pureed solids with nectar thick liquids. Continue all dietary restrictions. No date listed when ordered but signed on 10/11/17: Clarification order ST skilled services for dysphagia 5 x/wk for 4 wks(weeks) to ensure diet safety. During the end of day debriefing on 3/23/2018, the Facility Administrator and Corporate Regional Nurse were informed of the findings. The Administrator and Director of Nursing stated the clinical record should be complete and accurate. No further information was provided. 3. For Resident # 315, the facility staff failed to ensure a complete and accurate clinical record. Resident # 315 was a 78 year old male readmitted to the facility on 2/21/2018 with the diagnoses of, but not limited to, Peripheral Vascular Disease, Neuromuscular Dysfunction of the bladder,Diabetes, cerebrovascular disease, Dementia, Dysphagia, Glaucoma, Gout, Hypertension, Cardiac Arrhythmia, Chronic Kidney Disease, Convulsions, Major Depressive Disorder and Osteoarthritis.	F 842		

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F 842	Continued From page 250 Resident # 315 expired in the facility on 3/9/2018. Resident # 315's clinical record was a closed record. Review of the closed clinical record revealed none of the telephone orders listed below. The telephone orders for Resident # 315 that were placed in the wrong chart (in Resident # 32's chart) were: 10/23/17 downgrade to honey thick liquids. 11/21/17 ST (Speech Therapy) recertification: Continue skilled ST services 5 x/ week x 3 days to aid in tolerance /safety of least restrictive diet. No date listed when ordered but signed on 10/11/17: Diet Modification: D/C (Discontinue) mechanical soft diet and thin liquids. Change diet to pureed solids with nectar thick liquids. Continue all dietary restrictions. No date listed when ordered but signed on 10/11/17: Clarification order ST skilled services for dysphagia 5 x/wk for 4 wks(weeks) to ensure diet safety. During the end of day debriefing on 3/23/2018, the Facility Administrator and Corporate Regional Nurse were informed of the findings. The Administrator and Director of Nursing stated the clinical record should be complete and accurate. No further information was provided.	F 842		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i)	F 865	F 865 1. Adverse Events for identified residents #13, #9, #72, #364 have been reviewed and facility has implemented interventions and plan of care to prevent re-occurrence.	

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F 865	Continued From page 251 §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, facility documentation review, and clinical record review, the facility staff failed to implement and maintain an effective Quality Assurance and Process Improvement (QAPI) program to identify and prioritize quality deficiencies in care areas and services for it's resident population. The facility failed to effectively implement a QAPI program necessary to provide for the needs of the residents. The findings included; On 12-31-17 Resident #13 was burned with hot liquids. Before survey, and on 3-7-18, Resident #9 had been burned with hot liquids as well. Resident #9's care plan had not been updated to	F 865	2. QAPI committee will meet 4/18/2018 to review current facility quality and safety problems and will set action priorities, define goals, and develop plans. 3. Regional Director of Clinical Operations will educate Medical Director Executive Director, Director of Nursing and IDT on the utilization of resources, policy, procedures, and regulatory requirements related to QAPI, including identifications of quality and safety concerns, tracking, investigation, root cause analysis, monitoring adverse events, and referral to corporate management as indicated. Regional Director of Clinical Operations will educate facility QAPI committee on the development of a performance improvement plan and the policy requirements for identification of QA and performance improvement needs at daily and weekly interdisciplinary meetings. Facility QAPI coordinator will educate Facility Staff on how to bring a concern to QAPI committee.	

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F 865	Continued From page 252 include interventions to prevent further burns. The hot liquid evaluation, conducted before survey, recommended using lids on hot liquids. This intervention had not been completed, nor had the care plan for Resident #9 been updated with the new interventions to prevent burns. This omissions lead to immediate jeopardy identification in the facility, with two residents receiving burns. Since the facility staff themselves knew of the burn hazard, and conducted the hot liquids evaluation, they were aware of the hazard, and did nothing to prevent reoccurrence for this Resident or others. After two Residents were burned in the facility, the facility continued to fail to have a plan of correction instituted, and failed to discuss the hazard in risk or QAPI meetings, as of the time of survey on 3-20-18, resulting in Immediate Jeopardy for the Resident population. On 3-26-18, 3-27-18, and 3-28-18, the facility Administrator, Director of nursing (DON) and Corporate Regional Registered Nurses were told of issues concerning resident protected health information (PHI). Clinical records were commingled and in other resident charts. These PHI records remained in the wrong charts for the entire survey, and were never correctly filed in the correct charts. The facility was made aware of the deficient practice for days, and they did not correct the issue. The Administrator and DON were interviewed by surveyors in the conference room about staff education and competencies. The Administrator and DON stated that the education was being conducted by them during the 30 minute time	F 865	Medical Director/designee will continue to attend QAPI meeting monthly and review Quality Measure Reports, Pharmacy Reviews, Infection Control, Safety Committee Minutes, Behavior Management, Restraint Reduction, Wound Concerns, Weight Nutrition, and other requested by QAPI committee and/or facility Leadership 4. Regional Director of Clinical Operations will review QAPI reports each month to ensure compliance with QAPI policies and procedures.	

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F 865	Continued From page 253 frame at shift change when each 8 hour shift overlapped. The overlap occurred when one group came in to work, while another prepared to leave. During this shift change, the oncoming staff was receiving report on important resident information, that occurred on the previous shift, from the outgoing staff. Staff was also getting the next medication pour and pass prepared, and other responsibilities were being prepared. The Administrator and DON stated that the education appeared to not have been retained, and stated "we are going to have to change that, because I see it is not working." They were asked when general staff are educated about QAPI plans, and she responded that "general staff education is completed at our daily huddles, during shift change, but staff still have to answer call bells and assist residents if needed at that time, and so they are really interrupted." An interview was conducted on 3/28/2018 at 1:50 PM with Resident # 72. The Resident was cognitively intact and came to the conference room with all of the surveyors. Resident # 72 stated she was happy to see things beginning to improve at the facility since new management was in place over the past few months. However, she was concerned that the nurses passing medications often had to be interrupted to take care of residents who wander or need other assistance. Resident # 72 stated she was "afraid" to take her medicine several times because the nurses were interrupted so often. Resident # 72 stated she often inquired about the medications presented to her because she was unsure if what was being given by the nurses was correct. Resident # 72 also stated she often had to wait for pain medication because the nurses were busy doing paperwork. She stated the nurses	F 865		

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F 865	Continued From page 254 should be able to focus on their jobs and the residents. She stated the nurses often have too much to do that could be assigned to someone else. She stated that" Unit Secretaries should do more paperwork which would allow the nurses to give pain medications when requested by residents and do other things for the residents." The Resident was asked why she was not in the group council meeting with surveyors, and she stated that the staff never told her one was being conducted, and when she found out that she was not invited, that is when she sought out surveyors for help. Delayed medication administration for an infection involving Resident (#364), was observed by surveyors where staff failure to be able to provide needed care and services was known by staff. Resident #364, was ordered by the physician to be administered an Intravenous (IV) antibiotic for pneumonia through a PICC (peripherally inserted Central Line Catheter) at 09:40 a.m., on 3-26-18. At 4:00 p.m. that same day, the antibiotic had not been administered, and the PICC line had not been inserted. During observation, and interview with the unit 2 nursing manager (RN A) at 4:00 p.m., it was discovered that the orders received that morning for Resident #364 had not yet been "Taken off". This describes the act of applying the order to the MAR (Medication Administration Record) document where nurses are instructed to administer the medication, and further the medication is ordered from the pharmacy for administration. When RN A was asked if the doctor was aware that the order had not been acted upon, RN A	F 865		

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F 865	Continued From page 255 responded "no". RN A stated she was busy passing medications, doing treatments, and helping the CNA's (certified nursing assistants) give care to the Residents, and that they had no extra staff to take off orders, and there just wasn't enough staff to take care of everything. RN A went on to say she had to call a company which inserts PICC lines so that the medication could be administered, because the facility could not insert the line. This revealed that the PICC line may not be inserted for another day, and would further impede the antibiotic administration. RN A stated she would take care of the order at 4:00 p.m. Per facility documentation (Vascular Wellness Insertion Record) PICC line was not inserted for Resident #364 until 8:00 pm on 3-27-18, 36 hours after the order was received, and according to facility MAR (medication administration record), the first dose of antibiotic was not given until 4 hours after the IV access was obtained at Midnight on 3-27-18, . During the second week of survey, 3-26-18 through 3-29-18, lists from the Administration were requested 3 times by surveyors to indicate all residents with wounds, and then all residents with pressure sores. The result was the same each time. Resident #364 was omitted from the lists. When this was reported to the DON and Admin they asked "does he have a pressure sore?" Indicating they were unaware that one of the Residents in their facility (who was admitted with no wounds), had developed one in the facility, in less than 10 days from admission. Since this is a quality measure standard for the facility's QAPI program, the administration should	F 865		

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F 865	Continued From page 256 have been aware of all pressure wounds and their treatments in the facility. The QAPI program, and responsibilities of the medical director were reviewed with administration on 3-29-18 at 10:00 a.m.. The Administration stated facility corporate offices manage the QAPI program for all of it's facilities. This revealed that QAPI topics and goals are decided at the corporate level by reviewing quality measure reports from the MDS (minimum data set) data bank at CMS (Centers for Medicare and Medicaid Services). The facility then receives the goals and collects data in the facility to send to the corporate office for root cause analysis, and performance improvement plan. This pattern removes the facility from the actual quality improvement in their own facility, and leaves it to a corporate office who is not involved on a daily basis with this resident population. Examples continue below how lack of involvement contributed to the deficient practice. The Corporate office gives topics on which to base QAPI improvements, which is not decided at the facility level. The corporate office did the facility-wide assessment, and delivered it to the facility. None of the Administration there during survey was involved in the development of the assessment as stated by the Administrator, "We are all newly hired since October 2017", and the Administrator received it in October 2017, and reviewed it within the monthly QAPI meeting held in the facility on December 2017. Quarterly QAPI meetings are held at a regional corporate level according to policy. The facility assessment revealed 24 individuals from October 2016 to Sept 2017 had physical	F 865		

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F 865	Continued From page 257	F 865		

behaviors directed at others. This area should have been actively planned as a hazard in the QAPI program, however, it was not, and an individual was found during survey to have continued to assault other residents without administration intervention. The facility assessment documented under the heading "Resident behavior risked injury to others" answer "No" which was found to be incorrect during survey, however, the corporate office did not know that, and the facility was not involved in the assessment.

The facility - wide assessment numbers came from the MDS and quality indicators sent into CMS, which was also found during survey to be incorrect, as individual Resident MDS information was found during survey to be inaccurate. The corporate body would not have known the MDS information was incorrect, as they are not involved in the daily operations of the facility and do not know the resident population.

The facility assessment list of competencies required for staff, lists the competencies required to provide competent care and services revealing that the facility staff should have known what types of care and services the Resident population required, however, did not receive, as was evidenced in the deficient practices involving prevention of abuse and neglect, Identifying pressure sores, and identifying hazards and risks for Residents.

Part 3 of the facility assessment describes staffing as; based on the resident populations needs for care and support, and residents receive the minimum direct care staff to meet the needs of the residents at any given time. The document

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F 865	Continued From page 258 does not state numbers of nursing or direct care staff, stating residents needs and abilities are reviewed to ensure adequate staffing, no qualitative or quantifiable information is given. In the facility- wide- assessment, at area #3, and it's subset areas, the information was vague and not measurable in goal setting. Area 3.6 "Medical practitioners" states; The medical staff meets with the facility staff on a weekly basis at "Risk Meeting" and "QA" (quality assessment) meeting monthly to ensure all residents needs are met." Survey results indicate that residents needs were not met, and if a facility weekly meeting was occurring with the Medical Director, the staff, and the Administration, the facility should have been aware of the issues found during survey, prior to survey. At the time of problem identification, QAPI (quality assurance and process improvement) is mandated to develop and enact plans of correction. If the Administration and Medical director were aware of the issues found during survey, The Administrator and Medical director instituted no changes. The Administrator and DON were asked for any plans of corrections that had been previously written for the areas identified during survey involving harm and immediate Jeopardy to the Resident population. They stated there were none. A "QAPI plan" policy, and a "Medical Director" policy, were reviewed. The two policies revealed they were not followed. In regard to the "QAPI plan" policy, see below, the following letters (a.), through (h.); 1. (a.) "QAPI Plan" with an initial "effective" date	F 865		

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F 865	Continued From page 259 of 10-1-17. The document stated that QAPI data is used to identify quality and safety problems, and to identify opportunities for improvement, while setting priorities for action. (b.) QAPI identifies needs, identifies root causes, and sets goals to change and eliminate problems. The program uses evidence to define and measure goals and develop plans. (c.) The QAPI committee will identify QA and performance improvement needs at; daily and weekly interdisciplinary meetings, and at the QAPI monthly meeting at the facility. (d.) A quarterly QAPI meeting will be held at the regional corporate level. All staff will receive training upon hire and annually on how to bring a concern to QAPI. (e.) The facility will track, investigate, and monitor adverse events that must be investigated every time they occur and action plans will be implemented to prevent a recurrence. (f.) The facility leadership will respond to identified quality and safety concerns by using a performance improvement plan document, developed by the QAPI committee. (g.) "Development of a performance improvement plan; before starting a plan, the solution cannot be arrived at unless the problem has been thoroughly explored. Many identified problems are systematic and involve multiple departments and processes." First perform a root cause analysis, after identifying the problem, plan for how improvement will be measured, carry out the plan, study what you have learned and then	F 865		

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F 865	Continued From page 260 decide what to do next. (h.) "Charter teams (at the corporate level) analyze the root cause, identify priorities, identify if resources exist or are available for the plan, develop the plan, and deliver it to the facility for initiation, they then conduct ongoing review of progress and maintenance after compliance is achieved." Quality and safety concerns were not identified, investigated, nor tracked. No root cause analysis nor action plan was developed, or sent to the corporate level for "Charter team" review. No interventions were implemented in the facility to prevent reoccurrence of; Development of harm level pressure sores, burn hazards, or Resident abuse. In regard to the "Medical Director" policy see below; 2. The second policy was for the Medical Director job description, and "Roles/Responsibilities" which had no effective date, no review date, and no revision date. The document listed 12 policies that the medical director had oversight, and direction for. Of those 12, most were found to be involved in deficient practice and federal citations were written in regard to them. The 12 policies are listed below including some, not all, references to the federal citations associated with those areas found to be involved in deficient practice. The document revealed; Under the heading "Procedure": I. "Duties of the Medical Director in the facility"	F 865		

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F 865	Continued From page 261 Active member of the QAPI committee, and attend meetings at least quarterly, assist the QAPI committee in reviewing and updating existing resident care policies, and the development and implementation of new resident care policies. The Medical Director shall work with the facility to coordinate safe and effective care that may at times, include facility staff." II. "Oversight and direction for facility policies will include, but are not limited to: 1. Admission, transfers, and discharges 2. Infection control, and infection prevention 3. Physical and chemical restraint usage 4. Physician privileges and practices 5. Responsibilities of non-physician health care workers 6. Accidents and incidents 7. Ancillary services 8. Medication use 9. Use and release of clinical information 10. Overall quality of care 11. Ensure appropriate resident care provision through direct oversight and supervision of physician services, and the medical care provided to each resident. 12. The medical Director shall provide peer-to-peer counseling for other physician's/providers within the facility when conflict arises. The Medical director also was required by policy to review monthly reports, which would contain data based on facility experiences of resident need, involving each of the 9 topics below. These topics included those cited as deficient on this survey at immediate Jeopardy, and harm levels. These areas which should have been	F 865		

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F 865	Continued From page 262 captured and included in QAPI meetings, planning, tracking, investigation, and correction, were not, as evidenced by citing the deficient practices. III. Oversight and review: a. The Medical Director shall review the following reports on a monthly basis; 1. Quality Measure Indicator report (QMI) 2. pharmacy reviews 3. infection control 4. safety committee minutes 5. Behavior management 6. Restraint reduction 7. Address wounds concerns 8. Weight/nutrition 9. And other as requested by the QAPI committee or facility leadership. The QAPI documents were reviewed, and revealed discussions on the following topics for each of the 3 months prior to survey.; December 2017 the problem topics discussed for QAPI were - gait belts, shower schedule, unavailable medications, lab and x-ray tracking, CNA (certified nursing assistant) Kardex understanding, abuse neglect training, and CNA's reporting changes in condition leading to re-hospitalization. January 2018 the problem topics discussed for QAPI were - falls and updating interventions, identifying signs of depression, adding more restorative programs and aids, and ADL decline and referral to therapy.	F 865		

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F 865	Continued From page 263 February 2018 the problem topics discussed for QAPI were - pain with facial scale, weights current and completed with same device, new orders and signing the MAR/TAR (medication administration record/treatment administration record) and taking off orders, peri care. and hand washing. On 3-29-18 at the end of day debrief, the Administrator, DON, and Corporate RN were made aware of the failure of administration to effectively implement a QAPI program, and improvements process necessary to provide for the needs of the residents. No further information was presented by the facility.	F 865		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, facility documentation review, and clinical record review, the facility staff failed to implement and maintain an effective Quality Assurance and Process Improvement (QAPI) program to identify and prioritize quality deficiencies in care areas and services for it's resident population. The facility failed to effectively implement a QAPI program necessary to provide for the needs of the residents.	F 867	F 867 1. Adverse Events for identified residents #13, #9, #72, #364 have been reviewed and facility has implemented interventions and plan of care to prevent re-occurrence. 2. QAPI committee will meet 4/18/2018 to review current facility quality and safety problems and will set action priorities, define goals, and develop plans. 3. Regional Director of Clinical Operations will educate Medical Director Executive Director, Director of Nursing and IDT on the utilization of resources, policy, procedures, and regulatory requirements related to QAPI, including identifications of quality and safety concerns, tracking, investigation, root cause analysis, monitoring adverse events, and referral to corporate management as indicated.	

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F 867	Continued From page 264 The findings included; On 12-31-17 Resident #13 was burned with hot liquids. Before survey, and on 3-7-18, Resident #9 had been burned with hot liquids as well. Resident #9's care plan had not been updated to include interventions to prevent further burns. The hot liquid evaluation, conducted before survey, recommended using lids on hot liquids. This intervention had not been completed, nor had the care plan for Resident #9 been updated with the new interventions to prevent burns. This omissions lead to immediate jeopardy identification in the facility, with two residents receiving burns. Since the facility staff themselves knew of the burn hazard, and conducted the hot liquids evaluation, they were aware of the hazard, and did nothing to prevent reoccurrence for this Resident or others. After two Residents were burned in the facility, the facility continued to fail to have a plan of correction instituted, and failed to discuss the hazard in risk or QAPI meetings, as of the time of survey on 3-20-18, resulting in Immediate Jeopardy for the Resident population. On 3-26-18, 3-27-18, and 3-28-18, the facility Administrator, Director of nursing (DON) and Corporate Regional Registered Nurses were told of issues concerning resident protected health information (PHI). Clinical records were commingled and in other resident charts. These PHI records remained in the wrong charts for the entire survey, and were never correctly filed in the correct charts. The facility was made aware of the deficient practice for days, and they did not	F 867	Regional Director of Clinical Operations will educate facility QAPI committee on the development of a performance improvement plan and the policy requirements for identification of QA and performance improvement needs at daily and weekly interdisciplinary meetings. Facility QAPI coordinator will educate Facility Staff on how to bring a concern to QAPI committee. Medical Director/designee will continue to attend QAPI meeting monthly and review Quality Measure Reports, Pharmacy Reviews, Infection Control, Safety Committee Minutes, Behavior Management, Restraint Reduction, Wound Concerns, Weight Nutrition, and other requested by QAPI committee and/or facility Leadership 4. Regional Director of Clinical Operations will review QAPI reports each month to ensure compliance with QAPI policies and procedures.	

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F 867	Continued From page 265 correct the issue. The Administrator and DON were interviewed by surveyors in the conference room about staff education and competencies. The Administrator and DON stated that the education was being conducted by them during the 30 minute time frame at shift change when each 8 hour shift overlapped. The overlap occurred when one group came in to work, while another prepared to leave. During this shift change, the oncoming staff was receiving report on important resident information, that occurred on the previous shift, from the outgoing staff. Staff was also getting the next medication pour and pass prepared, and other responsibilities were being prepared. The Administrator and DON stated that the education appeared to not have been retained, and stated "we are going to have to change that, because I see it is not working." They were asked when general staff are educated about QAPI plans, and she responded that "general staff education is completed at our daily huddles, during shift change, but staff still have to answer call bells and assist residents if needed at that time, and so they are really interrupted." An interview was conducted on 3/28/2018 at 1:50 PM with Resident # 72. The Resident was cognitively intact and came to the conference room with all of the surveyors. Resident # 72 stated she was happy to see things beginning to improve at the facility since new management was in place over the past few months. However, she was concerned that the nurses passing medications often had to be interrupted to take care of residents who wander or need other assistance. Resident # 72 stated she was "afraid" to take her medicine several times because the	F 867		

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F 867	Continued From page 266 nurses were interrupted so often. Resident # 72 stated she often inquired about the medications presented to her because she was unsure if what was being given by the nurses was correct. Resident # 72 also stated she often had to wait for pain medication because the nurses were busy doing paperwork. She stated the nurses should be able to focus on their jobs and the residents. She stated the nurses often have too much to do that could be assigned to someone else. She stated that" Unit Secretaries should do more paperwork which would allow the nurses to give pain medications when requested by residents and do other things for the residents." The Resident was asked why she was not in the group council meeting with surveyors, and she stated that the staff never told her one was being conducted, and when she found out that she was not invited, that is when she sought out surveyors for help. Delayed medication administration for an infection involving Resident (#364), was observed by surveyors where staff failure to be able to provide needed care and services was known by staff. Resident #364, was ordered by the physician to be administered an Intravenous (IV) antibiotic for pneumonia through a PICC (peripherally inserted Central Line Catheter) at 09:40 a.m., on 3-26-18. At 4:00 p.m. that same day, the antibiotic had not been administered, and the PICC line had not been inserted. During observation, and interview with the unit 2 nursing manager (RN A) at 4:00 p.m., it was discovered that the orders received that morning for Resident #364 had not yet been "Taken off". This describes the act of applying the order to the MAR (Medication Administration Record)	F 867		

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F 867	Continued From page 267 document where nurses are instructed to administer the medication, and further the medication is ordered from the pharmacy for administration. When RN A was asked if the doctor was aware that the order had not been acted upon, RN A responded "no". RN A stated she was busy passing medications, doing treatments, and helping the CNA's (certified nursing assistants) give care to the Residents, and that they had no extra staff to take off orders, and there just wasn't enough staff to take care of everything. RN A went on to say she had to call a company which inserts PICC lines so that the medication could be administered, because the facility could not insert the line. This revealed that the PICC line may not be inserted for another day, and would further impede the antibiotic administration. RN A stated she would take care of the order at 4:00 p.m. Per facility documentation (Vascular Wellness Insertion Record) PICC line was not inserted for Resident #364 until 8:00 pm on 3-27-18, 36 hours after the order was received, and according to facility MAR (medication administration record), the first dose of antibiotic was not given until 4 hours after the IV access was obtained at Midnight on 3-27-18, . During the second week of survey, 3-26-18 through 3-29-18, lists from the Administration were requested 3 times by surveyors to indicate all residents with wounds, and then all residents with pressure sores. The result was the same each time. Resident #364 was omitted from the lists. When this was reported to the DON and	F 867		

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F 867	Continued From page 268 Admin they asked "does he have a pressure sore?" Indicating they were unaware that one of the Residents in their facility (who was admitted with no wounds), had developed one in the facility, in less than 10 days from admission. Since this is a quality measure standard for the facility's QAPI program, the administration should have been aware of all pressure wounds and their treatments in the facility. The QAPI program, and responsibilities of the medical director were reviewed with administration on 3-29-18 at 10:00 a.m.. The Administration stated facility corporate offices manage the QAPI program for all of it's facilities. This revealed that QAPI topics and goals are decided at the corporate level by reviewing quality measure reports from the MDS (minimum data set) data bank at CMS (Centers for Medicare and Medicaid Services). The facility then receives the goals and collects data in the facility to send to the corporate office for root cause analysis, and performance improvement plan. This pattern removes the facility from the actual quality improvement in their own facility, and leaves it to a corporate office who is not involved on a daily basis with this resident population. Examples continue below how lack of involvement contributed to the deficient practice. The Corporate office gives topics on which to base QAPI improvements, which is not decided at the facility level. The corporate office did the facility-wide assessment, and delivered it to the facility. None of the Administration there during survey was involved in the development of the assessment as stated by the Administrator, "We are all newly hired since October 2017", and the Administrator received it in October 2017, and	F 867		

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F 867	Continued From page 269 reviewed it within the monthly QAPI meeting held in the facility on December 2017. Quarterly QAPI meetings are held at a regional corporate level according to policy. The facility assessment revealed 24 individuals from October 2016 to Sept 2017 had physical behaviors directed at others. This area should have been actively planned as a hazard in the QAPI program, however, it was not, and an individual was found during survey to have continued to assault other residents without administration intervention. The facility assessment documented under the heading "Resident behavior risked injury to others" answer "No" which was found to be incorrect during survey, however, the corporate office did not know that, and the facility was not involved in the assessment. The facility - wide assessment numbers came from the MDS and quality indicators sent into CMS, which was also found during survey to be incorrect, as individual Resident MDS information was found during survey to be inaccurate. The corporate body would not have known the MDS information was incorrect, as they are not involved in the daily operations of the facility and do not know the resident population. The facility assessment list of competencies required for staff, lists the competencies required to provide competent care and services revealing that the facility staff should have known what types of care and services the Resident population required, however, did not receive, as was evidenced in the deficient practices involving prevention of abuse and neglect, Identifying pressure sores, and identifying hazards and risks	F 867		

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F 867	Continued From page 270 for Residents. Part 3 of the facility assessment describes staffing as; based on the resident populations needs for care and support, and residents receive the minimum direct care staff to meet the needs of the residents at any given time. The document does not state numbers of nursing or direct care staff, stating residents needs and abilities are reviewed to ensure adequate staffing, no qualitative or quantifiable information is given. In the facility- wide- assessment, at area #3, and it's subset areas, the information was vague and not measurable in goal setting. Area 3.6 "Medical practitioners" states; The medical staff meets with the facility staff on a weekly basis at "Risk Meeting" and "QA" (quality assessment) meeting monthly to ensure all residents needs are met." Survey results indicate that residents needs were not met, and if a facility weekly meeting was occurring with the Medical Director, the staff, and the Administration, the facility should have been aware of the issues found during survey, prior to survey. At the time of problem identification, QAPI (quality assurance and process improvement) is mandated to develop and enact plans of correction. If the Administration and Medical director were aware of the issues found during survey, The Administrator and Medical director instituted no changes. The Administrator and DON were asked for any plans of corrections that had been previously written for the areas identified during survey involving harm and immediate Jeopardy to the Resident population. They stated there were none.	F 867		

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F 867	Continued From page 271 A "QAPI plan" policy, and a "Medical Director" policy, were reviewed. The two policies revealed they were not followed. In regard to the "QAPI plan" policy, see below, the following letters (a.), through (h.); 1. (a.) "QAPI Plan" with an initial "effective" date of 10-1-17. The document stated that QAPI data is used to identify quality and safety problems, and to identify opportunities for improvement, while setting priorities for action. (b.) QAPI identifies needs, identifies root causes, and sets goals to change and eliminate problems. The program uses evidence to define and measure goals and develop plans. (c.) The QAPI committee will identify QA and performance improvement needs at; daily and weekly interdisciplinary meetings, and at the QAPI monthly meeting at the facility. (d.) A quarterly QAPI meeting will be held at the regional corporate level. All staff will receive training upon hire and annually on how to bring a concern to QAPI. (e.) The facility will track, investigate, and monitor adverse events that must be investigated every time they occur and action plans will be implemented to prevent a recurrence. (f.) The facility leadership will respond to identified quality and safety concerns by using a performance improvement plan document, developed by the QAPI committee. (g.) "Development of a performance improvement plan; before starting a plan, the solution cannot	F 867		

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F 867	Continued From page 272 be arrived at unless the problem has been thoroughly explored. Many identified problems are systematic and involve multiple departments and processes." First perform a root cause analysis, after identifying the problem, plan for how improvement will be measured, carry out the plan, study what you have learned and then decide what to do next. (h.) "Charter teams (at the corporate level) analyze the root cause, identify priorities, identify if resources exist or are available for the plan, develop the plan, and deliver it to the facility for initiation, they then conduct ongoing review of progress and maintenance after compliance is achieved." Quality and safety concerns were not identified, investigated, nor tracked. No root cause analysis nor action plan was developed, or sent to the corporate level for "Charter team" review. No interventions were implemented in the facility to prevent reoccurrence of; Development of harm level pressure sores, burn hazards, or Resident abuse. In regard to the "Medical Director" policy see below; 2. The second policy was for the Medical Director job description, and "Roles/Responsibilities" which had no effective date, no review date, and no revision date. The document listed 12 policies that the medical director had oversight, and direction for. Of those 12, most were found to be involved in deficient practice and federal citations were written in regard to them. The 12 policies are listed below including some,	F 867		

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F 867	Continued From page 273 not all, references to the federal citations associated with those areas found to be involved in deficient practice. The document revealed; Under the heading "Procedure": I. "Duties of the Medical Director in the facility" Active member of the QAPI committee, and attend meetings at least quarterly, assist the QAPI committee in reviewing and updating existing resident care policies, and the development and implementation of new resident care policies. The Medical Director shall work with the facility to coordinate safe and effective care that may at times, include facility staff." II. "Oversight and direction for facility policies will include, but are not limited to: 1. Admission, transfers, and discharges 2. Infection control, and infection prevention 3. Physical and chemical restraint usage 4. Physician privileges and practices 5. Responsibilities of non-physician health care workers 6. Accidents and incidents 7. Ancillary services 8. Medication use 9. Use and release of clinical information 10. Overall quality of care 11. Ensure appropriate resident care provision through direct oversight and supervision of physician services, and the medical care provided to each resident. 12. The medical Director shall provide peer-to-peer counseling for other physician's/providers within the facility when conflict arises.	F 867		

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F 867	Continued From page 274 The Medical director also was required by policy to review monthly reports, which would contain data based on facility experiences of resident need, involving each of the 9 topics below. These topics included those cited as deficient on this survey at immediate Jeopardy, and harm levels. These areas which should have been captured and included in QAPI meetings, planning, tracking, investigation, and correction, were not, as evidenced by citing the deficient practices. III. Oversight and review: a. The Medical Director shall review the following reports on a monthly basis; 1. Quality Measure Indicator report (QMI) 2. pharmacy reviews 3. infection control 4. safety committee minutes 5. Behavior management 6. Restraint reduction 7. Address wounds concerns 8. Weight/nutrition 9. And other as requested by the QAPI committee or facility leadership. The QAPI documents were reviewed, and revealed discussions on the following topics for each of the 3 months prior to survey.; December 2017 the problem topics discussed for QAPI were - gait belts, shower schedule, unavailable medications, lab and x-ray tracking, CNA (certified nursing assistant) Kardex understanding, abuse neglect training, and CNA's reporting changes in condition leading to re-hospitalization.	F 867		

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F 867	Continued From page 275 January 2018 the problem topics discussed for QAPI were - falls and updating interventions, identifying signs of depression, adding more restorative programs and aids, and ADL decline and referral to therapy. February 2018 the problem topics discussed for QAPI were - pain with facial scale, weights current and completed with same device, new orders and signing the MAR/TAR (medication administration record/treatment administration record) and taking off orders, peri care. and hand washing. On 3-29-18 at the end of day debrief, the Administrator, DON, and Corporate RN were made aware of the failure of administration to effectively implement a QAPI program, and improvements process necessary to provide for the needs of the residents. No further information was presented by the facility.	F 867		